TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	31/3/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

Committee/Group who have received or considered this paper PRIOR TO THIS MEETING		
Committee or Group	DATE	OUTCOME
Executive Management Board	7/3/22	NOTED
Quality, Safety & Performance Committee	24/3/22	NOTED

ACRONYMS	
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams

EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to:

- Share the February extract of risk registers to allow 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.
- Provide the Board with assurance on the steps agreed by the Executive Management Board during this reporting period.
- Outline approach to risk appetite review for May-June.

2 ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Key points for the Board:

Risk Register:

- The action plans for Velindre Cancer Centre and Corporate risks need clearer articulation. This will be prioritised for the risks scoring 20 and 16 for the next reporting cycle. Welsh Blood Service and Transforming Cancer Services risks already clearly articulate actions in their reporting. When this report was received by the Quality, Safety and Performance Committee on March 24th, the Committee placed further emphasis on the importance of this further development.

- Executive Management Board have asked that the Digital Health and Care Record project team review again the calibration of the level of granularity and the scoring of the project risk profile. This will be actioned and reflected in the next reporting cycle.

- The geo-political risks relating to the war in Ukraine are being assessed by the business continuity team, will be reviewed in Executive Management Board and shared with the Board. It may be appropriate that this is reported out of cycle to provide the Board with this analysis before the next meeting.

Implementation of Risk Framework:

- The final stages of implementation of the Risk Framework are dependent on the Policy and the Training being finalised. Once these are complete, the final milestones, particularly from a Welsh Blood Service migration into version 14, can be agreed upon.

2.1 THE TRUST RISK REGISTER

2.1.1 Total Risks

As discussed in the January reporting cycle, there has been a thorough review of the risks, scoring and associated records of management of those risks completed for all risks scoring 15 and above across the Trust.

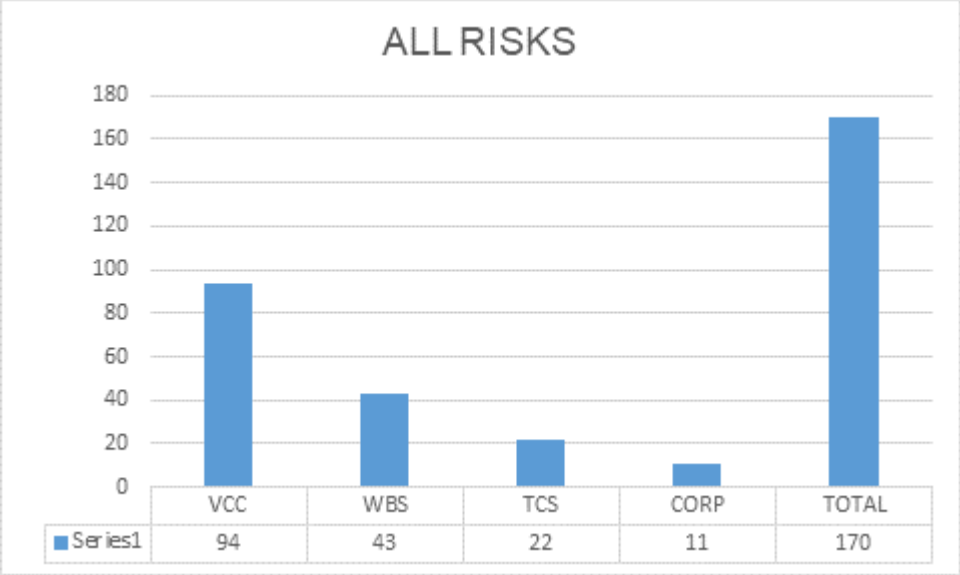
The same in-depth review will now take place for those scored 12 and above, phased over the next couple of reporting cycles.

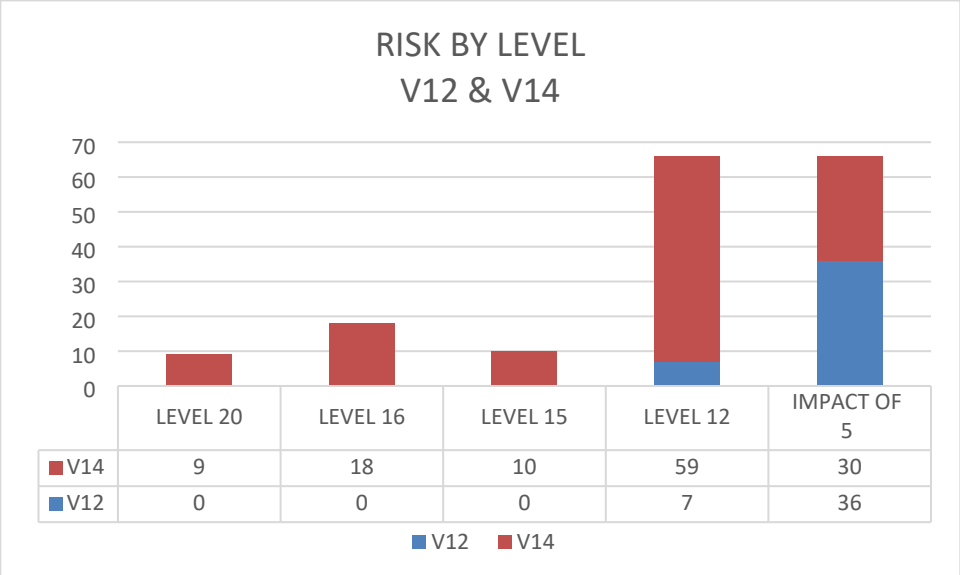
As a result of reviewing the reporting in the weekly risk Trust meetings, the key aspect that has come to light following this review has been that the “actions” field is not being used consistently across departments and divisions. This is going to be a focus for the next reporting cycle. Therefore in this report, the controls column is displayed, to provide some insight into the approach to mitigating the risk. Clearly this needs to be augmented with the specific, measurable, owned and time bound actions that will achieve the target risk score. The completion of this information in this way will be prioritised initially for the 20s and 16 for the next reporting cycle. For the Welsh Blood Service reporting in version 12, this information is clearly displayed in the Senior Leadership Team reporting.

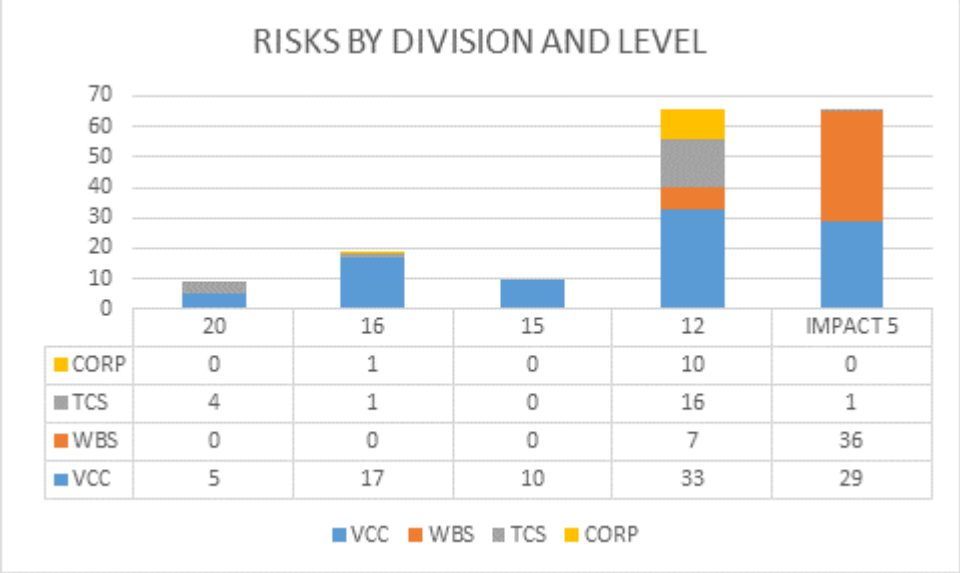
There are a total of 170 risks recorded in Datix Trust Risk Registers, 44 in version 12 and 126 in version 14. This is the same amount of total risks recorded in the February 2022 reporting cycle. The graph below provides a breakdown of the total number of risks by Division.

2.1.2 Risks by level

The graph below provides a breakdown of risks by level across the Trust. A further breakdown of risks by level and Division is also included.


ALL RISKS
180
160
140
120
100
80
60
40
20
0
VCC
WBS
TCS
CORP
TOTAL
Series1
94
43
22
11
170


RISK BY LEVEL
V12 & V14
70
60
50
40
30
20
10
0
LEVEL 20
LEVEL 16
LEVEL 15
LEVEL 12
IMPACT OF 5
V14
9
18
10
59
30
V12
0
0
0
7
36
V12
V14


RISKS BY DIVISION AND LEVEL
70
60
50
40
30
20
10
0
20
16
15
12
IMPACT 5
CORP
0
1
0
10
0
TCS
4
1
0
16
1
WBS
0
0
0
7
36
VCC
5
17
10
33
29
VCC
WBS
TCS
CORP

2.1.3 Analysis of risks

An analysis of risks by level is provided below. Tables provide detail of each risk including risk type, risk ID, review date and title of the risk.

Risks level 25

There are no level 25 risks to report in the March cycle. This is as per the January reporting cycle.

Risks level 20

The table below provides a breakdown of risks level 20. There are currently 9 risks with a current risk rating of 20 recorded, 5 for Velindre Cancer Centre and 4 for Transforming Cancer Services. This compares to 9 in the January 2022 reporting cycle, although there has been some movement within this:

- The risk regarding implications from Brexit has been closed by the Business Continuity Group and agreed by Executive Management Board.
- The Digital Health & Care Record team have reviewed their risk profile and some of the resulting changes are evident in this report:
    - 2206 – Digital Health & Care Record Project – Information Management and Technology Department - Covid-19 Pandemic – has increased from a 12 in January reporting cycle to 20 in March.
    - 2499 – Digital Health & Care Record Project - There is a risk that not all interfaces will be delivered timely for sufficient testing – is a new risk at score 20.
    - Previously risk 2437 was regrading delays in Radiographer graduates starting which has now been closed.
- As referenced in the developments section on page 13 of this report, as agreed in the January committee cycle of Quality, Safety & Performance and Audit Committees, the closure rationale is now a set automatic field to be completed on Datix when a risk is closed. This data is now being collated and will be reported from the system in the next reporting cycle.
- As referenced in the key points summary, in reviewing the risk profile in March Executive Management Board, there was an action agreed to request that the Digital Health & Care Record Project team reconsider the calibration of their scoring and the granularity of their project risk profile.
- Risk 2513 is a new risk with a score of 20; the risk is a Performance and Service Sustainability Risk relating to the number of practitioner's licenses held by staff for prostate brachytherapy.
- Risk 2360 is a new Transforming Cancer Services Programme level risk regarding the interdependencies between projects which was agreed to in the March Programme Delivery Board meeting.

ID	Risk Type	Division	Title	Rating (current)	Rating (Target)	RR - Current Controls
2206	Performance and Service Sustainability	Velindre Cancer Centre	Digital Health & Care Record DHCR003(R) - IM&T Departement - Covid-19 Pandemic	**20**	**9**	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2499	Performance and Service Sustainability	Velindre Cancer Centre	Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testing	**20**	**8**	Pressure on DHCW to provide interface on schedule. Testing window is fixed and protected not used as development contingency

2191	Performance and Service Sustainability	Velindre Cancer Centre	Inability to meet COSC / SCP targets	**20**	**4**	Plans are prioritised by start date to minimise delays. Physics staff are redirected to physics planning during periods of high demand. Weekly RT service capacity and demand meetings monitor position. Increased checkers rostered for a Friday to mitigate Monday starts. Plan to increase capacity is in progress. 4 additional surge posts have been created in treatment planning with recruitment ongoing (2 surge posts filled internally with backfill recruitment active, 2 filled externally but 1 staff member moved Trust).
2200	Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy Capacity	**20**	**6**	Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within department. - Outsourcing to The Rutherford centre for prostate and breast patients is underway. - Changes made to RT Booking processes, and staff flexibility used to maximise use of resources. - Understand and prioritise activities that promote wellbeing in the team. Diverse training sessions held to enhance mindfulness, wellbeing, and resilience. - Review of dose & fractionation, plan complexity and recruitment at clinical trials is being reviewed by SST's and Clinical Director.
2513	Performance and Service Sustainability	Velindre Cancer Centre	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	**20**	**10**	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2400	Workforce and OD	Transforming Cancer Services	Risk that there is lack of project support for Project 5, outreach model development, which could result in impact on the overall clinical model assumptions in the programme.	**20**	**6**	Executive agreement on priority of agreeing final plan and implementation of that. SRO escalation and awareness. To see further detail in new risk 360 below.
2501	Financial Sustainability	Transforming Cancer Services	Risk of inflation leading to increased costs	**20**	**12**	Specific actions reported in private paper, due to commercial nature.
2360	Performance and Service Sustainability	Transforming Cancer Services	There is a risk that as a number of Projects remain 'On Hold' and/or incur delays impacts on interdependencies with projects which are progressing resulting in Programme Master Plan objectives / outcomes being delayed / not being met	**20**	**12**	1) Stocktake of all Projects and Programme to be undertaken 2) Refreshed Project Self-Evaluation toolkit 3) Refresh of Master Programme Plan 4) Review Programme and Project resources /gaps and make appropriate investments where required. 5) Fully implement new ways of working – Velindre Futures & Strategic Infrastructure Board

Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 18 risks with a current risk rating of 16, 1 for TCS, 16 for VCC, 0 for WBS and 1 for Corporate. This compares to 15 in the February 2022 reporting cycle. The three new risks included are:

- A new risk, 2514; relating to out of date Standard Operating Procedures within the Brachytherapy area.
- A new risk, 2454, workforce risk relating to Digital Services Capacity / Skill Mix
- Following the review of Covid-19 related risks, as reported in the extraordinary meeting of the Quality, Safety & Performance Committee in February, there was a new risk, 2505 that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Service.
- The Quality, Safety and Performance Committee questioned that risks 2329 and 2328 have a target risk score the same as current. This is being addressed in the Digital Health & Care Record Project review of their risk profile.

Risks reported from V14:

ID	Risk Type	Division	Review date	Title	Rating (current)	Rating (Target)	RR - Current Controls
2190	Performance and Service Sustainability	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches	**16**	**10**	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2211	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	**16**	**12**	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working
2203	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	**16**	**8**	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.
2221	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	**16**	**12**	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected
2324	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	**16**	**8**	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.

2326	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	**16**	**9**	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2329	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	**16**	**16**	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.
2328	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes of booking/admitting patients	**16**	**16**	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2440	Performance and Service Sustainability	Velindre Cancer Centre	03/03/2022	Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	**16**	**6**	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2454	Workforce and OD	Corporate Services	01/05/2022	Digital Services Capacity / Skill Mix	**16**	**8**	Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.
2193	Performance and Service Sustainability	Velindre Cancer Centre	30/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	**16**	**2**	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).

2196	Performance and Service Sustainability	Velindre Cancer Centre	01/04/2022	Radiotherapy Department -COVID Isolation Impact	**16**	**4**	Ability to work from home with relevant IT equipment on completion of DSE risk assessmentIsolations rules to be reviewed regularly.7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.7/2/2022 - risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.
2345	Performance and Service Sustainability	Velindre Cancer Centre	06/12/2021	Radiotherapy Dept - Change to service due continued response to Covid19	**16**	**1**	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infectionDevelopment of outsourcing contract to private provider to deliver external beam for prostate and breast5/11/2021 - UpdateCurrently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix.Mitigation1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken.2.Undertaking escalation work to minimise breaches.3.SST's being asked to review current dose/# offered to patients.4.Review of trials.5. All vacancies out to advert.6. Outsourcing to Rutherford Cancer Centre.
2505	Performance and Service Sustainability	Velindre Cancer Centre	31/01/2022	Risk that Covid-19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Service	**16**	**6**	-SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full; increased virtual appointments-Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.
2428	Compliance	Velindre Cancer Centre	31/03/2022	There is a risk of increased infection transmission due to poor ventilation.	**16**	**9**	UPDATE 14.02.22 from Mark David - A temporary air con solution will need to be installed for this summer (as per last year setup) with the hope of the ventilation BC being signed off later this Summer.Next steps will be for service to sign off decant plan so it can be included in the BC, this can then be signed off by SMT, EMB and then forwarded on to WG.UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan.* Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc.* Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc.* Full root cause analysis undertaken to ascertain cause(s) of any infections.* Business Case currently under development to seek funding for compliant ventilation system.
2514	Quality	Velindre Cancer Centre	29/04/2022	There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date	**16**	**4**	Following the retirement of the former Head of Brachytherapy Physics, ownership of RT physics documents has transferred to another member of staff who is reviewing SOPs. Similarly a review of documentation is taking place within Radiotherapy

2198	Financial Sustainability	Velindre Cancer Centre	13/12/2021	VCC may face financial loss, legal action, inadequate service provision as a result of no coordinated system for SLAs, contracts	**16**	**6**	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2402	Performance and Service Sustainability	Transforming Cancer Services	31/01/2022	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	**16**	**9**	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment

3. **Development of Risk Framework**

Update on the progress during latest reporting cycle, in particular highlighting the action against feedback received by the Quality, Safety & Performance Committee, Audit Committee and Trust Board in the January reporting cycles:

- **Closure rationale**
    - Datix now has hard coding making rationale for risk closure a compulsory field.

- **Committee mapping of oversight:**
    - Currently Audit Committee, Quality Safety & Performance Committee and Trust Board receive full register.
    - Going forwards, Research and Development category of risks to Research, Development & Innovation Committee. Research and Development risks are reported and Datix currently, therefore specific reports can be developed for the committee.
    - There have been preliminary discussions with the Charity Director regarding the migration of the Charity risk register onto Datix. There is agreement in principle around this action, however a further meeting is planned in March to confirm the process, anticipating completion by end April for incorporation in risk reporting overall.
    - Transforming Cancer Services Programme risks will be continued to be reported to the Transforming Cancer Services Programme Sub-Committee.

- **Private risks** – review underlay and will complete in next cycle – see Private paper.

- **Link to Trust Assurance Framework** – the linkages between the risk and assurance frameworks is scheduled further development over coming months, in line with the further development of the Trust Assurance Framework, for completion and reporting Q3-4 2022/23.

- **Reporting of actions** – as articulated in the key points for the Board, the action plans for Velindre Cancer Centre and Corporate risks need clearer articulation. This will be prioritised for the risks scoring 20 and 16 for the next reporting cycle. Welsh Blood Service and Transforming Cancer Services risks already clearly articulate actions in their reporting.

- **Colours for reporting** of score – formatting changes completed.

- **Articulation of risks** in Datix and way in which summary of title pulls through to this cover paper.
    - All 20 and above risks have been reviewed for WBS, VCC, TCS and Corporate and where appropriate updated on Datix and therefore will be reflected in this report.
    - Level 16 risks have been reviewed and amended on Datix for WBS, TCS and Corporate. The review is still ongoing at VCC and will be completed by the next reporting cycle.

- **Initial view on approach to risk appetite** review for May-June discussed in Executive Management Board.
    - Important to link to strategy discussions and will therefore bring back to next Executive Management Board Shape meeting in April.
    - May want to change a number of the thresholds for risk categories to be more calibrated at 16/15 rather than 12 for reporting residual level of risk to Board level.
    - Executive leads for risk categories will engage with Independent Member leads prior to bringing to Board for sign off and approval.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Is considered to have an impact on quality, safety and patient experience
RELATED HEALTHCARE STANDARD	Safe Care
	If more than one Healthcare Standard applies please list below.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
	Completed for individual risks as appropriate
	Yes (Include further detail below)

LEGAL IMPLICATIONS / IMPACT	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 RECOMMENDATION

The **Trust Board** is asked to:

NOTE the risks level 20 and 16 reported in the Trust Risk Register and highlighted in this cover paper.

NOTE the on-going developments of the trust's risk framework.

ID	Is this a Private & Confidential Risk?	Risk Type	Division	Area	Handler	Manager	Approval status	Service	Opened	Review date	Closed date	Title	Risk (in brief)	Rating (initial)	Rating (current)	Rating (Target)	RR - Current Controls
2187		Performance and Service Sustainability	Velindre Cancer Centre	Medical Physics	Windle, Rebecca	Millin, Tony	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	31/03/2022		Radiotherapy Physics Staffing	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time Example of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. IMPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. IMPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	25	15	5	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.
2419		Safety	Velindre Cancer Centre	External Departments/Areas	Jones, Helen	Buswell, Stuart	Accepted	Operational Services	01/09/2021	31/01/2022		Risk Assessment of Marquee erected outside Out Patients Department	To manage the number of people in the Outpatients Department and to comply with Covid19 2m social distancing requirements additional waiting area space is required. In October 2020 a marquee was erected by County Marquees to provide additional waiting space. The marquee is provided with an electrical supply by the Trust Estates Department. There is a wooded floor covered by carpet. Patients are triaged on entering the marquee and then are able to wait there sitting on socially distanced chairs until it is their turn to enter the department. August 2021 the wooden floor was noted to have become uneven after a patient fell in the area. This is a temporary structure which is likely to remain on the VCC hospital site for some time and will require maintenance and inspection. Hazards identified: Deterioration in the structural condition of the Marquee over time A fault occurring with the structure of the marquee An electrical fault occurring within the marquee The marquee being damaged by inclement weather, antisocial behaviour or other damage	12	12	3	Bollards have be put in place to protect the marquee and people walking near it from being struck by vehicles. A hedge has been removed and replaced by concrete to increase the turning circle in the road adjacent to the entrance to the Out Patients Department. The edge of the flooring in the marque is demarcated with batons and high visibility tape. The marquee is fitted with fire detection and is situated 2m from the main building. Additional control measure are required to maintain and monitor the condition of the marquee.
2475	N	Performance and Service Sustainability	Velindre Cancer Centre	No Further Coding Required	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Whole Service	19/11/2021	31/03/2022		A risk that increase in COVID and the Winter pressures period potentially impacts Int. Care project delivery	COVID-19 and Winter Pressures - A risk that increase in COVID-19 pressures and the Winter pressures period potentially impacts project delivery Cause: Increase in demand that requires project resource to focus solely on clinical work Increase in staff sickness leading to gaps in capacity/back fills requirements/prioritisation of clinical requirements	16	12	8	Update 14.02.22 - Most projects have continued with minimal impact from staff absence. Progress of projects is closely monitored by the PMO office and weekly meetings take place with the Project Manager and IC service staff Update 10.12.21 - Regular meetings continue to take place with PMO to review status of projects and work plan. Activity monitored via the ICOG and sickness levels monitored by HODs. Mitigating actions: 1. Monitor staff sickness through the IC Operational Group 2. Monitor increase in demands via IC Operational Group 3. Update PM with resourcing issues for further escalation and re-prioritisation. Logged as a Project risk also for Integrated Care as may impact on project work streams
2523	N	Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Baker, MRS Kate	Baker, MRS Kate	New risk	Therapies	24/02/2022	18/03/2022		A risk to the delivery of the Physiotherapy Gynae-Oncology service	With monies successfully secured from Velindre Charitable Funds, and more specifically the Rhian Griffiths Forget Me Not Fund, a 0.8 FTE 3-year trainee Advanced Practice Gynae-oncology Physiotherapist role was recruited into in April 2020 with the primary aim of helping women to manage side effects from their cancer treatment. The staff member in post in unfortunately off work sick for at least the next month (4 weeks). The role is a single point of failure as we do not have any other physiotherapists who are trained in gynae-oncology to be able to review the patient caseload. Therefore the service will be put on hold for this period of time. The interventions provided for these patients can't be seen in general physiotherapy outpatient clinic due to the specialist nature of interventions delivered.	12	12	6	The VCC Gynae team are made aware of the service being put on hold for the time period of 4 weeks with the potential this may increase. Any new referrals to the physiotherapy clinic will be received and a waiting list letter sent to the individual patients
2503	N	Compliance	Velindre Cancer Centre	No Further Coding Required	Johnston, Sam	Gallop-Evans, Eve	Accepted	Medics	14/01/2022	01/02/2022		ALS Training Compliance	CTUHB have made the decision to cancel their Feb and March 2022 ALS training courses for external attendees. A number of SHO's, Registrars and Consultants who were booked on the course or have training expiring in the near future will be effected. This carries the risk of immediately impacting service such as the On Call rota for existing VCC staff. This will carry further impact when Junior Doctors join VCC as part of the next rotation. Junior Doctors are required to be ALS trained to enable them to work on the wards and assessment unit. Backlogs in training expired medical staff could result in further medical staff being out of compliance in the near future.	12	12	3	Business team has contacted the Resuscitation Council to query extension periods during COVID times. Made contact with Malcolm Jones, First Response Medical Training Ltd. with whom Nursing have an SLA contract to organise an additional training session for medical staff. Potential to undertake a RA to extend current compliance in the absence of future training courses, needs to be agreed and signed off by SLT.
2253	N	Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	27/10/2020	01/05/2022		Availability of CANISC System	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	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports - Paper Radiotherapy Workflow (IRMER) - Manual Registration - new patients on Chemocare - Manual Registration - new patients on Aria and Mosaiq - Availability of Clinical correspondence created at VCC in Document Management System (DMS) from April 2019 that feeds into Welsh Clinical Record Service (WCRS) - Access to paper record that holds inpatient documentation, charts etc
2190		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Payne, Mrs Helen	Powell, Emma	Accepted	Radiotherapy Services	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	16	16	10	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes
2511	N	Workforce and OD	Velindre Cancer Centre	No Further Coding Required	Johnston, Sam	Gallop-Evans, Eve	Accepted	Medics	28/01/2022	28/02/2022		Calculation of Medic A/L allowances	There is a risk that part time consultant A/L entitlements have been calculated incorrectly as a result of business processes which may lead to numerous risks including financial, reputational and compliance. A part time consultant queried that their A/L entitlement was incorrect due to the incorrect B/H A/L entitlement being issued. This was investigated by the medical business team and identified that the B/H A/L entitlement hadn't been included within the consultants A/L entitlement. Further investigation identified this wasn't an isolated case and that numerous part time consultants B/H entitlements were not included in the overall A/L. Other peripheral issues have been identified around medic A/L allocation and processes such as full time medics not being allocated or booking B/H A/L via the Intrepid system resulting in no audit trail or governance. Certain medics having various contractual arrangements without formal documentation (SLA/secondment documentation) in place detailing whose responsibility it is for A/L to be calculated and allocated by. This may lead to issues with up and coming guidance in relation to carryover/sell back of A/L.	12	12	2	Business team have added the risk to the directorates risk register. Business team have contacted and sought advice and support from WF colleagues. Business team have communicated has escalated the issue identified to the CD, MD and Director of Cancer Services Business team are currently exporting and requesting data to identify all part time medics who may be affected. Working group have met to discuss and identify all scenarios which could be present and affect medic A/L entitlement i.e. B/H allocation, contractual changes (years of service, role). WF currently reviewing contractual obligations and case law which is relevant. Working group have met to discuss current process, information sources and initial plan to resolve. Working group to develop SBAR detailing the above information for SLT. Raised for discussion at JLMC for discussion. --
2205		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Johns, Dewi	Wilkins, Paul	Accepted	Digital Services	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. No longer applicable - can be removed	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2202		Workforce and OD	Velindre Cancer Centre	Velindre Hospital	Sully, Nicola	Gallop-Evans, Eve	Accepted	Medics	23/02/2021	01/02/2022		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a career break in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	20	12	4	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.

2189		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Tranter, Bethan	Tranter, Bethan	Accepted	SACT	15/04/2020	01/05/2022		Covid - SCT - VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic	VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic As a stand-alone cancer centre, VCC has a vital role to play in ensuring continuation of essential cancer services throughout the pandemic and effective and rapid recovery of services afterwards. This will be essential to prevent worsening cancer outcomes from occurring as 'collateral damage' from the pandemic. VCC will be a 'cancer treatment hub' for the population of South-East Wales during the COVID-19 pandemic. Systemic Anti-Cancer therapy (SACT) is a highly effective cancer treatment, which can be given to cure cancer as primary treatment (with or without radiotherapy), to reduce the risk of relapse (after surgery) and to palliate symptoms and reduce complications. It is imperative that this service continues as comprehensively as possible throughout the pandemic and beyond. Clinical/Medical oncologists, pharmacists and nurses with SACT competencies are highly specialist NHS staff who will continue to utilise their skills throughout the pandemic to treat cancer patients. As the Covid-19 pandemic changes through the three identified phases (Acute phase (early & late pandemic), Recovery Phase (early & late recovery) and Reactivation Phase), there is a risk that VCC will be unable to match capacity with demand for SACT Services. This would result in patients being unable to receive the cancer care they require in a timely manner	20	12	9	Document providing strategic oversight of core documents produced by the Velindre Cancer Centre (VCC) SACT Strategic Group (SSG) and national bodies during Covid-19 and beginning to explore future adaptation to these as the risk from the pandemic changes, as well as a perspective on the recovery phase as the pandemic wanes - submitted to Silver Command 24.04.20 (Velindre Futures plan for SACT through COVID-19_Final Version 1.1 April 27 2020.docx) It is assumed that this evolution will happen over approximately six to nine months (March to December 2020), although the timings may vary. It is also accepted that there will be peaks and troughs in demand over this period so we need a system that will be agile. The aim is for VCC to be able to deliver a centralised, high quality, specialised SACT service, adapting quickly to the needs of cancer patients / services in SE Wales whilst minimising patient harm. VCC Futures: SACT Operational Plan currently in the final stage of production. This plan details options for how VCC will be able to operationally manage demand through the Recovery phase of the pandemic. Recovery of the SACT service is dependent on multi-professional capacity across the whole of Velindre Cancer Centre. In early Recovery, VCC will endeavour to adequately manage the predicted surge in demand for SACT Services and: A - Re-start SACT treatments that have been deferred in whom therapy is still appropriate (will need clinical review) B - Continue to deliver SACT in place of surgery for patients who cannot have surgery, as listed in the early phase plan C - Continue use of all adapted SACT regimens implemented during phase 1 and 2 of the response, to manage demand on the SACT service, until a phased adaptation is possible without impact upon new or existing patients D - Re-initiate outreach daycase services potentially following a different model, key areas to be considered. E - Embed changes to models of pre-SACT assessment clinics made during the peak of the COVID-19 crisis and to build on these through progress of the Virtual Assessment Pathways (VAP) project and continued SST leadership. 01.08.20 - Strategic and Operational papers have been approved. Pace of recovery has been unable to match demand with resultant impact on service. This is likely to be an ongoing issue and is included on the SACT SG general register Update - 29.10.20 - As we enter the second wave of COVID-19, demand is exceeding capacity and the number of target breaches has increased. PCH Outreach Unit now re-opened for 3 days a week and the MAH Parenteral Service on the Mobile Unit is being expanded as of November to help ease capacity issues - likelihood score raised from 2 to 3 Update - 12.01.21 - Mobile Unit with 3rd party provider service expanded to 2 days per week from mid-December. Proactive systems of SACT escalations introduce to manage urgent new referrals and on treatment demand. Current performance including and demand and capacity closely review in light of increased community incidents and effect impact on staffing service Update - 23.06.21 - Funding for SACT Surge approved and staff recruitment in progress. Timescales for recruitment will determine date for opening Outreach Unit at NHH - currently estimated as Sept / Oct 21 in coordination of obtainment of trained SACT staff - key pieces of work currently progressing to enable this
2504	N	Safety	Corporate Services	Infection Control	Wright, Lenisha	Fear, Lauren	New risk	Whole Service	18/01/2022	31/01/2022		Covid-19: Changing profile of Covid-19 infection risk, impacting our patients, donors and staff	Response to COVID-19 and the controls that need to be put in place. The Action plan: -Finalise operational review of Clinical Principles, including trigger points --governed through Gold 13.12.2022 via: -Strategic clinical advisory group -WBS risks based social distancing paper to be completed and approved	20	12	6	-Re-establishing command structure -Clinical governance strengthened, with establishment of Strategic Clinical Advisory Group at Gold level and Clinical Development Group at Silver level -Covid Cell established -Decision making framework refreshed, approved by Trust Board and reinstated -Changes to Board and Executive Meeting Structure, including increase frequency of Quality, Safety & Performance Committee
2480	N	Workforce and OD	Velindre Cancer Centre	No Further Coding Required	Sully, Nicola	Button, Mick	Accepted	Medics	23/11/2021	01/02/2022		Current and predicted shortfall of oncologists by 2025	A recent census (RCR 2021) has predicted a shortfall across Wales in clinical oncologists by 2025. Medical oncologist were not included in the census but should also fall under this risk due to overlapping clinical roles. There is a current shortfall with predictions that this will worsen over the next 5 years (NB this is likely to be a gradual worsening over a period of time; the census predictions only go up to 2025 so no data suggests sudden improvement after that time). Due to the nature of clinical work, these gaps may fall unevenly, for example one team/tumour site could be seriously affected while others are not. Drivers behind this are: increasing clinical care/complexity (increase in patient numbers, increase in treatment options/complexity for each patient), new demands (eg regional AOS delivery), increasing trend to LTFT working and predicted retirements. On top of this there are potential impacts from Covid (ill health), pension tax impact. This is likely to lead to: difficulties seeing new patients on time, managing all aspects of care (OP review, SACT, RT), delivering a regional model of care, supporting new areas such as AOS, impact on clinician health, wellbeing and teamworking. It may also impact on non clinical roles, ability to recruit/retain staff. Recruitment is challenging as this shortfall will be felt across the UK. Due to the nature of clinical work, finding backfill through re-allocations of individual sessions is challenging.	15	15	4	Training places have increased however will not feed through by 2025. Actively seeking to recruit Developing new multi-professional ways of working (but there are also workforce limitations in other professional groups and the time taken to train new colleagues is a challenge)
2395		Safety	Corporate Services	Estates Management	Fear, Jonathan	Fear, Jonathan	Accepted	Quality and Safety	26/05/2020	01/10/2022		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	15	12	9	1.As noted above, site has holistic fire strategy where compartmentation plays a key role 2.Site has high level of fire detection to WHTM 05 (Firecode) 3.Provision of fire safety training to support implementation of fire safety strategy 4.Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5.Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6.In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7.Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8.Consideration of fire risk assessment findings (including compartmentation issues) as part of Capital Refurbishment schemes.
2223		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Bell, Mrs Tracy	Miller, Lisa	Accepted	Operational Services	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	12	12	12	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards
2185		Safety	Velindre Cancer Centre	Radiotherapy	Windle, Rebecca	Johnston, Sam	Accepted	Medics	14/09/2020	31/03/2022		Delination Risk treatment delay (16284)	There is a risk of Radiotherapy physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. There is a lower risk that errors are missed at physics check and make their way to treatment. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced Clinical Scientists at final physics check, often the day before treatment. There have been a number of Datix incidents attributed to this - with Radiotherapy Physics previously trying to communicate the issues. Action is required to ensure these errors do not propagate to treatment.	12	12	6	Discussions, initiated by physics, have been held at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites). A physics quality improvement project categorised the errors - this information is available for learning. Further controls required – ensure volume peer review is in line with RCR recommendations and a Datix medic representative is available to ensure learning within medical teams. Also consider transferring PTV volume growth to the physics team.
2224		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Bell, Mrs Tracy	Miller, Lisa	Accepted	Operational Services	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	16	12	16	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.
2206		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	09/10/2020	03/03/2022		Digital Health & Care Record DHCR003(R) - IM&T Dept - Covid-19 Pandemic	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. DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/ demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	20	20	9	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.
2211		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	09/10/2020	03/03/2022		Digital Health & Care Record DHCR004(R) - Requirements for Standardisation process redesign & agreed Ways of Working	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. 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. 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	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working
2296		Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	11/01/2021	03/03/2022		Digital Health & Care Record DHCR010(R) - Data Migration Resource	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. DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided support/guidance in a timely manner.	15	15	6	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.
2203		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Rodgers, Suzanne	Accepted	Digital Services	12/01/2021	03/03/2022		Digital Health & Care Record DHCR013(R) - Accelerated Timelines of the DHCR Programme	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. DHCR013(R) - Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc instance for a longer period of time.	16	16	8	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.

2221		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Norman, Sarah	Accepted	Health Records	24/02/2021	03/03/2022		Digital Health & Care Record DHCR019(R) - Clinical Coding Copy Functionality within WPAS	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 eRMER 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	16	12	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected
2512		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Evans, Fran	Lloyd, Gareth	Accepted	Whole Service	02/02/2022	03/03/2022		Digital Health & Care Record DHCR022(R) - Business Continuity Risk following Implementation	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 order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. 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	DHCW to develop a solution as this would have an effect on every HB when they have an Electronic Patient Record
2324		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	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. DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	16	16	8	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.
2325		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	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 of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	20	12	8	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics
2326		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Evans, Fran	Stockdale, Ann Marie	Accepted	Operational Services	24/05/2021	03/03/2022		Digital Health & Care Record DHCR030(R) - Service unable to significantly reduce the capacity of clinics over the Go-Live period	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. 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	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.
2329		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Administration (inc Bookings)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	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	16	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.
2328		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	09/06/2021	03/03/2022		Digital Health & Care Record DHCR035(R) - SACT & Medicines Management – processes of booking/admitting patients	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. DHCR035(R) - The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	16	16	16	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role
2432	N	Workforce and OD	Velindre Cancer Centre	Information and Technology	Evans, Fran	Seary, Sarah	Accepted	Whole Service	05/10/2021	03/03/2022		Digital Health & Care Record DHCR036(R) - DHCR Project Support from Service	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services. 1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care. 2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation.	16	12	4	Update 14.02.22 - Monthly Project Group meetings taking place along with fortnightly Inpatient meetings. Process Maps now completed and signed off by service. Currently looking at resources that may be required to support the new ways of working. Update 10.12.21 - Regular meetings continue to take with project leads. Ways of working almost completed for IC. Some process maps completed and signed off by service. Update 03.11.21 -Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings. Update 27/10/2021 -Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Leads to monitor progress in DHCR project, but also to sense check the demands of the services.
2440		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Tranter, Bethan	Accepted	SACT	18/08/2021	03/03/2022		Digital Health & Care Record DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	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. 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 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	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints 23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.
2498		Performance and Service Sustainability	Velindre Cancer Centre	Chemotherapy Day Unit (CDU)	Evans, Fran	Lloyd, Gareth	Accepted	Digital Services	11/01/2022	03/03/2022		Digital Health & Care Record DHCR050(R) - There is a risk that Chemotherapy treatment information is not sent to Canisc post go	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. DHCR050(R) - There is a risk that Chemotherapy treatment information is not sent to Canisc post go live. During cutover this interface will be redirected to WCDS and WCRS. However it has been questioned whether this feed would still be required in Canisc, post DHCR golive i.e. would Chemo treatment information still be required for RT and Palliative Care (viewable in Canisc). The assumption would be that as the information would be available as a PDF in WCP, like the other results feeds, if we can get them elsewhere, let's turn the feed off. Additional development/cost maybe CIS,the ChemoCare, provider do not support multiple feeds, InSe would need to do additional work do send messages to multiple systems.	15	15	1	Two decisions required. 1. Turn off the interface (on the proviso that the results are available via PDF in WCP). 2. When should the interface be turned off – a.Precut over with suggested date. b. during cutover c. defined date post cutover
2499		Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Evans, Fran	Lloyd, Gareth	Accepted	Digital Services	11/01/2022	03/03/2022		Digital Health & Care Record DHCR051(R) - There is a risk that not all interfaces will be delivered timely for sufficient testin	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. DHCR051(R) - There is a risk that not interfaces will be delivered in a timely manner for sufficient testing. * Clinical information will not be available in WCP/WPAS. * VCC runs a clinical safety risk if data is not available for decision support. *Not enough time will be available to provide adequate assurance.	20	20	8	Pressure on DHCW to provide interface on schedule. Testing window is fixed and protected not used as development contingency
2438		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Evans, Fran	Ikin, Kathy	Accepted	Radiotherapy Services	21/06/2021	03/03/2022		Digital Health & Care Record Risk DHCR043(R) - Completion of process maps and ways of working	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. DHCR043(R) - Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource.	20	12	9	Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input
2454	N	Workforce and OD	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Digital Services Capacity / Skill Mix	There is a risk that the Digital Services team are unable to support agreed Divisional and/or Trust strategic and operational objectives as a result of limited capacity within the team, which may lead to a delay in the delivery of new / updated digital services.	20	16	8	Regular review of IT work plan, to ensure delivery is aligned to Trust / Divisional priorities. VCC and WBS IT work plans regularly reviewed, to be shared via relevant channels (BPG, SMT/SLT etc.). 'Agile' utilisation of Digital Services resource, to ensure focus on prioritised work.

2461	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/01/2022		Failure of Building Management System (BMS)	There is a risk of failure to the Building Management System (Trust wide). This is for multiple reasons including being run on legacy operating system (Windows 7), no patch management and faulty hardware - this has led to multiple issues previously.	12	12	4	No controls relevant to suppressing the risk. Machine either requires upgrading, replacing or migrated to a virtual machine.
2394		Performance and Service Sustainability	Corporate Services	Executive Management Team	Wright, Lenisha	Fear, Lauren	Accepted	Governance	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	12	12	3	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits for patients and carers.
2191		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Maggs, Rhydian	Ikin, Kathy	Accepted	Radiotherapy Services	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	There is a risk of poor compliance against COSC time to treat targets, potentially affecting patient outcomes and Trust reputation, due to inefficiencies in the current pathway and staffing issues. Staffing risks are raised separately for RT Physics, Radiotherapy and Medical directorate.	20	20	4	Physics mitigation described below: Plans are prioritised by start date to minimise delays. Physics staff are redirected to physics planning during periods of high demand. Weekly RT service capacity and demand meetings monitor position. Increased checkers rota'd for a Friday to mitigate Monday starts. Plan to increase capacity is in progress. 4 additional surge posts have been created in treatment planning with recruitment ongoing (2 surge posts filled internally with backfill recruitment active, 2 filled externally but 1 staff member moved Trust).
2393		Safety	Corporate Services	Health and Safety	Evans, Annie	OBrien, Cath	Accepted	Quality and Safety	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex.	12	12	9	To be inserted
2397		Safety	Corporate Services	Health and Safety	Evans, Annie	Evans, Annie	Accepted	Quality and Safety	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1.Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2.Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3.Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4.There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service improvement in clinical audit.	16	12	9	Control Measures in place: 1.Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2.Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks
2452	N	Performance and Service Sustainability	Velindre Cancer Centre	Information and Technology	Mason-Hawes, David	Daniels, Gareth	Accepted	Digital Services	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	15	12	3	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.
2456	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Lack of agreed software development standards	There is a risk that internal / 3rd party software development activity will fail (or be difficult to support) as a result of a lack of agreed software development standards, which may lead to inconsistent approaches to delivery of new software applications Outdated policies and procedures to support software development practices and processes within WBS have resulted in audit failures and the development of software products outside of existing procedures.	16	12	4	Currently software development follows existing guidelines. A Temporary SOP has expired but this is also being followed. Where possible peer review establishes validity of developments and stringent User Acceptance Testing is always followed.
2457	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Mason-Hawes, David	Accepted	Digital Services	29/10/2021	01/05/2022		Lack of dedicated web / SharePoint development resource within Digital Services	There is a risk that priority strategic / operational web / SharePoint developments cannot be supported as a result of a lack of dedicated web / SharePoint development resource within the Digital Services team, which may lead to a degradation of existing VUNHST websites and/or an inability to develop new website / SharePoint content to meet service needs. Current web development being managed on an ad-hoc basis by WBS Digital Services staff and Corporate Communications team. No dedicated full time support available to be responsive to the demands of the service	12	12	3	Ad-hoc support by trained individuals.
2254		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Fear, Jonathan	Wilkins, Paul	Accepted	Estates	16/06/2020	01/07/2022		Lack of mechanical ventilation at the VCC site (including inpatient ward areas)	This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms	12	12	4	Taking each of the three key elements of the risk: 1.Increased potential for infection due to sub-optimal ventilation •Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months). 2.Staff and patient discomfort in warm weather due to sub-optimal ventilation •Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer. •An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan •Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and mattresses for patients. 3.Non-compliance with Health & Safety standards due to sub-optimal ventilation across the VCC site •In order to address the sub-optimal ventilation at VCC, an external specialist been commissioned to provide recommendations to feed into the business case.
2252		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Staffurth, Mr John	Miller, Lisa	Accepted	Whole Service	14/09/2020	01/04/2022		Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR
2222		Performance and Service Sustainability	Velindre Cancer Centre	Outpatients	Arndel, Karen	Gent, Carolyn	Accepted	Nursing	07/11/2017	31/03/2022		Loss of CANISC - compromise patient care	There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy.	16	12	12	Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held of local infrastructure – SACT prescribing, dispensing and delivery can continue
2193		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Hooper, Sue	Ikin, Kathy	Accepted	Nuclear Medicine	05/02/2021	30/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk is that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT MPE cover within Nuclear Medicine for MRT has been extremely stretched for a number of years. There has been a large reliance on a single point of failure, for several molecular radiotherapies within Nuclear Medicine. An additional MPE was appointed in November 2018 but the individual appointed had no previous experience in radionuclide therapy (MRT). A temporary solution was implemented to provide MPE support for Ra223 by two individuals not employed within Nuclear Medicine. That offer of support was withdrawn (Jan 2021). Some experience has now been gained by the individual appointed in 2018 but there is now a requirement to provide back-up to that MPE (for Ra223). This is not feasible for the experienced MPE, who is already working in breach of working time directive and trying to respond to a predicted increase in MRT in the next 1-2 years at VCC. (This increase includes repatriation of a therapy to Cardiff from London, a potential large increase in prostate MRT 2022/23 (if NICE approved), personalised dosimetry for MRT patients to comply with legislation and involvement in a clinical trial). Wales is already behind England in implementing some of these treatments into routine clinical care, due to a lack of resilience in MPE support in recent years. Current predictions for MRT is that there will be an 18% compound annual growth (Journal of Clinical Oncology -Feb 2021).	20	16	2	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).
2258		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Walters-Davies, Rhiannon	Tranter, Bethan	Accepted	SACT	17/05/2021	28/02/2022		Medicines at Home Service:	There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities. There is a risk to financial sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been avoided OR because of lack of strategic leadership to continue to grow the service. There is a risk to patient experience and patient outcome if the benefits of released SACT service capacity provided via the Medicines at Home Service (oral and parenteral) cannot be maintained and increased There is a risk to VCC reputation because of an inability to progress action plan from RPS audit There is a risk to patient safety because of limited capacity for engagement by medical or nursing to review incidents, learn lessons and instigate remedial actions to reduce the likelihood for future reoccurrence There is a risk to patient safety because of limited resource within current team to review to manage oversight of all complaints and incident	16	12	4	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision
2396		Performance and Service Sustainability	Corporate Services	Executive Support Team	Morley, Sarah	Morley, Sarah	Accepted	Workforce and OD	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.
2255		Financial Sustainability	Velindre Cancer Centre	Private Patients	Stockdale, Ann Marie	Miller, Lisa	Accepted	Private Patients	24/02/2021	31/03/2022		Private Patients Debt	An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791.	12	12	4	1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance. 2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings. 3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement. 3. Meeting arranged to discuss automation of process options. 4. Private Patient Manager to benchmark systems with other organisations. 5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process. 6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process. 7. Regular meetings with Private Patient Manager and corporate Finance lead to be established.

2200		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Jenkins, Paul	OBrien, Cath	Accepted	Radiotherapy Services	01/05/2011	31/03/2022		Radiotherapy Capacity	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 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. 23/11/2021 - Update 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. Any delay in the development of the radiotherapy Satellite centre will significantly limit capacity within the radiotherapy service	20	20	6	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to maximise use of resources. Project to be commenced to address ongoing capacity led by COO. Implementation of the above measures will not mitigate this risk- further measures required from escalation to Trust board 22/4/20 - We have sufficient capacity at this moment in time due to covid. We have taken 2 linacs out of routine use. One due to it acting as the machine for treating covid + patients, the other is removed as we have halted treating prostate patients. We are working 7-7 shifts on one machine to compensate for the large amount of H+N patients being treated at present. 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches. 3.SST's being asked to review current dose/# offered to patients. 4.Review of trials. 5. All vacancies out to advert. 6. Outsourcing to Rutherford Cancer Centre. 23/11/2021 Update - Ongoing monitoring of capacity, demand breaches and waiting times targets. Development of breach escalation process to ensure, where needed patients are prioritised effectively. - Extended working hours are in place on the treatment machines and in many other areas of service. - Agency Radiographers are in place to support additional hours. Assessment of potential Agency staff experience at point of hire to ensure that Agency staff are able to rotate around more than one work area / linac type / OMS type within
2196		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Payne, Mrs Helen	Payne, Mrs Helen	Accepted	Radiotherapy Services	14/09/2020	01/04/2022		Radiotherapy Department - COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	16	16	4	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 7/2/2022 - risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.
2345		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Payne, Mrs Helen	Payne, Mrs Helen	Accepted	Radiotherapy Services	14/09/2020	06/12/2021		Radiotherapy Dept - Change to service due continued response to Covid19	There is a risk that there will be a continued change to service as a result of Covid 19 measures which may lead to contraction of the service and the creation of a waiting list As the service moves in to the recovery phase there is a continued risk of the availability of staff being impacted through infection prevention and control measures, thus potentially impacting on the service ability to deliver the required capacity to meet demand 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. □	9	16	1	Continuing to work through recover phase towards business as usual. Covid contingency plan in place to be deployed if required, ie, deferral of benign, prostate monotherapy, prostate external beam and skin if necessary 'Pod' working in place across radiotherapy clinical delivery service to minimise risk of cross infection Development of outsourcing contract to private provider to deliver external beam for prostate and breast 5/11/2021 - Update Currently we have insufficient capacity to meet demand. The number of hours available is restricted due to safe staffing and skills mix. Mitigation 1.Department is currently working under business continuity, with 2x weekly meeting with SLT, Radiation Service and Radiotherapy Service managers to discuss departmental position and actions being undertaken. 2.Undertaking escalation work to minimise breaches. 3.SST's being asked to review current dose/# offered to patients. 4.Review of trials. 5. All vacancies out to advert. 6. Outsourcing to Rutherford Cancer Centre.
2361		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Jenkins, Paul	Jenkins, Paul	Accepted	Radiotherapy Services	12/06/2020	01/04/2022		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	16	12	2	21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – Risk reviewed CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service. 7/2/2022 – Risk reviewed CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue, to ensure safety of staff, patients and the radiotherapy service.
2502	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/01/2022	01/03/2022		Risk of delay to start on site	There is a risk that the start of construction is delayed beyond the date stipulated in the outline planning permission decision notice 17/01735/MJR (27th March 2023), leading to delays to the project and a possible loss of planning permission.	12	12	4	1. Submit section 73 application to extend the date by which start on site must occur, to reduce the impact of any delays to the start of construction. Started 2. Regular monitoring and management of other projects/workstreams which may affect start on site date including enabling works and nVCC procurement. Ongoing
2501	N	Financial Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/01/2022	04/03/2022		Risk of Inflation leading to increased costs	There is a risk that increased rates of inflation lead to the capital costs of the project exceeding the affordability envelope.	20	12	12	1. Paper on affordability submitted to WG. Ongoing
2401	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	26/02/2021	03/03/2022		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	16	12	8	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)
2407	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Hague, Andrea	Accepted	Radiotherapy Satellite Centre	17/01/2020	20/05/2022		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	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	12	4	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline
2249		Financial Sustainability	Velindre Cancer Centre	Finance	Wilkins, Paul		Accepted	Operational Services	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instability,recruitment difficulties	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	12	12	4	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date
2402	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	10/05/2021	31/01/2022		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	16	16	9	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment
2424	N	Safety	Velindre Cancer Centre	Therapies Areas	Baker, MRS Kate	Baker, MRS Kate	Accepted	Therapies	28/07/2021	25/02/2022		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the vacant post. For the next 2-3 months, there will not be the required capacity to deliver a high quality, timely DT service. This will lead to breaches of waiting times, reduced patient experience and outcomes and stress on the remaining staff members. We are currently trying to recruit a Locum to cover this period however at present we are unable to secure one.	12	12	6	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway
2416	N	Quality	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	20	12	6	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress

2505	N	Performance and Service Sustainability	Velindre Cancer Centre	Human Resources	Wright, Lenisha	Miller, Lisa	Accepted	Whole Service	18/01/2022	31/01/2022		Risk that Covid 19 related absences for staff could significantly impact on ability to provide core SACT and Radiotherapy Servic	Further focus on demand and capacity modelling, linked to current action plan – subject to Gold review 19th January	20	16	6	-SACT staffing - realignment from wards, senior staff deployed, RD&I capacity utilised to full; increased virtual appointments -Radiotherapy - major limitations on capacity due to reduction in workforce but maintaining service with increase in breaches with prioritisation based on clinical need; Changes made to Prostate pathway based on agreed framework; maximising third party provision.
2507	N	Safety	Velindre Cancer Centre	No Further Coding Required	Wright, Lenisha	Miller, Lisa	Accepted	Medics	18/01/2022	31/01/2022		Risk that current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	current regulations in Wales regarding isolation has impacted on patients being able to commence treatment	16	16	9	-Research underway into practices nationally conducted via Silver Command for reporting into Gold -Finalise recommendation for Gold decision, as appropriate, on any changes
2403	N	Quality	Transforming Cancer Services	No Further Coding Required	Pinocci, Francesca		Accepted	Enabling Works	08/06/2020	04/03/2022		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	12	12	9	1. Regular review of possible areas which may cause delay: Most recent review of the plan shows only minimal slack between the end of the enabling works construction and beginning of MIM construction Ongoing 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. Scaling delay damages clause added to tender documentation to ensure contractor is incentivised to complete work on time. Complete 3. Focus to be applied to detailed construction programme following return of EW D&B bids. Complete
2423	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	08/09/2021	03/03/2022		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	12	12	6	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project
2408	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Bryce, Gavin	Accepted	Integrated Radiotherapy Solution	22/04/2021	03/03/2022		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	16	12	8	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing
2389	N	Safety	Velindre Cancer Centre	Therapies Areas	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Therapies	28/05/2021	25/02/2022		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	12	12	6	Update 10.12.21 - Recruitment underway for a Head & Neck Advanced Nurse Practitioner with interviews taking place w/c 13.12.21. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level • Advice available from PSU nursing team Mon-Fri in basic competency levels - needs scoping as there is potential for enhancing straining and assessment through this service. •Ward Nursing staff – some basic skills – training needs analysis needs to be completed •H&N CNS and consultant radiographer – skills need scoping but these work Mon-Fri, what are the opportunities for cover across the 7 days? •Training being sourced by nurse education lead •Group 2 & 3 patients •Recent survey of competencies of VCC physios (available on request) with an action plan for roll out to the other disciplines •Establish competencies and work out how best to complete/maintain them •Link with Pall Care to determine a clearer pathway for when suction is required •Benchmark as to what other areas do, i.e. Rookwood, Hospices, Cancer centres. •Explore research further to identify clear precautions/contraindications for certain respiratory techniques for oncology patients •Link with C&V physios and critical care team to access competency based training. •Staff competencies across the organisation to be scoped and potentially access the C&V training for all. •Re-instate the Altered Airways training for clinical staff asap
2405	N	Quality	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	16	12	6	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.
2413	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Hague, Andrea	Accepted	Radiotherapy Satellite Centre	29/06/2020	30/06/2022		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	15	12	6	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.
2418	N	Reputational	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Fear, Lauren	Accepted	Programme	05/10/2020	14/01/2022		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	16	12	4	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitement of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG 8) Monthly meeting with WG Head of Capital and Director General - ongoing
2400	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Williams, Nicola	Accepted	Transforming Cancer Services	30/06/2020	31/01/2022		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2417	N	Reputational	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Fear, Lauren	Accepted	Programme	08/07/2020	14/01/2022		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	12	12	4	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc
2410	N	Workforce and OD	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	Morley, Sarah	Accepted	Programme	05/10/2020	18/03/2022		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	12	12	2	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support
2229		Workforce and OD	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	12/03/2019	24/01/2022		Risk to timely communication /engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	12	12	4	Resource increased within corporate communications and TCS teams.

2256		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Tranter, Bethan	Tranter, Bethan	Accepted	SACT	26/03/2020	28/02/2022		SACT / Divisional	Reporting on treatment pathway changes As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned. It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured. There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information	16	12	12	A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted. Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet 1 - All Clinical Staff to be directed to (where appropriate): - utilise the drop down reason code "COVID-19" on ChemoCare, - include COVID-19 in all Canisc annotations and - include "COVID-19" as the "Description" title when utilising the "Other" tab in Canisc 2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations 3 - Recognition that a solution to identify patients whom have not been referred for treatment to VCC due to COVID-10 has not been identified. 1st Aug 2020 Solutions as identified within the paper were not consistently utilised throughout service. SST Lead and SACT Clinical Lead leading on pieces of work to identify all patients whom have had treatment pathway altered due to COVID. Work of clinical leads continues to endeavour to undertake this work and Head of P and P with BI support providing additional support and insight. This is an important piece of work which will help to identify future SACT demand and thus capacity requirements 12.01.21 - work to identify impact of first wave COVID on patient pathway was subsequently led by planning and performance colleagues and future demands work in on-going. For 2nd wave, clinical colleagues have the message reinforced that use of term COVID-19 is to be used (see above). No further mitigation available to the SACT service.
2243			Velindre Cancer Centre	Velindre Hospital	Membury, Rebecca	Tranter, Bethan	Accepted	SACT	30/06/2021	01/05/2022		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	16	12	3	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways Daily meetings to ensures that staffing levels are appropriate and that if needed patients are clinically prioritised.
2244		Workforce and OD	Velindre Cancer Centre	Medical Physics	Windle, Rebecca	Wilkins, Paul	Accepted	Medical Physics (previously Radiotherapy Physics)	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	12	12	4	Deputies for the programs to be identified without affecting service delivery
2245		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Jenkins, Paul	Jenkins, Paul	Accepted	Radiotherapy Services	12/04/2019	31/03/2022		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	15	12	3	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast treatment should ideally not be prolonged for more than 2 days). Regular update of staff from management re. New centre / satellite sites. TCS website, events to publicise new centres. Prioritisation list of latest technologies / innovations, to ensure that patients receive most prudent treatment. 22.7.20. New VCC - IRS cycle 5 ongoing. No update at this point. New linacs for current department tied up with IRS. Satellite - OBC submitted. 20.10.20. New VCC - IRS cycle 5 ongoing. No update at this point. New linacs for current department tied up with IRS. Satellite - OBC submitted. PJ. 25.1.21. Awaiting formal updates on IRS. Currently appraising options for maximising capacity PJ 21/5/2021 – Risk reviewed by PJ & CRD. Risk remains Awaiting formal updates on IRS. New linacs for current department tied up with IRS. Satellite – working on full business case, to be submitted Autumn 2021 1/11/2021 - Risk updated by CRD. Risk remains. IRS evaluation still to be completed. Work started on Breast service contingency to ensure resilience in the event La6 is no longer available.
2455	N	Performance and Service Sustainability	Corporate Services	No Further Coding Required	Mason-Hawes, David	Daniels, Gareth	Accepted	Digital Services	29/10/2021	01/05/2022		TAO Windows Server 2003 Failure (VUNHST Finance)	There is a risk that key Finance activity may be disrupted as a result of a failure of a Windows Server 2003 which hots a key IT application used by Finance, which may lead to an ability to perform critical finance activity (payroll, invoicing etc.). There is currently no resilience / business continuity arrangement in place for this server.	16	12	4	RegKey changes applied to change/add ProviderFlags to 1. New VM has been built to the latest supported version - DO to liaise with Finance for an appropriate upgrade time.
2513	N	Performance and Service Sustainability	Velindre Cancer Centre	Theatres	Millin, Tony	Gallop-Evans, Eve	New risk	Whole Service	09/02/2022	01/08/2022		There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Currently only one staff member has a practitioners licence for Prostate Brachytherapy	20	20	10	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2388		Safety	Velindre Cancer Centre	Outpatients	Stockdale, Ann Marie	Miller, Lisa	Accepted	Nursing	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	12	12	8	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.
2428	N	Compliance	Velindre Cancer Centre	First Floor	Miller, Lisa	Wilkins, Paul	Accepted	Nursing	02/08/2021	31/03/2022		There is a risk of increased infection transmission due to poor ventilation.	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	UPDATE 14.02.22 from Mark David - A temporary air con solution will need to be installed for this summer (as per last year setup) with the hope of the ventilation BC being signed off later this Summer. Next steps will be for service to sign off decant plan so it can be included in the BC, this can then be signed off by SMT, EMB and then forwarded on to WG. UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. * Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc. * Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc. * Full root cause analysis undertaken to ascertain cause(s) of any infections. * Business Case currently under development to seek funding for compliant ventilation system.
2236	N	Quality	Velindre Cancer Centre	Outpatients	Miller, Lisa	Stockdale, Ann Marie	Accepted	Operational Services	08/04/2019	31/03/2022		There is a risk of poor patient experience as a result of insufficient space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	15	12	12	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments
2248	N	Safety	Velindre Cancer Centre	Velindre Hospital	Seary, Sarah	Cooper, Mrs Vivienne	Accepted	Nursing	29/10/2020	31/03/2022		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	16	12	12	Update 14.02.22 - Social distancing still in place; enhanced cleaning and full IPC measures still mandated. IPC team continue to monitor compliance and undertake regular clinical practice and environmental audits in all departments. Update 10/12/21 - Regular updates and guidance given by IPC Team to all staff to remind them of IPC requirements. Enhanced cleaning still in place; social distancing measures remain in place; cleaning wipes and sanitiser freely available along with face masks. Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners, admin, pharmacy, RT etc.) -Hand Sanitiser stations installed -Hand washing posters at sinks -Sterilising materials, wipes, spray etc available for all staff -Enhanced hand washing regime -Staff who can work from home being assessed and if applicable currently doing so -Care taken to manage 2m space where applicable -Social distancing posters -If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc.PPE is provided for use on the FFW at all times. Process constantly reviewed against guidance. Analysis and then clear signage of occupancy levels in appropriate areas if applicable Enhance cleaning practices for all equipment as per standard and covid regulations. UV cleaning of rooms for high infections. Testing for staff with symptoms as per covid guidelines. Zoning during outbreak. COVID Patient pathway to minimise interaction with staff and other patients. Reduction of beds Restricted visiting in lines with All Wales Guidance. Patients are triaged on admission and rapid testing prior to admission to FFW

2188		Compliance	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	12	12	6	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas. 13. Trust has entered into formal lease agreement with for additional accommodation (Bobath). This has provided space for some staff displaced due to social distancing and to allow wellbeing space for staff. 14. Reassessment underway of corporate and other staff on VCC site that can be relocated to other Trust premises. 15. SACT and ambulatory care services operating extended hours, bank holidays and some Saturday working.
2515		Performance and Service Sustainability	Velindre Cancer Centre	Radiotherapy	Millin, Tony	Millin, Tony	New risk	Whole Service	09/02/2022	27/05/2022		There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	"Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff"	15	15	5	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place
2514	N	Quality	Velindre Cancer Centre	Radiotherapy	Millin, Tony	Millin, Tony	New risk	Whole Service	09/02/2022	29/04/2022		There is a risk that Standard Operating Procedures (SOPs) within Brachytherapy are not up to date	Key staff have not been available to review the SOPs due to work pressures and reviews are not routinely undertaken at an operational management level SOPs could be outdated which could potentially lead to the standard operating procedures at Velindre not aligning to National requirements, or requirements for patient safety. Staff could be operating in a sub-optimal way to treat patients.	16	16	4	Following the retirement of the former Head of Brachytherapy Physics, ownership of RT physics documents has transferred to another member of staff who is reviewing SOPs. Similarly a review of documentation is taking place within Radiotherapy
2517	N	Financial Sustainability	Transforming Cancer Services	No Further Coding Required	Hinton, Tracy		Accepted	New Velindre Cancer Centre	14/02/2022	01/03/2022		There is a risk that the competitive dialogue participants tenders excced the CAPEX limit leading to increase project costs and	CAPEX There is a risk that the competitive dialogue participants tenders excced the CAPEX limit leading to increase project costs and potential delays.	12	12	12	1. Discuss with Welsh government.
2431	N	Performance and Service Sustainability	Transforming Cancer Services	No Further Coding Required	Lewis, Bethan	James, Carl	Accepted	Programme	23/07/2021	31/12/2021		There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables	16	12	4	1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete 2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete 3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing
2486	N	Quality	Transforming Cancer Services	No Further Coding Required	Pinocci, Francesca		Accepted	Enabling Works	07/12/2021	04/03/2022		There is a risk that the Section 278 application takes longer than expected to be approved,	S278 Application There is a risk that the Section 278 application takes longer than expected to be approved, meaning that works traffic accessing the 'straight' TCAR are delayed, leading to a delay to construction and longer overall construction timeline.	9	12	6	This application process has started.
2220		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Windle, Rebecca	Maggs, Rhydian	Accepted	Medical Physics (previously Radiotherapy Physics)	07/11/2018	28/02/2022		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2198		Financial Sustainability	Velindre Cancer Centre	Velindre Hospital	Miller, Lisa	Miller, Lisa	Accepted	Operational Services	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	16	16	6	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism
2213		Performance and Service Sustainability	Velindre Cancer Centre	Velindre Hospital	Evans, Fran	Daniels, Gareth	Accepted	Digital Services	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	16	12	4	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.
2251		Compliance	Velindre Cancer Centre	Radiotherapy Physics	Windle, Rebecca	Jarvis, Richard	Accepted	Medical Physics (previously Radiotherapy Physics)	18/03/2016	30/03/2022		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health England and HIW are aware.	15	12	6	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the treatment superintendents must be informed if the units are regularly failing during a day, and these failures recorded in the unit log book. 6. Additional dose contributions are calculated for all patients affected and recorded in the Datix incident system. 7. Failure rates are reviewed weekly during the multidisciplinary linac status meeting and fault causes are actively investigated.

ID	Risk Type	Division	Approval Status	Review date	Title	Risk (In Brief)	Rating (Initial)	Current Rating	Rating (Target)	RR - Current Controls
2187	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	31/03/2022	Radiotherapy Physics Staffing	There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This may result in - patient treatment delay - Radiotherapy treatment errors. - key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental timeExample of areas of the service currently considered as routine that are detrimentally impacted by the lack of resource include i. Completion of incident investigations, reports and learning, essential to prevent future radiotherapy errors and incidents and improve local practice ii. Inability to provide engineering cover during weekend quality control activities iii. MPE advice on, and review of, treatment protocols to ensure they are in line with national guidelines whilst also appropriate for local practice iv. Development of workflow processes to increase efficiency v. Delays to the commissioning of new treatment techniques / service developments e.g., Partial Breast Irradiation (PBI) and Internal Mammary Node Irradiation (IMN) vi. Delays in performing local RTQA slowing opening of new trials and thus reducing recruitment of Velindre patients to trials compared with other centres (e.g. PACE C) vii. MPE support for imaging activities providing imaging to the radiotherapy service inside and outside VCC. Background The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile of this team is of concern, with up to 6 engineers planning to retire within 5 years. Linac engineering is a specialist area requiring in depth knowledge of complex machines and requires training to work at high voltages in a radiation environment. This is particularly critical with the age profile of our current linac fleet. The effects of incorrect repairs and / or maintenance can be significant on the patient and it is vital that this area is sufficiently resourced. Skill mix within physics enables most staff to be redirected to physics planning in order to meet fluctuating demand in the pre-treatment pathway and minimise patient delays and breaches. However, this negatively impacts on other essential core duties.	25	15	5	Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC. Recruitment is underway to mitigate this risk, currently at 15, as this resource will cover the business critical programmes. This is subject to dynamic risk assessment due to the anticipated shortage of appropriate candidates.
2253	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Availability of CANISC System	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	15	5	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is aviable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient demographic information - Welsh Results Reporting Service (WRRS) for all VCC radiology reports - Paper Radiotherapy Workflow (IRMER) - Manual Registration - new patients on Chemocare - Manual Registration - new patients on Aria and Mosaiq - Availability of Clinical correspondence created at VCC in Document Management System (DMS) from April 2019 that feeds into Welsh Clinical Record Service (WCRS) - Access to paper record that holds inpatient documentation, charts etc
2205	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	31/01/2022	CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no “fall-back” method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. No longer applicable - can be removed	25	15	9	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads
2260	Compliance	Velindre Cancer Centre	Accepted	01/01/2022	Control of Asbestos at VCC	Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors.	15	10	5	Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received “Management of Asbestos in Building Training” (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts. Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training. Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos and known locations. Prior to any destructive works on site Refurbishment and Demolition Surveys are completed. Socotec are the appointed consultants to support professional advice and assistance. Annual asbestos inspections are also undertaken. Annual staff Asbestos Awareness Training delivered.
2447	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Cleartext credentials stored in memory	There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2444	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - CVE-2019-0708 BlueKeep Vulnerability	There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC.	20	10	5	Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access.

2442	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - End of Life Desktop/ Client Operating Systems on the VCC network	There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National Firewalls. Anti-virus controls in place.
2458	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	20	10	5	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.
2450	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls used as protection for VUNHST.
2451	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	20	10	5	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.
2448	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - NTLM hashed credentials stored in memory	There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC.	20	10	5	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.
2445	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee)	There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC.	20	10	2	VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP. Mcafee still in use on various servers and DLP enabled.
2460	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	20	5	5	Controls in place include national firewalls, Anti Virus & ACLs.
2446	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2022	Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts	There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC.	20	10	5	Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth. Work ongoing to remove weak passwords.
2512	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	03/03/2022	Digital Health & Care Record DHCR022 (R) - Business Continuity Risk following Implementation	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 order to provide business continuity when Canisc is unavailable. The impact in this risk would be felt after go-live but could impact on service delivery. 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	DHCW to develop a solution as this would have an effect on every HB when they have an Electronic Patient Record

2261	Safety	Velindre Cancer Centre	Accepted	30/09/2022	Lack of electronic prescribing at Teenage Cancer Trust	There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions.	16	10	4	Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients. Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed. 31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the prescribing of regimens to occur electronically. Development of the SLA continues TCT to be included within VCC version 6 training and roll out programme subject to SLA agreement. With interim work around solution in place, risk= 5x2=10 11.05.21 – Workaround in place between UHW and VCC Pharmacy Dept continues to be supported with no safety issues or concerns noted. ChemoCare version 6 roll out will be paused in June 2021 due to overlap of implementation of DH and CR replacement and Wellsky and impact on staff training. Roll out (to include TCT) will re-commence post implementation and embedding of these 2 systems which is likely to be Autumn 2021 (date TBC). 27.05.21 – UHW informed that implementation is temporarily paused as above. VCC will continue to install and test latest patch (version j). Subject to successful UAT, VCC and UHW will liaise to determine if there is a) an immediate need for roll out to TCT ahead of the VCC programme, b) whether VCC can resource such a roll out and c) consequences to VCC of VCC clinicians utilising version 6 ahead of VCC site rollout.
2252	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/04/2022	Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	20	15	10	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR
2262	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	10	10	5	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.
2336	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury or ill health to Estates staff whilst working in a lone working environment	Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person.	15	5	5	Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are illuminated. Medical staff available on site should a medical emergency occur. Maintenance staff will assess the need to use a safety person when required (out of hours Security may be used or a member of Estates staff may be requested to return to work to assist). All chemicals being used will have a COSHH risk assessment.
2338	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Risk of injury or ill health to staff whilst working in subterranean ducts (confined space)	Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness.	15	5	5	Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training. Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3 masks, safety shoes, and gloves). A personal gas monitor is used by the Estates team. Sub-contractors competency to access confined spaces is confirmed prior to any works being undertaken by sub-contractors within the confined space. Risk assessments and method statements are provided for all tasks undertaken by sub-contractors. Currently, access to the main service ducts has been prohibited to the Estates staff.

2339	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	15	5	5	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.
2340	Compliance	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	15	5	5	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.
2341	Safety	Velindre Cancer Centre	Accepted	01/01/2022	Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	5	5	5	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.
2342	Safety	Velindre Cancer Centre	Accepted	01/07/2022	Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	10	5	5	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.
2400	Workforce and OD	Transforming Cancer Services	Accepted	31/01/2022	Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	20	20	6	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC
2513	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/08/2022	There are a lack of staff holding a practitioners licence for prostate Brachytherapy	Currently only one staff member has a practitioners licence for Prostate Brachytherapy	20	20	10	Clinical service is dependent on one consultant - another is in training and about to apply for an ARSAC licence
2515	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	27/05/2022	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service	Brachytherapy Staffing Levels at Velindre are low and recruitment and retainment of staff is not at the level required. There are a number of staff nearing retirement. There are also staff on maternity leave, sick leave, sabaticals etc. affecting staffing levels day to day." "There are a number of single points of failure within the service with a lack of cross cover, loss of single members of key staff could interupt patient treatment. Loss of trained staff leaves the service with a number of additional single points of failure. Training times are often long and impact on staff's current role. Staff can be sought from university cohorts but these are limited and the time required to train them to work within the Velindre service means they are not direct replacement for lost staff	15	15	5	Capacity is managed by careful examination of rotas, refusing leave and redeployment of staff from other areas. A programme of training sufficient staff to cover all areas and a review of staff numbers is taking place

2472	Safety	Velindre Cancer Centre	Accepted	31/03/2022	There is a risk that there is a traffic accident on site which may lead to someone being injured or damage to vehicles	All car parking areas on site. Vehicle movements on site including Staff, patients, deliveries and contractors. Pedestrian walkways on site. Specific risks include adverse interaction of vehicles and or pedestrians, slips trips/ falls, theft and vandalism.	15	10	5	Hazards identified: LPG storage cage close to road with no bollard protection (behind LA 2 and 3) Large vehicles encroach on coming traffic on narrow roads Pedestrians getting hit by cars Poor lighting resulting in slips, trips ,falls List control measures in place: Car park: 5mph speed restriction. Directional flow traffic system and road marking in place. Information signage directing visitors to the different departments on site. Designated ambulance parking areas and Ambulances fitted with audible reversing warning signals. Designated patient drop off/ pick up areas. Designated disabled parking spaces and pharmacy collections. Patient parking located near entrances allowing easier access for users. No parking zones are in place around the site and clearly visible. Dropped kerbs in place with tactile surface for pedestrians. Road and pavement surfaces in good condition. Drainage is good with no evidence of excess water holding during period of heavy rain. Junctions are clearly marked for right of way. Digital speed signs in place to show drivers their speed. Pedestrian crossings in place. No contractor parking on site unless essential to works and prior agreement must be made, with areas/ spaces agreed for use. Bollards are in place to protect the temporary waiting area (Marquee) from any traffic at the entrance to out-patients. Max height signage in place at main entrance to warn drivers because of canopy. Deliveries: Any planned deliveries using large vehicles are arranged to take place outside of patient hours, usually 6am with bollards/ barriers removed where needed and vehicles martialled into place. Any un-planned large vehicles/ deliveries are martialled through the site where possible, the junction to radiotherapy/ stores can be used to turn them around. Large vehicles might have difficulty accessing stores area for delivery so unloading may take place on road near the junction to the stores, and items moved by pallet truck to the stores. However, deliveries to the stores are mostly vans, they reverse un-aided to stores entrance. Waste: Waste contractor collections are mostly before 7am there are exceptions to this with SDCL
2220	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	28/02/2022	Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and alternative no planning system for all breast patients to be treated	15	15	1	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through
2343	Compliance	Velindre Cancer Centre	Accepted	27/07/2021	Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	20	5	5	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.

ID	Division	Approval status	RA Date	Title	Description	Controls in place	Current Risk Rating	Review date
16894	Welsh Blood Service	Final approval	28/10/2021	Transfusion associated acute lung injury risk reduction strategy	WBS supply of apheresis platelets from female or previously transfused donors, not screened for HNA antibodies	Donor screening identifies donors that may have experienced sensitising events (previous transfusion/pregnancy) but without HNA antibody screening is not able to mitigate the risk of these antibodies being present.	5	07/05/2022
16900	Welsh Blood Service	Final approval	18/10/2021	Apheresis Premises at Velindre cancer Centre	Velindre Cancer Centre Hospital building	Hospital facilities are inspected by an external contractor (Hurley & Davies). The VCC collection suite has been licenced by the HTA and will be regularly inspected by the WBS. H&S, Fire inspections regularly undertaken.	5	18/10/2022
16809	Welsh Blood Service	Final approval	06/09/2021	Malaria Risk – Delay in Implementation of the Process to Support Amended Malarial Testing for a Specific Donor Group	Non-compliance with donor assessment based on the JPAC Donor Selection Guidelines for donors with MALR, MALF and MALP risks. No malaria discretionary test is undertaken following re-exposure to a malarial risk for donors in this group.	This issue has been fully discussed at JPAC / SACTTI-(Parasites) group. The MHRA have laisied with the Chair of JPAC- the conclusion is that whilst WBS practice is safe, the recommendation is to align WBS practice with other UK Services. By definition all these donors will have tested negative for malaria at their first donation - this part of the process is robust. It is the subsequent testing post re-exposure that is missing.	5	06/09/2022
16762	Welsh Blood Service	Final approval	13/08/2021	Supply Chain disruption of Blood Collection tubes	All other tubes not on the shortage list (10ML, 6ML etc)Update-17/08/2021	"Internal stock take and regular monitoring and management of WBS stock position. Stock holding of 8 weeks supply at present. Stock projection received from BD for coming months and identification of WBS allocation."	10	18/03/2022
16780	Welsh Blood Service	Final approval	22/04/2021	Transport of Donor Records to and From WBMDR Collection Centre	Transport of paperwork that may contain donor personal identifiable information (PII)	Paperwork transported by WBMDR staff is kept to the minimum required (note: all WBMDR documentation only contains the minimum required PII to facilitate the collection). Staff are aware of the GDPR requirements, and have received training in Information Governance. Information and training provided by the WBMDR and stated in the standard operating procedure for the stem cell/PBL collection (SOP HUB-903). Staff advised to drive directly between the WBS and the collection centre unless absolutely necessary to stop or divert. Paperwork stored together securely (in a closed folder or bag) and out of sight in the vehicle.	5	22/04/2022
16788	Welsh Blood Service	Final approval	16/03/2021	Apheresis Premises at Nuffield The Vale Hospital	Nuffield the Vale Hospital building	Hospital is HIW inspected, HTA licenced and inspected by the WBS. H&S, Fire and HIW inspections regularly undertaken.	5	16/03/2023
16398	Welsh Blood Service	Final approval	11/12/2020	Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	25/04/2022
16467	Welsh Blood Service	Final approval	27/11/2020	Receipt, Storage and Distribution of Covid 19 Vaccines	Recording time of vaccine removal from -80 freezer	Labels printed with time Print labels before removal of vaccine from freezer risk treatment - validate printed labels	5	22/10/2022
16295	Welsh Blood Service	Final approval	22/09/2020	Use of Female Plasma for Manufacturing Pooled Cryoprecipitate	WBS Cryoprecipitate made from female donors not tested for HLA/HNA antibodies	"Prevention 2) Low level of plasma from each donor, reducing any potential antibody concentration"	5	12/04/2022
16266	Welsh Blood Service	Final approval	15/09/2020	Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment, Also looking at options around a potential fixed site.	12	01/08/2022
15973	Welsh Blood Service	Final approval	19/05/2020	Exposure to Potential Pre-symptomatic, Asymptomatic Individuals at Verification Sample Procurement, Donor Information, Medical A	Donor Exposure to potential pre-symptomatic, asymptomatic individuals at VT sample collection - Performed by a Health Care at Home under contract to the WBMDR.	Assurances received from Health Care at Home that correct protocols are being implemented with regards to social distancing and use of appropriate PPE.	5	06/03/2022

16009	Welsh Blood Service	Final approval	18/05/2020	Social Distancing measures within the Laboratory environment (Lab Services and WTAIL)	See attached FMEA	See attached FMEA. Reviewed FMEA attached. Risk further reduced by staff vaccination program. All other measures remain in place. GS, 27/05/21	5	27/05/2022
15937	Welsh Blood Service	Final approval	04/05/2020	Covid-19 implications of handling biological samples within the WBS	Handling of untested or presumed COVID-19 negative samples for laboratory testing	Appropriate staff training, supervision and comptetence. Good laboratory practice. Use of standard laboratory PPE including nitrile gloves and labcoats. Risk treatment plan and recommended actions: All staff should be aware that there is the potential for any sample to be positive for COVID-19, as patients or donors may be asymptomatic. If appropriate, all primary samples should be centrifuged and left for at least 10 minutes before decapping to reduce aerosol risk. Centrifuge bucket lids must be used to reduce aerosol production risk in the event of tube breakage. Aerosol-generating or potential splashing procedures should be performed in a Class-2 microbiological safety cabinet if possible and appropriate. If these cannot be performed in a cabinet these procedures must be identified and additional proportionate controls put in place, such as capping of tubes, safety screens or PPE. Local Risk assessment within each laboratory should be performed to identify these procedures. Update 06/01/2021. Vaccination for all front line/lab staff has ben tolled out, Increased UK testing capability, increased use of PPE for all staff. No evidence of laboratory COVID-19 transmission has been seen, and no evidence (either locally or worldwide) that COVID-19 has been transmitted by aerosol from laboratory samples.	5	05/10/2022
15932	Welsh Blood Service	Final approval	23/04/2020	Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options.	12	12/08/2022
15533	Welsh Blood Service	Final approval	27/09/2019	Manual Double Entry of Test Results in Automated Testing - Contingency Process	Manual entry of test results which are normally interfaced directly from an analyser into BECS.	Components from a positive donation are physically removed from the supply chain by Automated Testing staff.	5	14/06/2022
15456	Welsh Blood Service	Final approval	11/07/2019	Clinical RA for not providing HbS negative red cells	HbS negative blood not supplied by WBS as recommended by JPAC guidance	"- low incidence of HbS in Welsh population (0.02% in 2013) '- Most HbAS units block leucodepletion filters and don't make it to a usable donation"	5	25/08/2022
15373	Welsh Blood Service	Final approval	27/06/2019	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA).	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG).	12	31/08/2022

15398	Welsh Blood Service	Final approval	06/06/2019	Facilities Infrastructure	Electrical circuitry is not installed to current standards	Not installing any new equipment until power supply has been updated..	10	19/08/2022
15297	Welsh Blood Service	Final approval	29/04/2019	WBS Cyber Security Attack or Breach	WBS Systems and Services	Antivirus software deployed to detect threats. Device control deployed to limit access to removable devices. E-mail messages are scanned for threats and spoofing by NWIS. Web browsing is via a proxy server that scans for viruses and malicious content. Software updates are rolled out to address vulnerabilities in operating systems and key applications. Firewalls are enabled at device level as well as network levels to restrict access from unwanted systems. Newer operating system deployments are harden against security baselines recommended by suppliers and NCSC. Regular backups of critical and key data. Vulnerability scanning conducted against WBS devices. Phishing exercises targeted at WBS users	10	22/04/2022
15261	Welsh Blood Service	Final approval	01/04/2019	Microsoft Windows 7 and Server 2008 R2 End of Support	Windows Server 2008 R2 server operating system (ePROGESA)	Server operating systems are protected by local and network firewalls - this limits which devices can access the servers. Antivirus software provides detection and remediation against known threats. Internet usage and E-Mail is generally blocked from servers. System have been hardened against best practices. General users are only able to access limited parts of the ePROGESA environment, for example, Database Servers are not accessible	10	04/01/2023
15262	Welsh Blood Service	Final approval	01/04/2019	Oracle Java 8 End of Support	Oracle Java Runtime Environment	Java environment has been hardened to limit where applications can be launched from. Client operating systems are protected by local and network firewalls - this limits which devices can access the clients. Antivirus software provides detection and remediation against known threats. Removable media controls limit threats from USB/DVD drives. Internet usage is monitored to protect from web and downloadable threats. E-mail messages are scanned for threats. System have been partially hardened against best practices	5	22/04/2022
15189	Welsh Blood Service	Final approval	22/01/2019	Red Cell Antibody detection on the PK7300	Failure to detect high level anti-D on PK7300 - impact on Apheresis donations - not neonatal	None	5	13/01/2023
14764	Welsh Blood Service	Final approval	09/10/2018	Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	06/04/2022
14744	Welsh Blood Service	Final approval	03/09/2018	Abbott Microbiology Platform	Result Transfer to eProgesa	WBS Procedures Peer Review	5	13/01/2023
14508	Welsh Blood Service	Final approval	09/07/2018	Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels WBS Sickness and Absence Deep Dive Stress Related Absence document produced Dec 2018 Ongoing wellbeing initiatives Initiatives introduced to look at finances - Home finances impact on stress Menopause Policy developed and initiatives to look at this introduced (Menopause Café) which impacts on work place stress	12	01/08/2022

14215	Welsh Blood Service	Final approval	06/03/2018	Risks associated with the implementation of Prometheus into WTAIL	Failure of WTAIL to meet its regulatory obligations (e.g HTA)	URS signed off and agreed. Regular meetings with supplier to ensure URS requirements are fulfilled. Regular communication with supplier in respect of changing/ new regulatory requirements. Development complete. Update 13/10/2020 UAT is complete.	10	01/04/2022
13311	Welsh Blood Service	Final approval	08/11/2017	Reprinting Group Labels for overweight imported red cells	Reprint group label for imported red cell which is overweight (outside maximum volume parameter)	"NHSBT & SNBTS have an automatic discard set for components that are overweight/ over-volume (i.e. all Blood Services comply to the Red Book Guidelines and have their processes controlled accordingly). Laboratory staff identify non-conforming donations.	5	12/04/2022
12342	Welsh Blood Service	Final approval	29/03/2017	Use of the External Plasma Freezer	Safety of staff whilst using the freezer	None (PPE)	5	01/11/2022
12104	Welsh Blood Service	Final approval	02/02/2017	Movement of WBS personnel within the service yard area	Staff movement in the service yard .	Designated speed limit of 10 mph within the service yard area. Entrance gate controlled from central point (reception). Entrance gate is kept closed and access to the service yard is via intercom. Adequate lighting located in service yard area. All transport department staff and CCA drivers who use the service yard are provided with a service yard awareness briefing. This is undertaken as part of their training and is detailed in the training booklet prepared by transport department. Donor Services personnel and facilities staff are issued with hi visibility jackets /vests to wear when working on service yard area and this is a compulsory requirement. Transport and Facilities staff provide hi visibility jackets/vests to visitors and these visitors are escorted whilst on the service yard. Additional controls include hi vis paint work, periodic service yard inspections, contractor leaflet read and understood before work commences. CCTV coverage of the service yard.	10	01/08/2022
11522	Welsh Blood Service	Final approval	17/10/2016	Antibody detection by Luminex based technology	Detection of HLA antibodies by Luminex based methods	sample collection requirements are stated in WTAIL user guide. samples are only taken by trained phlebotomists and nursing staff. Acceptance of results based on review of patient history as and when available and take into consideration patient own type. Platelet cases require increment data for review of increment levels to determine further support required. Multiple samples are tested for those patients requiring long term support.	10	29/10/2022
9515	Welsh Blood Service	Final approval	03/07/2015	WBMDR Sterile Tube Welder	Sterility	Documented system at Collection centre (by two individuals) to check docking undertaken correctly (recorded on form WBM-551). Use of standard concession system (SOP 566/HUB) in the event of a dock failure. Routine sterility testing of all HPC products (100% testing)	5	04/11/2022
8719	Welsh Blood Service	Final approval	17/12/2014	GMP-0273 (Premises)	Storage area	Restricted access to authorised staff only. Physical segregation of product from routine blood stocks. Clear identification as HPC product	5	20/11/2022
8706	Welsh Blood Service	Final approval	15/10/2014	GMP-0062 (PBSC Collection)	Collection of product	pre-assessment of veins by 2 different healthcare practitioners. BM collection available as possible back-up	5	09/02/2023
8712	Welsh Blood Service	Final approval	15/10/2014	GMP-0066 (Assess Donor Fitness)	Failure to receive completed report in time for 'Final Clearance'.	None	5	09/02/2023
8717	Welsh Blood Service	Final approval	15/10/2014	GMP-0071 (HPC Storage & Transport)	Storage of PBSC/PBL	Stored in GMP monitored area of WBS. Stored in secure area. Controlled product release.	5	05/11/2022
8713	Welsh Blood Service	Final approval	15/10/2014	GMP-0067 (G-CSF administration)	Incorrect dose.	Prescription calculated according to SOP by consultant with nurse. Dosage actually given is recorded on prescription at time of administration.	5	03/03/2023
8715	Welsh Blood Service	Final approval	15/10/2014	GMP-0069 (Final Release)	Product Inspection	Visual inspection of each bag in accordance with documented procedure. Documentation to allow audit trail. Formal concession system to account for any sterile docking failures. 02/11/2016 No change to control measures required.	5	09/02/2023
8707	Welsh Blood Service	Final approval	15/10/2014	GMP-0063 (PBL Collection)	Collection of product.	IDM Testing and Lifestyle questionnaire performed	5	09/02/2023
8708	Welsh Blood Service	Final approval	15/10/2014	GMP-0064 (Whole blood for immunotherapy)	Donor Fitness for purpose	IDM testing and lifestyle questionnaire	5	26/11/2022

7746	Welsh Blood Service	Final approval	02/04/2014	Liquid Nitrogen supply system for TT1-17.	DATIX 2725 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17 immediately: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; Overfill or fan failure will cause nitrogen supply to be stopped by emergency cut-off valves, PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by specialist external contractors; Warning signs; Overfill and low pressure alarms on individual units linked to EMS; On-call staff available to respond to alarms out of hours; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112. Annual insurance inspection, CCTV in yard and alarmed external doors near external tank.	5	15/04/2022
7736	Welsh Blood Service	Final approval	31/03/2014	Liquid nitrogen storage and retrieval of frozen cells - room TT1-17	DATIX 3482 - transferred from paper assessment	Wall mounted oxygen depletion sensors- which are regularly serviced and tested (SOP: 008/FAC), linked to an audible and visible alarm in the area and an alarm on the Environmental monitoring system (EMS). In the event of an alarm staff are instructed to leave room TT1-17: Calibrated personal oxygen depletion monitors in use; Exhaust ventilation for the room, which alarms on the EMS system if it fails; Two emergency stop buttons, one inside the room, one outside to cut-off liquid nitrogen feeding to cryogenic vessels in the event of an over-fill; PPE including eye protection BSEN166 (2002) goggles and full-face safety masks (supplied in area), special blue cryoprotective gloves of various sizes. and Lab coats; Safety rules detailed in POL(S)009, including a “buddy system” outside normal hours; Restriction of access, cleaners instructed not to work in the area unless supervised by WTAIL laboratory staff; Safety Training given to new staff at induction; Staff trained to POL(S)-009, and SOP 001/TTY for working with biological agents; Regular servicing of cryogenic refrigerators, and system pipe work by external contractors; Warning signs; Written instructions on safe manual handling displayed on wall; Steps available to aid access to vessels for staff as required; Risk assessment on manual handling carried out by Hu-tech; Laboratory Safety procedures POL(S)-009 instructions on spillages; COSHH assessment completed; First aid; Management of liquid nitrogen system covered by SOP: TTY/112.	5	04/02/2022
7137	Welsh Blood Service	Final approval	07/11/2013	Electrophoresis in WTAIL Molecular Genetics - analysis of PCR-SSP reactions by agarose electrophoresis	DATIX 3486 - transferred from paper assessment	SOP: MOL/022 Safety policies POL(S)-009, POL(S)-007 Training PAT testing Visual inspection during cleaning Intact lids prevent access to energised liquid or electrodes whilst in use. Annual H&S inspection Use of electrophoresis will significantly reduce due to implementation of new technologies - will only be used for HPA typing. Technique will probably be fully superseded in a few years.	5	15/04/2022

7026	Welsh Blood Service	Final approval	03/10/2013	WTAIL liquid nitrogen automated filling system (low pressure) TT1-17	DATIX 3467 - transferred from paper assessment	Cryostorage refrigerators are sited so their open lids cannot damage the piping; The system has a regular Insurance inspection (Zurich); Piping, valves and controllers have regular maintenance by specialist contractors; Room has mechanical ventilation (monitored and alarmed by the EMS system); Laboratory Safety procedure POL(S)-009; Oxygen depletion sensors are present in the room, with audible and visual alarms; Induction training; Liquid Nitrogen emergency cut-off switches present both inside and outside of room to stop flow in event of problem: SOP 112/TTY, Management of the liquid nitrogen system in the Welsh Transplantation and Immunogenetics Laboratory. CryoVent system bleeds Nitrogen gas from lines before filling to prevent splashing. Use of cryo-protective gloves, coats, enclosed shoes and goggles mandatory. Laboratory safety procedures (POL-S 009), includes 'buddy system' for out of hours access.	10	02/08/2022
6987	Welsh Blood Service	Final approval	23/09/2013	Operation of the BacT/ALERT	Operation of the System	Staff trained to SOPs Good Laboratory Practise Process Design Competency Assessment Appraisal Controls	5	06/01/2022
5394	Welsh Blood Service	Final approval	21/05/2012	Remove the class I HLA-A, HLA-B, PCR-SSP result from the UBM database for stem cell donor 15568709	Remove incorrect HLA type from UBM Database	IT working instructions Post implementation check performed	5	15/11/2022
2556	Welsh Blood Service	Final approval	23/04/2010	Missing Hazardous Items	9-4-10:The standard procedures for storage and transportation of all hazardous material created during a blood donation clinic should ensure that none of these items go missing. Hazardous material is defined for the purposes of this SOP as:- "Sharpsafes containing used items e.g. needles "Boxes containing contaminated waste "Vacutainers containing blood samples "Blood transportation boxes containing full blood donations/Non Conforming Donations	9-4-10: Standard operating procedure SOP: 014/BCT. WBS Transport record sheet (SOP: 022/BCT).Donor are health screened, before giving blood, which reduced the risk of contamination with blood borne pathogens. Training to SOP's. Agency Drivers have ID checks.	5	06/09/2022

TRUST BOARD

TRUST ASSURANCE FRAMEWORK

DATE OF MEETING	30/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable – Public

PREPARED BY	Emma Stephens, Head of Corporate Governance and Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	21/03/2022	Noted
Strategic Development Committee	23/03/2022	Noted

1. SITUATION

1.1 The purpose of this paper is to provide the Trust Board with an update on:

- The status of the Principal Risks identified in the Trust Assurance Framework, which may affect the achievement of the Trust's Strategic Objectives, and the assurances in place to evidence the effectiveness of the management of those risks.

- The ongoing work to support the continued development, articulation and operationalisation of the Trust Assurance Framework within the Trust.

1.2 The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

b. **NOTE** the progress made in supporting the continued development and operationalisation of the Trust Assurance Framework since January 2022.

2. BACKGROUND

2.1 The Trust Board must be able to assure itself that the Trust is operating effectively and meeting its Strategic Objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

2.2 The Trust Board received the first iteration of the populated Trust Assurance Framework at its September 2021 meeting, which outlined the high-level Principal Risks that may threaten the achievement of the organisation's Strategic Objectives and intent, a further update was reported to the Trust Board in January 2022.

2.3 As previously indicated there is not expected to be significant movement in the articulation of these risks in the short-term, instead these will be reviewed and evolved in line with the Trust's Integrated Medium Term Planning cycle or in response to significant external changes.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The following provides a high level summary of the work undertaken since January 2022, to update the Trust Assurance Framework, support its continued development, articulation and operationalisation within the Trust.

3.1 Revised reporting mechanism

3.2 Discussion and engagement with risk colleagues in other Health Boards across Wales has been undertaken to identify and assess options available to support increased automation of the Trust Assurance Framework.

3.3 It has been identified that there is an opportunity to utilise Datix Version 14, to record the management of the Trust's ten high level Principal Risks detailed in the Trust Assurance Framework. Datix is currently already utilised to record the Trust's Operational Risks and is in the process of managing a phased data migration exercise from Version 12 to Version 14. As such, transfer of the management of the Trust Assurance Framework to Datix Version 14, would present a number of possible opportunities. In particular, utilisation of a single shared platform to record all risks i.e. Principal and Operational would enable a

hierarchy of risks to be developed, that provided a holistic view of which risks feed up into the overarching Principal Risks to afford increased scrutiny and assurance. This has previously been discussed via the Trust Audit Committee as a key requirement to support the continued development and maturing of the Trust Assurance Framework.

3.4 Transfer of the management of the Trust Assurance Framework to Datix 14 would also enable further automation, providing more streamlined and effective reporting arrangements, monitoring of agreed action plans and enhanced data analysis. In particular, this would also lay the foundations for the medium to long term objective to move towards increased utilisation of Power Business Intelligence Reporting. Scoping work has already been initiated to assess the feasibility of moving to Datix 14 within existing resources, possible timelines and how this may be best supported and achieved within the context of the wider risk management arrangements/framework. A clearer view of the anticipated timelines for this transition will be reported to the May 2022 Trust Board, once further discussion with key leads has taken place.

3.5 What the Trust Assurance Framework is reporting this month

3.5.1 The updated Trust Assurance Framework Dashboard Report is included at ***Appendix 1.***

3.5.2 Overall the Trust Assurance Framework Dashboard is showing that progress updates have been received since January 2022 in respect of the following Principal Risks:

			NO REVIEW TAKEN PLACE			
			REVIEWED NO CHANGES			
			REVIEWED AND UPDATE			
			MARCH	APRIL	MAY	JUNE
01	Demand and Capacity	COB				
02	Partnership Working / Stakeholder Engagement	CJ				
03	Workforce Planning	SFM				
04	Organisational Culture	SFM				
05	Organisational change / 'strategic execution risk'	CJ				
06	Quality & Safety	NW				
07	Digital transformation - failure to embrace new technology	CJ				
08	Trust Financial Investmnet Risk	MB				
09	Future Direction of Travel	CJ				
10	Governance	LF				

3.5.3 The following is a high level summary of the key changes that have been made to the Trust Assurance Framework since January 2022, a full overview of these changes is provided in the Trust Assurance Framework Dashboard at ***Appendix 1:***

- To note, 'Residual' Risk Score is the current score, with the current control environment, and it's effectiveness, taken into account. 'Inherent' is the risk score without the control environment operating.

- **TAF 01: Demand and Capacity**

    - ***Residual Risk Score -*** has remained the same at **12**.
    - ***Overall Level of Control Effectiveness -*** has been assessed as 'Partially Effective'. However, the recent review has identified an opportunity to reconsider the risk to broaden the controls and the assurance to include actions being undertaken to address capacity and demand planning that are wider than data sources and their use which are the elements currently included in this risk theme. This is being reconsidered by the senior leadership teams and will be reported through Executive Management Board Shape to then update on in the May 2022 reporting cycle.
    - ***Sources of Assurance –*** The original key controls are in place but again these will be reviewed and enhanced.
    - ***Action Plan for Gaps Identified –***These will be reconsidered as part of the review.

- **TAF 02: Partnership Working / Stakeholder Engagement**

    - ***Residual Risk Score*** - has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is being developed to specifically address the control deficiencies and will be reviewed through Executive Management Board Shape to then update on in the May 2022 reporting cycle.
    - ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
    - ***Action Plan for Gaps Identified*** – Ways of working changes, including with partner organisations, has been agreed with Internal Audit as an advisory piece for the 2022/23 work programme.

- **TAF 05: Organisational Change / 'strategic execution risk'**

    - Risk been developed and reported for first time, residual risk score of **12**.

- **TAF 06: Quality & Safety**

    - ***Residual Risk Score*** - has remained the same at **15**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. However, an action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review, this is detailed further below.
    - ***Sources of Assurance*** - ratings have now been added and assessed for the majority of the key controls in place operating as the first line of defence.
    - ***Action Plan for Gaps Identified*** - has been updated with revised target dates to address gaps in controls and assurance. Key updates to highlight include the completion of the Trust wide consultation on the Quality & Safety Framework with final draft due in May 2022. Progress in the constitution of the Divisional Quality Hubs has been adversely affected since January 2022, due to the impact of the Omicron Variant.

- **TAF 07: Digital Transformation – Failure to embrace new technology**

  - ***Residual Risk Score*** - has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review. However, progress has been limited since January 2022, due to the current vacancy held within the Trust for the Chief Digital Officer, recruitment for this post is underway with interviews scheduled for the end of March 2022.
  - ***Sources of Assurance:*** all key controls now have in place a first line of defence and the majority also now have a second line of defence assessed and in place.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance, slippage as outlined above has been the result of the existing vacancy for the Chief Digital Officer.

- **TAF 08: Trust Financial Investment Risk**

  - ***Residual Risk Score*** – has remained the same at **12**, however the target risk score has been increased from 9 – 12 following review to reflect the current context.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review. Key changes are reflective of the current position with the ongoing discussions with commissioners, health board colleagues and WHSSC around funding arrangements for the next financial year and beyond.
  - ***Sources of Assurance:*** the existing key controls in place have been strengthened with additional lines of defence now provided for C3-7.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance. A key update to highlight includes the review of the contracting model for impact of COVID-19 related measures.

- **TAF 9: Carl James – Future Direction of Travel**

  - ***Residual Risk Score*** – has remained the same at **12**.
  - ***Overall Level of Control Effectiveness*** - has been assessed as 'Partially Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
  - ***Sources of Assurance:*** the existing key controls in place have been reviewed and further articulated.
  - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance.

- **TAF 10: Lauren Fear – Governance**

    - ***Residual Risk Score*** – has remained the same at **12**.
    - ***Overall Level of Control Effectiveness*** - has been assessed as 'Effective'. An action plan is in place to address the gaps in controls identified and has been updated to reflect progress made as part of this review.
    - ***Sources of Assurance:*** the existing key controls in place have been strengthened with the addition of a further key control Quality to Assurance provided to the Board, which has been currently assessed as 'Partially Effective'.
    - ***Action plan:*** has been updated with revised target dates to address gaps in controls and assurance. The detail of the action plan will be completed following the Board's receipt of the 2022/23 Governance Development Plan paper at its March 2022 meeting.

3.5.4 In addition to the above, the following provides a high level summary of the two remaining Principal Risks that were reviewed with no changes made to the overall risk status, key controls and sources of assurance in place:

- **TAF 03: Workforce Planning** - Key Control **C1** - People Strategy is due to be finalised in May 2022. This will provide the strategic framework for effective workforce planning arrangements going forward and an update reflective of this will be included in the May 2022 reporting cycle.

- **TAF 04: Organisational Culture** - it is anticipated that an overall change to the status of this risk will also be reflected in the May 2022 reporting cycle as this will reflect the planned completion of the Trust Enabling Strategies that underpin this risk that will ultimately effect the culture of the organisation and the way in which it works as a whole to effectively deliver services and achieve its ambitions

3.6 Next Steps in Development

3.6.1 Annual Review of Principal Risks

A Board Development Session will be planned and utilised to support the annual review/refresh of the existing Principal Risks following the completion and submission of the Trust Integrated Medium Term Plan to Welsh Government. This is to be taken forward as part of the Board Development Programme for 2022/23.

3.7 Key Points from March Governance Cycle

3.7.1 Strategic Development Committee

There were three key themes which were discussed in the March Strategic Development Committee for the Trust Board to note:

3.7.2 The concept of "issues" was discussed, as events which are/have already occurred that may have an adverse consequence. These would be reflected in the Trust Assurance Framework through sources of assurance and also in the control effectiveness ratings of the current control environment.

3.2.2 In addition, as noted in the Risk Register paper in this meeting, the link between the risk register and the TAF is to be developed further to link relevant risks on the register to the strategic risks in the TAF with this year's work plan. Following the development of the performance and quality frameworks, key metrics relating to the strategic risks will also be linked. The connections between these four key frameworks is important to the ability of the Board to more effectively triangulate and assure going forwards,

3.7.3 The third key theme discussed in Strategic Development Committee was to understand the impact of the overall profile and the impact of a collection of these risks being brought together. The concept of reverse stress testing was commented on, that is the identification of a pre-defined adverse outcome, for instance the point at which an organisation may be considered as failing, and severe, but plausible, risks materialising that might result in this outcome are then explored. This is an important development in the organisation's risk maturity and capability and will again be worked into the TAF development for this year' programme.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes
	Please refer to ***Appendix 1*** for relevant details.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the update to the Trust Assurance Framework Dashboard, included at ***Appendix 1.***

b. **NOTE** the progress made and next steps in supporting the continued development and operationalisation of the Trust Assurance Framework.

RISK DESCRIPTORS			
RISK NUMBER	**RISK THEME/TITLE**	**DRAFT RISK DESCRIPTION**	**RISK OWNER**
01	**Demand and Capacity**	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	**Cath O'Brien** Chief Operating Officer
02	**Partnership Working / Stakeholder Engagement**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** Director of Strategic Transformation, Planning & Digital,
03	**Workforce Planning**	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	**Sarah Morley** Executive Director of OD and Workforce
04	**Organisational Culture**	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	**Sarah Morley** Executive Director of OD and Workforce
05	**Organisational change / 'strategic execution risk'**	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	**Carl James** Director of Strategic Transformation, Planning & Digital,
06	**Quality & Safety**	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	**Nicola Williams** Executive Director of Nursing, Allied Health Professionals & Health Scientists
07	**Digital transformation - failure to embrace new technology**	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	**Carl James** Director of Strategic Transformation, Planning & Digital,
08	**Trust Financial Investmnet Risk**	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	**Matthew Bunce** Executive Director of Finance

09	**Future Direction of Travel**	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	**Carl James** Director of Strategic Transformation, Planning & Digital,
10	**Governance**	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	**Lauren Fear** Director of Corporate Governance & Chief of Staff

LEVELS OF ASSURANCE DESCRIPTORS

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

KEY CONTROLS

KEY CONTROLS		
CONTROL TYPE	**DESCRIPTION**	**EXAMPLES**
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	• Authorisation limits of and separation of duties • Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	• Passwords or other access controls • Staff rotation and regular change of supervisors • Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	• Periodic performance reporting • Regular review

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

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

DEFINITIONS

CONTROL EFFECTIVENESS

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

ASSURANCE RATING

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA

Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Asessment of the assurance arrangements is pending.	Not Assessed

RISK SCORE

IMPACT MATRIX

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which on a large number of patients
Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/enquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complain (stage 2) complaint Local resolution (with potential to go to independent Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/competence	Short term low staffing level that temporilly reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for manadtory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

Statutory duty/ inspections	No or minimal impact or breach of guidance/statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5-1.0 percent of budget Claim(s) between £100,000 and £1million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage loss of contract/payment made by results claim(s) >£1million
Service/ business interruptionenvironmental impactr	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on enrionment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

LIKELIHOOD MATRIX

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

RISK RATING MATRIX - IMPACT X LIKELIHOOD

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

TAF DASHBOARD

DEMAND AND CAPACITY

RISK ID:	TAF 01	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Cath O'Brien	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	BI Strategy?											
C1a	Business intelligence Plan which is based on the Velindre Cancer Service	Lisa Miller	X			NE	Divisional Performance Review and the Quality & Perfomance Report. Velindre Futures Programme Board. Patient and Donor feedback		Assurance source			

TAF DASHBOARD

DEMAND AND CAPACITY

C1b	Trust Business intelligence plan which is based on the Welsh Blood Service	Alan Prosser	X			PE							
C2	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.					PE							
C3	Active work ongoing to establish data sets and pathways for the Cancer Service with health boards supported by the Delivery Support Unit.	Cath O'Brien	X			PE							
C4	Active engagement with Health Boards in Service Planning including the established Service Level Agreement Arrangements in place to plan demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Alan Prosser	X			PE							
C5	Active operational engagement with health boards on demand		X			PE							

GAP IN CONTROLS	GAPS IN ASSURANCE

TAF DASHBOARD

DEMAND AND CAPACITY

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
1.1 Review our Business Intelligence Structures	Cath O'Brien	Agreed approach with both Divisions - need to work through a plan and agree	Plan to be agreed by May 2022

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

RISK ID:	TAF 02	**PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT:** Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
4	4	16	3	4	12	2	4	8

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

GAP IN CONTROLS							GAPS IN ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	System structures – core cancer services commissioning arrangements;		X			PE	Commissioning contracting reporting	IA				
1.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	IA				
1.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
2.1	Blood - core blood services commissioning arrangements;			X		PE	Commissioning contracting reporting	IA			Regulatory scope re MHRA	
2.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	IA				

TAF DASHBOARD

PARTNERSHIP WORKING AND STAKEHOLDER ENGAGEMENT

2.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	IA				
3.1	South Wales Collaborative Cancer Leadership Group system model;		X			PE	Agreed to model for next phase	IA				
3.2	with effectively delivering ways of working/ work programmes			X		PE	Collectively agreed to and documented work programme	IA				
3.3	and data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	IA				
4.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	IA				
4.2	with effectively delivering ways of working/ work programmes			X		NE	Collectively agreed to and documented work programme	NA				
4.3	and data and measures to clearly track progress against objectives.				x	NE	With respective measures reported	NA				

GAP IN CONTROLS	GAPS IN ASSURANCE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line of defence assurance are in place to a certain extent across most of the key controls. However, there is limited coverage from second and third line perspectives

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	Carl James	Progress has been made across all controls since the Janaury update. However, the pulling together of an overall plan will now be progressed and taken the the April EMB Shape meeting for then onward reporting to the Board and Committees in May.	May-22
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	Carl James	Action progressed with the ways of working changes being agreed with Internal Audit as an advisory piece for the 2022/23 work programme. Scope and timing to be agreed further.	May-22

TAF DASHBOARD

WORKFORCE PLANNING

RISK ID:	TAF 03	**WORKFORCE PLANNING:** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	3	6

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy		Internal Audit Reports		To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			PE	Staff Feedback		Trust Board reporting against Trust People Strategy		To be completed as per compliance/ reg tracker update	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	Susan Thomas	X			PE	reports via divisional and committee structures					
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE						

TAF DASHBOARD

WORKFORCE PLANNING

C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE						
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE						
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE						
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE						
C9	Agile Workforce Programme established to assess implications for planning a workforce followinf COVID and learning lessons will inlcude technology impact accessments.	Sarah Morley			X	PE						

GAP IN CONTROLS	GAPS IN ASSURANCE
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

WORKFORCE PLANNING

1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Sarah Morley		May-22, previously Dec-21
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		May-22, previously Dec-21

TAF DASHBOARD

ORGANISATIONAL CULTURE

RISK ID:	TAF 04	**ORGANISATIONAL CULTURE:** The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	**Goal 1**
EXECUTIVE LEAD	Sarah Morley	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL	Likelihood	Impact	TOTAL
3	3	9	3	3	9	2	2	4

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	RATING	Overall Trend in Assurance	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) to be agreed to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			PE	Working group led by CJ		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	
C2	Developing Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training Steering Group		Trust Board reporting on strategy and controls via cycle of business		To be completed as per compliance/ reg tracker update	

TAF DASHBOARD

ORGANISATIONAL CULTURE

C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training Steering Group					
C4	Values to be reviewed and Behaviour framework to be considered Values of the Organisation used in induction, recruitment and via PADR processes	Susan Thomas	X			PE	Healthy and Engaged Steering Group Education and Training Steering Group					
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group					
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health & Wellbeing Steering Group					
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Executive Management Board					
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group					

TAF DASHBOARD

ORGANISATIONAL CULTURE

C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings					
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings Edcucation and Training Steering Group					
C11	Development and implementation of a Management Framework that supports cohesive work across the organisation	Carl James	X			PE	To be determined					

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Development of 3rd Line of defense assurance to be completed
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an "effective" level	Sarah Morley		May-22, previously Jan-22
1.2	Development of 3rd Line of defense assurance to be completed in line with the development of the compliance and regulatory tracker	Sarah Morley		May-22, previously Jan-22

RISK ID:	TAF 05	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	2	**4**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**

KEY CONTROLS & SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	Trust strategy to provide clear set of goals, aims and prioritoies	Carl James	x			E	Executive Management Board review		Internal Audt Review		Audit Wales	
1.2	Intergrated Medium Term Plan to translate strategy into clear delivery plans	Carl James	x			E	Executive Management Board review		Internal Audt Review / CHC		Audit Wales	
1.3	Performance reporting in place to ensure delivery of required quality/performance in core service	Carl James	x		x	PE	Executive Management Board review/ patient and donor		Internal Audt Review / CHC		Audit Wales	
1.4	Risk managament framework / arranagments in place to identfiy/monitor/manage risks at corporate and service level	Lauren Fear		x		E	Executive Management Board review		Internal Audt Review		Audit Wales	
1.5	Well defined change programmes at a local level to manage change effectively (WBS Change programme & Velindre Futures)	Cath O'Brien	x			PE	Executive Management Board review / staff feedback		Internal Audt Review		Audit Wales	

1.6	Effective leadership and management of change at Executive Management Board	Steve Ham	x			PE			Internal Audt Review		Audit Wales/HIW	

GAP IN CONTROLS	GAPS IN ASSURANCE
Currently gap in ability to measure all desired outcomes	
Lack of capacity in business intelligence to develop range of information and automate it	
Revised performance management framework not fully implemented	
Not all supporting strategies approved by the Board	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
Finalise all strategies and plans	Carl James	Drafts well developed with final engagement exercise ongoing - Board approval in may 2022	May-22
Develop IMTP t provide priority for action and application of resource	Carl James	Final draft going to Board for approval march 2022	Mar-22
Information requiremsnts being scoped	Cath O'Brien	First phase to support new performance measures	Jul-22
Implement revised performance management framework	Carl James	New scorecards being finalied for implementation	Jul-22

TAF DASHBOARD

QUALITY AND SAFETY

RISK ID:	TAF 06	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes and datasets including ability to on mass learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in the Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	Goal 1
EXECUTIVE LEAD	Nicola Willams	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
5	5	**25**	3	5	**15**	2	5	**10**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Once for Wales Datix System implemented	Nicola Williams			X	PE
C2	CIVICA pt/donor feedback system system being implemented	Nicola Williams			X	NE
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	EXECS	X	X	X	PE
C4	Quality & Safety Teams in place corporately & in each Division	NW, AP, PW	X	X	X	PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Staff feedback	IA	Internal Audit Reviews	Not Assessed	Audit Wales Reviews	Not Assessed
Patient/Donor Feedback	IA	Quality, Safety & Performance Committee	IA	HIW Inspect	Not Assessed
15 Step challenge	IA	Peer reviews	Not Assessed	MHRA	Not Assessed
EMB	IA			Professional bodies	Not Assessed
Divisional Q&S Groups	IA			Delivery Unit	Not Assessed
PMF	IA				Not Assessed

TAF DASHBOARD

QUALITY AND SAFETY

C5	PMF in place & under review to include experience & outcomes	Carl James			X	NE	Perfct Ward audits	IA				
							PMD	IA				
C6	Trust Risk Register in place	Lauren Fear	X	X	X	PE	Mortality reviews					
C7	Regular Staff Feedback sought	Sarah Morley			X	PE						
C8	Staff Q&S training & Education	Nicola Williams	X			PE		IA	Internal Audit Reviews	Not Assessed		

GAP IN CONTROLS	GAPS IN ASSURANCE
National standards / best practice standards (including benchmarkable outcome & experience measures) are not explicit across all departments of the Trust & /or regularly reviewed	Currently mechanisms to automatically & systematically review and triangulate & integrate quality & safety information at corporate and VCC Divisional level are insufficiently robust due to lack of cohesive infrastructure
Data / information infrastructure currently insufficient and unable to provide triangulation	Currently the mechanisms to evidence learning and improvement service level to Board remains under development
Quality & Safety Framework not finalized due to pandemic	There are gaps in the Quality & Safety reporting mechanisms from service level to Board in respect of meeting structures and reporting lines
National Duty of Quality & Candor guidance still under development	Trust Quality, Safety & Performance Committee needs to further refine its work plan, quality of papers and triangulation methodologies
Work required to ensure consistent and recognized Floor to Board lines accountability & responsibility for Quality & Safety	The Trusts performance framework does not currently adequately monitor service level to board quality, safety, outcome and experiential measures
Work required to ensure robust links between incidents, feedback, complaints, mortality review outcomes clinical audit and improvement plans and to be able to demonstrate improvement	Quality & Safety assurance infrastructure for hosted organisations is unclear
Trust wide and VCC Quality & Safety Teams have insufficient capacity and capability to currently be able to fully execute responsibilities	Quality & Safety Operational Group requires establishment - to operationally pull together all stands and feed into EMB & QSP

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date

TAF DASHBOARD

QUALITY AND SAFETY

1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	Nicola Williams	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	May-22
1.2	Corporate & Divisional Quality Hubs to be established	Nicola Williams Paul Wilkins Alan Prosser	Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team. OCP Process has commenced. WBS Quality Hub requirements determined – minor changes required from existing arrangements VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	May-22
1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team Divisional Directors	Will be developed once Framework finalised	Jun-22
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	Nicola Williams	Will be established once OCP completed	Jun-22
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	Nicola Williams	Training arranged for March - delayed due to Omicron	Jun-22
1.6	Implement a robust compassionate leadership programme	Sarah Morley		
1.7	Ensure all responsible officers receive Investigation Training	Nicola Williams Cath O'Brien	Planned for March 2022	Jun-22
1.8	Implement National Duty of Candour guidelines / requirements	Jacinta Abraham	Awaiting National statutory Guidance. Nicola Williams Chairing national Duty Quality / Duty Candour Steering group	Apr-23
1.9	Implement National Duty of Quality guidelines / requirements	Nicola Williams		Apr-23
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	Lauren Fear	Governance and Assurance mechanisms have been agreed and establishe for Shared Services, reporting through to the Quality, Safety and Performance Committee, Shared Services Audit Committee and Shared Services Partnership Committee. A review is underway of Health Technology Wales and required Governance and Assurance mechanisms. This will be progressed in quarter 1 2022/23	Jun-22

1.11	Complete Risk Register Review, transmission onto Datix v14 (04W when available) & ensure regular reviews at all levels in line with Quality and Safety outcomes	Lauren Fear	Regular reviews are taking place and work is ongoing to transfer of all risks to Datix V14, followed by Once for Wales when available.	Jun-22

TAF DASHBOARD

DIGITAL TRANSFORMATION

RISK ID:	TAF 07	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e. assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
3	4	**12**	3	4	**12**	2	3	**6**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
C1	Trust Digital Strategy, target approval at Trust Board in May 2022	Carl James	X			PE
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS	Chief Digital officer		X		E
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital officer	X			PE

SOURCES OF ASSURANCE

1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	PA	SIRO Reports	PA	To be completed as per compliance/ reg tracker update	PA
Trust digital governance reporting	PA	Internal Audit Reports	PA		
Staff feedback	IA	Trust Board reporting against Trust Digital Strategy	PA		

TAF DASHBOARD

DIGITAL TRANSFORMATION

C4	Training & Education packages for donors, patients	Chief Digital officer	X			PE	Patient and donor feedback	IA	Feedback and progress of working with Universities	IA		
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C6	Specifically development of digital resources capacity and capability	Chief Digital officer	X			PE	Review of proposals via EMB / Trust Board	PA				
C7	Digital inclusion – in wider community	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust	PA	Trust digital governance reporting	PA		
C8	Opportunities for digital career paths	Chief Digital officer	X			PE	Tracking key outcomes and benefits map – aligned to Trust	PA	Trust digital governance reporting	PA		
C9	Prioritisation and change framework to manage service requests	Chief Digital officer	X			PE	Trust digital governance reporting	IA				
C10	Levels of unsupported applications/ legacy systems	Chief Digital officer			X	PE	Trust digital governance reporting	PA				
C11	Trust digital governance	Carl James		X		PE	Trust digital governance reporting	PA				
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital officer			X	PE	Review via Divisional SMT / SLT	PA	Review via EMB / Trust Board	PA		

GAP IN CONTROLS	GAPS IN ASSURANCE
Each of the controls (with exception of c2) requires further development and progression, the plans for which are at varying levels of maturity – see action 1.1	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker see action 1.2
	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls, as per action 1.1

TAF DASHBOARD

DIGITAL TRANSFORMATION

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to April / July meeting of SDC.	April/ July Strategic Development Committee
1.2	December Strategic Development Committee	Chief Digital officer	Action carried forward following departure of Chief Digital Officer in December 2021. Aim to bring paper to April / July meeting of SDC.	April/July Strategic Development Committee

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

RISK ID:	TAF 08	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	**Goal 5**
EXECUTIVE LEAD	Matthew Bunce	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	3	4	**12**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	PE		

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	**Key Control**	**Owner**	**Preventative**	**Mitigating**	**Detective**	**Control Effectiveness Rating**	**1st Line of Defence**	**Assurance Rating**	**2nd Line of Defence**	**Assurance Rating**	**3rd Line of Defence**	**Assurance Rating**
C1	Trust Financial Strategy	Matthew Bunce	X			PA	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives and Senior Management	PA	Internal Audit cycle of assurance on financial strategy	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	Matthew Bunce		X		PE	Inclusion in Health Board IMTP Financial Plans	IA	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

KEY CONTROLS							SOURCES OF ASSURANCE					
ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	David Osborne	X			PA	Monthly Financial Performance Review Reported to Execs and	PA	Quarterly Directorate financial reviews	PA	Monthly Budget Holder Meetings with Business Partners	PA
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	Matthew Bunce		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	IA	Routine meetings with Depts to support business cases and any impacts on currencies	IA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA
C5	Benchmarking with appropriate services to ensure value	Matthew Bunce			X	PE	Non Surgical Benchmarking Group with Welsh Cancer Centres	PA	National Costing Cycle	PA		
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	David Osborne			X	PE	Monthly Financial Performance Review Reported to Commissioners with Monthly	PA	Annual Review of Contracting Model (focus on pandemic legacy impact)	IA	Introduction of Service Line Reporting	IA
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	Matthew Bunce	X			PE	Chief Executive Consideration of Investment at a Trust Level	IA	Divisional Senior Management Team investment review	IA		

TAF DASHBOARD

TRUST FINANCIAL INVESTMENT RISK

GAP IN CONTROLS	GAPS IN ASSURANCE
C3 – Governance of investment at Velindre Cancer Centre is being enhanced through the embedding of resource authorization, prioritization and allocation process, linked to Velindre Futures. Framework not fully embedded at present.	Inclusion of Velindre funding requirements with respective Commissioner financial planning requires formal clarification from Commissioners. Whilst requirements may be acknowledged, the financial challenges that Commissioners are prioritizing may not align with Velindre intents, consequently, assurance cannot be given that Velindre requirements will be met.
C4 – Whilst the contracting model has been continuously reviewed, the impact of COVID related measures has had a potential significant shift in cost base. This requires further understanding to identify mitigations.	The impact of COVID on current performance and cost base remains volatile, with recurrent funding also unclear. Capacity and demand modelling being undertaken in key risk areas.
C7 – Trust Investment Prioritisation Framework to be established.	Investment is limited in it's prioritisation to the Executive Team and Senior Management Teams

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Support the embedding of investment framework within Divisions	David Osborne	Process continues to be embedded, terms of reference and process established. Communications throughout Division and "live" operation to follow.	Jul-22
1.2	Review of contracting model for impact of COVID related measures	David Osborne	Areas of concern identified, discussions to inform are underway with Services. Board to	Jul-22
1.3	Establish Trust Investment Prioritisation Framework	Matthew Bunce	Initial proposals prepared, Executive discussions to shape and take forward	Jul-22

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

RISK ID:	TAF 09	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal: (See definitions tab)**
NEXT REVIEW	May-22	**Goal 2**
EXECUTIVE LEAD	Carl James	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: Rating and Rag (see definitions tab)	**RATING**	**Overall Trend in Assurance**	THIS WILL INCLUDE A TREND GRAPH
	PE		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority	Carl James	x			PE	Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
C2	Trust Clinical and Scientific Strategy	Nicola Williams	X			PE	Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel	Jacinta Abraham				PE	Executive Management Board review		Strategic Development Committee		Audit Wales Reviews	
C4	Development of improved local, regional and national clinical commissioning arrangements	Matthew Bunce	x			PE	Executive Management Board review		Strategic Development Committeen and performance		Audit Wales Reviews	

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

C5	Agreement of system leadership roles for primary services: 1. Blood Services 2. Cancer Services	Cath O'Brien	x			PE	Executive Management Board review/ patient and donor feedback		Strategic Development Committee		Audit Wales/MHRA & HIW/ regulators	
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth	Sarah Morley	x			PE	Executive Management Board review		Strategic Development Committee		Audit Wales/MHRA & HIW/ regulators	
C7	Refresh of Investment and Funding Strategy	Jacinta Abraham	x			PE	Executive Management Board review		R< D & I Sub-Committee and Performance Management		Audit Wales/External Research organisations & Welsh	
C8	Development of commercial strategy	Matthew Bunce	x			PE	Executive Management Board review		R< D & I Sub-Committee and Performance		Audit Wales/External Research organisations &	
C9	Attraction of additional commercial and business skills	Matthew Bunce		x		PE	Executive Management Board review				Audit Wales/External Research	

GAP IN CONTROLS	GAPS IN ASSURANCE
Lack of clinical and scientific strategy	
Commercial expertise within the Trust	
Robust commissioning arrangements across Wales	
Clear understanding of strategic direction/system design with partner LHBs	
Ability to identify and secure funding	
Lack of clarity about future services and required skills, capacity and capaility to leverage the strategic opportu	

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

TAF DASHBOARD

FUTURE DIRECTION OF TRAVEL

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity on future direction of travel	Carl James		May-22
1.2	Board decision on strategic areas of focus/to pursue	Board		May-22
1.3	Discussion with partner(s) to determine whether opportunity viable	Execs		tbc (dependent on Board
1.5	development of clinical and scientifc strategy	Jacinta Abraham		tbc
1.4	Identify capability required and funding solution/source	Execs		tbc (dependent on Board decisions in may 22

TAF DASHBOARD

GOVERNANCE

RISK ID:	TAF 10	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
LAST REVIEW	Mar-22	**Most Relevant Strategic Goal:** **(See definitions tab)**
NEXT REVIEW	May-22	**Goal 1**
EXECUTIVE LEAD	Lauren Fear	

RISK SCORE (See definitions tab)

INHERENT RISK			RESIDUAL RISK			TARGET RISK		
Likelihood	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**	**Likelihood**	**Impact**	**TOTAL**
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness: **Rating and Rag** (see definitions tab)	**RATING**	**Overall Trend in Assurance**	**GOING FORWARD THIS WILL INCLUDE A TREND GRAPH**
	E		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	PA	Audit Committee Trust Board	PA	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	PA
C2	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Annual Review	PA	Audit Committee	PA	Internal Audit of Board Committee Effectiveness	PA

TAF DASHBOARD

GOVERNANCE

								Trust Board		Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements		

KEY CONTROLS

SOURCES OF ASSURANCE

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	Lauren Fear			X	E	Divisional Management Arrangements for overseeing effective implementation and monitoring	PA	The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	PA	Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided substantial assurance) Audit Wales review outcomes of report as part of Annual Report - Accountability Report	PA
C4	Board Development Programme	Lauren Fear	X			PE	Programme established PA	IA	Independent Member Group repurposed and second meeting now held. Further	IA		
C5	All-Wales Self-Assessment of Quality Governance Arrangements	Lauren Fear		X		E	Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	PA		PA	Audit Wales review of Quality Governance Arrangements	PA
C6	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting	IA	Trust Board assessment via formal	IA	Internal Audit Reports. Audit Wales	PA

TAF DASHBOARD GOVERNANCE

GAP IN CONTROLS	GAPS IN ASSURANCE
None	Third line of defense in respect of C4 – Board Development Programme: no course of action is proposed

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

Action Plan	Owner	Progress Update	Due Date
C4 • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme.	Lauren Fear	Supported by the development priorities identified through an externally facilitated programme of Board development underway.	Apr-22
Ongoing input from the Independent Members via the repurposed Integrated Governance Group	Lauren Fear	Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by mid December.	Complete
Actions as agreed in the Governance Development paper for 2022/23	Lauren Fear	Will be completed in detail following the Board's receipt of the 2022/23 Governance development plan paper in March 22 meeting.	Various - to be detailed following March 22 Board

TRUST BOARD

BOARD COMMITTEE STRUCTURE - REVIEW

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	21/03/2022	IN SUPPORT

ACRONYMS	

1. SITUATION

1.1 Velindre University NHS Trust Board approved a new Board Committee Structure effective from November 2020, resulting in the move from a top line nine Committee model to a five Committee model.

1.2 Amongst a host of fundamental key changes, the revised model resulted in the establishment of a newly formed Strategic Development Committee, designed to create the time and space to discuss and endorse aspects of strategic direction and development to the Trust Board for approval, together with the establishment of a newly formed Quality, Safety and Performance Committee, designed to provide a more holistic and triangulated assurance to the Board encompassing the remit of the previous:

- Quality & Safety Committee
- Workforce & Organisational Development Committee
- Planning & Performance Committee
- Digital & Information Governance Committee

The new Board Committee structure is included at ***Appendix 1*** for ease of reference.

1.3 The purpose of this report is to **DISCUSS & REVIEW** the effectiveness of the new Board Committee Structure and operating arrangements following its first year of implementation. This review, whilst not limited to the following, has been both informed and augmented by a number of key elements:

- Renewed Benchmarking of Board & Committees across NHS Wales
- Quality, Safety & Performance Committee Annual Report 2020 – 2021 (Inclusive of the findings and recommendations of its Committee Effectiveness Survey)
- Strategic Development Committee Annual Report 2020 – 2021 (Inclusive of the findings and recommendations of its Committee Effectiveness Survey)
- Audit Wales Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements
- Internal Audit Report of Board Committee Effectiveness January 2022

2. BACKGROUND

2.1 When considering the Committee structure that a Trust Board decides to establish, it is important to consider both its statutory requirements, and the areas requiring a greater level of **SCRUTINY** and **ASSURANCE**, that are linked to the strategic objectives of the Board.

2.2 As part of its Statutory Requirements the Trust Board is required to have Committees that cover the following functions:

- Audit
- Quality and Safety
- Remuneration and Terms of Service
- Charitable Funds
- Information Governance
- NHS Wales Shared Services Partnership

This does not mean that the Board requires a separate Committee for all of these functions. Rather it is for the Board to be satisfied that there are robust Committee arrangements in place to ensure each of these areas is properly covered.

2.3 As a University Trust the Board is also required to have:

- A University Partnership Forum
- Local Partnership Forum

2.4 Any Committees established are required through the **Trust Standing Orders** to perform a number of functions in order to discharge the requirements set out in their terms of reference. These include:

- Holding regular meetings with formal agendas and minutes
- Producing reports for consideration by the Board
- Producing an Annual cycle of business
- Producing Annual Reports on their activities

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Benchmarking of Board & Committees across NHS Wales

A renewed benchmarking exercise was undertaken across NHS Wales in the autumn of 2021, to review the number, type and remit of Committees on a pan Wales' basis, the outcome of which is included at ***Appendix 2,*** and was reported and discussed at both the Deputy and Board Secretaries networks.

This review confirmed and provides **ASSURANCE** that the new Board Committee Structure adopted by the Trust is both proportionate, in terms of the size and composition of the Trust when compared to the Board Committee arrangements across NHS Wales, and is also effectively aligned to the Trust's responsibilities and accountabilities in terms of each of the Committee's agreed remit, accountability and delegated authority.

3.2 Quality, Safety & Performance Committee

3.2.1 Annual Report

Under **Standing Order 4.3.2**, each Committee of the Trust Board is required to submit an Annual Report ***"setting out its activities during the year and detailing the results of a review of its performance".***

In November 2021, the Quality, Safety & Performance Committee provided its first Annual Report to the Trust Board detailing the activities and performance for its inaugural year of operation for the reporting period November 2020 – October 2021. The Quality, Safety & Performance Committee's first Annual Report is included at ***Appendix 3***.

The report outlines the breadth and depth of activity undertaken in the Committee's first year of operation, including how it has evolved and matured since its initial establishment, together with the plans for its continued development over the year ahead.

One of the reported benefits of this integrated Committee is that triangulated analysis can take place to provide enhanced assurance to the Board. It is recognised that the supporting infrastructure for this requires enhanced further development. It has therefore been proposed that an operational **Quality and Safety Group** will be established in early 2022 that will feed into the Committee. It is anticipated that this will also go some way to address some of the feedback received in the Committee's Annual Effectiveness Survey regarding the level of detail and quantity of information currently being provided to the Committee.

The Annual Report also sets out the Committee's established role and clear commitment to ensuring the safety and performance across the Trust continues to be effectively managed in accordance with all relevant legislative and regulatory requirements, national frameworks and best practice guidelines. In particular, the Annual Report highlights that over the next year the Committee will be required to have strategic oversight of the Trust's arrangements and plans to meet its statutory responsibilities in respect of the new **Quality & Engagement Act (2020)** that will be operating in shadow form by October 2022 and the new **National Quality Framework (2021)**.

3.2.2 Annual Effectiveness Survey

The Quality, Safety & Performance Committee's Annual Report also incorporates the findings from its first Annual Effectiveness Survey, designed to assess its performance together with any opportunities for continuous improvement going forward.

The outcomes from the survey will help to inform the continued evolution of the Quality, Safety & Performance Committee as it enters its second year of operation. In addition to the above, key areas of focus identified for the coming year will include:

- Further review of the Trust 'hosted organisation' reporting arrangements in respect of Quality, Safety & Performance
- Training being provided to Trust officers in relation to Board Committee report writing for **ASSURANCE** (*ref. 3.6.1*)
- Continuous review of the Committee Cycle of Business
- Review of the quality and level of details of reports received by the Committee to enhance and engineer more effective triangulation
- Flow of operational and divisional reporting to the Committee

3.3 Strategic Development Committee

The Strategic Development Committee's Annual Report, due to the April 2022 meeting, will incorporate the findings from its first Annual Effectiveness Survey, designed to assess its performance together with any opportunities for continuous improvement going forward.

The outcomes from the survey will also help to inform the continued evolution of the Strategic Development Committee as it enters its second year of operation.

3.4 Audit Wales Structured Assessment 2021 (Phase Two)

In January 2022, Audit Wales reported to the Trust Board, as part of its Annual Report, the findings of its Structured Assessment of the Trust Corporate Governance and Financial Management Arrangements, included in full at ***Appendix 4***.

The Audit was conducted in the context of the ongoing response to the pandemic. It considered how corporate governance and financial management arrangements adapted over the year. Auditors also paid attention to progress made to address previous recommendations.

The main conclusions pertinent to this review of the new Board Committee structure are summarised below.

3.4.1 Governance Arrangements

The Trust's ability to maintain sound governance arrangements while having to respond to the unprecedented challenges presented by the pandemic have been assessed. The key focus of the work assessed the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. It also considered how business deferred in 2020 was reinstated and how learning from the pandemic is shaping future arrangements for ensuring continued good governance and recovery. It was determined that:

- The Trust has good arrangements to conduct Board and Committee business.

- The Trust has good governance arrangements which adapted well to the pandemic. The Trust has streamlined its Board Committee structure, and postponed Board and Committee business is being reactivated.
- The quality and presentation of information at Board and Committees is good, on occasions, papers include content which is perhaps too detailed.
- Transparency of Board business to the public is good, with some opportunities for improvements, including ensuring that video recordings and Committee papers are uploaded to the website shortly after meetings. It was noted at the time of issuing the report that measures to address this finding have already been completed and fully addressed.

3.5 Internal Audit Board Committee Effectiveness January 2022

In January 2022, Internal Audit reported to the Trust Audit Committee the findings of its review of the Trust Board Committee Effectiveness, included in full at ***Appendix 5***.

The Audit was conducted to provide the Trust Board with assurance over the:

- Effectiveness of the new Board Committee Structure.
- The adequacy and effectiveness of controls in operation.

The report concluded that the Trust is committed to improving effectiveness and efficiency in its accountability and decision-making at Board level through the November 2020 Board Committee restructuring and ongoing development work in this area. The report identified some recommendations to further ensure robustness in the process and support the Trust in maximising efficiency and effectiveness. These are summarised below:

- Clearer alignment of committee cycles of business and agendas with the Trust's objectives and risks.
- Developing a robust process to ensure all required reports are included in agendas.
- Clearly defining what success looks like for the new structure to support continued assessment of benefits realisation.

Internal Audit concurred with the management actions taken to date and acknowledged, via the Trust's own established development work, that the Trust has plans in place or is already acting to address many of the areas it identified throughout its review.

3.6 Key Areas of Focus for 2022-2023

3.6.1 Board Committee Report Writing

A comprehensive and robust training programme has been developed to support Trust Officers in preparing reports for the Trust Board and Committees. The training has been designed to achieve three main objectives:

I. How to write clear, succinct, triangulated reports to provide effective **ASSURANCE**
II. How to write reports for different audiences, in particular the Executive Management Board, Public Committees and Trust Board.
III. Identify any changes required to the Board Committee report template to support the achievement of the first two objectives.

The training programme has been structured to commence initially with three cohorts during April and May 2022. A Training Needs Analysis has been undertaken to identify key Trust Officers responsible for the completion of Board Committee reports, with validation provided by Divisional Directors supported by further Executive Oversight to confirm and provide assurance on this process. A wider roll out of the training programme is also anticipated later in the year which will be informed by a further Training Needs Analysis and supported by an evaluation of the initial roll out.

Discussion and ongoing engagement with both the Independent Members and feedback from the Executive Team has supported the development of this training programme and is augmented by the findings of Audit Wales' Structured Assessment and Internal Audit review outlined earlier in this report. Executive leads have been asked to oversight

In parallel to this development, the paper template will be updated to reflect. This will be discussed and agreed by both Executive and Independent Members to ensure meeting expectations for all in the best way. The "impact assessment" section has already been updated ready to insert, with an updated articulation of the considerations to document, including the Wellbeing and Future Generations Act and Socio-Economic Duty.

3.6.2 Board Committee Minute Taking and Action Recording

Key personnel that support and underpin the wider Board Committee structure will receive minute taking training in how to write clear, succinct and accurate minutes. The training programme will be informed by a Training Needs Analysis and is planned for the beginning of Quarter 2 of 2022-2023. This will enable the required engagement with key leads across the Trust to inform the course content. In particular, the identification of a preferred Trust **'style'** for minute taking by both the Executive Team and Independent Member to ensure that a clear and consistent approach to preferred expectations can be collectively agreed by all stakeholders. In addition, there will be discussion via the Trust Board Development Programme for 2022-2023, for there to be an agreement on a Trust approach on how to summarise key themes, decisions made and agreed actions, to enable more effective recording and reporting arrangements across each of the Trust Board Committees.

3.6.3 Cycle of Business

A continuous review across each of the Board Committee's Cycle of Business will be undertaken in the coming year with a sharp focus on the flow and alignment with divisional reporting arrangements. Considerable work has already been undertaken for the 2022-2023 reporting period in this regard in relation to the Quality, Safety & Performance, and will be strengthened further over the duration of the year across the wider Board

Committee structure. The Chief Operating Officer is also leading a review across each of the divisions to develop a flow 'wire diagram' to further underpin this continuous review process and programme of work.

3.6.4 Hosted Organisations Assurance & Reporting Arrangements

A review of the mapping of the Trust's accountability for hosted organisations to the Board Committee Structure and associated oversight and assurance mechanisms has been completed for the NHS Wales Shared Services Partnership Committee. This will now be implemented fully during the March 2022 reporting cycle onwards. A further review has also been initiated in respect of the Trust's second hosted organisation i.e. Health Technology Wales. The conclusions of this work and any proposed changes will be worked through with the Chairs and Chief Executive of Health Technology Wales and each of the respective Committees and ultimately Trust Board.

3.6.5 Patient Engagement Framework

A review of the role and responsibilities performed by Patient Representatives across the breadth and depth of the Trust Board Committee structure will be undertaken to support the effective implementation of a new Patient Engagement Framework in 2022 - 2023.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Training & Development Programme to support key areas of focus identified for 2022-2023.

5. RECOMMENDATION

5.1 The Trust Board is asked to:

a. **DISCUSS AND REVIEW** the findings of the review of the new Board Committee Structure following its inaugural year of operation.

b. **NOTE** the progress made to date in continuing to strengthen and develop its operating arrangements.

c. **ENDORSE** next steps to support recommended actions and key areas of focus identified for the 2022 – 2023 reporting period.

Statutory, Public Trust Board Committees

Quality, Safety & Performance Committee (Bi-Monthly)	Strategic Development Committee (Bi-Monthly)	Audit Committee (Quarterly)	Audit Committee (NWSSP) (Quarterly)	Remuneration Committee (Bi-Monthly)	Charitable Funds Committee (Quarterly)
Quality & Safety Compliance & Standards Commissioning Arrangements Risk Management Trust Assurance Framework Annual Plan / IMTP Monitoring Listening & Learning Workforce Digital Delivery Information Governance	Strategy for Commissioning Innovation TCS future direction setting & other Major Programmes Trust Strategies Development of IMTP Partnerships (Academia / Industry / Third Sector) Digital Developments Organisational Development	Governance & Risk Accounts Internal Audit External Audit Counter Fraud Audit Tracker	Partnership Committee between NHS Wales Shared Services Partnership and Velindre University NHS Trust	Executives Objectives Executive Performance Anonymous Correspondence Voluntary Early Release Scheme (VERS)	Governance & Risk Strategy & Performance Financial Reporting Investment Fundraising Activity Advanced Radiotherapy Programme Board

Sub Committee: TCS Scrutiny
- Programme Highlight Report
- Risks & Issues
- Close Out Report

Sub Committee: TCS Scrutiny
- TCS Future Direction Setting
- Proposed Actions to be taken forward

Sub Committee: R,D & I
- Highlight Report
- Progress against Trust R, D & I Annual Operational Plan

Sub Committee: R,D & I
- Trust R, D & I Strategy Updates
- Steering Group Updates

Sub Committee: R,D & I
- Alignment to Strategy & Funding

Sub Committee: Investment Performance Review

Forums & Advisory Groups:
Local Partnership Forum & Advisory Groups / Advisory Consultants Appointment Committee / Academic Partnership Board / Integrated Governance

Mission: Partnering people to live well

Vision: *By 2025 we will have helped more people to live longer, better lives and be the organisation others come to learn from*

MAPPING OF BOARD AND COMMITTEES ACROSS NHS WALES

The following table maps the Number and Types of Committees within each organisation as extracted from public facing websites:

SUMMARY DETAILS

Organisation	Number of Committees	Number Sub-Committees	Number of Advisory Groups
Aneurin Bevan University Health Board	7	2	3
Betsi Cadwaladr University Health Board	8	1	4
Cardiff & Vale University Health Board	11	?	
Cwm Taf Morgannwg University Health Board	9	1	3
Hywel Dda University Health Board	9	6	3 (Statutory)
Powys Teaching Health Board	7	1	1
Swansea Bay University Health Board	8	1 sub-committee and three sub-groups	3 (but only two are formally standing)
Public Health Wales Trust	5	0	0
Velindre University NHS Trust	5	3	3
Welsh Ambulance Service NHS Trust	7	?	
Digital Health and Care Wales	3	0	1
Health Education Improvement Wales	3	0	2
Welsh Health Specialised Services Committee	5	0	1 (but will be formally dis-established)

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
Aneurin Bevan University Health Board	7	Audit, Finance and Risk Committee *(bimonthly)* Charitable Funds Committee *(x3 per year)* Mental Health Act Monitoring Committee *(quarterly)* People and Culture Committee *(quarterly)* Strategy Planning, Partnerships and Wellbeing Group *(x5 per year)* Patient Quality, Safety and Outcomes Committee *(bi-monthly)* Remuneration and Terms of Service Committee *(x2 per year)*	Audit, Info Gov Charitable Funds MHA Quality and Safety, Info Gov (patient data) RATS	Power of Discharge Sub Committee Quality and Patient Safety Operational Group	Lessons learned from COVID-19, together with the Structured Assessment and Internal Audit reviews, led to a review of the Committees and implementation of a leaner structure. Reducing the number of Committees from 10 to 7	• Stakeholder Reference Group • Trade Union Partnership Forum • Healthcare Professionals Forum	Committees not currently live streamed but this is something we are looking at for the future
Betsi Cadwaladr University Health Board	8	Audit Committee Charitable Funds Committee Digital and Information Governance Committee Mental Health and Capacity and Compliance Committee Quality Safety & Experience Committee Partnerships, People and Population Health Committee	Audit Charitable Funds Info Gov MHA / MCA Quality and Safety	Power of Discharge Sub Committee	Not necessarily due to COVID 19 but governance review to be implemented from Sept 2021. Approved at July Board (item 4.5: https://bcuhb.nhs.wales/about-us/health-board-meetings-and-members/health-board-meetings/health-board-meetings/agenda-health-board-15-7-21-v3-0-revised-and-uploaded-13-7-21/)	Charitable Funds Advisory Group Stakeholder and Reference Group Healthcare Professionals Forum (HPF) Local Partnership Forum	Committees not currently live streamed but something we are considering for the future

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
		Performance, Finance and Information Governance Committee Remuneration and Terms of Service Committee	 RATS				
Cardiff & Vale University Health Board	11	Audit Committee Board of Trustees Charitable Funds Committee Digital Health Intelligence Committee Finance Committee Health and Safety Committee Mental Health and Capacity Legislation Committee Quality, Safety and Experience Committee Remuneration and Terms of Service Committee Shaping Our Future Hospitals Committee Strategy and Delivery Committee	Audit Charitable Funds Info Gov MHA Quality and Safety RATS	Charitable Funds Bid Panel Staff Benefits Group Digital Directors Peer Group ICT Capital Management Group Operational Health and Safety Group Mental Health Legislative Group Power of Discharge Sub-committee Future Hospitals Programme Board 7 Clinical Board Quality and Safety Sub – Committees Clinical Effectiveness Committee SI Concerns Organisational Learning	Board and Committee meetings have been held virtually due to COVID. There are no plans at the moment to bring these back to face to face meetings. At the start of COVID monthly Board meetings were instigated to ensure appropriate reporting on key areas during the pandemic. They were subsequently stepped down. From this month, we have re-introduced monthly Board meetings. We plan to review our Committee structure in the next few months and anticipate that we may reduce the number of Committees we currently have.	Stakeholder Reference Group Healthcare Professionals' Forum Local Partnership Forum	Board meetings are livestreamed. We record our Board meetings and have just started to record our Committee meetings. The recordings are then made available on our website. At the moment there are no plans to livestream our Committee meetings.
Cwm Taf Morgannwg University Health Board	9	Audit & Risk Committee Charitable Funds Committee Digital & Data Committee Mental Health Act Monitoring Committee People & Culture Committee Population Health and Partnerships Committee	Audit Charitable Funds Info Gov MHA		Learning from Covid-19 – is the continued use of the Consent Agenda to support focus on business critical activity. Questions are sought in advance for consent agenda items. The Health Board is currently reviewing its Board Committee structure to align with its new strategic goals which may result in the number of Committees being reduced.	Stakeholder Reference Group Local Partnership Forum Clinical Advisory Group (formerly known as the Health Professions Forum)	Board Committee meetings are not currently being livestreamed. This has been risk assessed and is under review.

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
		Planning, Performance & Finance Committee Quality & Safety Committee Remunerations and Terms of Service Committee	Quality and Safety RATS	Health, Safety & Fire Sub Committee	Terms of reference for all Board Committees and Advisory Groups are published on the Health Boards website under the Standing Orders.		
Hywel Dda University Health Board	9	Audit and Risk Assurance Committee *(bimonthly)* Charitable Funds Committee *(bimonthly)* Health and Safety Committee *(bimonthly)* Mental Health Legislation Committee *(quarterly)* People, Organisational Development & Culture Committee *(bimonthly)* Strategic Development & Operational Delivery Committee *(bimonthly)* Sustainable Resources Committee *(bimonthly)* Remuneration and Terms of Service Committee *(bimonthly)* Remuneration and Terms of Service Committee (RTSC) - Hywel Dda University Health Board (nhs.wales) Quality, Safety and Experience Committee *(bimonthly)*	Audit Charitable Funds MHA Info Gov RATS Quality and Safety	Hospital Managers Powers of Discharge Sub-Committee Research and Innovation Sub Committee Information Governance Sub-Committee Capital, Estates & IM&T Sub-Committee Listening and Learning Sub Committee Operational Quality Safety & Experience Sub Committee	The Health Board has reviewed its Board Committee structure to align with its new strategic and planning objectives which has resulted in the establishment of an additional Committee and a change of focus for a number of others.	Stakeholder Reference Group Healthcare Professionals Forum Staff Partnership Forum	No plans to livestream other than the Board.
Powys Teaching Health Board	7	Charitable Funds Committee RATS Committee Audit, Risk & Assurance Committee Patient Experience, Quality & Safety Committee Delivery & Performance Committee Workforce & Culture Committee	Charitable Funds RATS Audit Quality and Safety	MHA Power of Discharge Group	The Health Board has reviewed its Board Committee structure to align with its new strategic and planning objectives, which has resulted in the establishment of an additional Committee, and a change of focus for several others.	Healthcare Professionals Forum (yet to be established) Local Partnership Forum Stakeholder Reference Group (yet to be established)	Board is livestreamed but committees are not.

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
		Planning, Partnerships and Population Health Committee					
Swansea Bay University Health Board	8	Quality & Safety Committee Workforce & OD Committee Audit Committee Performance and Finance Committee Mental Health Legislation Committee Health and Safety Committee Remuneration and Terms of Service Committee Charitable Funds Committee Terms of reference Meeting structure included as a separate file in the folder.	Quality and Safety Audit and IG MHA **RATS** **Charitable Funds**	Hospital Managers Powers of Discharge Sub-Committee Charitable Funds Bids Panel Quality and Safety Governance Group Clinical Ethics Group	Meetings are held via Teams. Initially, attendance by execs and agendas were reduced but arrangements are now back to normal.	Healthcare Professionals Forum (not currently meeting) Local Partnership Forum Stakeholder Reference Group	Board is livestreamed but committees are not.
Public Health Wales Trust	5	Audit and Corporate Governance Committee Quality, Safety and Improvement Committee People and Organisational Development Committee Knowledge, Research and Information Committee Remuneration andTerms of Reference Service Committee	Audit Quality and Safety, Health and Safety Info Gov RATS	None listed on website	ACGC and QSIC increased frequency during COVID to 8 weekly. KRIC and PODC were stood down during COVID, with the statutory elements of these Committees being reported to other Committees / Board. PODC recommenced in April 2021. KRIC due to resume in Quarter 3 of 2021/22. All meetings moved to virtual in March 2020, via Microsoft teams.	During Covid the Board Set up a People Advisory Group (Nov 2020 to March 2021). The purpose of the Group was to support the work of the full Board by providing timely advice and assurance on the following: Staff health and wellbeing; Staff resilience; Staff recruitment – particularly in relation to the health protection response and microbiology (sampling/testing capacity targets). This group was stood down when the PODC was reinstated in April 2021.	Not currently livestreamed, plans to progress this this Financial year, to livestream the public Committee meetings.
Velindre University NHS Trust	5	Quality, Safety & Performance Committee Strategic Development Committee	Quality, Safety, Performance, Workforce matters, Digital delivery, Information Governance Strategic decision making and	• Transforming Cancer Services Programme Scrutiny Sub Committee • Research Development & Innovation Sub Committee	Board & Committee meetings have been held virtually due to COVID. Learning from Covid-19 – is the continued use of the Consent Agenda to support focus on business critical activity. Questions are sought in advance for Consent Agenda items.	• Local Partnership Forum • Advisory Consultants Appointment Committee • Academic Partnership Board	Trust Board is live streamed via Zoom Webinar, Committees are not.

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
			organisational development				
		Audit Committee	Audit, strategic governance and assurance arrangements				
		Charitable Funds Committee	Charitable Funds	• Charitable Funds Investment Performance & Review Sub Committee • Advancing Radiotherapy Fund			
		Remuneration and Terms of Reference Committee	RATS				
Welsh Ambulance Service NHS Trust	7	Academic Partnership TOR	Education, University Status		No changes		Board is livestreamed but Committees are not
		Audit Committee	Audit, Compliance, Risk				
		Charitable Funds TOR	Charitable Funds	Charitable Funds Bid Panel			
		Finance and Performance	Information Governance	Capital & Estates Group			
		People and Culture Committee TOR	Workforce, training, organisational learning	Health & Safety & Committee			
		Quality, Patient Experience and Safety Committee	Quality and Safety, MHA	Clinical and Quality Governance Group			
		Remuneration Committee	RATS				
Digital Health and Care Wales	3	Audit & Assurance Committee	Audit, Compliance, Risk, Finance	No Sub Committees	Virtual Board and Committee Meetings. No other changes were made due to Covid as the organisation only came into being with the Board governance structure in April 21.	Local Partnership Forum	Live Streamed Board Meetings. Committee meetings are currently being considered.
		Digital Governance & Safety Committee	Cyber Security, Information Governance, Informatics Assurance, Information Services, Health and Care standards relevant to the remit of the Committee, Incident Review and Organisational Learning				
		Remuneration and Terms of Service Committee	RATS				

NHS Organisation	Number	Name Of Committees, link to ToR and frequency of meeting	SO Check: Aspects of Board business specified in SOs covered by these committees*	Sub Committees	What has changed due to Covid-19	Advisory Groups	Livestreamed
Health Education Improvement Wales	3	HEIW SO's and ToR Audit & Assurance Committee (pages 64-69 SOs) (*quarterly)* Education, Commissioning & Quality Committee (pages 72-75 SOs) *(quarterly)* Remuneration and Terms of Service Committee (pages 70-71 SOs) (*bi-monthly)*	Audit and Assurance Education, Commissioning and Quality RATS	None.		Education Advisory Group Multi-Professional Quality and Education Group	Live stream Board and Committee meetings.
Welsh Health Specialised Services Committee	5	(The WHSSC Joint Committee is the equivalent of the HB and Trusts Boards. The JC sub-committees are the WHSSC equivalent of your sub-committees). Integrated Governance Committee *WHSSC attends Part B of the Cwm Taf Morgannwg Audit & Risk Committee – Hosted Bodies Quality and Patient Safety Committee https://whssc.nhs.wales/joint-committee/sub-committees/quality-patient-safety-committee/q-ps-terms-of-reference All Wales IPFR Panel https://whssc.nhs.wales/joint-committee/sub-committees/all-wales-individual-patient-funding-request-panel/ipfr-terms-of-reference/ Welsh Renal Clinical Network Microsoft Word - WRCN Board ToR - Approved 14.05.2019 (nhs.wales) Management Group https://whssc.nhs.wales/joint-committee/sub-committees/management-group1/mg-terms-of-reference/	 Audit and Assurance Quality and Safety	None	All meetings moved to virtual in March 2020, via Microsoft teams.		Joint Committee Meetings and sub-committee meetings are not live streamed.

*__Health Board Model Standing Orders state:__

3.4.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board business:

- Quality and Safety;
- Audit;
- Information governance;
- Charitable Funds;
- Remuneration and Terms of Service; and
- Mental Health Act requirements.

*__Trust Model Standing Orders state:__

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which cover the following aspects of Board
business:

- Quality and Safety;
- Audit;
- Information Governance;
- Charitable Funds [as appropriate];
- Remuneration and Terms of Service; and
- Mental Health Act requirements [as appropriate].

* **HEIW Model Standing Orders state:**

3.3.1 The Board shall establish a Committee structure that it determines best meets its own needs, taking account of any regulatory or Welsh Government requirements. As a minimum, it must establish Committees which covers the following aspect of Board business:

- Audit and Assurance;
- Remuneration and Terms of Service, and
- Education, Commissioning and Quality Committee.

*** DHCW Model Standing Orders state:**

Schedule 3 - The DHCW Board has agreed initially to set up three committees:

- Audit & Assurance Committee;
- Remuneration and Terms of Service Committee; and
- Committee or committees to provide oversight and scrutiny of quality, safety, information governance, data quality, security and risk to be known as the Digital Governance and Safety Committee

Velindre University NHS Trust

Quality, Safety & Performance Committee

Annual Report 2020-2021

Table of Contents

Foreword

Jan Pickles,

Chair of Quality, Safety & Performance Committee (2020/21) and

Independent Member

(2012-2021)

As I come to the end of my nine year tenure as Chair of the Quality & Safety Committee, and this past year, Chair of the Quality, Safety and Performance Committee, I feel enormous pride in the work undertaken by all of the staff who make up the Trust.

This last year has tested us all and I have seen staff rise to the challenge whilst coping with the appalling losses both within our families and loved and treasured colleagues. These awful times we faced together, some staff working from their kitchen tables offering care and support to patients and their families others striving to deliver the best treatment and support they could in the Cancer Centre during the pandemic. The Welsh Blood Service has shown remarkable agility and fortitude in changing its delivery model overnight. The 'backroom staff' who ensured professionals could continue to work from home and had the right IT. The staff in Procurement who also had to compete in a fast changing world market to ensure staff had the vital equipment they needed.

I wish to express my heartfelt thanks and those of the Trust Board to all of our staff, it has been a privilege to be part of it.

Jan Pickles

Nicola Williams,

Executive Director of Nursing, Allied Healthcare Professionals, & Health Scientists and

Executive Lead for the Quality, Safety & Performance Committee

I am extremely pleased at how the Quality, Safety and Performance Committee has developed over the last 12 months during one of the most difficult periods the NHS has had. It has been really advantageous to see all relevant information and assurance in one place so that triangulation can take place. This puts us in a very good position in respect of the Velindre University NHS Trust meeting its emerging new statutory responsibilities in relation to the Wales Quality & Engagement Act (2020) and responsibilities as outlined in the NHS Wales Quality Framework. The work of the Committee will be further enhanced in the forthcoming year with an increased focus on analysis and triangulation, the quality and depth of papers and information and further reviews of the work programme.

Nicola Williams

1. Introduction

In September 2020, the Trust Board approved a new Board & Committee model resulting in the move from a top line nine committee model to a five committee model. Amongst a number of key changes, the revised model resulted in the establishment of a newly formed Quality, Safety and Performance Committee, encompassing the remit of the previous:

- Quality & Safety Committee;
- Workforce & Organisational Development Committee;
- Planning & Performance Committee, and
- Digital & Information Governance Committee.

A key aim of the new Quality, Safety & Performance Committee was to bring information together across a number of key areas to enable the integration of, quality, safety and performance reporting, together with finance, digital and workforce, facilitating more effective oversight and holistic assessment of work being undertaken across the Trust, to triangulate information and promote enhanced scrutiny and assurance.

This Annual Report summarises the key areas of business activity undertaken by the newly established Quality, Safety & Performance Committee in its first year of operation, encompassing the period from the 12th November 2020 up to and including the 16th September 2021.

The Quality, Safety & Performance Committee's full annual business cycle will conclude on the 31st October 2021. As detailed later in the Annual Report, as part of the Committee's ongoing commitment to continuous review and improvement, the established Cycle of Business has been subject to regular review, in order to actively seek and identify any opportunities for improvement in its inaugural year; this surpasses that required to meet its annual governance standard and requirement.

The Annual Report reflects the Committee's key role in the development and monitoring of the Quality, Safety & Performance governance and assurance framework, as well as the outcome of the 2020-2021 Quality, Safety & Performance Committee Annual Effectiveness Survey.

2. Roles and Responsibilities

The primary purpose of the Quality, Safety & Performance Committee is to provide:

- Evidence based, timely advice and assurance to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to:
  - quality, safety, planning and performance of healthcare;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects of workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

The Quality, Safety & Performance Committee met six times during the year and received and discussed presentations and reports on matters that fall within its terms of reference.

During 2020/2021, the Quality, Safety & Performance Committee business was underpinned and informed through the work of a number of Management Groups, and Governance and Assurance Processes as set out in ***Appendix 1***. It is recognised that further work is required in respect of the management groups and it is proposed that an operational Quality & Safety Management Group is established in 2022, to undertake work prior to the Committee in relation to detailed analysis, triangulation and evidencing of learning.

3. Agenda Planning Process

In line with the agreed Committee Cycle of Business, the Chair of the Quality, Safety & Performance Committee, in conjunction with the Executive Director of Nursing, Allied

Healthcare Professionals, & Health Science and the Head of Corporate Governance, set the agenda for Committee meetings. The Committee secretariat for the meeting is provided by the Business Support Officer to the Executive Director of Nursing Allied Healthcare Professionals, & Health Science.

The Committee's agenda and meeting papers are disseminated to members and attendees a minimum of ten working days before the meeting, and are also made available on the Trust website. All papers are required to be accompanied by a cover report which provides a summary of key matters for consideration, and supporting details on the action required by the Committee.

4. Terms of Reference and Operating Arrangements

The Committee's Terms of Reference and Operating Arrangements are reviewed on an annual basis. Their first annual review was commenced in October 2021 and the proposed revised Committee Terms of Reference and Operating Arrangements will be received at the 18th November 2021 meeting of the Quality, Safety & Performance Committee for **ENDORSEMENT**, and then subsequently submitted to the Trust Board for **APPROVAL**.

5. Membership, Frequency and Attendance

The Committee's Terms of Reference and Operating Arrangements specify that the Committee comprises a minimum of two members including:

- Committee Chair (Independent Member of the Board & Quality and Safety Lead)
- One Independent Member of the Board

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise. During the year, the Committee met on six occasions with attendance as outlined below:

	Committee Attendance						
Members	**Date 12/11/20**	**Date 18/01/21**	**Date 15/03/21**	**Date 13/05/21**	**Date 15/07/21**	**Date 16/09/21**	**Attendance**
Janet Pickles (Chair of the Committee for the reporting period)	✓	✓	x	x	✓	x	50%
Professor Donna Mead OBE (Chair of Velindre University NHS Trust)	✓	✓	✓	✓	✓	x	83%
Stephen Harries (Interim Vice Chair of Velindre University NHS Trust)	✓	✓	✓	✓	✓	✓	100%
Hilary Jones (Independent Member of the Board)	✓	✓	✓	✓	✓	✓	100%

6. Quality, Safety & Performance Committee Activity

The Trust's strategic approach to quality, safety and performance is informed by national and local drivers, and is underpinned by developing and established planning and delivery processes: robust performance monitoring and quality assurance mechanisms;

and a culture of increasing quality/services improvement knowledge and expertise amongst staff.

The Committee's Cycle of Business is configured to obtain assurance, on behalf of the Board, in relation to Trust activities falling within the Committee's scope. A mapping exercise was undertaken to support the introduction of the Quality, Safety & Performance Committee which mapped all previous items of business received by the:

- Quality & Safety Committee;
- Workforce & Organisational Development Committee;
- Planning & Performance Committee, and
- Digital & Information Governance Committee.

This exercise was undertaken through engagement with the Chairs of each of the respective Committees and Executive Leads to ensure that all of the required items of business were captured and any changes at that point were included. In addition, a legacy report was received at its inaugural meeting to ensure that any residual actions that remained open from the previous operating Committees transferred across to the new Quality, Safety & Performance Committee for completeness and assurance.

The Committee recognises that external regulation is a key component of the Trust's quality, governance and assurance framework, and received information about external inspection, regulation and accreditation activities as part of its Cycle of Business. The Committee also received and reviewed information in relation to serious incidents reportable to Welsh Government, complaints about services provided, personal injury and medical negligence claims, and findings from audit and review activity. The Committee seeks assurance that the Trust has processes in place to act on findings, and recommendations for improvement. During 2020/2021 the Committee obtained assurance in relation to a wide range of additional quality, safety and performance related activities over and above those just highlighted, these are summarised below.

6.1 Patient / Donor / Staff Stories

The Quality, Safety & Performance Committee is committed to ensuring that as a Trust, we firmly place patients, donors and our staff at the heart of everything we do. To support this, at each meeting of the Committee is opened with a patient / donor / staff story, so that the Committee is able to hear about our their individual experiences of the services we provide in order that we may pursue any learning opportunities that can be identified, to further enhance and improve the services we deliver; a selection of which are summarised below for the reporting period.

Patient Stories – Velindre Cancer Service	Presented by
The Committee received a patient story presentation that had been developed in conjunction with the family of a patient of Velindre Cancer Service who has sadly passed away. The story provided an overview of the patient's background and experience of attending a Velindre clinic held at an Outreach location.	Viv Cooper, Head of Nursing, Quality, Patient Experience and Integrated Care, Velindre Cancer Service
The Committee received the story of a patient who had been receiving treatment at Velindre Cancer Service for advanced lung cancer. The story described overwhelmingly positive experiences of all care, treatment and interactions at the Cancer Service.	Lisa Miller, Chief of Operations, Velindre Cancer Service

Donor Stories – Welsh Blood Service	Presented by
The Committee received a video donor story that described a difficult situation in respect of a donor's experience when trying to arrange to give blood via the online booking process following a miscarriage. The Committee learned how the Welsh Blood Service turned what could have been received as negative feedback into making a positive difference for donors.	Alan Prosser, Interim Director, Welsh Blood Service
The Committee received a video developed by the Welsh Blood Service on a donors' experience of giving blood during the COVID-19 pandemic.	Jonathan Ellis, Head of Donor Engagement
The Committee received a film about a blood donor's feedback that supported the introduction of a new clinic venue by the Welsh Blood Service, and an excellent example of co-production.	Alan Prosser, Interim Director, Welsh Blood Service

6.2 Divisional Assurance Mechanisms and Reports

The two operational divisions of the Trust, i.e. the Welsh Blood Service and the Velindre Cancer Service, each provide a divisional report to the Quality, Safety & Performance Committee on a rotational basis for assurance. The purpose of each report is to provide the Committee with an update on the key quality, safety and performance outcomes and metrics for the reporting period, together with an overview of key priority areas, any issues, corrective actions and monitoring arrangements in place, together within any service developments planned or underway. These reporting arrangements have developed and matured throughout the year, with reporting initially required at each meeting to the Committee, due largely to the increased assurance required against the COVID 19 backdrop. Frequency of reporting to the Committee has since been reduced to every other meeting, as the level of risk and assurance required has altered in requirements as the pandemic has progressed.

6.3 Presentations

The Quality, Safety & Performance Committee has also received a number of presentations throughout its inaugural year, two of which are highlighted below.

Topic	Highlight of Presentation	Presented by
COVID 19 Vaccination Programme 	The Committee received a presentation on the Trust's Covid-19 Vaccination Programme and its pivotal role supporting the National Programme.	Nicola Williams, Executive Director of Nursing, Allied Healthcare Professionals, & Health Scientists

Topic	Highlight of Presentation	Presented by
Developing and Sustaining a Healthy & Engaged Workforce 	The Committee received a detailed presentation that outlined the steps the Trust is taking to implement plans developed for a healthy and engaged Workforce following the impact of COVID-19 and concerns raised in the staff survey.	Susan Thomas, Deputy Director of Workforce

6.4 Policy Approvals

The Committee approved a number of Trust and All Wales policies during 2020 / 2021:

- Medical Devices and Equipment Management Policy;
- Respect and Resolution Policy;
- Interim Revised Trust Handling Concerns Policy;
- All Wales Information Governance Policy;
- All Wales Information Security Policy;
- All Wales Internet Use Policy;
- All Wales Reserve Forces Training and Mobilisation Policy, and
- All Wales Secondment Policy.

6.5 External Reviews, Internal Audit Reviews and Reports

The Committee received and considered external reviews and reports, and enquired about transferable learning, including in relation to:

- Care Inspectorate Wales (CIW) National Review of Prevention of Independence for Older Adults - Listen and then listen again
- Health Inspectorate Wales (HIW) Annual Report 2020/21 and Work Plan 2021/22
- COVID Governance Advisory Report

- Audit Wales Structured Assessment Report
- Annual Quality Audit Statement
- Nurse Staffing Levels Act – Internal Audit
- Welsh Blood Service Medicines and Healthcare products Regulatory Agency (MHRA) Inspection Report
- National Delivery Unit Quality & Safety Report
- Welsh Nursing Care Record Post-Implementation Paper
- CIVICA (patient experience feedback system implementation update
- Cwm Taf Maternity Review: Self-Assessment Progress Report

6.6 Highlight Reports

Highlight reports from key quality, safety and performance related management groups were considered by the Committee as part of the normal Cycle of Business. Each Highlight report provides a facility for the management group to alert/escalate; advise; assure; or inform the Committee in relation to the subject matter. Areas of activity reported via highlight reports include:

- Safeguarding and Public Protection
- COVID-19 Cells:
  - *Quality & Safety Cell;*
  - *Personal Protective Equipment;*
  - *Test, Trace & Protect Cell, and*
  - *Social Distancing Cell*
- Infection Prevention & Control
- Clinical Audit
- Datix Project Board
- Trust Estates Assurance Group
- Patient Safety Alerts Group
- Medicines Management Group
- Medical Gas Committee

In addition, the Quality, Safety & Performance Committee received a highlight report at its each meeting from its two sub-committees i.e. (1) Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and (2) Research, Development & Innovation Sub-Committee.

6.7 Items ENDORSED for Board APPROVAL by the Committee

The Committee **ENDORSED** for **BOARD APPROVAL** a number of documents to support and enable the Trust's ongoing commitment towards quality, care and excellence:

- Health & Safety Annual Report 2019/20;
- Patient & Donor Experience Feedback 2019/20 Annual Report;
- Patient Experience Plan;
- Putting Things Right Annual Report (including Complaints and Serious Incidents), and
- Safeguarding & Public Protection Annual Report.

6.8 Risk Management and Safe Services

The Committee received and discussed a number of reports providing information and assurance about key aspects of the Trust's business, including:

- The Trust Risk Register;
- Claims Reports;
- Concerns Reports (complaints and incidents);
- Information Governance Report (incidents);
- Influenza and COVID-19 Vaccination Programme;
- Medical Devices Regulation and Impact on Service Update;
- Covid-19 Rapid Sharing of Early Learning Report;
- Health and Care Standards Report (incl. Trust Self-Assessment and Action Plan);
- Application of Putting Things Right Report (PTR) during COVID Phase 2;
- Safety Alerts Report;
- Medical Examiner Service and Velindre University NHS Trust;
- For the Assessment of Individualised Risk (FAIR) Progress Report;

- Trust Revalidation Update 2019/20, and
- Trust engagement in the Infected Blood Inquiry (IBI).

In Particular the Committee was assured and pleased to note, that the Trust not only played its part in responding effectively to the direct impact of the pandemic on our services but also by delivering over 13,664 Vaccinations of which 7,039 1st dose and 6,625 were 2nd doses at our Trust vaccination centre as part of the National programme. The Trust has now progressed to the administration of 'booster' vaccinations as part of its firm commitment to the health & safety of its workforce and the wider public health agenda.

6.9 Strategy, Policy and Performance

The NHS Wales Annual Planning Framework Guidance for 2021/22 required the production of an Annual Plan for 2021/22 rather than the normal three year Integrated Medium Term Plan (IMTP), recognising the unprecedented challenges caused by the pandemic. Accordingly, the Velindre University NHS Trust Board approved a Draft Annual Plan covering the financial year 2021/22 which was subsequently submitted and approved by Welsh Government. Following which, the Committee has received regular progress reports to provide the Committee with the necessary assurance around performance against the Annual Plan.

The Committee also sought assurance through regular review and scrutiny of the Divisional Quality, Safety and Performance Reports. These provide the Committee with an update on the key quality and safety outcomes and metrics for the Welsh Blood Service and Velindre Cancer Service. This report provides a pivotal mechanism for the Committee to triangulate information and gain a clear view on performance across the divisions. This will continue to mature and evolve as the Committee enters its second year; a noteworthy development in Quarter 3 has seen a revised structure of the report around the six domains of quality and safety. This will be further strengthened in the coming period. In addition, the Committee received a number of reports on the development of the Trust Performance Management Framework and its plans for phased implementation commencing in quarter 4 of 2021/22 and beyond which will support enhanced triangulation within the divisional performance reports.

The Committee has also received regular progress reports and assurance in respect of the Trust's financial performance in achieving a balanced position against its income and expenditure position for the year ending 31 March 2021 as reflected in the Trust Annual Accounts.

Finally, in terms of performance, the Committee also received assurance on the Digital arm of the service via the Digital Service Operational Report. The Committee received reports on key projects / programmes of work underway for Digital Services, this included but was not limited to:

- Launching Digital Services & progress of the Digital Organisation Change Process
- Progress against the Trust Annual Plan
- Key Digital Threats for the Trust
- Any significant incidents

6.10 Cycle of Business Review

At the 16 September 2021 meeting of the Quality, Safety & Performance Committee, the Committee received a report summarising the work completed to date, to review the established Cycle of Business alongside further plans, to identify any areas for improvement, optimise any learning opportunities identified, and incorporate feedback received from service leads and Audit Wales as part of its Structured Assessment *(Phase 2)* Report.

The Committee **NOTED** that the functioning of the Committee has been affected by the COVID-19 pandemic as frequency of reporting to the Committee has been enhanced in order to provide the required assurance commensurate with the level of risk at different points in time as the pandemic has progressed. In addition, the Committee **APPROVED** a number of immediate changes in advance of its Annual Review to further refine and strengthen the Committee reporting and assurance arrangements. Following engagement with the Executive and Service leads this included:

- ***Digital Service Operational Report:*** frequency of report to reduce from each meeting to quarterly unless there is need for escalation or additional assurance in line with the Divisional Quality, Safety & Performance Report.
- ***Datix Highlight Report:*** frequency of report to reduce from every meeting to bi-annually as the project is now well established and most of the implementation is completed.
- ***Patient / Donor / Staff Stories:*** formally incorporated into the Cycle of Business.
- ***Amalgamation of themed reports:*** to reduce instances of duplication and/or misalignment and strengthen reporting and opportunities to easily read across and triangulate information.

In addition to the areas summarised above, the Quality, Safety & Performance Committee Cycle of Business, was updated in April 2021 and July 2021 to reflect two key aspects, namely:

1. NHS Wales Informatics Service

The NHS Wales Informatics Service (NWIS) was formed on 1 April 2010 when it was established as an organisation sitting within Velindre University NHS Trust under a hosting agreement. The agreement included a requirement for NWIS to provide assurance of its governance processes by the submission of a number of standing items to Velindre University NHS Trust Audit Committee. This was in addition to any requirement for escalation of other matters to Trust Board. NWIS also attended Velindre NHS Trust Quality & Safety Performance Committee to report on Serious Incidents and other issues of note.

On the 30th September 2019, the then Minister for Health and Social Services, Vaughan Gething, announced that the NHS Wales Informatics Service (NWIS) was to transition from its current structure, as part of Velindre University NHS Trust, to a new Special Health Authority (SHA) – Digital Health and Care Wales (DHCW). This transition was subsequently effective from 1 April 2021.

The DHCW Chair and Chairs of Velindre University NHS Trust Audit Committee and Quality & Safety Performance Committee provided their respective Committees with a handover report; this was received at the May 2021 meeting of the Quality, Safety & Performance Committee. The handover report detailed

the business previously received by the Committee and any ongoing actions that were to transfer to the equivalent Committee under the new SHA structure.

2. Quality & Safety Governance Arrangements for NHS Wales Shared Services Partnership (NWSSP) Committee

In May 2021, the Quality, Safety & Performance Committee and Shared Services Partnership Committee endorsed a revised approach to Quality & Safety governance arrangements designed to fulfil the purpose agreed by the Shared Services Partnership Committee to: "*advise and assure the Shared Services Partnership Committee and Accountable Officer on whether effective arrangements are in place for quality and safety"* (in line with the approved NWSSP Standing Orders). This was coupled with ensuring that Velindre University NHS Trust Board, as the host organisation and statutory body, also having appropriate assurance to fulfil its accountabilities in this respect.

As such, it was recommended that an additional section be included at the start of the Velindre University NHS Trust Quality, Safety & Performance Committee to cover NWSSP quality and safety business. This was subsequently approved by the Velindre University NHS Trust Board at its June 2021 meeting. The revised approach came into effect at the July 2021 meeting of the Quality, Safety & Performance Committee and will continue to be kept under review as the NWSSP business model continues to develop.

7. Discussion held in Part B / Private Committee

There is facility for the Committee to consider reports that contain commercially sensitive or potentially identifiable/sensitive information in Part B/Private Committee. The Committee considered reports in Private in relation to:

- NHS Wales and Informatics Service Serious Untoward Incidents (SUIs) and No Surprise Notification;
- Patient Safety Task Force Close Out Report;
- Infected Blood Inquiry Update

- Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee – Part B / Private Highlight Report
- Relocating Blaenavon Data Centre and Impact on the CANISC Replacement Programme Update Report
- Convalescent Plasma Project Update
- Highlight Report from the Medicines Management Group
- Velindre Cancer Service First Floor Outbreak Report
- Patient Nosocomial Transmission Paper
- Velindre Cancer Service Drug Advisory Group Highlight Report
- Claims and Legal Report / Annual Report 2020/21
- Overview of non-conformities within Radiology following ISO Accreditation Visit
- Review of Information Governance Incidents and Trends
- Digital Health Care Wales Teams Incident Closeout Report
- Cyber Security Strategic Delivery Plan

8. Reporting the Committee's Work

The Chair of the Quality, Safety & Performance Committee reports the key issues discussed at each of its meetings by way of a Highlight Report to the Board. The Highlight report provides facility for the Committee to alert/escalate; advise; assure; or inform the Board in relation to quality, safety and performance maters. Committee papers, including minutes, are published on the Trust's internet pages.

9. Quality, Safety & Performance Committee Annual Effectiveness Survey

The Quality, Safety & Performance Committee Effectiveness Survey is undertaken on an annual basis to determine the effectiveness of the Committee in meeting its operations in accordance with its Terms of Reference and the Trust Standing Orders.

9.1 Methodology

A Committee survey consisting of eighteen questions was established via an online survey platform. Questions were designed and selected to gain valuable feedback and harness the opinion of both Members and regular Attendees, to ascertain views with respect to the Committee's inaugural year of operation. The aim of which was to identify any learning opportunities in the pursuit of continuous improvement.

All questions were posed in a structured format with survey respondents invited to provide a reason / supporting comments for each question. The questionnaire was designed to require respondents to answer each question before enabling them to progress onto the next question. No personal data was collected in the completion of the survey questionnaire; hence, all responses are anonymised.

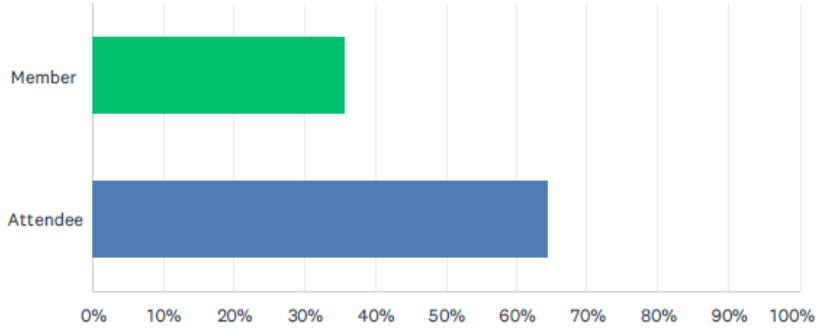
9.2 Findings

20 surveys were sent out and a total of 14 responses were received, therefore a completion rate of 70%. The full survey results are provided below:

9.2.1 Survey question 1

Please indicate if you are a ‘Member’ of the Quality, Safety & Performance Committee i.e. Independent Member or a regular ‘Attendee’ of the Committee.

Answered: 14 Skipped: 0



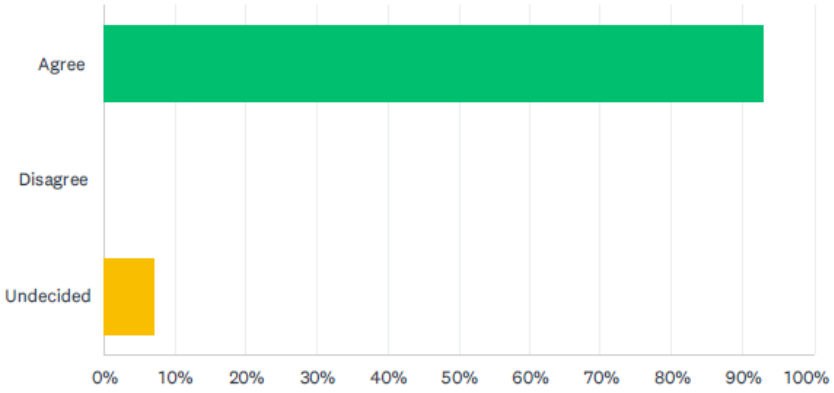
ANSWER CHOICES	RESPONSES	
Member	35.71%	5
Attendee	64.29%	9
TOTAL		14

#	COMMENTS	DATE
	There are no responses.	

9.2.2 Survey question 2

There are clear Terms of Reference, with clarity as to the role of the Quality, Safety & Performance Committee and the relationship between the Committee and the Trust Board.

Answered: 14 Skipped: 0



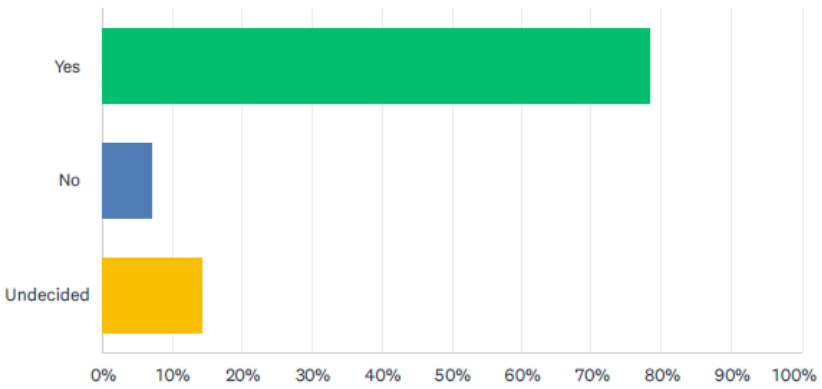
ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

#	COMMENTS	DATE
1	These are in place, however I feel that we have a knowledge and understanding gap with some staff. It is not where it needs to be to be able to clearly understand the intent. This is a longer term issue and not just applicable to this committee. However the understanding of the thread from operations to EMB, committee and Board needs to be improved (in my opinion).	10/28/2021 12:39 PM
2	Reviewed annually	10/20/2021 11:08 AM
3	This is a new Committee and still finding its feet - the ToR could be clearer around its delegated authority. There is still a lot of duplication around what is presented to this committee first and then re-presented to the Board.	10/20/2021 9:29 AM

9.2.3 Survey question 3

Has the Quality, Safety & Performance Committee been provided with sufficient authority and resources to fulfil its role effectively?

Answered: 14 Skipped: 0

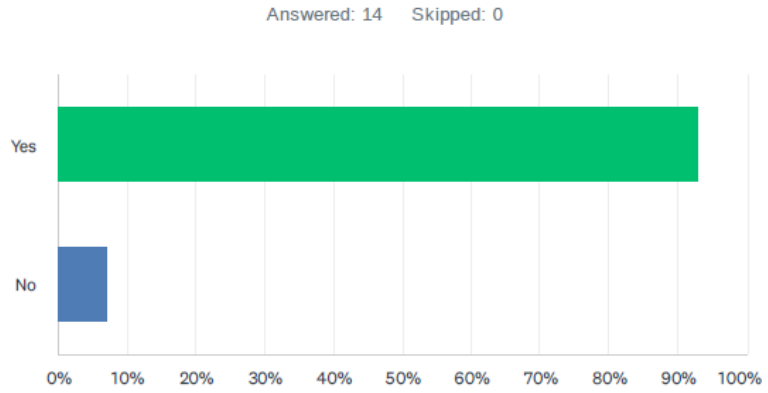


ANSWER CHOICES	RESPONSES	
Yes	78.57%	11
No	7.14%	1
Undecided	14.29%	2
TOTAL		14

#	COMMENTS	DATE
1	I feel that the interface between the committee and Board is still working through.	10/28/2021 12:39 PM
2	Large agenda, but one which will be made easier with the performance dashboards which are currently being developed in place of the narrative reports	10/25/2021 1:15 PM
3	I believe that more authority could be provided to ensure that there is no duplication of work between committees and the Board	10/20/2021 9:29 AM
4	Part of the purpose of the Committee is to enable the triangulation of the information across performance, workforce and finance. I don't think we have exploited this opportunity as yet given the resource that would be necessary to accomplish that.	10/19/2021 2:46 PM

9.2.4 Survey question 4

Has the Quality, Safety & Performance Committee established a Cycle of Business to be dealt with during the year?

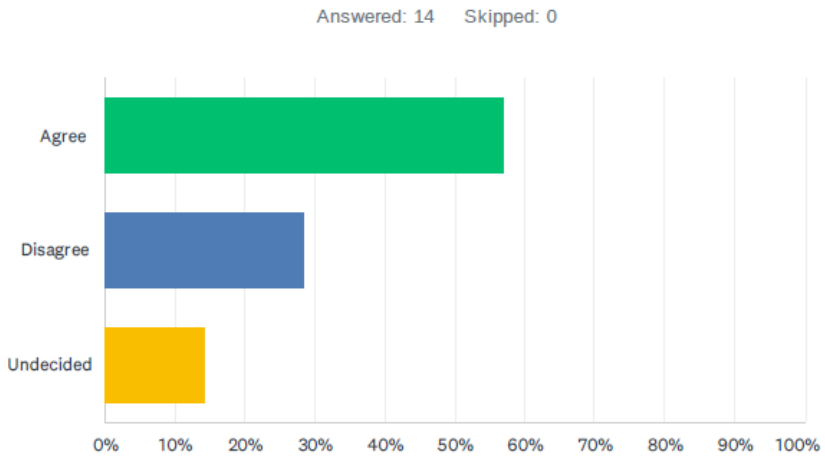


ANSWER CHOICES	RESPONSES	
Yes	92.86%	13
No	7.14%	1
TOTAL		14

#	COMMENTS	DATE
1	The cycle of business was established and has been further developed. I am not sure that this is yet completely embedded fully but it is in progress.	10/28/2021 12:39 PM
2	QSPC is certainly developing, but is still in relative infancy so a cycle of business is emerging	10/26/2021 2:33 PM
3	Annually reviewed	10/20/2021 11:08 AM

9.2.5 Survey question 5

The number and length of meetings is sufficient to allow the Quality, Safety & Performance Committee to fully discharge its duties.



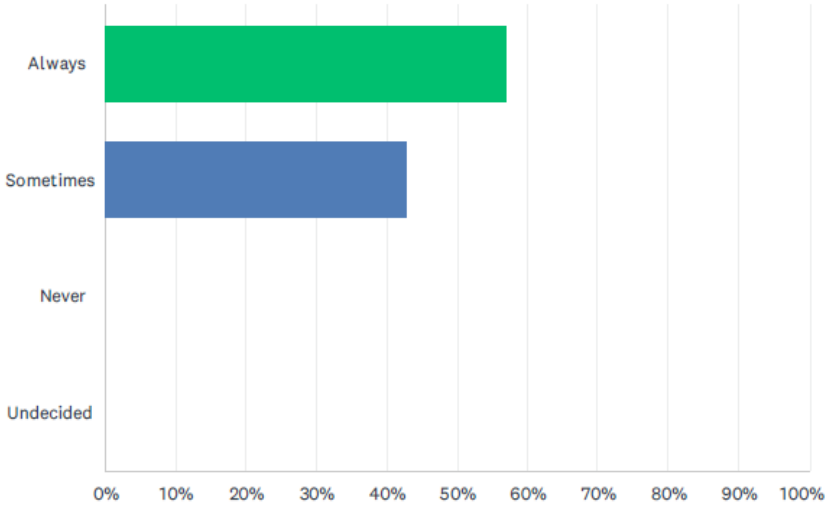
ANSWER CHOICES	RESPONSES	
Agree	57.14%	8
Disagree	28.57%	4
Undecided	14.29%	2
TOTAL		14

#	COMMENTS	DATE
1	There is a large agenda and all items require detailed analysis and discussion given their importance.	11/1/2021 10:54 AM
2	I feel that we are still exploring the level of detail and how we bring specific topics/ items of assurance. Until we have further matured this I dont think I can reply to this question.	10/28/2021 12:39 PM
3	Long agendas sometimes mean that items towards the end of the agenda get squeezed - this has improved since the cycle of business allows for some standing items not having to be presented on at every meeting	10/25/2021 6:22 PM
4	Again, will be made easier with quality / performance dashboards rather than narrative reports	10/25/2021 1:15 PM
5	There can often be too many agenda items on the agenda and too much information to work through	10/20/2021 11:28 AM
6	Agenda for committee is substantial and could risk meaning due diligence and attention not paid to some key areas but to date meeting timings appear sufficient.	10/20/2021 11:08 AM
7	As the Committee beds in and the way that papers are written develops I think the timings will be ok	10/20/2021 10:16 AM

9.2.6 Survey question 6

Is sufficient time allowed for questions, discussion and debate at the Quality, Safety & Performance Committee meetings?

Answered: 14 Skipped: 0

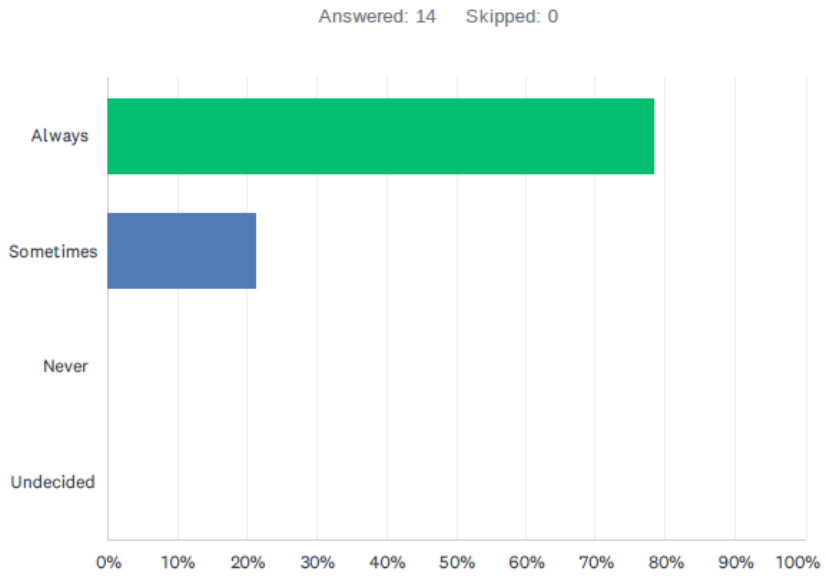


ANSWER CHOICES	RESPONSES	
Always	57.14%	8
Sometimes	42.86%	6
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	The discussions are always good. It can sometimes feel that we repeat the same discussion. See comments on previous question	10/28/2021 12:39 PM
2	My response to be read in conjunction with response to previous question - sometimes items at the end of a long agenda get squeezed due to time constraints	10/25/2021 6:22 PM
3	The amount of time for discussion / questions is not always sufficient due to the size of the agenda	10/20/2021 11:28 AM

9.2.7 Survey question 7

The Quality, Safety & Performance Committee papers are received sufficiently far in advance of meetings?



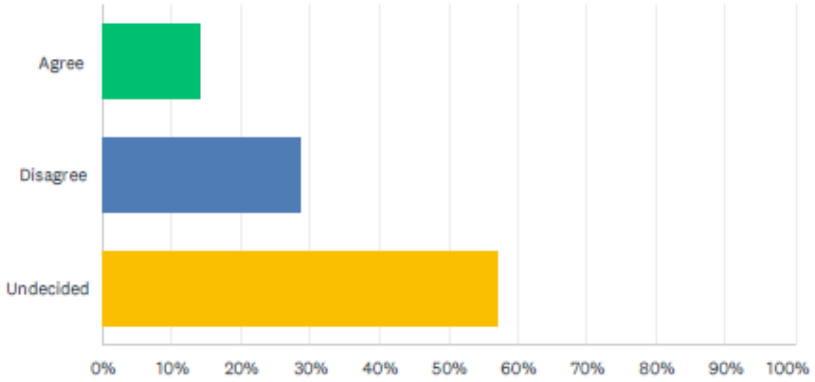
ANSWER CHOICES	RESPONSES	
Always	78.57%	11
Sometimes	21.43%	3
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	More work required administratively to align meeting papers across the organisation	10/26/2021 2:33 PM

9.2.8 Survey question 8

The papers received by the Quality, Safety & Performance Committee are concise and relevant?

Answered: 14 Skipped: 0

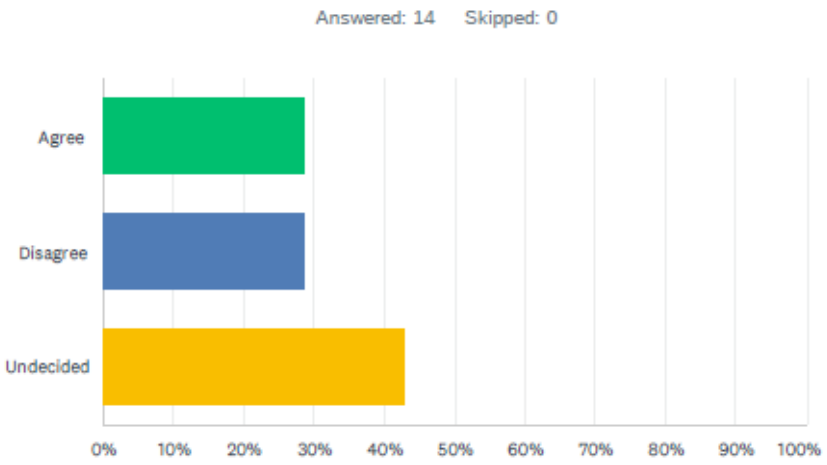


ANSWER CHOICES	RESPONSES	
Agree	14.29%	2
Disagree	28.57%	4
Undecided	57.14%	8
TOTAL		14

#	COMMENTS	DATE
1	Chose agree but would ideally have said 'mostly agree' as some papers issued are not always concise and clear in terms of their intended purpose and aims.	11/1/2021 10:54 AM
2	I feel that in the beginning there was far too much information at the wrong level not written for the audience. We have undertaken some considerable work on that but there is probably a bit more to do and that is linked to the staff understanding I mentioned above.	10/28/2021 12:39 PM
3	The Trust could better develop papers (not only QSPC) to be more concise and consistent	10/26/2021 2:33 PM
4	The papers are usually relevant but they are not always concise in the sense of picking out the main points for discussion/decision/debate - sometimes the key points are lost among a lot of general details.	10/25/2021 6:22 PM
5	The papers will be more concise when the performance / quality dashboards are in place	10/25/2021 1:15 PM
6	A number of papers are / a number aren't. Some papers are very very detailed and can lose the main message	10/20/2021 11:28 AM
7	Sometines papers can appear to be overly detailed but we work in a complex health system and balancing this can be tricky	10/20/2021 11:08 AM
8	The way that key issues are triangulated and drawn out needs to be developed	10/20/2021 10:16 AM
9	New committee, still in the settling in stage - there has been an improvement and everybody is working on this	10/20/2021 9:29 AM
10	Papers are too long and are not written for assurance or exception escalation - some papers contain too much operational information	10/13/2021 3:00 PM
11	The documents bundle for the committee is usually extensive and some papers can run to 30 or more pages.	10/6/2021 2:25 PM

9.2.9 Survey question 9

I feel the Quality, Safety & Performance Committee receives sufficient detail, at the right level to allow me to focus on asking the right questions.

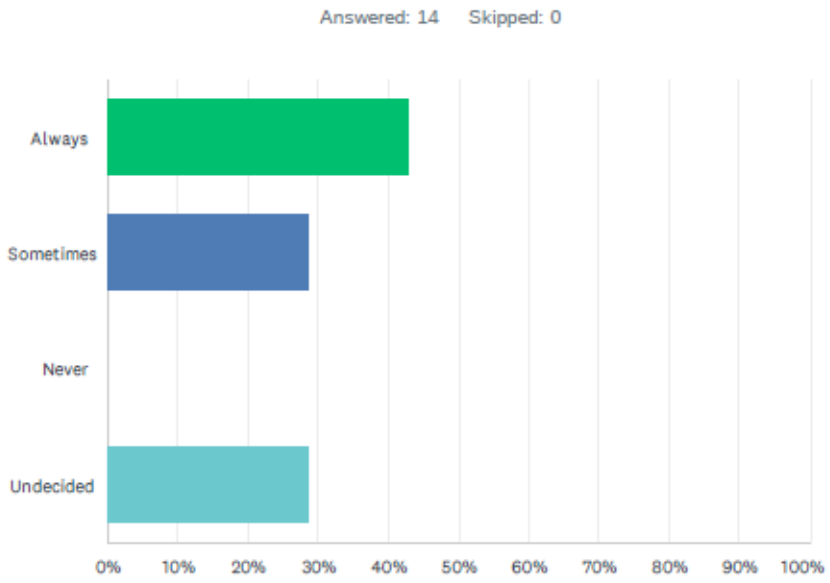


ANSWER CHOICES	RESPONSES	
Agree	28.57%	4
Disagree	28.57%	4
Undecided	42.86%	6
TOTAL		14

#	COMMENTS	DATE
1	I have already made comment on this in general terms but as a provider of information I cannot be the best judge of this	10/28/2021 12:39 PM
2	Paper could be more concise	10/26/2021 2:33 PM
3	See my response to the previous question - sometimes we get too much detail - but sometimes Board Members expect detail to be there on any and every aspect, so this can be a difficult balance to achieve. It is far less often the case that there is not enough detail.	10/25/2021 6:22 PM
4	Performance / quality dashboards will really help	10/25/2021 1:15 PM
5	Many papers often contain too much detail	10/20/2021 11:28 AM
6	At present I think the Committee receives too much detail and papers need to focus more on triangulation and escalation issues	10/20/2021 10:16 AM
7	There is too much detail provided in some papers- appears as if there is not always a filter between EMB & Committee through relevant leads & execs & therefore same level of detail is provided	10/13/2021 3:00 PM
8	See above answer, some papers go into unnecessary operational detail and it can be difficult to identify and scrutinise the important points	10/6/2021 2:25 PM

9.2.10 Survey question 10

Are Quality, Safety & Performance Committee meetings scheduled prior to important decisions being made?



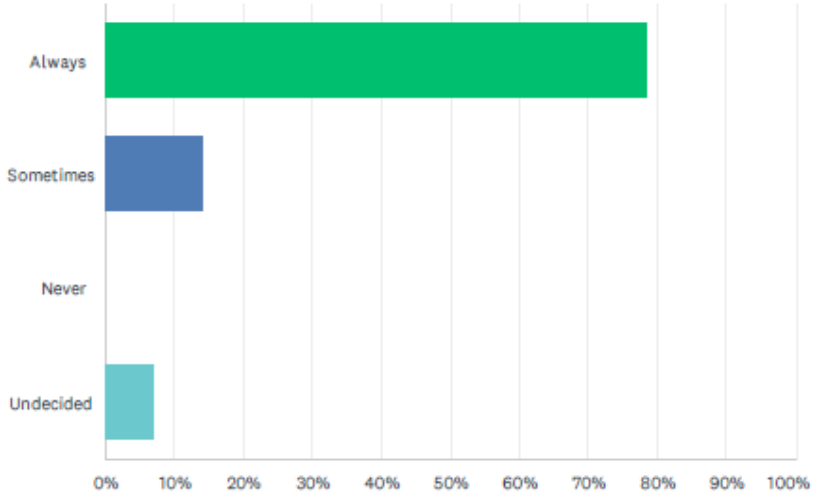
ANSWER CHOICES	RESPONSES	
Always	42.86%	6
Sometimes	28.57%	4
Never	0.00%	0
Undecided	28.57%	4
TOTAL		14

#	COMMENTS	DATE
1	I would say "usually"	10/25/2021 6:22 PM
2	Committee does not have approval rights	10/13/2021 3:00 PM

9.2.11 Survey question 11

Is the behaviour of all Members / Attendees at the Quality, Safety & Performance Committee meetings courteous and professional?

Answered: 14 Skipped: 0

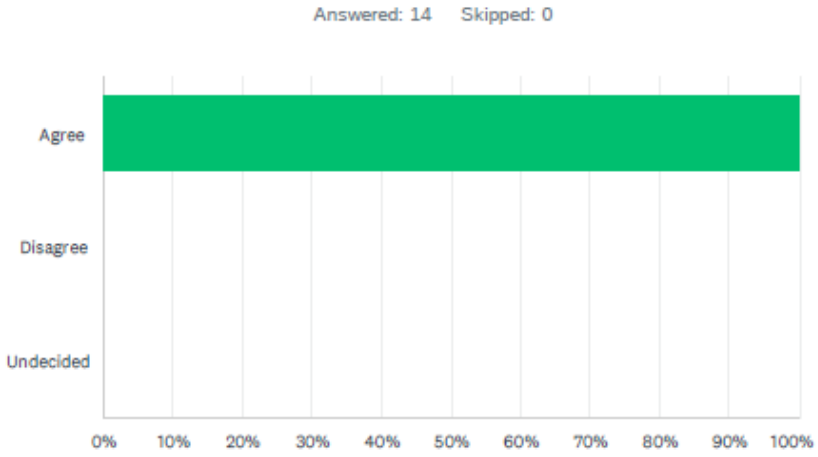


ANSWER CHOICES	RESPONSES	
Always	78.57%	11
Sometimes	14.29%	2
Never	0.00%	0
Undecided	7.14%	1
TOTAL		14

#	COMMENTS	DATE
1	Mostly and it is clear that all involved want to do the right thing, yet culturally the Trust could develop itself to ensure self awareness and their impact upon others is a feature of all staff members development	10/26/2021 2:33 PM

9.2.12 Survey question 12

The Quality, Safety & Performance Committee Chair has a positive impact on the performance of the Committee.



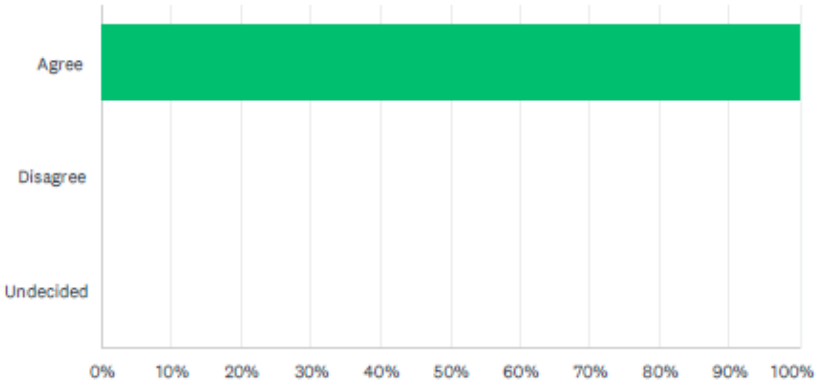
ANSWER CHOICES	RESPONSES	
Agree	100.00%	14
Disagree	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	Well chaired to date and positive discussion and scrutiny	10/20/2021 11:08 AM

9.2.13 Survey question 13

The Quality, Safety & Performance Committee Chair meetings are chaired effectively with clarity of purpose and outcome.

Answered: 14 Skipped: 0

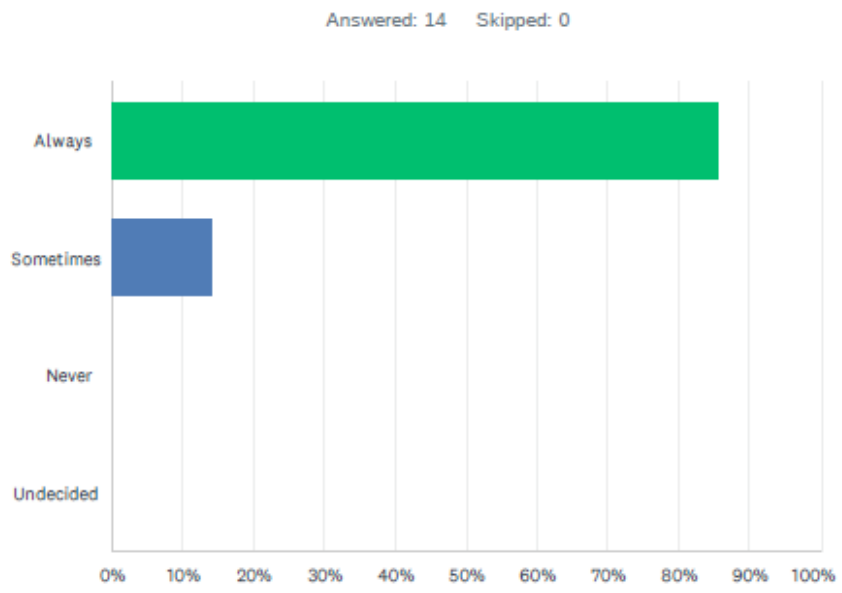


ANSWER CHOICES	RESPONSES	
Agree	100.00%	14
Disagree	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	in answering this question I think we also need to consider the wider points about how clear we are in agenda setting to enable the chair to do this. We are improving and maturing.	10/28/2021 12:39 PM

9.2.14 Survey question 14

Is each agenda item at the Quality, Safety & Performance Committee closed off with clarity on the decision / outcome of discussion?

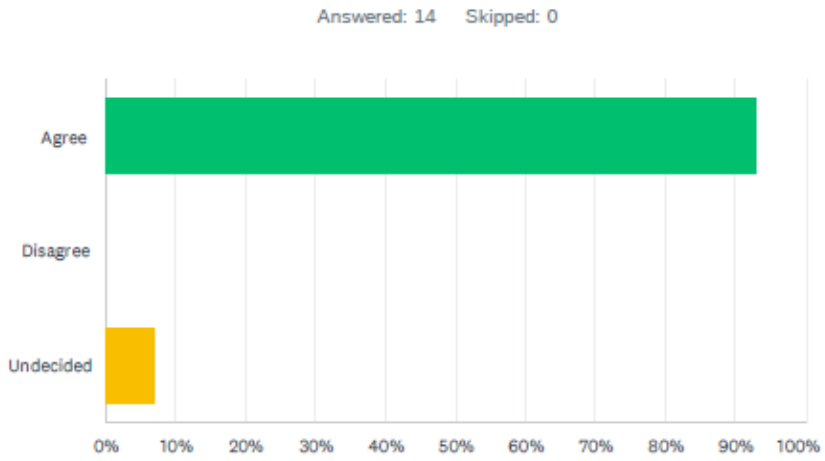


ANSWER CHOICES	RESPONSES	
Always	85.71%	12
Sometimes	14.29%	2
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	Sometimes we could be clearer in whether the actions are achievable and in what timescale, particularly when they are part of longer term developments.	10/28/2021 12:39 PM

9.2.15 Survey question 15

The Quality, Safety & Performance Committee Chair allows debate to flow freely and does not assert their own views too strongly.

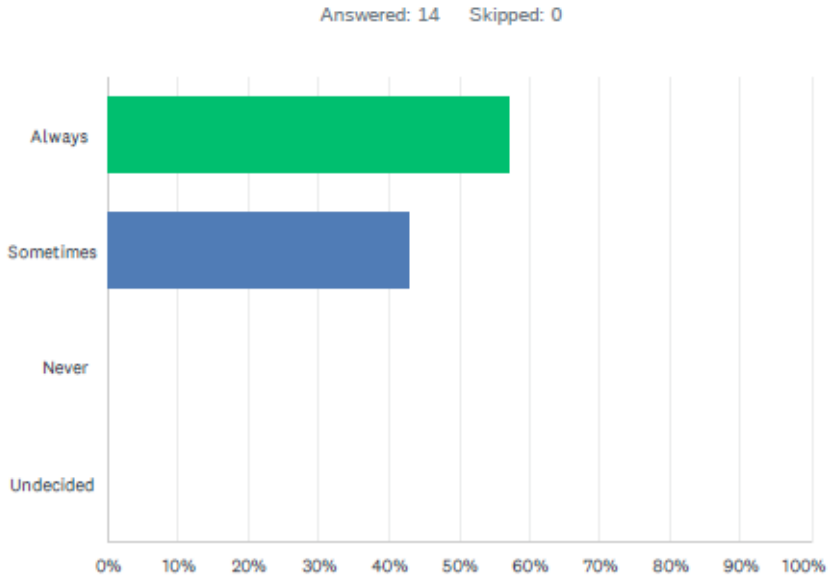


ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

#	COMMENTS	DATE
1	There is an allowance of debate, but is difficult due to the Chair being a specialist in the subject matter. The Chair does however demonstrate restraint.	10/26/2021 2:33 PM

9.2.16 Survey question 16

Is the atmosphere at the Quality, Safety & Performance Committee meeting conducive to open and productive debate?



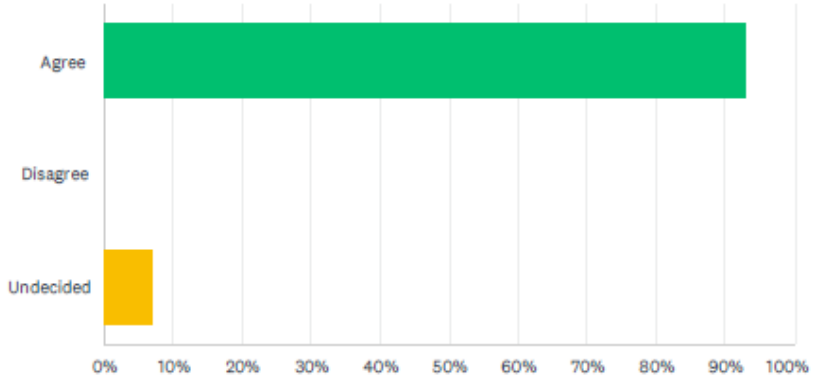
ANSWER CHOICES	RESPONSES	
Always	57.14%	8
Sometimes	42.86%	6
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	The atmosphere is good but we can sometimes repeat discussions	10/28/2021 12:39 PM
2	Delivery of meetings via teams during a pandemic has been critical but can stifle atmosphere and personal face to face arrangements.	10/20/2021 11:08 AM

9.2.17 Survey question 17

The Quality, Safety & Performance Committee has effective escalation arrangements in place to alert relevant individuals, Committees, Board of any urgent / critical matters that may affect the operation and / or reputation of the Trust.

Answered: 14 Skipped: 0

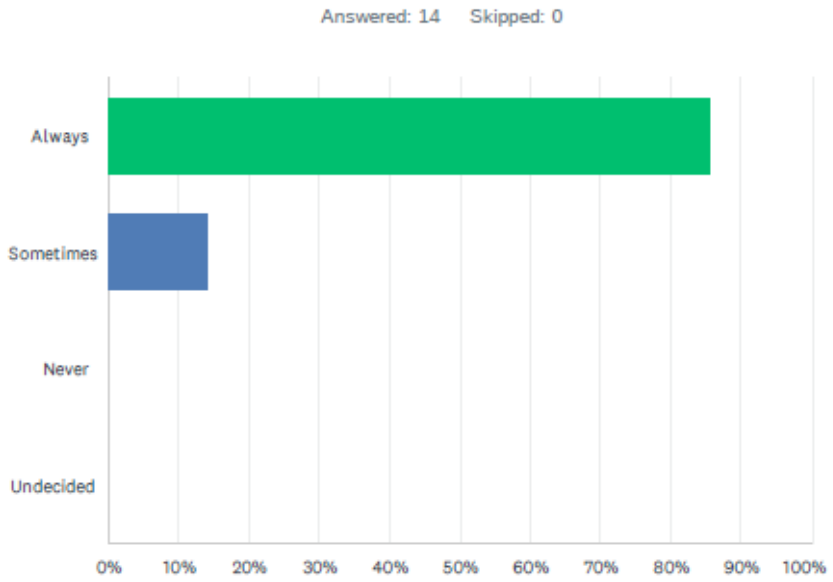


ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

#	COMMENTS	DATE
1	Highlight report to Board	10/20/2021 11:08 AM

9.2.18 Survey question 18

Do you consider that where Private (Part B) Quality, Safety & Performance Committee meetings are held, that these have been used appropriately for items that should not be discussed in the public domain?



ANSWER CHOICES	RESPONSES	
Always	85.71%	12
Sometimes	14.29%	2
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

#	COMMENTS	DATE
1	I cant answer always as I am sure one or two have been ones that could have been public. But they are mostly and the intent is there to make that appropriate assessment	10/28/2021 12:39 PM

10. Conclusions and way forward

The Quality, Safety & Performance Committee is committed to ensuring that quality, safety and performance, across Velindre University NHS Trust continues to be managed in accordance with all relevant legislative and regulatory requirements, national frameworks, and best practice guidance. One of the benefits of this integrated Committee is that triangulated analysis can take place. However, it is recognised that the supporting infrastructure for this requires development. It is therefore proposed that an operational Quality and Safety Group will be established in early 2022 that will feed into the Committee. It is anticipated that this will also go some way to address some of the feedback received in the survey regarding the level of detail and quantity of information currently being provided to the Committee.

Over the next year the Committee will be required to have strategic oversight of the Trusts arrangements and plans to meet its statutory responsibilities in respect of the new Quality & Engagement Act (2020) that will be operating in shadow form by October 2022 and the new National Quality Framework (2021).

Members of the Trust Quality, Safety & Performance Committee have extended thanks to all those involved in supporting the work of the Committee in its inaugural year, and for the constructive and positive way in which attendees have contributed to the work of the Committee as it evolves and continues to develop and mature.

The outcomes from the Committee Annual Effectiveness Survey will help to inform the continuing evolution of the Quality, Safety & Performance Committee as it enters its second year. In addition to the above key areas of focus will include:

- Further review of 'hosted organisation' reporting arrangements;
- Training being provided to officers in relation to report writing for assurance and escalation;
- Further review of the Cycle of Business;
- Review of the quality and level of details of reports received by the Committee to enhance and engineer more effective triangulation, and
- Flow of operational and divisional reporting to the Committee.

END OF REPORT

Archwilio Cymru
Audit Wales

Structured Assessment 2021 (Phase Two) – Corporate Governance and Financial Management Arrangements – Velindre University NHS Trust

Audit year: 2021

Date issued: November 2021

Document reference: 2579A2021-22

This document has been prepared for the internal use of Velindre University NHS Trust as part of work performed/to be performed in accordance with statutory functions.

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

Contents

Summary report

About this report

1 This report sets out the findings from phase two of the Auditor General's 2021 structured assessment work at Velindre University NHS Trust (the Trust). Our structured assessment work is designed to help discharge the Auditor General's statutory requirement to be satisfied that NHS bodies have made proper arrangements to secure economy, efficiency, and effectiveness in their use of resources under section 61 of the Public Audit (Wales) Act 2004. Our 2021 structured assessment phase one report considered the Trust's operational planning arrangements and how these are helping to lay the foundations for effective recovery.

2 The COVID-19 pandemic required NHS bodies to quickly adapt their corporate governance and decision-making arrangements to ensure timely action was taken to respond to the surge in emergency COVID-19 demand and to ensure the safety of staff and patients. Our 2020 structured assessment report considered the Trust's revised governance arrangements and was published in September 2020.

3 NHS bodies have continued to respond to the ongoing challenges presented by COVID-19, whilst also starting to take forward plans for resetting and recovering services affected by the pandemic. Our 2021 structured assessment work, therefore, was designed in the context of the ongoing response to the pandemic thus ensuring a suitably pragmatic approach to help the Auditor General discharge his statutory responsibilities whilst minimising the impact on NHS bodies as they continued to respond to COVID-19.

4 Phase two of our 2021 structured assessment has considered how corporate governance and financial management arrangements have adapted over the last 12 months. The key focus of the work has been on the corporate arrangements for ensuring that resources are used efficiently, effectively, and economically. We have also considered how business deferred in 2020 has been reinstated and how learning from the pandemic is shaping future arrangements for ensuring good governance and delivering value for money. We have also sought to gain an overview of the Board's scrutiny of the development and delivery of the Trust's 2021-22 Annual Plan.

5 We have provided updates on progress against any areas for improvement and recommendations identified in previous structured assessment reports.

Key messages

6 Overall, **the Trust is well governed with clear, effective arrangements to manage its finances.**

7 The Trust has good governance arrangements which adapted well to the pandemic. The Trust has streamlined its Board committee structure and postponed Board and committee business is being reactivated. The quality and presentation

of information at Board and committees are good, but on occasions, papers include content which is perhaps too detailed. Transparency of Board business to the public is good, but there are some opportunities for improvements.

8 The Trust has introduced improved risk management arrangements and is currently refreshing quality governance arrangements. The Trust is developing detailed plans to ensure ongoing business continuity and increase capacity to respond to increasing demand for services. However, not all strategic priorities are supported by specific, timebound actions for delivery.

9 The Trust has good arrangements to manage its financial resources and continues year on year to meet its financial duties. Financial controls are effective, and the Trust uses clear, timely financial information to monitor and report its performance.

Recommendations

10 Recommendations arising from this audit are detailed in **Exhibit 1**. The Trust's management response to these recommendations is summarised in **Appendix 1**. **Appendix 1** will be completed once the report and management response have been considered by the relevant committee.

Exhibit 1: 2021 recommendations

Recommendations
Transparency of Board business R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign off and timely publication of: • committee meeting papers; and • recordings of Board meetings.
Articulation of strategic priorities R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.

Detailed report

Governance arrangements

11 Our structured assessment work considered the Trust's governance arrangements while continuing to respond to the challenges presented by the pandemic.

12 **The Trust is well governed with a commitment to continuous improvement and embedding good governance across its business.**

Conducting business effectively

13 **The Trust has good arrangements to conduct Board and committee business effectively, but opportunities to enhance public transparency remain.**

Public transparency of Board business

14 The Trust's Board and committee meetings continue to be virtual, with people attending remotely. All public Board meetings are broadcast live to allow the public to attend virtually and video recordings are made available on the Trust's website. Our review of the Trust's website in August 2021 identified that recordings were available for six out of eight Board meetings held since July 2020[1] (see **Recommendation 1**). The Trust currently has no plans to live stream or make available recordings of committee meetings.

15 Board papers are published in advance of meetings on the Trust's website. Committee meeting papers should be published in advance, but we identified some exceptions[2]. We note that the Trust upgraded its website earlier in 2021, and therefore needed to migrate content from the previous website, which may explain some omissions. (See **Exhibit 2, 2018 R1** and **Recommendation 1**).

16 Board and committee minutes are published on the Trust's website when included in papers for the next meeting. The Trust may want to consider publishing unconfirmed minutes a few days after each Board and committee meeting, whilst retaining agreement of accuracy in the following meeting. This would help increase transparency, particularly as the public is currently unable to attend committee meetings in person or watch a live stream or a recording.

17 The Trust has continued to engage regularly with patient advocates from the Community Health Council. Representatives also regularly attend Board and committee meetings and provide views on service changes and public accessibility to Trust business.

[1] There were no video recordings available for March and June 2021 Board meetings on the website.

[2] Papers for the 28 June 2021 Strategic Development Committee meeting are omitted, as are papers for the 15 July 2021 and all 2020 Quality, Safety and Performance Committee meetings.

18 The Trust's register of Board members' interests is updated on an annual basis.

Exhibit 2: progress made on previous year recommendations

Recommendation	Description of progress
Transparency of Board business 2018 R1 The Trust publishes agendas for public committee meetings in advance of meetings, but not the full set of papers. The Trust should publish all committee papers in advance of public meetings.	**Superseded** We have made a new recommendation that the Trust should ensure that it strengthens the process for the collation, sign off and publication of committee meeting papers in advance of meetings, and unconfirmed minutes added shortly after meetings. See 2021 **Recommendation 1**.

Board and committee arrangements

19 Last year, our structured assessment set out the Trust's streamlined Board and committee arrangements implemented in March 2020 to respond to COVID-19 and allow focus on business-critical matters. Rather than revert to the pre-pandemic Board committee structure, the Board approved a new streamlined structure in September 2020[3] (see **paragraph 20**).

20 Assurance of Trust performance is now considered alongside quality and safety matters in the Quality, Safety and Performance Committee. Whilst agenda items are relevant and appropriate, we feel that the amount of detail provided to the committee on many items is too great[4]. Further work is needed to agree the amount and level of detail needed to provide necessary assurance to the committee. Consideration is also needed on how to best summarise and synthesise information to help provide focus on key matters.

21 The new Strategic Development Committee provides space for the Board to discuss and approve aspects of strategy direction and development prior to full Board approval. The Trust is still developing the work programme for the committee; however, Board members told us that it provides a good opportunity to scrutinise matters relating to developing strategic intent.

[3] The required variation to the Board's Standing Orders was scrutinised and approved by the Audit Committee and Board in autumn 2020, and again in July 2021 (to reflect changes to the NHS Model Standing Orders).

[4] The May 2021 and July 2021 Quality, Safety and Performance Committee papers were both more than 700 pages.

22 We have considered the Board committees' cycles of business and agendas and have undertaken observations of committee meetings. The new structure provides clarity in Board committee (and sub-committee) assurance responsibilities. The structure has good potential to ensure increased triangulation of workforce and financial data alongside both performance and quality/safety issues.

23 Until April 2021, the Audit Committee agenda included assurance on NHS Wales Informatics Service matters as a service hosted by the Trust. On 1 April 2021, hosting arrangements ceased[5]. This presents an opportunity for the Audit Committee to allocate greater time to undertake deeper dives in existing agenda items, or support the work of other committees, for example, matters relating to information governance and/or cyber security.

24 The Board plans to undertake a review of its new streamlined committee structure later in 2021 and has confirmed it will consider our views on the Quality, Safety and Performance Committee at the same time (**paragraph 18**). Given the length of some committee meetings, the Board should consider piloting re-ordering agendas by placing items for assurance at the start of meetings. At other health bodies, we have observed that re-ordering agendas in this way helps to manage the time and energy levels in meetings to enable good scrutiny where it is needed most.

Board and committee information

25 During the first peak of COVID-19 in 2020, some items of Board and committee business were necessarily paused and added to the recovery log. In autumn 2020, items were brought back into active management with appropriate scrutiny arrangements mapped to the new committee structure. In February 2021, whilst the Trust was responding to the second peak of COVID-19, the Board reviewed and agreed proposals to pause items of Board and Committee business and some Trust work programmes. At the time of writing this report, paused items had either recommenced, or there was an agreed timescale by which to do so.

26 The Trust continues to provide good quality, accessible information to its Board. As we observed last year, officers provide clear verbal presentations identifying specific issues or under-performance. Cover reports set out the purpose of papers and include relevant impact assessments undertaken. There is clarity about which committees and/or management groups have previously considered papers. The Trust told us it intends to provide guidance and training on writing and presenting Board and committee reports. The training/guidance provides an opportunity for the Trust to ensure that all Board and committee papers focus on key issues and address concerns we set out in **paragraph 18**, regarding the amount and level of detail in some committee papers.

[5] NHS Wales Informatics Service ceased as a hosted service following the creation of Digital Health and Care Wales as a separate Strategic Health Authority.

27 The Trust has long intended to make significant improvements to performance information reports (the performance measurement framework). Progress has been delayed due to the pandemic. However, the Trust has undertaken an initial tranche of work in relation to Velindre Cancer Centre performance reporting. A summary dashboard of performance across all measures is now included, and improvements have been made to the explanations of current performance and actions to be taken. Further work is planned later in 2021 and in 2022 to develop a fully revised performance measurement framework using improved business intelligence reporting. Plans also include developing more outcome-based measures, adding benchmark comparisons, and aligning reporting to strategic priorities.

Board commitment to continuous improvement

28 The Board is required to undertake an annual self-assessment of its effectiveness. The Board concluded that it could define itself as 'having well developed plans and processes and can demonstrate sustainable improvement throughout the organisation'[6]. Our observations of Board and committee meetings found they continue to be effective and well chaired. Attendees abide with good meeting etiquette and opportunities are provided for questions and comments. There continues to be a constructive relationship between executive officers and independent members.

29 During the pandemic, board development sessions were paused at times to enable regular Board briefings, ensuring IMs have been fully briefed on the Trust's response to COVID-19 and associated issues and risks. In September 2020, a Board development programme was developed to support the Board and executives in meeting the challenges of a continually evolving operating environment. The programme will be delivered by the end of 2021.

30 The Trust has undertaken a review of governance lessons learnt across NHS Wales whilst responding to the pandemic. The Trust assessed its governance arrangements to identify areas where improvements could be made. Generally, the Trust's governance arrangements compared well, although some further improvements were identified.

Ensuring organisational design supports effective governance

31 In our Structured Assessment 2020 report we described the Trust's incident management structure that was set up to ensure agile and rapid decision making during the pandemic. Whilst the incident management structure was stood down

[6] Velindre University NHS Trust, Accountability Report 2020-21.

during summer 2020, Gold and Silver Command groups[7] were reactivated in October 2020 until spring 2021, which enabled continued agility in the Trust's decision making through the second wave of COVID-19. The Trust is now considering how to embed new ways of working implemented during the pandemic, including improved clarity of decision-making responsibilities, agility of decision making and retaining the Clinical Advisory Group (set up during the pandemic) to provide expertise in developing strategic intent.

32 The Trust has aligned some key business support functions, such as digital support, to enable more efficient working across the Trust (see **Exhibit 3**, **2018 R8**). The Director of Corporate Governance has taken on an additional Chief of Staff role, for an interim period. After six months, the Trust will assess whether the arrangement should continue on a permanent basis; this will be dependent on ensuring that there is no impact on the postholder's existing responsibilities, including ensuring the effective functioning of the Board and its committees.

Exhibit 3: progress made on previous year recommendations

Recommendation	Description of progress
Closing capacity and capability gaps 2018 R8 The Trust should prioritise a review of support services in the two divisions to identify areas that could be integrated to reduce the duplication of effort, increase organisational learning and to inform plans to address capacity and capability gaps.	**Complete** The Trust has aligned some business support functions where similar services are provided by separate teams within the two divisions. The Trust told us that aligning support functions has enabled it to work more efficiently and ensure organisational learning across the divisions.

[7] Gold Command Group was responsible for strategic decision making. Silver Command groups in the Welsh Blood Service and Velindre Cancer Centre were responsible for tactical decision making, supported by Bronze Command groups making operational decisions.

Planning for recovery[8]

33 **The Trust is developing detailed plans to ensure ongoing business continuity and increase capacity to respond to increasing demand for cancer and blood services. However, not all strategic priorities are supported by specific, timebound actions for delivery**.

34 The Board discussed and approved the Trust's draft operational plan for 2021-22 (the Annual Plan) in its March 2021 private Board meeting. In June 2021, the Strategic Development Committee endorsed the final Annual Plan and supporting financial plan. The Board subsequently approved the final Annual Plan on 30 June 2021 via a Chair's Urgent Action. There was good scrutiny of both the draft and the final versions, with the Board seeking assurance that the plan was realistic and achievable.

35 The Annual Plan focusses on continued service sustainability and ongoing recovery. It provides detail on how the Trust intends to increase capacity to meet the anticipated surge in referrals for cancer services and increased demand for blood and blood products during 2021-22 and beyond. Welsh Government feedback on the draft plan noted that further information on 'prevention, inequalities, mental health, decarbonisation and social partnerships' would strengthen the final plan, but the Trust did not add any further information in these areas.

36 The Annual Plan sets out six overarching strategic priorities for the Welsh Blood Service. Each strategic priority is underpinned by several objectives with specific and timebound actions for delivery. There are five strategic priorities for Velindre Cancer Centre, each supported by only one key objective covering many topics; actions for delivery are generally vague and none include delivery milestones. It will be difficult to assess whether the action was delivered or not, and whether delivery was on time. Velindre Cancer Centre should develop strategic priorities underpinned by specific, timebound actions for delivery. Both divisions would benefit from articulating intended outcomes to help assess the impact achieved (**Recommendation 2**).

37 The Trust has a Consolidated Action Tracker, which contains a summary of delivery of the actions set out in its plans. The tracker is regularly updated with a short summary of progress against each action and a traffic light system shows the status of the action. The tracker is reviewed each month by the Operational Management Groups and the Executive Management Board. The Trust provides a

[8] NHS bodies are required to submit a three-year Integrated Medium Term Plan (IMTP) to the Welsh Government on an annual basis. The IMTP process for 2020-23 was paused by the Welsh Government in March 2020, to allow NHS bodies to focus on responding to the COVID-19 pandemic. Instead, health bodies were required to submit quarterly plans during 2020-21 as well as prepare an annual plan for 2021-22 by 31 March 2021. Our 2021 structured assessment phase one report considered the Trust's operational planning arrangements.

summary of progress against actions set out in the plans to the Board on a quarterly basis (see **Exhibit 4**, **2019 R3**).

38 In June 2021, the Board received a report on the progress set out in the Trust's 2020-21 quarterly plans. 185 out of 235 actions were completed, nine were considered no longer relevant, seven were paused due to COVID-19 and 34 rolled forward to the Annual Plan.

Exhibit 4: progress made on previous year recommendations

Recommendation	Description of progress
Monitoring delivery of strategic priorities 2019 R3 The Board should agree the information it requires to support its scrutiny of progress made to deliver all strategic priorities (and supporting actions) set out in the Integrated Medium Term Plan. Information should include as a minimum, progress to date and, where milestones are not met, resulting remedial actions.	**Complete** The Board has agreed the information need to scrutinise delivery of strategic priorities, and reviews progress on a quarterly basis.

Systems of assurance

Managing risk

39 **The Trust is making good progress to develop and embed new risk management arrangements.**

40 In previous structured assessments, we have recommended that the Trust develop a Board Assurance Framework[9]. During 2020, several workshops were held to seek staff views, and independent members were involved in developing a Board Assurance Framework. Ten principal risks to achieving strategic priorities and a template were approved by the Board in 2020.

41 During 2021, work to progress the Board Assurance Framework was paused due to COVID-19 pressures. Work recommenced in summer 2021, with executive officers taking the lead for populating the template with key controls and sources of assurance for the risks falling in their areas of responsibility. The first draft

[9] A key document for recording and reporting the risks to achieving strategic priorities, the controls needed to mitigate against risks, sources of assurance, responsible executive officers and committee scrutiny arrangements.

populated Board Assurance Framework was shared at the September 2021 Board meeting. The next steps involve refining the information in the Board Assurance Framework and ensuring it is comprehensive and progressing work to fill identified gaps in sources of control and assurance.

42 The Trust and Board recognise that the Board Assurance Framework must be a live tool which drives the Board's agenda and requires regular Board committee scrutiny and oversight of delegated risks. Our view is that significant positive progress has been made, but it is too early to comment on the success of application of the Board Assurance Framework. The Trust will need to ensure there is sufficient training for Board members, and the Board will collectively need to agree how to utilise the Board Assurance Framework to assess the risks to achieving strategic priorities (see **Exhibit 5**, **2019 R2**).

43 When reviewing the performance measurement framework and addressing **Recommendation 2** (specific, timebound actions for delivery), the Trust should consider how to map/align performance information to the Board Assurance Framework as an additional layer of intelligence.

44 Last year, our structured assessment found that the Trust had effectively adapted its risk management arrangements to identify and manage new COVID-19-related risks and was making good progress towards introducing longer-term risk management improvements. In September 2020, the Board approved the Trust's new Risk Management Framework, Risk Appetite Statement and associated risk management procedures and user guides. Risk management training for managers and staff has been developed, with plans for roll out later in 2021. The new Risk Management Framework (and associated documents) is comprehensive and provides clarity on arrangements to manage risk; however, it is too early to assess its application (see **Exhibit 5**, **2019 R2**).

45 The Trust undertook a significant review of all open risks on operational risk registers during 2021. The review was necessary to ensure all risk information is current and complete prior to the migration of all risks to a new version of DATIX[10]. Once complete, operational risk registers will be standardised across the Trust. Escalation of risks to the Trust Risk Register will be consistent Trust-wide, with escalation trigger scores appropriate to risk tolerance levels set out in the risk appetite.

46 The Trust took the Trust Risk Register to the September 2021 Board meeting. An update confirmed that most, but not all risks had been transferred to the new version of DATIX. There were 111 risks on the Trust Risk Register. The Trust recognises that there may need to be some consideration of either scoring, or escalation trigger scores as it was felt that some of the risks were not significant enough to warrant Board level scrutiny. Further refinement is planned. The Trust must ensure that all teams/departments within the Trust are consistently using

[10] Datix is a web-based incident reporting and risk management system used by healthcare organisations.

DATIX risk registers, and do not use separate, local arrangements[11]. See **Exhibit 5**, **2016 R7c** and **2019 R2**.

47 The Trust had originally intended to start reporting the revised Trust Risk Register, (incorporating the changes set out in **paragraph 43)** by December 2020. However, the review of operational risks was impacted by COVID-19 pressures and capacity gaps in the risk management team. Consequently, prior to September 2021, the Board and its committees last received a Trust Risk Register in July 2020, this was not challenged by the Board. In our view, the legacy Trust Risk Register should have continued to be maintained and considered by the Board in the absence of the new version. The Trust told us that the Executive Management Board and the Board and its committees have continued to review key risks relating to quality and safety; Transforming Cancer Services[12]; research, development, and innovation; Brexit-related issues; and COVID-19. We found that papers in these areas have been provided to the Board and/or its committees for consideration. However, the absence of a Trust Risk Register for more than 12 months means it is not possible for us to assess whether any other significant risks had arisen, but not sighted by the Board.

Exhibit 5: progress made on previous year recommendations

Recommendation	Description of progress
Risk management 2016 R7c The Trust should standardise the format of its various risk registers, ensuring the good practice elements of each register are spread across the organisation.	**In progress (overdue)** The Trust is reviewing all operational risks. Risk registers will be migrated to a new version of DATIX. The Trust has developed a standardised approach to reporting and escalating risks Trust-wide.

[11] Internal Audit's Velindre Cancer Centre Divisional Review (March 2021) identified at that time some departments that did not use DATIX to record risks.

[12] The Transforming Cancer Services programme aims to meet the increasing demand and complexity of cancer care and to deliver more care closer to home.

Recommendation	Description of progress
Board assurance and risk management 2019 R2 The Trust should complete the development of its Board Assurance Framework with pace, ensuring that it is appropriately underpinned by up to date risk management arrangements. Specifically, the Trust should • review the principal risks to achieving strategic priorities and ensure the necessary assurances have been mapped and reflected in the new BAF; • update the risk management framework, ensuring clear expression of risk appetite and arrangements for escalating strategic and operational risks; and • provide risk management training to staff and Board members on resulting changes to the risk management framework.	**In progress (overdue)** The Board Assurance Framework template and key strategic priorities are complete. Key controls and sources of assurance are being developed. The aim is for the Board Assurance Framework to be operationalised in September 2021. Work on the Risk Management Framework and Risk Appetite is complete. Work on operational risks and risk registers is ongoing, with the aim of completion by the September 2021 Board meeting. Risk management training for staff has been developed and due for roll out later in 2021.

Tracking progress against audit and review recommendations

48 **The Trust has good arrangements to monitor its progress in responding to audit and review recommendations, although there is no mechanism to ensure that action taken fully addresses the recommendation**.

49 The Audit Committee has an established approach for tracking progress against audit recommendations. However, there is still no mechanism in place for the Audit Committee to satisfy itself that actions taken were satisfactory (see **Exhibit 6, 2018 R4b**). The Quality, Safety and Performance Committee has a tracker for external and internal audit improvement recommendations.

50 The Trust has developed a record of their regulatory and inspection. The record includes the date of last formal review, management responses to recommendations and any further scheduled reviews. It is proposed that the document become a standing item on the Audit Committee agenda.

Exhibit 6: progress made on previous year recommendations

Recommendation	Description of progress
Tracking Internal and External audit recommendations 2018 R4b Implement a mechanism for ensuring that when Internal Audit and External Audit actions are completed, the responsible officer provides a brief summary of the actions taken to the Audit Committee, along with a request to close the action.	**No progress (overdue)** No progress has been made on this recommendation.

Quality and safety assurance[13]

51 **The Trust continues to provide assurance on staff and service user safety and is refreshing its quality governance framework.**

52 The Trust provides good information on staff safety and wellbeing to the Board. In the early stages of the pandemic, the Board took responsibility for overseeing staff safety and wellbeing, with updates provided at Board meetings. In July 2021, the Quality, Safety and Performance Committee received a wellbeing update, which set out the initiatives in place, results from staff surveys and associated learning, and a summary of further actions. The Trust continues to work closely with Trade Union representatives to monitor the workforce dashboard, which includes performance information on personal protective equipment training and risk assessment completion rates along with sickness absence rates.

53 Through its scrutiny of the performance measurement framework, the Board continues to monitor potential harm to patients from longer than normal waits for treatment. The Quality, Safety and Performance Committee receives regular patient and donor feedback, and reports outline learning and resulting actions. The Quality, Safety and Performance Committee continues to consider patient stories and how learning is shared.

54 In previous structured assessments, we have made recommendations relating to addressing weaknesses in the scrutiny of clinical audit planning and reporting. We have provided our recommendations on clinical audit in **Exhibit 7,** we will consider the progress made in our review of quality governance arrangements.

[13] We have limited the work we have undertaken on quality governance arrangements as part of our 2021 structured assessment as we are undertaking a separate review of quality governance arrangements at the Trust. The review will consider whether the organisation's governance arrangements support delivery of high quality, safe and effective services. We will report our findings later in 2021.

Exhibit 7: progress made on previous year recommendations

Recommendation	Description of progress
Clinical audit scrutiny 2018 R5a The Quality and Safety Committee should review and approve clinical audit plans, ensuring that clinical audit plans address any risks to achieving strategic priorities and organisational risks.	To be considered and reported in our quality governance arrangements report. Therefore, we currently consider these recommendations to be outstanding.
Clinical audit scrutiny 2018 R5b Improvements should be made to the content of clinical audit reports from both VCC and WBS to clearly identify the audit findings, any associated risks and actions for improvement and follow-up.	
Clinical audit scrutiny The Quality and Safety Committee should assure itself that clinical audit findings are addressed.	
2018 R5d Clinical audit scrutiny The Audit Committee should clarify how it assures itself that the clinical audit function is effective.	

Managing financial resources

55 Our work considered the Trust's financial performance, financial controls and arrangements for monitoring and reporting financial performance.

56 **The Trust manages its financial resources well and has good arrangements to monitor and report its financial activity.**

Achieving key financial objectives

57 **The Trust achieved its financial duties at the end of 2020-21, and has a clear financial plan to deliver services in 2021-22.**

Financial performance 2020-21

58 In 2020-21, the Trust reported a small surplus of £16,000. The Trust also achieved its statutory financial duty to achieve break-even over a rolling three-year period (2018-19 to 2020-21). However, COVID-19 had a considerable impact on the Trust's finances in the year.

- the Trust reported a year-end underachievement of £1.077 million on income, this was largely related to underactivity caused by COVID-19.
- the Trust underspent (against the plan) on pay by £1.116 million, partly caused by vacancies and staff being re-directed and supported by additional Welsh Government COVID-19 funding (see **paragraph 56**). However, pay costs increased on the prior year, due to the pay award, the NHS bonus payment, an increase in agency spend and additional staff recruited to respond to COVID-19.
- the Trust reported an overall underspend (against the plan) of £23,000 on non-pay expenditure. General reserves were used to support overspending in some areas.

59 The Trust had a savings requirement of £1.4 million for 2020-21 (£1.2 million recurrent and £200,000 non-recurrent). Of this amount, £800,000 was categorised as savings schemes and £600,000 as income generating schemes. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation; however, COVID-19 meant it was impossible to enact the changes. The Trust reported an underachievement of £700,000 against the savings plan as a direct result of COVID-19.

60 The total expenditure relating to COVID-19 during 2020-21 was £15.591 million[14] – £11.532 million relating to non-pay and pay expenditure, £3.984 million relating to pay and £700,000 relating to non-achievement of savings. This was offset by a reduction in activity-related costs of £625,000, and the rest by additional funding

[14] This excludes NHS Wales Shared Services Partnership expenditure.

from the Welsh Government. Additional costs included hospice funding, the Wales convalescent plasma service pilot, and mass vaccinations.

Financial performance 2021-22

61 The Trust's financial plan for 2021-22 was included in the Annual Plan. The financial plan includes:

- an underlying deficit of £700,000 brought forward from 2020-21 (the underachievement of savings);
- new cost pressures/investment of £9.307 million, with a recurring effect of £1.357 million;
- an ambition to achieve new recurring income of £8.582 million and achieve savings of £1.1 million (with a recurring effect of £925,000); and
- the aim to reduce the underlying deficit into the next financial year to £500,000.

62 By month six, the Trust had received an additional £4.846 million funding from the Welsh Government towards COVID-19 response and recovery costs. The Welsh Government has confirmed the Trust will receive additional funding for COVID-19, costs.

63 The Trust's approved capital funding for 2021-22 totalled £9.156 million. This includes all-Wales capital funding of £7.245 million and discretionary funding of £1.911 million. The Trust reported capital spend to Month 6 was £2.045 million and is forecasting to remain within the agreed £9.156 million. The Trust is seeking additional all-Wales capital funding for bespoke infrastructure projects.

64 The Trust's month six 2021-22 financial report shows that it is likely to meet its financial duty to break even over a three-year rolling period and achieve its saving target for the financial year.

Financial controls

65 **The Trust continues to have good controls to monitor financial activity, and to prevent, detect and respond to fraud**.

66 Internal Audit's review of the Trust's financial systems, reported in January 2021, gave reasonable assurance of financial controls it examined; these were debt, cash, and financial management. Whilst the review found there were sound processes in place in the areas examined, the review made recommendations to improve controls and monitoring in specific areas of debt management.

67 No significant control weaknesses were identified from our 2020-21 accounts opinion work at the Trust.

68 The Trust reports regularly to the Audit Committee on procurement, losses, and special payments, and counter-fraud matters. Procurement reports clearly set out the number of Single Tender Actions and Single Quotation Authorisations and the

reasons why officers did not follow standard procurement procedure. The value and reasons for deviation from standard procurement procedures are clearly set out in the Trust's procurement reports which are scrutinised by the Audit Committee.

69 Where Chair's actions out of committee have been necessary, there is a log of the decision, evidence of Board scrutiny and subsequent ratification by the Board.

70 The Trust has maintained decision logs relating to COVID-19 financial expenditure. Expenditure relating to COVID-19 is included on the monthly monitoring returns to the Welsh Government and reported to Board.

71 Our October 2020 review of the Trust's counter-fraud arrangements found that the Trust demonstrates a commitment to counter fraud, has suitable arrangements to support the prevention and detection of fraud and is able to respond appropriately where fraud occurs.

Monitoring and reporting

72 **The Trust uses clear and accessible information to monitor and report its financial performance.**

73 The Trust reports financial performance at every Board meeting, and we have observed good scrutiny of their content. Alongside verbal presentations from officers, the reports provide more context on the reasons for over or under spends and the factors affecting planned savings. The information is published on the Trust's website with its Board papers. Our review of financial reports reported to Board found they provide high-quality and timely information on financial performance, including financial savings and cost drivers related to COVID-19. Finance reports also clearly identify financial risks and cost implications.

Appendix 1

Management response to audit recommendations

The following table sets out the Trust's management response to our 2021 (phase 2) structured assessment audit recommendations. The Trust should also ensure that outstanding recommendations from previous structured assessments are actioned. Any recommendations from previous years, that we consider to still be open are set out in the body of this report.

Recommendation	Management response	Completion date	Responsible officer
Public transparency of board business R1 Some committee meeting papers are missing from the website, as are links to recordings of Board meetings. The Trust should ensure that it strengthens the process for the collation, sign-off and timely publication of: • committee meeting papers in advance of meetings; and • recordings of Board meetings.	The Corporate Governance team have introduced a new end to end Board Committee tracker, to strengthen and tighten the process for effective management of Trust Board and Committee meetings and papers. A review of the website content has been completed and all missing content has been added All of the Corporate Governance team are to be trained to upload papers directly on the Trust website to further increase resilience.	November 2021 (Completed) November 2021 (Completed) March 2022	Director of Corporate Governance and Chief of Staff

Recommendation	Management response	Completion date	Responsible officer
	An error led to the deletion of the June 2021 Board meeting recording. A governance note to explain the missing recording was added to the minutes of the July 2021 Board meeting. On the website, the links to the Board meeting recordings were updated to make clear the June 2021 recording is unavailable.	November 2021 (Completed)	
Articulation of strategic priorities R2 Not all the Trust's strategic priorities in the Annual Plan are supported by specific, timebound actions for delivery, and the intended outcome. In future, the Trust should ensure that all strategic priorities are supported by discrete objectives, each underpinned with specific, timebound actions for delivery and the intended outcome.	We recognise that there are differences in the granularity of the information provided by the service divisions, which in some cases is due to the different type of strategic priority, however, we acknowledge that there are improvements to be made including the identification of timelines and this will be included in the Integrated Medium Term Plan 2022-25.	March 2022	Chief Operating Officer and Director of Strategic Transformation Planning and Digital

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We welcome correspondence and telephone calls in Welsh and English.
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg a Saesneg.

Board Committee Effectiveness
Final Internal Audit Report

January 2022

Velindre University NHS Trust

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

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

Contents

Review reference:	VT-2122-02
Report status:	Final
Fieldwork commencement:	20th September 2021
Fieldwork completion:	8th December 2012
Draft report issued:	13th December 2021 / 17th December 2021
Debrief meeting:	14th December 2021
Management response received:	10th January 2022
Final report issued:	10th January 2022
Auditors:	James Quance, Head of Internal Audit Emma Rees, Audit Manager Philip Lewis-Davies, Principal Auditor
Executive sign-off:	Lauren Fear, Director of Corporate Governance & Chief of Staff
Distribution:	Emma Stephens, Head of Corporate Governance
Committee:	Audit Committee Trust Board

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

To provide Velindre University NHS Trust (the Trust) with assurance over the:

- effectiveness of the new Board Committee structure; and,
- the adequacy and effectiveness of controls in operation.

Overview

The Trust is committed to improving effectiveness and efficiency in its accountability and decision-making at Board level through the September 2020 committee restructuring and ongoing development work in this area. We concur with the actions taken to date and acknowledge that, via its own development work, the Trust has plans in place or is already acting to address many of the matters we identified throughout our review (see section 2).

We have identified some recommendations to further ensure robustness in the process and support the Trust in maximising efficiency and effectiveness:

- clearer alignment of committee cycles of business and agendas with the Trust's objectives and risks (matter arising (MA) 1);
- developing a robust process to ensure all required reports are included in agendas (MA1); and
- clearly defining what success looks like for the new structure, identifying key performance measures to objectively assess benefits realisation going forward and developing robust action plans to support realisation (MA2).

All recommendations are set out in Appendix A.

Report Classification

Reasonable

Some matters require management attention in control design or compliance.

Low to moderate impact on residual risk exposure until resolved

Assurance summary[1]

	Assurance objectives	Assurance
1	Defined Board and committee governance and assurance structures	Substantial
2	Structures that support effective and efficient decision-making and scrutiny	Reasonable
3	Cycles of business – alignment with objectives and risks	Reasonable
4	Clear reporting and triangulation of business activity	Reasonable
5	Assurance over benefits realisation	Reasonable

Key matters arising

		Assurance Objectives	Control Design or Operation	Recommendation Priority
1	Cycles of Business and Committee Agendas	2, 3	Design	Medium
2	Benefits Realisation	2, 5	Design	Medium

[1] The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

1.1 Following a benchmarking exercise against NHS Wales Health Boards / Trusts and Canterbury Health in New Zealand, Velindre University NHS Trust (the Trust) Board approved a new Board Committee structure.

1.2 Effective from October 2020, the Trust moved from nine to five Board committees: Quality Safety & Performance (QSPC); Strategic Development (SDC); Audit & Assurance; Remuneration & Terms of Service and Charitable Funds.

1.3 There are two sub-committees under these committees: Transforming Cancer Services Programme Scrutiny and Research, Development & Innovation.

1.4 The expected benefits of the new structure were identified as:

- better delivery, planning and triangulation of business activity;
- plans considered and implemented in a local and partnership context;
- clear decision-making process on areas of accountability;
- enhanced collaborative working given the increasing agenda with local stakeholders; and
- defined governance and assurance structures.

1.5 To support the new committee structure, the Trust is in the process of developing a new Performance Management Framework (PMF) which will triangulate reporting on quality, safety, workforce and finance. The aim is that the PMF will harmonise floor to Board reporting across the Trust.

Purpose

1.6 Our review sought to provide the Trust with assurance over the:

- effectiveness of the new Board Committee structure; and,
- the adequacy and effectiveness of controls in operation.

1.7 We took into consideration:

- the process undertaken by the Trust to develop the new committee structure and its ongoing work on the Performance Management Framework;
- work undertaken on committee effectiveness by Audit Wales in their Structured Assessment and review of Quality Governance arrangements; and
- the impact of the Covid-19 pandemic in our assessment of the arrangements in place.

1.8 Our work was predominantly focused around the QSPC and SDC as the two newly created committees.

1.9 The audit excluded governance arrangements over hosted bodies.

Associated risks

1.10 The key risk considered in this review was an ineffective committee structure, potentially resulting in:

- failure to deliver strategic objectives;
- failure to effectively manage risk; and,
- financial or reputational damage.

Context

1.11 Through the September 2020 committee restructuring and ongoing development work, the Trust is seeking to optimise efficiencies in accountability and decision-making at Board level. A recent area for improvement it identified is further streamlining of committee cycles of business.

1.12 The new committee structure had been in place for just over twelve months at the time of our audit, during which the first annual committee reviews for the two newly formed committees (QSPC and SDC) were also being undertaken.

1.13 At the time of writing, the QSPC Annual Review had been completed and reported to the November 2021 QSPC meeting. The Annual Review also identified areas for development and improvement in terms of efficiencies that could be gained from the new committee structure (see paragraphs 2.14-2.16).

1.14 Our audit was undertaken within the context of the Trust's journey, and our conclusions and recommendations provide assurance over progress to date and identify further areas where there is opportunity to improve robustness and maximise efficiency.

2. Detailed Audit Findings

Audit objective 1: the Trust has clear, defined Board and committee governance and assurance structures

2.1 The Trust has defined Board and committee governance and assurance structures which were reviewed and approved by the Board.

2.2 The restructure process was managed by the Corporate Governance team, led by the Director of Corporate Governance & Chief of Staff.

2.3 Under the revised structure, each committee (and sub-committee) has approved Terms of Reference and Operating Procedures (ToR) and a cycle of business.

2.4 The Board was presented with the new committee structure in September 2020 and noted the draft new and updated ToR and cycles of business. The Board supported these documents to be finalised through the inaugural meetings of each of the committees and sub-committees, prior to being brought back to the Board

for approval in November 2020. At that point, the Board also approved revisions to the Trust Standing Orders to reflect the new committee structure.

2.5 Whilst the new committee ToR have been published on the Trust's public website, we noted that the Standing Orders on the site do not reflect the new committee structure. See matter arising 7 in Appendix A.

Conclusion:

2.6 The Board has defined governance and assurance structures in place. No significant matters for reporting were identified in this area. Therefore, we have provided **substantial assurance** over this audit objective.

Audit objective 2: the new committee structure provides for clear, effective and efficient decision-making and scrutiny on areas of accountability

2.7 The committee ToRs follow a standard format that details delegated powers, committee authority, and reporting and assurance matters.

2.8 To ensure all previous committee activity was captured, and nothing was lost under the new structure, the Corporate Governance team undertook a detailed activity mapping exercise. This also aimed to ensure there was no duplication in reporting.

2.9 The mapping exercise was a starting point for refining the committee cycles of business. The Trust has undertaken further streamlining work throughout 2021 in this area, particularly at the QSPC due to the amount of business it inherited from the predecessor committees. Changes to the QSPC cycle of business have included amalgamation of several reports and removal of items from the cycle, where considered appropriate (see also paragraph 2.24). The Trust recognises there is further opportunity to streamline committee agendas and we understand it intends to continue this work going forward.

2.10 We concur with the Trust's approach in this area and have identified recommendations to support in this process in matter arising 1 in Appendix A.

2.11 During our attendance at committee meetings, we noted that allocated agenda timings are often not adhered to, potentially limiting time available for appropriate scrutiny of other agenda items. This impacts the QSPC particularly, due to the large volume of items on its agendas and where time allocated for each agenda item is often not adhered to in the meetings. A recent example is where discussions at the November 2021 QSPC meeting about significant matters arising in Radiotherapy overran the allocated time, resulting in the remaining agenda items being rushed. We recognise the importance of discussions around significant matters arising and have provided recommendations to support the management of this in matter arising 1 in Appendix A.

2.12 Through our discussions with Independent Members, we identified there remains some concern about the risk of duplication or gaps in reporting to committees.

Members identified areas of concerns in general terms as being where a sub-committee reported to more than one committee (for example, the Research Development & Scrutiny Sub-Committee) and where a subject matter is being reported to more than one committee (for example, digital matters are presented to SDC and QSPC). We also identified a specific example where the annual Clinical Audit report was presented to the Audit Committee, QSPC and the Board. See matter arising 4 in Appendix A.

2.13 Scrutiny over committee performance is provided in a range of ways including the delivery of an annual report to the Board. This includes:

- a self-assessment of performance;
- an annual survey of committee members / attendees; and
- a review of the committee's ToR and cycle of business.

2.14 The QSPC Annual Report was discussed at its November 2021 meeting. In particular, the annual survey reiterated our findings around:

- the large agendas and level of detail in reports, and the impact that this has had on the efficiency of meetings; and
- the potential for duplication of activities between the committees and the Board.

2.15 Survey respondents also requested further clarity around the role of the QSPC.

2.16 The QSPC Annual Report identified high-level actions to address concerns raised in the survey, including:

- establishing of an operational Quality & Safety Group in early 2022 to feed into the QSPC and streamline the level of detail and quality of information received at QSPC – we were informed this action is captured as part of the Trust's development work on its new Quality & Safety Framework;
- training for report writing for assurance and escalation – we understand the Trust was due to deliver its first cohort of training in this area in mid-December 2021, but the training was postponed due to the escalation of the Covid-19 pandemic (command and control structures were stood back up due to increasing case numbers and concerns about the Omicron variant);
- review of quality and level of detailed of reports to the QSPC to enhance and engineer more effective triangulation – we were informed that reporting quality will be covered as part of the above training; and,
- flow of operational and divisional reporting to the QSPC – see paragraph 2.26 for work ongoing in this area.

2.17 Whilst we recognise action is being taken, we identified that the Trust has not developed a formal action plan with identified responsible individuals and deadlines

to ensure the actions and improvements are implemented effectively. See matter arising 2 in Appendix A.

2.18 The SDC Annual Report (including the Committee Annual Survey) was due to be discussed at its December 2021 meeting. However, we were informed committee members are to be given additional time to complete the survey, therefore the report will be taken to the February 2022 meeting.

2.19 We understand the Trust intends to undertake a formal Trust-wide review of the restructured committees through feedback from Independent Members and Executive Directors, supported by the committee annual reports and feedback from Audit Wales and ourselves (via this report). The review was initially planned to be presented at the January 2022 Board meeting. However, due to the impact of the developing position resulting from the prevalence of the Omicron variant, this review will now be concluded and presented at the March 2022 Board meeting. This will also ensure the findings and outcomes of the SDC Annual Report and Effectiveness survey are able to be incorporated into the overarching review.

Conclusion:

2.20 The new committees have clearly documented ToRs, and their performance is subject to scrutiny in a structured manner. The Trust is continuing its development work to fully optimise the effectiveness of the QSPC. We have identified recommendations to support and enhance this process. We have provided **reasonable assurance** over this area.

Audit objective 3: Board and committee cycles of business are aligned to strategic objectives and risks

2.21 Cycles of business are in place for each committee and are linked to the committee ToR.

2.22 With the development of the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) (subject to a separate audit during 2021/22), the Trust has an opportunity to clearly demonstrate the link between its cycles of business and its objectives and risks. This may also help to further drive efficiency in agenda setting and reporting. See matter arising 1 in Appendix A.

2.23 We were informed that committee chairs are engaged in agenda setting. However, we identified instances (set out in matter arising 1 in Appendix A) where required reports (for example, on the cycle of business, or requested by members) should have been included within Board or committee agendas but were missing.

2.24 The cycles of business are subject to review by each committee on a continuing basis:

- the QSPC made changes to its cycle of business in March and September 2021 and proposed further changes at its November 2021 meeting; and

- the SDC made changes to its cycle of business in November 2021.

2.25 Supporting cover reports provided explanations for the proposed changes to both committees' cycles of business.

2.26 We were informed these changes are being identified through ongoing work by the Corporate Governance team in conjunction with service leads and report authors to ensure the right information is being reported at Board / committee level and to determine where efficiencies could be achieved (for example, where reports can be amalgamated or are no longer needed at this level).

Conclusion:

2.27 The committees' cycles of business have been defined and subject to regular review, although the Trust has an opportunity to clearly demonstrate the link between its committee ToR and cycles of business and its objectives and risks. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 4: Board and committee reporting is clear and concise and provides effective triangulation of business activity

2.28 The new committee structure brings performance reporting on all aspects of the Trust (for example, operational, quality & safety, finance, workforce, etc) together into the QSPC, with the intention of triangulating performance more effectively through:

- triangulation within committee reports, where appropriate: we note this is a new approach for report writers and, as such, will take time to become embedded and fully effective. We understand triangulation is included in the report writing training (see paragraph 2.16) and that the new Performance Management Framework will further support triangulation in reporting.
- time allocated at the end of each agenda to discuss triangulation: we understand the main purpose for this is to identify triangulation for inclusion in the QSPC highlight report, although we note that this time can be limited due to the size of the QSPC agenda (see matter arising 1 in Appendix A).

2.29 We identified that there is some variability in the quality of the content of reports at the committees. Issues include high levels of operational information, reports not always tailored to the audience and purpose of report and a lack of effective executive summaries. Similar points were identified by respondents to the QSPC Annual Survey.

2.30 Whilst this was not the case for all committee reports, these issues may impact the Trust's ability to optimise efficiencies in the committee structure and ensure effective triangulation of performance. We were informed this will be addressed

through the report writing training (see above). We have identified further recommendations to support this in matter arising 3 in Appendix A.

2.31 We also noted that whilst agendas have been issued on a timely basis (i.e., seven days before the meeting), committee papers are often issued after this. This may impact on Independent Members' ability to undertake appropriate pre-meetings scrutiny and review, potentially causing inefficiencies in committee meetings. See matter arising 5 in Appendix A.

Conclusion:

2.32 Committee reporting is evolving but requires further refinement to maximise the potential for efficient monitoring and scrutiny. Therefore, we have provided **reasonable assurance** over this audit objective.

Audit objective 5: the Trust has assurance that the expected benefits of the new structure are being realised

2.33 The Trust identified the expected benefits of the Board committee restructure during the development phase. The expected benefits are set out in paragraph 1.4. We were informed that the Trust-wide review of the restructured committees is to be reported to the March 2022 Board meeting (paragraph 2.19) will include consideration of benefit realisation to date.

2.34 However, the identified benefits are not SMART (Specific, Measurable, Achievable, Realistic, and Timely) and the Trust has not clearly defined what success looks like in terms of the new structure. Therefore, it will be difficult to objectively assess whether the benefits have been realised.

2.35 The QSPC annual committee review process (paragraph 2.13-2.16) identified that, whilst progress has been made, further development is required to achieve the intended benefits (we note earlier that action is already underway to address the areas for development).

2.36 We recognise that the new committee structure has only been in place for just over twelve months and that the Trust has further to go to fully achieve the intended benefits. The Trust now has the opportunity to revisit the intended benefits to ensure they remain appropriate, identify performance measures to better assess realisation and clearly define what success will look like. The Trust could use the annual committee review process to support ongoing assessment of benefits realisation.

2.37 See matter arising 2 in Appendix A.

Conclusion:

2.38 The annual committee review process has identified further actions required to realise the intended benefits of the committee restructure. The Trust needs to

ensure it defines performance measures to allow clear monitoring of benefits realisation going forward. Therefore, we have provided **reasonable assurance** over this audit objective.

Appendix A: Management Action Plan

Matter arising 1: Cycles of Business and Committee Agendas (Design)	Impact
Cycles of Business With the development of the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) (subject to a separate audit during 2021/22), the Trust has an opportunity to clearly demonstrate the link between its cycles of business and its objectives and risks. This may also help to further drive efficiency in agenda setting and reporting. We acknowledge that the QSPC is aware of the impact of the high volume of items on its cycle of business / agendas, as highlighted in its 2021 Annual Survey results. It is actively reviewing its cycle of business and has identified actions for improvement (see matter arising 3). We have identified further opportunities to optimise efficiencies below. **Committee Agendas** A review of committee agendas indicated that it is not clear why each item is included, for example, as a standing item, required by the cycle of business, as a significant matter arising, etc. During our attendance at committee meetings, we noted that allocated agenda timings are often not adhered to, potentially limiting time available for appropriate scrutiny of other agenda items. This impacts the QSPC particularly, due to the large volume of items on its agendas and where time allocated for each agenda item is often not adhered to in the meetings. For example, at the November 2021 QSPC meeting, the Committee overran the allocated timing for the Velindre Cancer Centre divisional performance report due to discussions about significant matters arising within Radiotherapy and also issues noted in Outpatients. This led to the remaining agenda items being rushed. We were informed that further discussions about Radiotherapy at the subsequent Board meeting also overran the allotted time, although a decision was taken to hold further discussions at a future meeting. We recognise the importance of the discussions held on these matters and have provided recommendations to support the management of this below. **Capturing Required Agenda Items** We identified instances where reports should have been included within agendas, as demonstrated in the table below. We were informed during the debrief that Independent Members have requested the relevant committee's cycle of business be included as a consent item at every meeting. We concur with this to ensure members are aware of items that should be considered within that meeting.	Potential risk of: • committee reporting and scrutiny may not focus on key objectives or risks; and • inefficient committee scrutiny.

Report subject	Board or committee	Expected on the agenda	Comment
Private Patient Debt	Audit Committee	October 2021	On action log from July 2021. Item was on the October 2021 agenda, but as a verbal update (no report was provided). The Audit Committee Chair stated at the meeting that they were expecting a written report.
Trust Assurance Framework (TAF) dashboard	Board	November 2021	Not on action log or cycle of business, but the September 2021 TAF cover report stated the full TAF dashboard would be provided in November. No explanation for the delay was provided at the November meeting. Note: it was presented at the December 2021 SDC meeting as a consent item and is also to be received at the January Trust Board as a main agenda item.
Committee Annual Report	SDC	December 2021	Not on action log or scheduled on cycle of business for this meeting. We were informed report was being drafted for this meeting due to the Trust-wide review of the restructure planned for the January 2022 Board. However, the report was delayed allowing committee members / attendees further time to complete the survey. This was not mentioned at the December 2021 meeting.

Recommendations	Priority
1.1 The Trust should: a. link the committee cycles of business and agendas to its objectives and risks through: i. cross-referencing with the Trust Assurance Framework (TAF) and Trust Risk Register (TRR) – this should also help to ensure a more streamlined agenda for the QSPC and greater clarity in the Committee's role; ii. consideration of the TAF and TRR during agenda setting, alongside identification of any significant matters arising at the time (for example, the recent issues noted in Radiotherapy); iii. ensuring the running order of, and allocated timing for committee agendas reflects the importance of individual items, potentially with significant matters scheduled earlier in the meeting;	Medium

b. include relevant committee sections of the TAF dashboard and TRR at the beginning of all meetings and demonstrate (for example, via the cover report) where key risks are addressed during the meeting;

c. we concur with including the committee cycle of business at the beginning of all meetings and further recommend this be accompanied by a cover report identifying and providing explanations for any departures from the cycle of business;

d. allow committee members to bring forward items relating to important issues at the beginning of each committee meeting, similarly to when members are asked if they want to move items from the consent agenda to the main agenda; and

e. consider calling for and, where appropriate, answering Independent Members' questions in advance of committee meetings to enable more efficient use of time during the meetings (an approach that has proven successful at other NHS Wales organisations);

f. ensure effective use of the Board and committee action logs to capture and present items not on cycles of business at the appropriate meeting and hold individuals to account for providing requested reports; and

g. consider whether the NWIS transfer provides opportunity for the Audit Committee to support the cycles of business of other committees.

	Management response	Target Date	Responsible Officer
1.1	a. The TAF/TRR will be cross-referenced with the cycles of business and agendas and will be used during agenda setting. Running orders will reflect the importance of items scheduled for discussion.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
	b. Relevant sections of the TAF/TRR will be included at the beginning of all Committee meetings.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
	c. A log to capture any deviations from Committee Cycles of Business will be established as part of standard practice across all Board / Committees and matters arising / action logs will track progress against this accordingly.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

d. Committee members may bring forward agenda items for earlier discussion if required.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
e. We will consider using a 'questions in advance' approach for committee papers.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
f. As per above captured under point 1.1 (c)	See 1.1 (c)	See 1.1 (c)
g. Consideration will be given to whether the NWIS transfer has provided opportunity for the Audit Committee to support the cycles of business of other committees.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 2: Benefits Realisation (Design)	Impact
Our review of the benefits of the committee restructure identified that: • the benefits are not SMART (i.e., Specific, Measurable, Achievable, Realistic, and Timely); and • the Trust has not defined what success would look like, or when it should be achieved by. Therefore, going forward, it will be difficult to objectively assess whether the benefits have been realised. The QSPC Annual Report identifies areas for improvement and focus and action is underway to address this. However, we found that there is no formal action plan with responsible individuals and deadlines to ensure the improvements are implemented to support the realisation of the identified benefits.	Potential risk of: • inability to objectively measure benefits realisation; • inability to effectively deliver the defined benefits; and • committee restructuring may not reach its full potential.

Recommendations	Priority
2.1 The Trust should: a. revisit the identified benefits to: i. ensure they remain appropriate; ii. establish what success in the committee restructuring looks like; iii. identify key milestones and performance measures to objectively measure benefits realisation; and b. develop action plans with identified responsible individuals and deadlines to support achievement of success (including actions identified through committee reviews), ensuring progress against the action plans is monitored by the Board. Any changes to deadlines (for example, due to the pandemic) should be clearly identified and explained.	Medium

Management response	Target Date	Responsible Officer
2.1 The established annual review process for each committee will form the baseline against which all actions / recommendations will be formally reviewed and assessed following the conclusion of the second year of operation for both the QSPC and SDC.	N/a	N/a

There is not a requirement for an additional layer to be introduced over and above this process which has proven effective across all of the Board Committees

Matter arising 3: Committee Reporting (Design)	Impact
We recognise that the Trust has developed training for committee report authors, although has had to stand down the training due to the escalation of the Covid-19 pandemic and concerns around the Omicron variant. We concur with the intended training and have identified further mechanisms to support the quality of committee reporting below.	Potential risk of: • key issues not appropriately identified and considered; • inefficient committee oversight and scrutiny; • inefficiency in report writing / presenting; and • failure to reap the benefits of triangulation that the QSPC offers.

Recommendations	Priority
3.1 The Trust should develop a quality assurance mechanism for committee reports, including: a. communicating with report writers for each committee meeting to make them aware of the audience, the purpose of the required reports and the level of detail that will be required; and b. reviewing reports in advance of issue to Independent Members to verify that they address the report purpose, include a succinct executive summary identifying key matters for escalation and assurance and contain an appropriate level of detail.	Low

Management response	Target Date	Responsible Officer
3.1 a. Report authors will be informed of the purpose of committee reports and the level of detail required.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. A mechanism to review reports in advance of issue will be developed to ensure the points in recommendation 3.1 (b).	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 4: Gaps or Duplication in Reporting (Design)	Impact
We identified that there remains some concern about the risk of gaps or duplication in reporting to committees. Members identified areas of concern in general terms as follows: • the Research Development and Innovation Sub-Committee (RDISC), which reports to multiple committees. Independent Members interviewed feel the reporting process is well controlled. However, the process is reliant on key individuals rather than a defined process to ensure information is reported effectively; and • members noted that some topics are discussed at more than one committee, for example digital matters (QSPC, SDC and Audit Committee). We also identified that the annual Clinical Audit report was presented to the Audit Committee, QSPC and Board.	Potential risk of: • inefficiencies in the committee restructure due to duplication of effort or gaps in reporting.

Recommendations	Priority
4.1 The Trust should: a. review and clearly define the RDISC reporting lines to minimise the risk of gaps or duplication in reporting; and b. provide clarity on the purpose for reporting where a subject matter is reported to more than one committee, ensuring reports are tailored according to the audience and purpose.	Low

Management response	Target Date	Responsible Officer
4.1 a. The RDISC reporting lines will be reviewed and defined to minimise the risk of gaps or duplication.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. Clarity will be provided on the purpose for reporting where a subject matter is reported to more than one committee.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 5: Timeliness of Committee Paper Availability (Operation)	Impact
Through discussions with Independent Members and our attendance at committee meetings, we identified that committee agendas are issued on a timely basis (i.e., seven days in advance of the meeting). However, often, some of the supporting papers are issued after this. We understand that committee members pre-allocate time to review papers and lateness in delivery may limit their time available to undertake appropriate pre-meeting scrutiny and review. This may cause inefficiencies in committee meetings. We understand action has been taken to address this, for example, earlier calls for agenda items and papers. However, this remains an issue despite action taken.	Potential risk of: • inefficient committee scrutiny.

Recommendations	Priority
5.1 The Trust should: a. remind staff reporting into the committees of the importance of timely submission of their reports; and b. monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	Low

Management response	Target Date	Responsible Officer
5.1 a. Staff will be reminded of the importance of timely submission of committee reports.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff
b. The Corporate Governance team will monitor delays in the lateness of delivery of papers and provide challenge where appropriate.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 6: Record of meetings (Operation)	Impact
In our review of committee minutes, we identified: • instances where individuals were listed as in attendance and as having provided apologies; • it was difficult to understand whether all required attendees (i.e., required by the ToR) were present, especially if no apologies had been noted; and • the minutes did not clearly establish why individuals were present at meetings, for example, as a required attendee, presenter, observer, etc.	Potential risk of: • confusion as to quorum status of meetings; • inadequate record keeping.

Recommendations	Priority
6.1 The Trust should accurately record those present at committee meetings in the minutes, including the status in which individuals attend.	Low

	Management response	Target Date	Responsible Officer
6.1	Management will ensure committee minutes accurately record those present at meetings, including the status of individuals in attendance.	April 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Matter arising 7: Standing Orders (Operation)	Impact
The Trust updated and approved its Standing Orders to reflect the new committee structure in November 2020. However, the new Standing Orders have not been uploaded to the Trust's public website.	Potential risk of: • public confusion over the legitimacy of the Board restructure.

Recommendations	Priority
7.1 The Trust should update its website with the revised Standing Orders.	Low

Management response	Target Date	Responsible Officer
7.1 The revised Standing Orders will be uploaded to the Trust website.	January 2022	Lauren Fear, Director of Corporate Governance & Chief of Staff

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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4-5 Charnwood Court
Heol Billingsley
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Cardiff
CF15 7QZ

Website: Audit & Assurance Services - NHS Wales Shared Services Partnership

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

Integrated Medium Term Plan (IMTP) 2022 - 2025

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital; Cath O'Brien, Chief Operating Officer; Matthew Bunce, Executive Director of Finance
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**
Executive Management Board	21 March 2022	ENDORSED FOR SUBMISSION TO THE STRATEGIC DEVELOPMENT COMMITTEE
Strategic Development Committee	23 March 2022	ENDORSED FOR SUBMISSION TO THE TRUST BOARD

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
IMTP	Integrated Medium Term Plan
MDS	Minimum Data Sets

1. SITUATION/BACKGROUND

1.1 The Welsh Government NHS Wales Planning Framework for 2022 - 2025 confirmed the re-instatement of three year Integrated Medium Term Plans (IMTP) on 21 December 2021. Further planning guidance and a set of Ministerial Priority measures were then issued on 12 January, followed by the final version of the Minimum Data Set on 20 January 2022.

1.2 In recognition of the pressures facing Local Health Boards and NHS Trusts, the deadline for the single submission of plans was extended until the 31 March 2022.

1.3 The submission of an IMTP 2022- 2025 approved by the Trust Board, on or before 31st March 2022, is part of the Trusts' statutory duty under the Finance (Wales) Act 2014. The Trust's IMTP for 2022 - 2025 will be subject to internal performance management arrangements and reporting to various stakeholders, including the Welsh Government and audit/regulatory bodies throughout the year.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The development of the IMTP has been challenging given the level of uncertainty in the operating environment resulting from the ongoing impact of Covid-19 together with the range of challenges faced by the healthcare system/wider public services in Wales.

2.2 The IMTP 2022-2025 is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2032*' and brings together the immediate, medium and long-term ambitions of the organisation.

2.3 Notwithstanding this, and in accordance with the Welsh Government guidance, the IMTP is particularly focused on 2022 - 2023 and in ensuring that there are robust plans in place to deliver the required levels of service which achieve the appropriate levels of quality, safety and experience in a Covid-19 operating environment.

2.4 The key elements of the plan are outlined below.

Structure

2.5 This IMTP sets out our plans in three distinct areas. Firstly, the plan sets out our commitment to delivering high quality, safe services which provide an excellent experience and outlines how we deliver this in context of the living with COVID-19.

2.6 Secondly, the plan identifies our priorities related to the implementation of enhanced models of care and services for blood and cancer services.

2.7 The third area, and related priorities, signal the continued strategic development of the Trust and its transformation into new and potentially exciting areas of work in accordance with the challenge laid down by '*A Healthier Wales'*.

Note: There are a number of appendices to support the delivery of the IMTP and these are available upon request.

Core Principles – '*Our Golden Thread*'

2.8 The core principle in developing the IMTP has been our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving. This is the '*golden thread*' throughout our organisation. Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve.

Summary of our Plan

2.9 Whilst the IMTP sets out our initial view of the 2022 – 2025 period, its primary focus is on the 2022 - 2023 period given the level of uncertainty regarding Covid-19 and

its impact. Our focus during this period will be on delivering the fundamental cornerstones of healthcare provision. These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Delivering services which are '*COVID safe*' and reducing / eliminating (as far as is possible) the 5 harms from COVID.
- Developing agile and flexible capacity plans which allow us to respond quickly to the challenges presented by Covid-19 and its related impacts
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past two years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

2.10 In addition we have identified a number of important strategic areas of work. These include:

- Improving population Outcomes and reducing inequalities
- Regional working, partnerships and collaboration to improve outcomes
- Developing our system leadership role in areas where we can add value
- Delivery of our Transformation Programmes
- Continued delivery of our research, development and innovation Programmes
- Delivery of our programme of work to support the physical, mental and emotional well-being of our staff across a number of areas
- Delivery of our decarbonisation strategy

Planning Assumptions

2.11 The IMTP is based on the most recent Welsh Government policy requirements and guidelines on COVID-19 e.g. social distancing requirements and infection prevention control requirements during 2022 - 2023. Given the complex nature of Covid-19 and its wider impacts, it is difficult to provide a high level of confidence that these assumptions may not change during 2022 - 2023. The service response

will continue to be agile so that we can find solutions to any risks and issues which present during this period.

Forecasting Demand and Capacity

2.12 A number of planning scenarios have been modelled with the most likely selected as the basis for our Cancer and Blood and Transplant plans.

Demand for Blood and Transplant Services (increase over 2021/22)	**2022/23**
	1%
Demand for Cancer Services (increases over 2021/22)	**2022/23**
Radiotherapy	8%
Nuclear Medicine	12%
Radiology Imaging	12%
Preparation & Delivery for Systematic Anti-Cancer Therapy	12%
Ambulatory Care Services	8%
Outpatient Services	8%
Inpatient Admitted Care	2%

Capacity to deliver safe, high quality services with an excellent experience

2.13 The IMTP sets out a range of capacity solutions to deliver the required level of activity during 2022 - 2023. If the forecast demand and capacity assumptions are within reasonable tolerances/variation, then the Cancer and Blood Services will deliver the required level of service e.g. blood and commercial products supplies will meet demand; cancer waiting times and quality of care requirements will be achieved.

2.14 The delivery of the national targets and requirements will however require increased levels of efficiency and productivity; a prudent healthcare approach to reduce unwarranted variation, activity of limited value, and prioritise standardisation of best practice; together with clinical/medical/scientific and technological advances to achieve a sustainable position.

Commissioner Engagement

2.15 The priorities set out within the IMTP have been discussed and agreed with our commissioners and reflects their service needs.

Finance

2.16 The Welsh Government requires the submission of '*balanced*' IMTP plans, where commitments to deliver services are matched by available resources, in terms of workforce, physical infrastructure and finance. The imperative to recover from the COVID-19 pandemic is compounded by significant financial challenges due to system wide exceptional cost pressures, which include energy & fuel cost increases, Employers National Insurance uplift, living wage and other extraordinary levels of cost inflation.

2.17 The Trust took the decision during 2021 - 2022 to make upfront investment in permanent staffing and infrastructure to create additional capacity sufficient to meet forecast demand growth in 2021 - 2022 and into 2022 - 2023.

2.18 Whilst commissioners have recognised and supported this decision in order to ensure that cancer patients referred to Velindre receive timely care and that blood supply across Wales is able to meet demand, this presents a significant financial risk to the Trust as income remains uncertain and is dependent upon Health Boards ability to create additional capacity for diagnostics and surgery to generate onward referrals to Velindre for specialist cancer treatment.

2.19 However, the balanced financial plan contained within our IMTP assumes:

- Welsh Government income will be provided for the above system-wide exceptional cost pressures and the ongoing transitional costs of responding to COVID-19 that cannot yet be removed from our clinical operations
- Additional income from commissioner contracts.

2.20 The Trust received correspondence from the Welsh Government on 14th March 2022 which provided some assurance around funding cover for ongoing Covid-19 response costs and exceptional national cost pressures. Further work will be undertaken with the Welsh Government and commissioners to provide clarity by the end of March 2022.

Risks to delivery

2.21 There are numerous risks associated with the delivery of the IMTP plans, and in particular during 2022 - 2023 e.g. uncertainties around COVID-19 and any new

variants, sensitivity of the planning assumptions and the significant cost pressures in the system and contracting process.

2.22 These risks will be captured within the service level/Trust risk registers and Trust Assurance Framework and will be actively managed during the year.

Governance and Approval Arrangements

2.23 The IMTP has been developed with the full involvement of both VCC and WBS divisions and corporate enabling functions. The plan has been reviewed and endorsed by both the Executive Management Board and the Strategic Development Committee.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Delivery of the actions included within the IMTP (2022 – 2025) will help to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	The IMTP Plan contains a range of financial risks. Further work will be undertaken to reduce this risk in a number of specific areas (i) Covid response (ii) National pressures (iii)

	Covid recovery regarding national funding and commissioner activity.

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the IMTP (2022 - 2025) for submission to the Welsh Government on 31st March 2022.

4.2 The Trust Board is also asked to **NOTE** the next steps / actions summarised below:

- To submit the IMTP (2022 - 2025) to the Welsh Government on 31st March 2022.
- To receive and respond to any feedback from the Welsh Government in relation to the IMTP (2022 - 2025).
- To develop an '*easy read*' version (3-5 pages only) of the IMTP (2022 - 2025).
- To continue to work with our key partners and stakeholders to support the implementation of our IMTP (2022 – 2025) and the successful delivery of the key actions and priorities identified.
- To report progress against the implementation of the key actions identified in the IMTP (2022 - 2025) in line with existing governance arrangements.

Final Submission to Welsh Government

Velindre University NHS Trust

Integrated Medium Term Plan

2022/23 to 2024/25

(1st April 2022 to 31st March 2025)

CONTENTS

Introduction

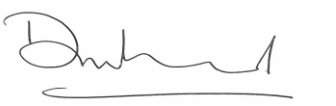
We are delighted to present the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2022 - 2025. The IMTP builds upon the excellent work undertaken by teams from across the Trust, working with our many partners, to develop a set of ambitious priorities, which build on our strengths and which will result in people who use our services receiving excellent care, service and support. This IMTP sets out our plans in three distinct areas.

Firstly, the plan sets out our commitment to delivering high quality, safe services which provide an excellent experience and outlines how we deliver this in context of the living with COVID-19. It describes what services we will provide, where they will be provided from and how we will meet the expected increase in demand for services over the coming years. The foundation of our services will be work we are progressing on our clinical and scientific plans and value-based healthcare.

Secondly, the plan identifies our priorities related to the implementation of enhanced models of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, receive a wider range of information services digitally, and have access to a trials and other services provided by our partners which may add value for them. We will also seek to significantly develop our buildings and upgrade our equipment by 2025 and this, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon Net Zero organisation and a range of wider benefits to support the development of thriving and resilient communities across Wales.

The third area, and related priorities, signal the continued strategic development of the Trust and its transformation into new and potentially exciting areas of work in accordance with the challenge laid down by 'A Healthier Wales'. This will see us explore opportunities across the health and social care system to identify areas where we can further support our partners in achieving outcomes and benefits for the populations we serve.

The plan we have set out demonstrates the exciting times ahead of Velindre University NHS Trust. We look forward to working with our staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.



Professor Donna Mead OBE
Chair

Steve Ham
Chief Executive Officer

The Structure of Our Plan

Part 1: **Organisation Overview** – providing an overview of Velindre University NHS Trust and the services we provide

Part 2: **The Context for Service Delivery** – making sense of our environment, our commitment to quality and the challenges we face

Part 3: **How will we respond**? – setting out the main strategic priorities for 2022 to 2025

Part 4: **Translating our priorities into high quality services** – describing our service delivery framework for Strategic Trust Programmes

Part 5: **Our Service Delivery Plans** – our Velindre Cancer Centre and Welsh Blood & Transplant Service delivery plans for 2022 to 2025

Part 6: **Our Trust-wide Support Functions** – setting out how our Trust-wide enabling functions support the delivery of our Plan

Part 7: **Our Strategic Financial Plan** – laying out our 3 Year Financial Plans for 2022 to 2025

Part 8: **Our Performance Management Framework** – explaining how we will manage the delivery of our plan and monitor progress

Part 9: **Appendices** (separate attachments) Velindre Cancer Centre & Welsh Blood Service Key IMTP Deliverables and Minimum Data Set

Part 1

Organisation Overview

An overview of Velindre University NHS Trust and the services we provide

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

Overview of Our Services

The Trust was established in 1994 and is one of eleven statutory NHS organisations in Wales. We provide a range of specialist services at the national and regional level.

Non-surgical tertiary oncology services

Our Trust provides non-surgical tertiary oncology services to patients covering South East Wales, working closely with local partners in ensuring services are offered at appropriate locations, in line with best practice standards. An increasing number of services are delivered on an outreach basis. Our specialist treatment, teaching and research work serves a population of 1.7million.

Blood and Transplant Services

The Trust also delivers a range of essential and highly specialised services including the collection and production of blood and blood components to treat patients; and supporting the transplant programmes through our Welsh transplantation and immunogenetics laboratory services.

Hosted Services

Our Trust is responsible for hosting the following organisations on behalf of the Welsh Government and NHS Wales:

- **NHS Wales Shared Services Partnership (NWSSP):** who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services

- **Health Technology Wales (HTW):** a national body working to improve the quality of care in Wales. It collaborates with partners across health, social care and the technology sectors to identify, appraise and advising on the adoption of technology or models of care to ensure an all-Wales approach.

Part 2

The Operating Environment

Making sense of our environment, our commitment to quality and the challenges we face

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

Our commitment to Quality and Safety: our golden thread

Healthcare is changing rapidly, locally, nationally and globally and the pace of change will continue to intensify as we seek to respond the challenges across the healthcare system and continue to respond to the Covid-19 pandemic. Our Trust strategy '*Destination 2032*' sets out our commitment to quality and safety:

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: A leading provider of exceptional clinical services that always meet, and routinely exceed, expectations

In respect of these goals, we will ensure that putting our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving; is the '*golden thread*' throughout our organisation. Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve. The Trust is in the process of delivering a range of transformational changes across its cancer, blood and transplant services which will provide better care, enhanced clinical experiences and improved outcomes. We are committed to ensuring that quality, safety and experience is at the centre of all changes. This includes knowing '*what good looks like*' across all services and always striving to achieve this as well as pushing forwards these quality boundaries. We will also seek to continually obtain real time experience feedback as well as obtaining regular patient, donor and staff engagement to which will help to inform and influence decision-making. We are also committed to providing kindness and compassion when delivering care and services and to acting in an open and transparent manner at all times; this includes a willingness to learn when things don't go as planned.

Our Trust has a strong track record of patient safety and quality improvement in all services we deliver across the Trust. We will further build on this and embrace all opportunities for improvement across the organisation, which are strengthened by the clear requirements set out with the Health and Social Care (Quality and Engagement) (Wales) Act 2021; the Welsh Governments Quality Framework (2021); The National Clinical Plan (2021); The Healthcare Standards for Wales (2015); Wales Cancer Plan (2021); and Blood Health Plan (2017). We aspire to be leading the way in respect of Quality, Safety & experience and have a clear plan over the next three which will help us make continued progress.

The scale and pace of change required will not be possible without the development of our multi-professional clinical, scientific, medical, and nursing professional leaders. We are developing a strong cadre of clinical leaders at all levels (service delivery level

to Board) who will help to drive the required clinical transformation and quality improvement forward.

This will need to be supported by high quality integrated digital, business intelligence and informatics systems to provide us with clinically driven, outcome and patient / donor focussed triangulated data and information to provide meaningful insight into our clinical decision-making, service delivery and how we are learning and improving. This will include significantly enhancing the Trusts Performance Management Framework ensuring it is focussing on the golden thread of quality, safety and experience. Our Chief Clinical Information Officer and Chief Nursing Information Officer will work with technical specialists to guide us.

The Trust will also further strengthen our quality improvement infrastructure through working with Improvement Cymru.

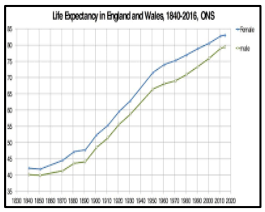
The Trusts Quality, Safety and experience infrastructure will be greatly enhanced through the development of '*Quality Hubs*' utilising an integrated governance approach from departmental level to Board.

Whilst we are proud of what we have achieved to date, we are excited by the future. This IMTP has been developed with quality, safety and experience at its centre and will work with all partners to secure the best possible outcomes over the coming three years.

The main drivers facing the NHS its partners

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

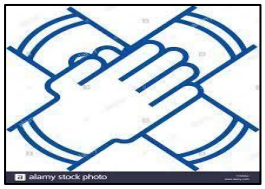
People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. This is challenging us to think differently about how we can modernise and improve the way people access care and the quality and experience of it.



There are significant differences in healthy life expectancy and quality of life across different areas within Wales, with recent data suggesting that this gap is widening.

Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS.

Digital technology, innovation and artificial intelligence are creating opportunities to transform the delivery of our services as well as opportunities to personalise our services so that we can make them more effective, efficient and valuable to people.



The Trust has been growing opportunities to collaborate across our regional health system and wider networks to join up care, share learning and improve outcomes.

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

Policy Context: responding to the drivers

Local Context

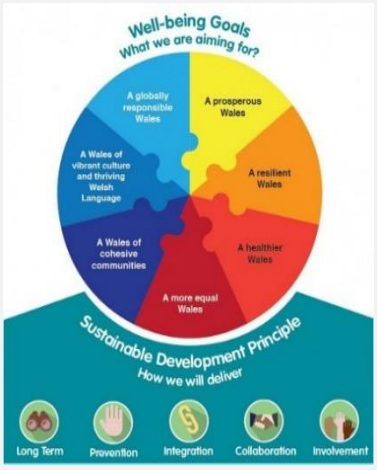
Current Performance:

- Waiting times
- Clinical outcomes (post COVID-19)
- Quality and safety
- Patient and donor experience
- SWOT analysis
- Financial delivery
- Workforce (post COVID-19 wellbeing)

Local Drivers:

- Patient and donor outcomes
- Health inequalities
- Population changes
- Surge recovery demand
- Increasing complexity
- Commissioner priorities
- Patient, donor and carer experience
- Addressing the 'five harms' & COVID-19 guidance

National Context



Statutory Duties and Key Policies:

- A Healthier Wales 2018
- Well Being of Future Generations Act (2015)
- Health and Social Care (Quality and Engagement (Wales) Act 2020
- Public Health Wales Act (2017)
- Social Services and Well-being Act (2014)
- Nurse Levels (Wales) Act (2016)
- Equalities Act 2010
- Welsh Language (Wales) Measure (2011)
- Equality Act (2010)
- Health & Safety at Work Act (1974)
- Socio-economic Duty 2021
- A Healthier Wales
- Prudent Health Care/Value Based Health Care
- Working Differently- Working Together
- De-carbonisation strategy
- WG Digital strategy
- National Clinical Plan (2021)

What do our Local Health Board partners require from us?

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
NHS Wales Information Services	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality

Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

Cancer Services - Non-surgical Tertiary Oncology

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last 12 months.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond in a timely and efficient manner, capturing mini-stories and signposting to wider online surveys.

Blood and Transplant Services

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

What are the challenges we face?

At an organisational level ……..

Providing high quality services as we manage and transition out of Covid-19: returning to '*business as usual*': In March 2020, Covid 19 arrived in the United Kingdom and fundamentally changed the lives of the population during the pandemic and as we seek to move to an endemic state; living with Covid-19. The impact of people's health and well-being in Wales has, and will continue to be, profound in range of ways. At the societal level, within healthcare and across the wider public services the current environment remains highly complex regarding the pandemic, as is the ability to plan and deliver services of the highest quality. The move towards re-establishing '*business as usual*' during 2022/2023 will continue to be challenging as we learn to live with Covid-19 whilst also finding solutions to some of its direct impacts e.g. increased staff sickness.

Service delivery is complex: Our frontline services face a number of challenges with the blood and transplant service working to maintain a healthy donor base, meet the national demand for blood and maintaining regulatory compliance. The non-surgical tertiary oncology service faces increasing demand, accentuated by Covid-19; the challenge of providing capacity to see patients quickly; and the need to keep pace with new treatments and continuously improved levels of quality, safety and experience.

Maintaining a healthy workforce: The commitment, resilience and professionalism of our staff has been remarkable over the last two years. However, there are direct costs to this, with staff becoming unwell due to COVID-19 and the impact it's having on their mental well-being. As we move to an endemic position, our staff will be required to continue to provide high quality care to more patients and donors as we work hard to reduce any backlogs and reduce any waits.

Developing a sustainable workforce: The NHS workforce across the UK is fragile with shortages in a number of areas/specialisms. These are particularly acute in a number of services provided by the Trust e.g. a shortage of oncologists, physicists and scientists.

Delivering key transformation programmes: The Trust is currently delivering a number of highly complex transformation programmes including the Transforming Cancer Services Programme and the Welsh Blood Service Lab Modernisation and Infrastructure Programmes. The level of change required is significant and the risk to delivery has increased as a result of the direct and indirect impact of COVID-19.

Working effectively as a partner across the system: The Trust is a provider of specialist services at a regional and national level which enables strategic step change in the quality and experience of services to be achieved by the healthcare system at scale. It also brings challenges, including the need to manage numerous relationships with commissioner organisations.

Decarbonisation and Net Zero: The NHS is committed to transitioning from an ill-health service to a well-being service. As one of the largest carbon emitters, the delivery of carbon net zero is essential. It will require careful planning, huge cultural and behavioural change and capital investment; at a significant scale.

Sustainability and wider social value:
The Trust is fully committed to making a wider contribution to the communities it serves to deliver a thriving and prosperous Wales. The Welsh Governments policy requires the Trust to think innovatively about how it can maximise the social value it can generate as an Anchor Institution in accordance with key policies such as the Foundational Economy. This is a relatively new area to explore for the Trust with limited resources to apply outside of core service delivery.

Funding: The medium-term funding position for the NHS is a challenging one, both in revenue and capital terms. Redesigned models of care, using technology and different skills will see improved levels of productivity and efficiency. However, this may be insufficient to deliver the levels of service quality and change over the next three years.

So what does all this mean for the Trust, the services we provide and our 2022 – 2025 plan?

The next three years will undoubtedly provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to support us in taking the learning from the pandemic to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Whilst this plan sets out our initial view of the 2022 – 2025 period, its primary focus is on the 2022 -2023 period given the level of uncertainty across the globe regarding Covid-19 and its impact. Our focus during this period will be on:

Delivering the fundamental cornerstones of healthcare provision
These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework

and the National Clinical Framework to provide services of the highest possible quality
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Delivering services which are '*COVID safe*' and reducing / eliminating (as far as is possible) the 5 harms from COVID. This will see us:
    - Focusing on infection prevention control standards
    - Responding quickly and robustly to Public Health Wales/Welsh Government guidelines and translating it into safe operational service delivery
    - Continuing to manage the challenges presented by nosocomial transmission
- Developing agile and flexible capacity plans which allow us to respond quickly to the challenges presented by Covid-19 and its related impacts
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past two years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

We have a number of important strategic areas of work. These include:

Improving population Outcomes and reducing inequalities

The Trust will work with our Local Health Board and wider partners to identify opportunities where we can support the improvement of public health and population outcomes through primary and primary and secondary prevention. This will focus on a number of areas:

- Improving access to our services to increase uptake and reduce inequalities and ill-health
- Strengthening our decision-making (systems/processes/culture) regarding the Equality Impact Assessment and Socio-Economic Duty to consciously address poor outcomes and inequalities in the communities we serve
- Working with our health partners where it is clear and compelling that we can add value and make a difference
- Developing a range of strategies and plans that enable us to help our staff to improve their health and well-being
- Secondary prevention: making the most of the opportunities of '*every contact counts'* with patients, donors, partners to support them in improving their health and well-being.

Regional working, partnerships and collaboration to improve outcomes

The Trust will:

- Work with Local Health Board partners to strengthen the Cancer Collaborative Leadership Group and to lead on the delivery of improving cancer outcomes for patients in South East Wales
- Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales
- Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales

System leadership

The Trust will continue to develop our system leadership role in Wales in areas where we can add value. Our initial focus will be on developing the contribution we can make in:

- Working with Health Boards, the Cancer Collaborative Leadership Group and wider partners to improve cancer services
- Working with Health Boards to deliver the National Blood Health Plan
- Working with Health Boards, universities and commercial partners to deliver a range of cutting edge research, development and innovation

Delivery of Transformation Programmes

Non-surgical tertiary oncology Services

The Trust will progress a number of key areas of work within the Transforming Cancer Services Programme and Velindre Futures programmes:

- Implementation of the Nuffield Trust recommendations including:
    - Delivery of the Acute Oncology Service regional model
    - Implementation of revised pathways for unscheduled care
    - Development of a phased implementation plan for the V@UHW research hub

Development of the infrastructure to support regional cancer services including:

- Award of the contract for the Integrated Radiotherapy Solution and implementation of 2 LINACS at the Velindre Cancer Centre
- Completion of the enabling works for the new Velindre Cancer Centre
- Completion of the competitive dialogue for the new Velindre Cancer Centre and identification of the preferred bidder
- Work in partnership with our Local Health Boards to secure approval of the final business case for the radiotherapy satellite centre in Nevill Hall, Abergavenny

Blood and Transplant Services

The Trust will progress a number of key areas of work within blood and transplant services including:

- Laboratory Modernisation programme
    - Scoping and planning of the future laboratory services plan
    - Refurbishment of Talbot Green facility and carbon reduction
- Plasma for Fractionation: developing the case for change and delivery programme

Research, development and innovation

The Trust will continue to drive our research, development and innovation ambition for our patients and donors and focus on

- Implementing our Cancer R&D Ambitions Strategy 2021-2031
- Building on our Welsh Blood Service R&D Strategy
- Embedding our Innovation Plan
- Developing our national and international RD&I Partnerships

Mental Health and emotional well-being/supporting the workforce (WG)

The Trust will continue our programme of work to support the physical, mental and emotional well-being of our staff across a number of areas:

- Promoting healthier lifestyle choices including healthier food options, access to physical activities, and support to reduce and stop smoking
- Providing accessible information and resources on physical health and well-being for people who experience mental health problems
- Delivering staff training on mental health issues
- Increasing access to the Employee Assistance Programme and other support and counselling services
- Establishing a part-time dementia liaison nurse position within the Trust
- Providing a programme of mental health awareness training for all staff, with a proposal for Mental Health Awareness to become a mandated module in the Trust's core management training framework
- Providing a range of other initiatives and schemes to support well-being such as Menopause Café

Decarbonisation

The Trust will focus on delivering the first stages of our journey to Net Zero. This will include:

- Infrastructure: we will develop a range of green infrastructure including:
    - Submitting an outline business cases to refurbish/decarbonise the Welsh Blood Service, Llantrisant facility
    - A full business case for the radiotherapy satellite centre in Nevill Hall; and identifying a preferred partner for the new Velindre Cancer Centre (where we have an ambition to be the Greenest Hospital in the United Kingdom)

Part 3

How will The Trust respond?

In this chapter we set out the main strategic priorities for 2022 to 2025.

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

Destination 2032: our view of the future

In response to the operating environment, the Trust has undertaken a strategic refresh to set out the future direction for the Trust over the next 5 -10 years. In January 2022, the Trust Board approved our 10 year strategy '*Destination 2032*' which sets out the framework for the Trusts' development.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

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

Our strategy will support us in:

- Focusing on delivering excellence in our core clinical services
- Placing quality and safety at the centre of everything we do
- Developing our clinical, scientific and healthcare professional leadership
- Becoming world leaders in specific areas of research, development and innovation
- Expanding our culture of learning across staff, students and the communities we work with
- Delivering carbon net zero operations and wider benefits and social value for our communities
- Moving towards a future which will see us becoming a valued partner in the prevention, public health and wider social policy areas; helping to find solutions to deep-seated problems in Wales such as poverty and deprivation

To deliver our strategic goals by 2032, we have refreshed our key service strategies:

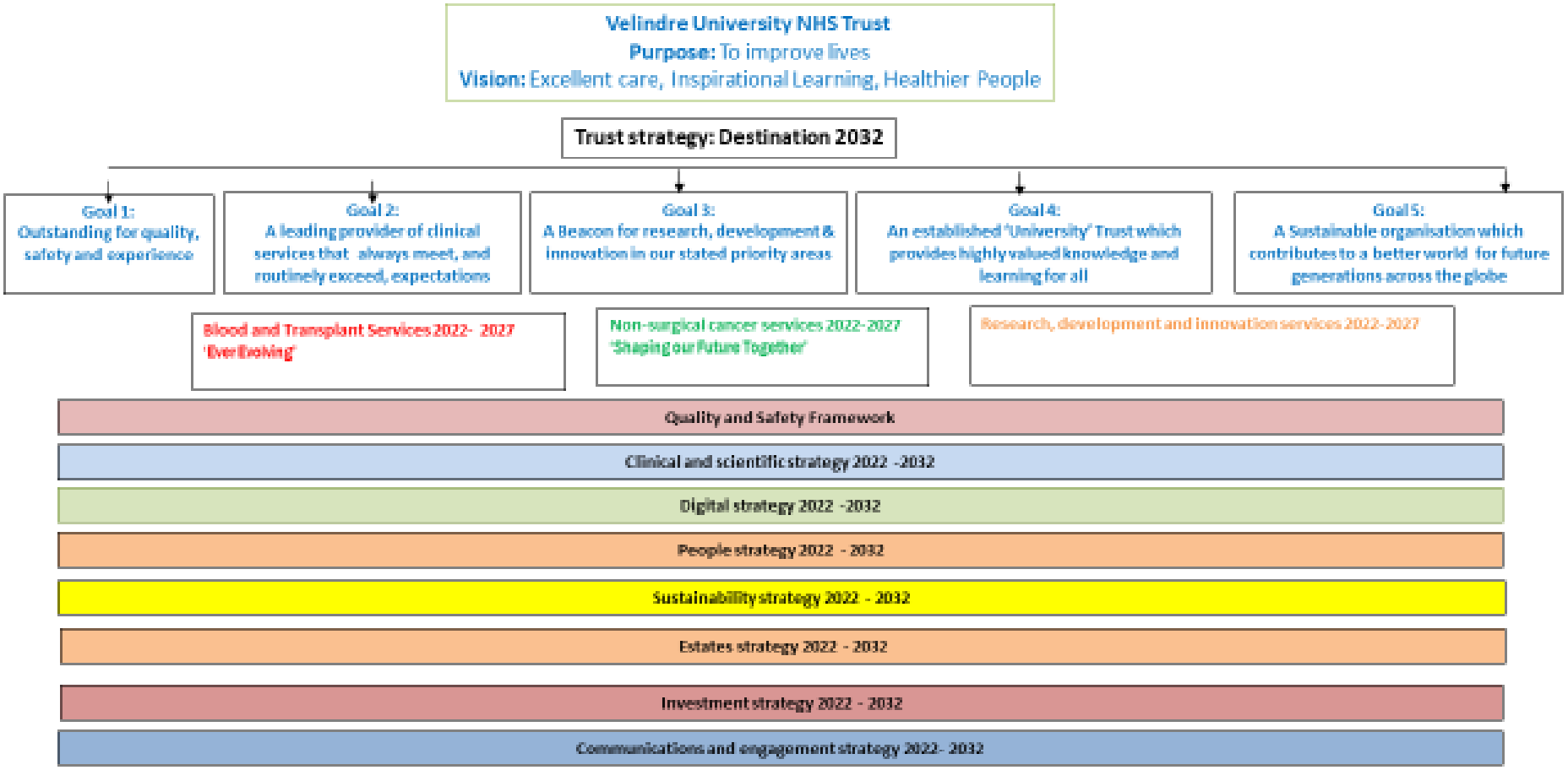
- Welsh Blood Service Strategy 2022 – 2027
- Velindre Cancer Strategy 2022 -2027

These are supported by a range of refreshed enabling strategies / frameworks including:

- Quality and Safety Framework
- Clinical and Scientific Strategy (being developed)
- Sustainability Strategy
- People Strategy
- Digital Strategy
- Estates Strategy

Our strategic refresh provides the Trust with a clear line of sight between our Purpose, Vision, Strategic Goals and the priorities contained within our Integrated Medium Term Plan **(*see Figure 1***). This will provide us with the ability to effectively prioritise our activities and resources over the coming years.

Figure 1 Our Purpose Vision and Destination to 2032



Trust priorities for 2022 – 2025

Our Trust strategy '*Destination 2032*' identifies a number of priorities which will support us in achieving our goals. In light of the current operating environment and the impact of Covid-19, our priorities are focused on 2022/2023.

Strategic Goal 1: Outstanding for quality, safety and experience
Key priorities:

- Implementing the requirements of the Health and Social Care Quality and Engagement Act
- Implementation of all infection, prevention and control requirements
- Implementing a quality and safety management framework which will drive every action we take and decision we make
- Implementing the National Clinical Framework for the services provided by the Trust
- Development of a targeted and innovative value based healthcare programme to drive quality, safety and experience of services

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

- Recovery from Covid-19 with the recommencement of all core services and reduction of any patient backlog
- Developing clinical service models which support sustainability e.g. more care at home and locally Implementing our sustainability strategy
- Implementing the National Clinical Framework for the services provided by the Trust
- Improving our engagement processes with our donors and patients to support service design, delivery and improvement
- Development of a sustainable workforce plan to meet the needs of today and the future
- Supporting our staff in maintaining their health and well-being
- Reducing health inequalities in the services we provide

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

- Implementation of our research strategies
- Implementation of our innovation plan
- Increasing the number of staff routinely involved in R, D & I
- Developing a culture of curiosity and supporting infrastructure and facilities to support research, development and innovation

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

Key priorities:

- Increasing the number of staff involved in formal learning
- Development of a programme for learners aligned to the needs of our business and that of our partners
- Improved facilities and digital resources to improve the learning experience
- Development of learning opportunities for learning in specialist areas with initial focus on developing the School of Oncology

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

Key priorities:

- Decarbonisation of our business
- Implementation of our sustainability strategy
- Development of education and training programme to provide staff with the knowledge to make sustainable-based decisions in work and at home
- Implementation of all equalities and diversity requirements including the Welsh Language Act
- Development of our role as an anchor organization within the communities we serve to generate broader social value

The Trust priorities are delivered through a range of organisational and service plans for non-surgical oncology tertiary cancer services and blood and transplant services.

Part 4

Translating our priorities into high quality services

We describe our service delivery framework for Strategic Trust Programmes

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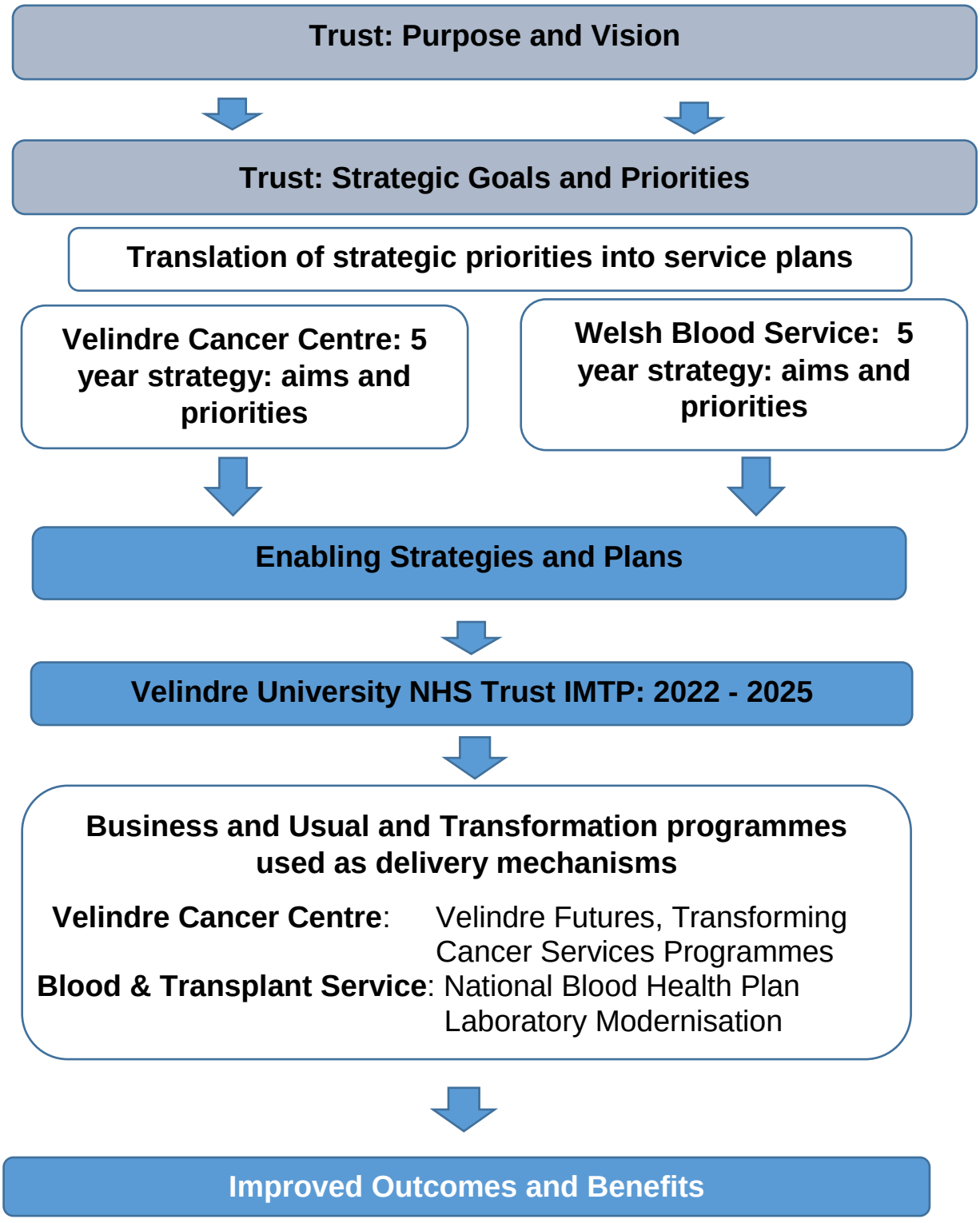
Our Strategic Delivery Framework

Our strategic delivery framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation.



Trust Programmes

There are a range of programmes that we will progress at an organisational level, embedding them into the services that we deliver. These include:

Clinical Quality and Safety - delivery of the Health and Social Care (Quality and Engagement) (Wales) Act 2021 & National Quality Framework

Quality, safety and experience as our golden thread are in fundamental in everything we do. The Trust will fully implement the Act and Framework requirements. This requires further strengthening our core foundations across all areas of the organisation. We will work with patients, donors, staff and partners to:

- Define what '*good looks li*ke' across all services - measure, assess and report against this in an open & transparent manner (Duty of Quality) – aligning this to the revised Trust Performance Management Framework
- Monitor patient / donor outcomes and experience '*en masse*' to continually improve what we do
- Be able to demonstrate publically the learning & improvement that has taken place (Duty of Quality)
- Further improve how we investigate and learn from '*things that go wrong*', incidents, concerns, inquests etc.
- Roll out investigation training to all involved in investigations
- Fully implement the duty of candour requirements
- Develop integrated Quality Hubs – Trust wide and within each Division to enhance governance oversight at all levels
- Implement the CIVICA system across WBS and VCC
- Further enhance our multi-professional clinical audit mechanisms including fully role out '*Tenable*' Nurse Audit system
- Mainstream the 15 step challenge process into Independent members assurance mechanisms
- Fully implement the Medical Examiner process and revise mortality review processes
- Ensure full implementation of revised cleaning standards

Sustainability: Delivering value and decarbonisation

Our Sustainability Strategy '*Destination 2032*' sets out a clear ambition for the organisation over the coming years with the following aims:

- Deliver sustainable services which add wider social value for the communities we serve
- To be recognised as an exemplar organisation in relation to the delivery of the Well-Being of Future Generations Act
- Deliver Biodiversity Net Gain and enjoyment of our green spaces to improve health and well-being
- To be Carbon Neutral by 2030
- Use resources efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

It provides a roadmap for us to maximise our contribution to our communities and to mitigate our impact on the planet whilst delivering high quality services for our donors, patients and carers. It is supported by a decarbonisation plan which will allow us to deliver Carbon Net Zero.

Value-Based Healthcare:

The Welsh Government and NHS Wales has set out on an ambitious and exciting journey which focuses on the delivery of high quality patient outcomes through improving patients involvement in decision-making using the best evidence available; avoiding unnecessary variation in care and by being innovative in determining who to best use resources in order to improve overall outcomes.

The financial strategy for Velindre University NHS Trust aims to be an enabler to the clinical, service, workforce, digital & estates plans, which set out how the Trust, in conjunction with National Public Health Service for Wales (NPHSW), its commissioners and Welsh Health Specialised Services Commissioner (WHSSC), will:

- Address cancer population healthcare needs and specialist cancer service delivery requirements
- Deliver the Laboratory modernisation programme & infrastructure improvements in the Welsh Blood Service, support implementation of the Blood Health Plan for Wales and continuous improvement in technology and practice in transplant services

The financial strategy is designed to support the Trust in meeting the aims of '*A Healthier Wales*" and '*Wellbeing of Future Generations Act*'. Our approach aims to meet the '*quadruple aims*' of improved population health and wellbeing; better

quality and more accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce as well as sustainable development principles contained in the Act. Whilst the Trust is at an early stage in its VBHc journey, as evidenced through our self-assessment, it we are keen to move at pace to deliver on some of the key objectives with its 3 strategic priorities for VBHc:

- Culture, Socialisation and Education
- Measurement of Outcomes & Cost in a meaningful way
- Prudent Healthcare and Service Prioritisation

The Board has agreed:

- To adopt VBHc as a way of improving the outcomes for its patients and donors
- That the Trust Executive lead for delivering VBHc is the Director of Finance (DoF)
- That our approach to VBHc will not be the creation of a separate programme of work, but to embed value and prudent principles within the existing clinical & service delivery teams and business mechanisms

- In parallel the DoF has initiated the following approach to VBHc:
  - Leading a wider debate around what value is and what it means at the Board, Executive Management Board, Divisional SMTs, Innovation Forum and Clinical Improvement Group
  - Engaging with the National VBHc team and the FDU to provide advice & support on the Trust's approach

- Recognising the need for all staff within the Trust to consider value as part of their every-day work, we intend to:
  - Embed value and prudent healthcare principles at the centre of the work of the Trusts cancer SSTs, Velindre Futures, clinical audit, quality & safety and improvement / transformation teams.
  - Invest in a dedicated expert VBHc role, additional Digital and BI posts and a project management structure to support the embedding of value principles by building capacity & capability and changing behaviour. This resource requirement will form part of the Trust business Case submission to WG against the £5m VBHc fund.
  - Identify and deliver some quick wins where the application of value principles can improve services for patients and donors with better outcomes and / or experience

The Trust VBHc Strategic priorities, key objectives and specific actions are set out in the VBHc template at *Appendix A.*

VCC Four Components of plans to Improve Value

Within VCC Tertiary services: removing waste & variation and improving the technical efficiency of its services.

Across the South East Wales region: working with partners through the Collaborative Commissioning Leadership Group, HB / Trust Cancer Partnership Boards and HB Cancer Boards to improve cancer pathways and focus around linking outcomes & cost, prehabilitation, prevention and improving outcomes.

Optimise the clinical delivery model: through workforce redesign that places duties with appropriate roles, for example, non-medical outlining and prescribing whilst maintaining the highest standards of clinical care and patient outcomes.

PROMs & PREMs rollout: ensuring effective capture of data for the Trust tertiary services and across the wider cancer pathways through patient engagement work, PhD student work to collate the current PROM data collection by clinical teams and to digitise and store this data in the Trust data warehouse to feed into SST dashboards, together with clinical data, patient level cost data and clinical audit data.

Use of Digital to Drive value: by creating and connecting a digital cancer services community in South East Wales that will transcend organisations and form the digital environment to enable data collection for service improvement & transformation to be facilitated.

WBS plans to Improve Value

Strategic priorities for the Welsh Blood Service are aligned with the NHS Wales Blood Health Plan in '*supporting individuals to manage their health and wellbeing, avoiding unnecessary intervention, using evidence and transparent data to drive service planning and improvement to reduce unnecessary variation and to avoid harm, placing safety and quality at the core of patient care*'. The spirit and substance of these priorities support the delivery of value based prudent healthcare.

Specific objectives include changes in practice to meet service development needs, including the potential development of a new plasma for fractionation service, subject to Ministerial approval, establishment of an Occult Hep B testing service, a programme for Laboratory Modernisation, and a reduction of variation in the usage of intravenous immunoglobulins (IVIG), ensuring continuity of patient care in an efficient and effective way. Additionally, a key objective is in the development of an increasingly prudent & sustainable supply chain flexible to match patient demand in Wales, with the ambition to optimise supply chain efficiency whilst maintaining and

improving donor experience and care, alongside positive outcomes and the avoidance of harm for patients.

Trust wide Infrastructure for Value – Digital, BI & Project Management

Ensuring that there is insightful business intelligence to aid service planning and re-design is key to support the debate for alternative models of care or delivery platforms, to improve patient reported outcome measures and experience as well as securing sustainability, efficiency and value. Across the Trust there is a need for investment in Business Intelligence and other infrastructure. This is an investment priority that the Trust will progress through a Business Case to Welsh Government against the £5m VBHc fund.

The Financial Strategy will evolve over the term of the plan to support the Trust in its strategic ambitions for both cancer and blood services to be health sector leaders in these fields. A key aspect of the Financial Strategy will involve a review of how the Trust spends the total income that it receives annually. Initially this review will focus on traditional assessment of efficiency & effectiveness, but as we are able to link the cost of service delivery with appropriate outcome measures a more appropriate assessment of value will be undertaken to enable the Trust clinicians to make informed decisions around the prioritisation, allocation and distribution of its resources.

A key part of the Financial Strategy for Velindre Cancer Centre (VCC) is the application of the new contracting model following the 2022-23 interim national funding flow protection mechanism. There will need to be work undertaken with the Trust clinicians to review the currencies and costs to and amend the model to reflect any permanent changes to clinical pathways that have been added as a result of the Covid pandemic. These changes will require agreement from HB clinicians and commissioners. The Trust financial plan assumes that this go live date will be agreed by HBs and will be operating within the agreed all Wales Funds Flow model whist the impact of the pandemic continue to affect normal activity flows and levels.

The new costing and contracting model will also enable clinicians and managers to have a better understanding of the costs of their services and how those costs change with activity and case mix complexity. We have undertaken a major piece of work with the FDU to benchmark VCC services with the two other cancer centres in Wales. The next phase of this work will be to bring this cost information together with non-financial information to provide context and help explain cost differences. This benchmarking data will provide focus in identifying areas of inefficiency and waste.

The Trust plans to implement the Trust costing system in WBS to help the service understand in more detail the cost of each part of the blood supply chain and identify where there are inefficiencies. The Blood Supply Chain 2020 programme of work has already mapped processes in detail and identified key areas for change some of which have been implemented and others planned for implementation. WBS already participates in a European benchmarking club for blood services, which together with the new cost information will help the service identify areas of inefficiency and waste.

Research, Development and Innovation:

In line with the Trusts' Strategic goal to be ***"A beacon for research, development and innovation",*** we are committed to building on our excellent national and international reputation, based on successful delivery and management of a wide portfolio of research, development and innovation and a firm commitment to partnership working. The overarching prioritisation of research and innovation within the Trust is clear and embedded within the two divisions: Velindre Cancer Centre and the Welsh Blood Service, both of which are focused in their approach and have developed robust research strategies and plans for innovation. Patients and donors remain at the centre of this activity and through the 4 key priorities identified below, we seek to radically improve access to research and innovation whilst building a sustainable and capable clinical and scientific workforce for the future.

Velindre Cancer Centre has a key role to play in the cancer research network in South East Wales (SEW). It provides an important link between the 3 University Health Boards in the region (Cardiff & Vale, Aneurin Bevan and Cwm Taf Morgannwg UHBs) for collaborative clinical cancer research, offering opportunities for patients to access clinical trials and a range of other research studies, either at Velindre Cancer Centre (VCC) itself or in outreach facilities at the UHBs. Velindre is also in a prime position to provide the crucial connection between laboratory cancer researchers and patients, enabling research to '*bridge the translational gap*' and bring new discoveries from the laboratory to the clinic for patient benefit. The development of a new state of the art Velindre Cancer Centre brings with it opportunities for both clinical and non-clinical research and innovation, which are being explored and will contribute to the design and facilities of the new build.

The Welsh Blood Service is a unique organisation within the Welsh healthcare system, with the capacity to perform research and to implement and disseminate evidence-based innovations and new technologies on an all Wales basis, in order to advance donor care and our reputation for transfusion and transplantation medicine.

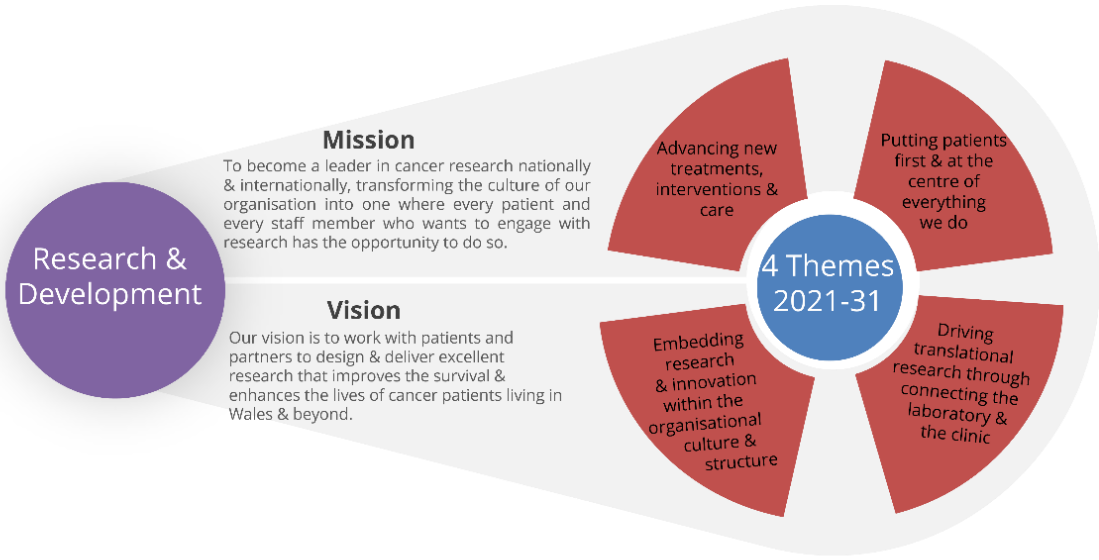
It is an exciting time for research and innovation at the Trust in 4 key Strategic Priority areas.

Our Priorities:

Strategic Priority 1: The Trust will drive forward the implementation of its Cancer Research and Development Ambitions 2021-2031

Overarching Cancer Research & Development Ambitions 2021-31 developed by multidisciplinary research leads from the Cancer Centre, University partners and Patient and Public representatives received approval from the Trust Board in March 2021.

These describe our vision, mission and aims for future Cancer Research at Velindre that will be delivered through research in 4 interconnected strategic themes.



Our vision is to work with patients and partners to design and deliver excellent research that improves the survival and enhances the lives of patients and their families.

Our mission is to become a leader in cancer research nationally and internationally, transforming the culture of our organisation into one where every patient, family and staff member who wants to engage with research has the opportunity to do so.

To enable this, we will work with our NHS and academic partners, with a shared strategic focus and collaborative ethos.

Our Aims are to:

- Enhance **patient experience** and care
- Improve **patient outcomes** and reduce variation
- Accelerate the **implementation** of new discoveries into the clinic
- Demonstrate the **impact** of our research on patients and the NHS
- Build research **capacity and capability** at Velindre & across SE Wales.

Our Research Themes:

- **Putting patients first and at the centre of everything we do**: patients will help set the research agenda and we aim to increase opportunities for patients and their families to take part in research, so that within 10 years most of our patients are offered research and innovation opportunities at some point in their cancer journey.
- **Advancing new treatments**, **interventions and care:** We will lead and take part in well-designed Clinical Trials and other research studies, providing the evidence base required to bring new, improved treatments and interventions into the clinic to enhance patient care. Research that is led from Wales will be prioritised and new infrastructure for research delivery will be developed, including a Tripartite Cardiff Cancer Research Hub for Early Phase and Translational research delivery on the University Hospital of Wales (UHW) site and a firm footprint for research at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research.
- **Driving translational research** through connecting the laboratory and clinic: We will work closely with our academic (university) partners to enable translational ('*bench to bedside*') research, bringing new discoveries (novel drugs, imaging techniques and/or technological advances) through from the laboratory to the clinic to benefit patients. We will also enable reverse translation ('*bedside to bench*') research where patient samples/scans and/or data are taken back to the laboratory to generate new knowledge. Developing Clinical Academic posts that link across clinical-academic boundaries will be key to success in this theme.
- **Embedding research and innovation within the organisational culture:** We will establish an organisational culture that values research and build capacity and capability within the multi-disciplinary workforce, providing dedicated ring-fenced time and training opportunities for staff from all disciplines who wish to engage with research. The appointment in 2020 of a Velindre Professor of Nursing and Interdisciplinary Research is important in this endeavour.
- A newly appointed implementation team will map out and lead this work. Our research will be facilitated by a governance and enabling infrastructure, supported by a communication, engagement and funding strategy and delivered by an agile research workforce. Close collaboration with our regional NHS and Academic partners and engagement across different sectors will be key to success (see Strategic Priority 4).

Strategic Priority 2: The Trust will maximise the Research and Development ambitions of the Welsh Blood Service

The Welsh Blood Service has an established Research and Development (R&D) strategy, developed in collaboration with our staff, scientists, clinicians, academia and other UK blood services. Our aims are to drive improvement, increase our

research activity, be open to collaboration and build our reputation for research & development, in order to improve donor and patient health.
We will continue to develop our 4 Welsh Blood Service R&D themes which are:

- **Transplantation**: including solid organ and stem cell transplants
- **Donor Care and Public Health**: including donor recruitment and retention strategies, aiming to enhance their experience and continued engagement.
- **Products**: including blood components, immuno-haematology, manufacturing and quality management.
- **Therapies**: including preparation of cellular and blood therapies for research.
- We will also honour the expectation of our staff that R&D is an embedded function that is part of an evidence based, first class service, delivered with pride. We will also maximise opportunities to improve and expand the services at WBS, through feasible and evidence-based R&D.

The Welsh Blood Service R&D team will continue to grow commercial R&D opportunities and the significant potential of our Component Development Lab. We will continue to actively seek strong academic and professional R&D partners, nationally and internationally. These will include high quality networks such as the international BEST Collaborative and the European Blood Alliance. We will leverage these partnerships to further explore the potential of Advanced Therapies aligned to our unique Service. Finally, we will continue to build the capacity and capability of our workforce and to embed a positive culture around R&D activity.

Strategic Priority 3: The Trust will implement the Velindre Innovation Plan
In partnership with the Welsh Government Health and Care Innovation Team and the Velindre Charity, a new dedicated Velindre Innovation infrastructure is being established to develop a plan that will deliver a step change improvement in the quality and quantity of multi-disciplinary and multi-partner innovation to achieve our Trust's purpose to improve lives. In the '©Velindre 7P Value-Based Innovation Plan' we will set out a clear structure for delivering the Trust's innovation ambition.

In the plan we will have a clear **Purpose** and definition of innovation. We will have agreed innovation **Priorities** and themes that will including emerging technology and informatics, commercialisation, workforce, engagement, arts & creativity, new hospital design, sustainability and future generations and social innovation with community benefit. At the Velindre Cancer Service, these will also include patient outcomes and patient experience, primary & community oncology care, diagnostics, advanced cancer treatments and therapies, supportive care and palliative care. At the Welsh Blood Service these will include, plasma fractionation, donor engagement, experience and care, components and products, stem cell and transplant, along with advanced blood-based therapies and innovative logistics.
We will have a clear **Process** for triaging and accelerating innovation. We will have a strong **Platform** for delivering innovation that will include the right people and

culture, flexible and responsive innovation funding, toolkits, and a responsive IP protection procedure. To increase our capability and capacity we will have strong **Partnerships** that will include the Welsh Government and NHS Wales Innovation Leads and RIIC Networks, HTW, LSH, Bevan, academia, industry and the third sector. We will build an innovation premium through awards, targeted promotion, **Publication** and delivering value through a **Performance** framework, aligned to the Welsh Government's new Innovation Strategy and Programme.

Strategic Priority 4: The Trust will maximise collaborative opportunities locally, nationally and internationally

Across the Health Boards we will work with our colleagues to maximise research opportunities for our patients and donors. This will include the Velindre@ Programme which aims to evolve the research infrastructure across South-East Wales, enabling local access to clinical research. The specific tripartite partnership with C&V UHB and Cardiff University to develop the Cardiff Cancer Research Hub will provide a safe environment to provide cutting edge and complex advanced therapies for patients and enable translational research in collaboration with Advanced Therapies Wales and our Haematology and University colleagues.

We will also work with scientists within Cardiff and beyond to bring new therapies into the clinic for the very first time as well as generating reverse translation opportunities involving both systemic therapy and radiotherapy. Moreover, we will increase the number of Velindre Chief Investigators who can collaborate with the Centre for Trials Research (CTR) in Cardiff University. Through interactions with the Cardiff Experimental Cancer Research Centre (ECMC), the Wales Cancer Research Centre (WCRC), and Health and Care Research Wales (HCRW), we will maximise research opportunities across all fields of cancer research including early diagnosis, interventional therapies and palliative and supportive care.

In addition, with the All Wales Medical Genomics Service, we will become the only hub in the UK to offer a 500 gene panel to all new metastatic cancer diagnoses, providing outstanding potential for precision medicine research opportunities with all our patients.

Nationally we will continue to work with our colleagues across the UK, including the National Cancer Research Institute (NCRI). We will also develop our already healthy relationship with the third sector, industry partners and contract research organisations (CROs) to both deliver commercial research and to collaborate in the design and delivery of clinical trials with Velindre University NHS Trust acting as Sponsor.

We will strengthen our Academic Partnership Board with multiple HEI partners across Wales to help us to shape our Trust University Status whilst ensuring that

multi-professional development of research and innovation remains central to this agenda. Lastly, and most importantly, we will work with patients and the public through PPI to ensure that the research we develop and offer is relevant to their needs.

Conclusion

Healthcare research is vital for patients, donors and the NHS. It underpins the evidence needed to provide the best care and services for patients and donors, improves outcomes, underpins innovation and service improvements, improves efficiency and effectiveness and motivates, attracts and retains staff. The work in each of the 4 Strategic Priority areas detailed above will be coordinated and focused to enhance the Trusts' reputation for RD&I, maximise opportunities to collaborate with partners and ultimately to benefit our patients and donors.

System Leadership and Regional Partnership Working

The development of leadership roles, partnerships and collaboration are vital in NHS Wales achieving the best outcomes for the population we serve. The Trust is a partners in a number of exciting programmes of work which we will continue to pursue. These include:

Cancer Services

The development of the cancer system across South East Wales and the implementation of the Nuffield Trust recommendations.

Development of Acute Oncology Services Across South East Wales

Acute oncology (AO) ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting.

Development of a Cardiff Cancer Research Hub

Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) have a shared ambition to work in partnership together and with other partners to develop a Cardiff Cancer Research Hub.

Blood and Transplantation

Advanced Therapies Wales (ATW)

The Programme was established in 2019 on behalf of the Welsh Government after the publication of their Advanced Therapies Statement of Intent (SOI). The Programme is part of the Precision Medicine initiative within the Health and Social Services Group. The SOI outlines the challenges, opportunities and actions necessary to develop a sustainable strategic approach to developing the Advanced Therapy Medicinal Products (ATMP) sector in Wales.

Funding for the Programme is through an annual non-recurring basis from Welsh Government, with ATMP treatment funded through specific Welsh Government funding allocated to Welsh Health Specialised Services Committee.

COVID 19 has had a significant impact on progressing the ATMP agenda across Wales and the UK with much of the work in relation to ATMPs and clinical trials being paused.

As we move into 2022/23, we have taken the opportunity to review the programme expectations, structure and work plan. The appointment of a clinical lead to the Programme will provide clinical leadership, specialist clinical knowledge and experience of regenerative medicine and ATMPs, support, advice and guidance to the Programme and the wider NHS Wales service.

Focus will continue to be on supporting the developing of Clinical trials in Wales and facilitating a collaborative approach to research and development with the Cardiff Cancer Research Hub, a tripartite partnership between Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) is driving the development of a Cardiff Cancer Research Hub (CCRH) and the Clinical Research Hub, established by Cardiff and Vale UHB (the main tertiary services provider in Wales) to provide the opportunity for key stakeholders, including Health and Care Research Wales (HCRW), the Cell and Gene Catapult, health and academia to work together to implement new clinical studies for the population of Wales.

There will also be a focus on working with WHSSC and Health Boards in Wales to support the implementation of NICE approved ATMP treatments for the Welsh population. As ATMPs are classified as highly specialised because of the small number of patients diagnosed with these conditions, the delivery of these services is normally through a very small number of specialist centres, which may require specialist accreditation, equipment or highly trained and skilled workforce. Where possible the preference is to treat people in Wales. However, it is recognised that this is not always beneficial to the Patient or economically viable and accessing the best care for patient may mean some patient having to travel out of their local areas, and in some cases having to travel to England for treatment.

Plasma Derived Medicinal Products

Over the past 5+ years there have been sustained annual increases in the global demand for Plasma Derived Medicinal products (PDMP's), in particular Immunoglobulin (IG). As a result, all UK blood services have devoted resource to scoping out potential plasma collection programs to improve availability of IG. The Welsh Blood service will work in collaboration with other UK services to be able

achieve sufficient volumes of plasma to be able to negotiate with the pharmaceutical industry.

WBS is working with the Welsh Government to determine these arrangements and what the implementation of any associated work programme would be over the next 3-5 years, including agreeing of the annual Welsh demand for plasma-derived Immunoglobulins that WBS would seek to contribute. The work will be delivered through a Wales Programme Board linking to the other UK nations as the work progresses and final agreements on a model are made. Through the early part of 2022/23 the ongoing UK discussions will take place with the implementation programme establishing later in the year.

The action plans for our Trust programmes are set out in *Appendix A*.

Part 5

Our Service Delivery Plans

Our Velindre Cancer Centre and Welsh Blood & Transplant Service delivery plans for 2022 to 2025

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

Our clinical services

Cancer Services Non-surgical Tertiary Oncology

Our cancer services have inevitably been disrupted as a result of COVID-19. From a range of causes, from changes in public access to general practice for diagnosis, changes in screening services and onward referrals through secondary care to the impact on our VCC elements of patient pathways. The impact of social distancing and other infection prevention control interventions, as well as the centralisation of services from LHBs to the VCC site have all impacted on the patient flow, site use and how we provide the services our patients need. We adapted our '*Clinical Model*' based on professional guidance and established a set of clinical principles to inform patient treatment decisions and choices.

The introduction of virtual consultation methods, the extension of SACT delivery with additional service through the mobile unit with Tenovus and the expansion of the SACT homecare service as well as increasing radiotherapy capacity through a partnership agreement with the independent sector are all adaptations that will need to be sustained in the medium term to enable us to meet the projected increase in demand and changes in patient need as we work with our Health Board partners to continue the recovery from the pandemic alongside delivering our ambition for the further development of cancer services in South East Wales.

The cancer centre has an ambitious programme of change that was planned and underway prior to the pandemic and which has been maintained wherever possible alongside the service changes implemented to manage services through the pandemic. This includes major work programmes such as the CaNISC replacement (DHCR) and work to support the new Velindre Cancer Centre (nVCC) development as well as initiatives to deliver on our ambitions for individual services that make up our overall support for patients on the whole of their care pathway. This includes substantial changes in elements of service provision for Outpatients, SACT, and radiotherapy as well as plans to further develop our active engagement and support to primary care, palliative care and therapies. This list is not exhaustive.

The leadership and co-ordination of this work through the Velindre Futures initiative continues. In addition, the delivery of the VCC elements of regional programmes such as the Acute Oncology Service, the recommendations of the Nuffield Report dovetail with the VF initiatives wider service modernisation and transformation projects.

The move to implementation phase of the Integrated Radiotherapy Solution, which is currently in procurement, also provides a further key work programme that is crucial for the continued delivery of radiotherapy service as well as enabling the new

Radiotherapy Satellite Centre at Neville Hall. Together these changes form an agenda of unprecedented change for Velindre cancer services. They will be delivered alongside the repatriation of services back to Health Boards following the centralised delivery at VCC that was established during the pandemic as well as growing service capacity to meet the patient demand that has been supressed in the past two years.

The delivery of our plan for 2022/23, and the subsequent years, will be dependent on the recovery plans of health board partners and the ongoing pandemic situation and associated population interventions. The development of outreach services to meet the Transforming Cancer Services model will also form a key element of our service plans as we move towards the transition to the move to the new Velindre Cancer Centre.

Our Priorities for 2022 -2025

The Cancer Strategy 'Shaping our Future Together' 2016-2026 sets out the strategic priorities.

Strategic Priority 1:	**Equitable and consistent care, no matter where; meeting increasing demand.**
Strategic Priority 2:	**Access to state-of-the-art, world-class, evidence-based treatments**
Strategic Priority 3:	**Improving care and support for patients to live well through and beyond cancer**
Strategic Priority 4:	**To be an international leader in research, development, innovation and education**
Strategic Priority 5:	**To work in partnership with stakeholders to improve prevention and early detection of cancer.**

The five strategic priorities and the key programmes of work that underpin these priorities continue in the main to be those commenced prior to the pandemic, including the Transforming Cancer Services projects such as the delivery of the Integrated Radiotherapy Solution, the Radiotherapy Satellite Centre and delivering the nVCC including planning transition to the new site. Wider ongoing service transformation delivered through the Velindre Futures initiative and the delivery of the replacement for CaNISC are also a priority.

Alongside this work, the sustainable delivery of our services for patients and providing sufficient capacity continues to be our primary focus. Our capacity challenge will not only be in the delivery of treatment by SACT or radiotherapy, but also in the other

services that support patient care including radiology, therapies, pharmacy and palliative care.

This requires the delivery of outpatient and SACT services at local hospital sites in collaboration with LHBs as well as expanding capacity across our full range of services on site at the cancer centre. This will enable us to plan to meet expected levels of demand, following reduced numbers of patient entering cancer pathways during the pandemic. For radiotherapy services the capacity challenge is limited by our LINAC fleet and availability of third party capacity.

In addition to this, we will continue to deliver a number of key business critical initiatives. These all require fundamental changes in systems, processes and ways of working and have the potential to have significant operational impact.

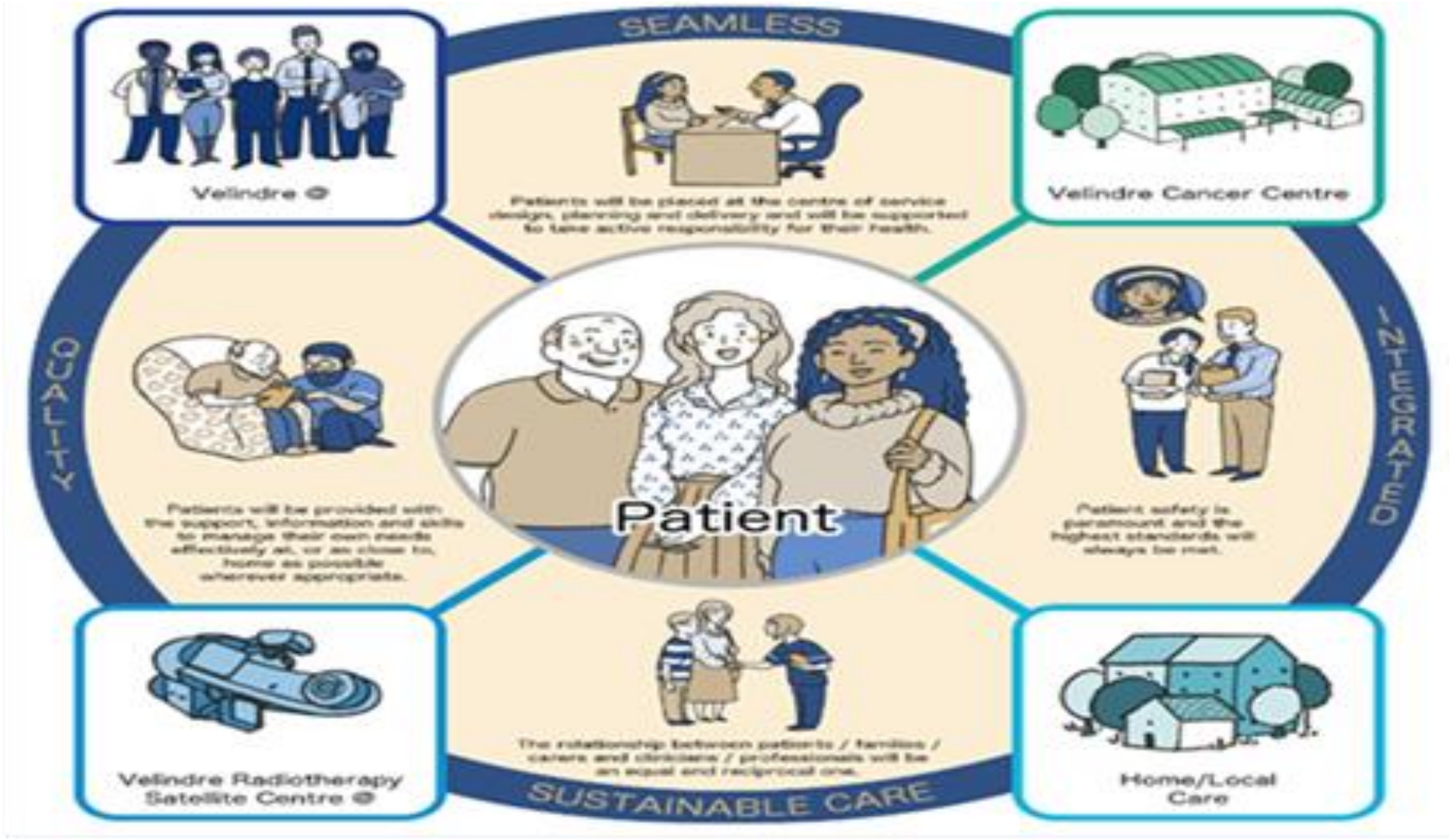
Velindre Futures will be the vehicle through which we will deliver the changes we need to meet service change aspirations including the VCC element of the regional work and the implementation phases of the TCS programme. Established in 2020, Velindre Futures is a clinically led initiative that directs the development of the clinical model and future service configuration, working in partnership and collaboration with staff, patients and carers and the public. It will ensure that the Cancer Centre systems and processes remain fit for purpose and patient centred, now and in the future. It will enable the VCC aspects of regional collaborative working.

It considers the Velindre System; a series of networked services for patients that ensures an integrated regional approach. Through this initiative we will both shape and deliver these aspirations and inform strategic discussions internally and across the region through a clear, planned and managed programme of service change to take us to where we want to be.

Through 2022 and beyond, the Velindre Futures work programme will ensure the delivery of the key recommendations identified alongside the existing service changes planned.

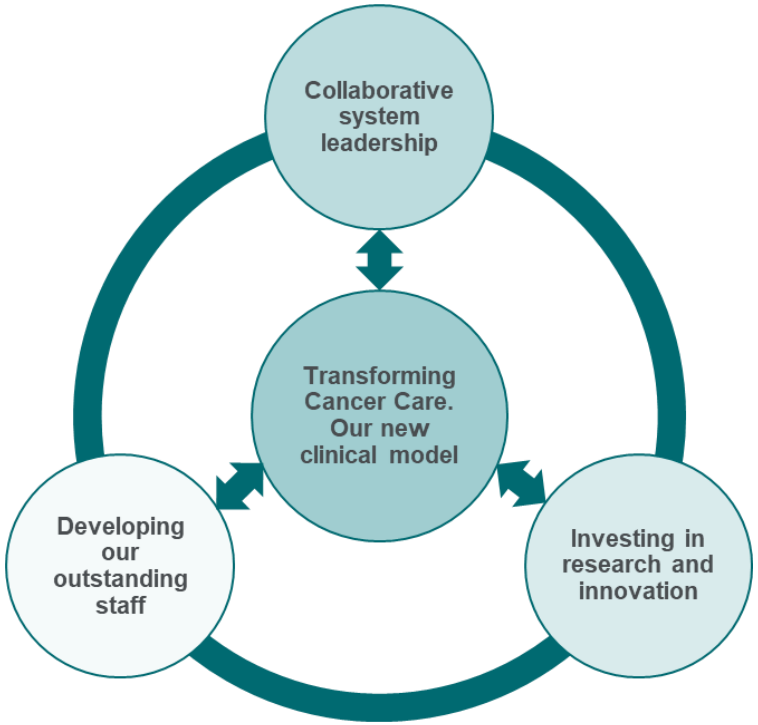
This is an ambitious programme of work that will be prioritised and delivered through 2022-25 as we continue to focus on increasing capacity to manage demand increases. Core to service change is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do. To enable this, a new framework for engaging with patients and the public will be developed to draw on best practice and set our expectations and ideas **(*see Figure 2*).**

Figure 2 - Our Clinical Model



Our Approach

The four areas of focus within our Velindre Futures and Transforming Cancer Services programme will allow us to realise our vision. These are deliverable within an overall environment of maintaining our excellent quality, operational and financial performance, which also encourages us to be enterprising.



Responding to more people living longer with cancer: an improved model of care:

- An improved model of care: at home or local where possible, centralised where necessary, and based around delivering equitable access to high quality care and research.
- A new state-of-the-art cancer centre in Cardiff networked across south Wales delivering acute oncology services and research centres of excellence.
- A Radiotherapy Satellite Centre in Nevill Hall and chemotherapy in a variety of outreach locations across south-east Wales.
- Delivery of outreach services in V@ facilities in Local Health Boards.
- Complete digital transformation through our 'connecting for the future' programme.

Collaborative System Leadership:

- Play a lead role in the development of a system wide approach to cancer services in the region through the Cancer Collaborative Leadership Group.
- Continue to lead and contribute to key areas of care and research, including through embedding our new clinical model, both nationally and internationally.
- Support the development of the diagnostic network and single cancer pathway as key enablers of service transformation.
- Support the development of integrated health and social care and research models across south Wales/Wales.

Investing in research and innovation:

- Increase participation in clinical trials, Velindre sponsored studies, and become renowned for qualitative research.
- Developing a research network across South East Wales with our LHB and University partners.
- Lead the research and innovation agenda through taking an active leadership role in partnership with universities, commercial partners and the Research Network.
- Increase our opportunities to be at the forefront of innovation.

Developing our outstanding staff:

- Developing our clinical, scientific, nursing and allied health professional leadership capability
- A consistent approach to quality improvement through the Quality and Safety Framework.
- Developing a comprehensive approach to Education and Training.
- A focus on engaging and empowering staff.
- New workforce skills and leadership development to meet our workforce challenges.

Velindre Cancer Centre: How we will Meet Our Challenges

The Challenge…	We will meet this by…
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages – making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Our priorities for 2022 – 2025
We have identified a range of key deliverables:

Strategic Priority 1: To meet increasing demand

- Reduce patient backlog and waiting times
- Provide safe services in a Covid environment:
    - Achieve Covid/flu vaccination requirements
- Implementation of the Single Cancer Pathway and transition to COSC standard
- Implementation of quality and safety framework, assurance and reporting tools
- Delivery of clinical audit programme
- Deliver quality improvements in Brachytherapy service
- Delivery of quality and safety requirements and Healthcare Associated Infections/Infection Prevention Control Requirements
- Delivery of next phase of Velindre Futures / TCS Programme:
    - Implementation of unscheduled care pathways
    - Implementation of regional acute oncology service model
    - Implementation of V@UHW Research hub: phase 1
    - Agreement of V@ CTM and AB service model and phased implementation
    - Complete competitive dialogue for the new Velindre Cancer Centre
- Development of sustainable workforce model and agreement for funding with LHB to support transition to improved clinical model and stepped change in capacity

Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments

- Identify and secure additional capacity to deliver radiotherapy and SACT requirements
- Deliver infrastructure phase of TCS Programme:
    - Award Integrated Radiotherapy Solution contract
    - Secure approval of full business case for the radiotherapy satellite centre in Nevill Hall
    - Implementation of 2 new linear accelerators in Velindre Cancer Centre
    - Identification of V@ outreach requirements in LHB models/facilities

Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer

- Enhance our self-assessment unit to improve access and support for patients with acute needs
- Increase the range of holistic therapies available to patients during/following their treatment
- Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners
- Patient self-management programmes
- End of life/palliative care

Strategic Priority 4: To be an international leader in research, development, innovation and education

- Implementation of Research and Development strategy (year 1)
- Implementation of V@UHW Research hub: phase 1
- Progress a range of strategic partnerships to take innovation to market

Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer

- Deliver our secondary prevention programme to support patients in improving their health and well-being
- Deliver our McMillan primary care programme to support improved detection and diagnosis of cancer

Forecasting Demand & Capacity to Deliver Services

The demand for cancer services is comprised of care for patients newly diagnosed with cancer as well as new cycles of treatment for existing patients e.g. patients with metastatic disease requiring further cycles of treatment over time and the availability of new treatment regimens.

Demand for non-surgical cancer services at VCC has been increasing steadily over recent years. Notwithstanding the COVID-19 pandemic, demand for our services was predicted to increase by between 2%-5% which was derived based upon growth, improved access and increasing treatment complexity.

The demand forecast for 2022/23 and beyond uses this pre pandemic baseline supplemented with additional data from a major exercise we have led in conjunction with our LHBs, the Wales Cancer Network, Improvement Cymru and the Welsh Government Delivery Unit to develop a model to guide to identify new patient demand.

The demand modelling initially focused on using historic flows of patients from primary care to diagnosis and to treatment to develop a predictive model that to determine external demand from new patient referrals. This informs tactical decisions on timing of implementation of capacity changes likely to be required, with forecasting of actual demand over the next 16 weeks and informing capacity plans for next 12 months. We have used this to quantify capacity requirements for 2022/23 and beyond.

We recognise the pattern with which patients that have not yet presented will come forward is unknown and will be dependent on actions taken by Health Boards to develop their service capacity including diagnostics. This is variable between geographic areas and by patient tumour site. We will continue to use this model to review demand and going forward.

The table below provides a summary of the planning assumptions that underpin the capacity and delivery plan for 2022/23

Growth in service above the 2021 - 2022 baseline

Service	22/23
Radiotherapy	8%
Nuclear Medicine	12%
Radiology Imaging	12%
Preparation & Delivery for Systematic Anti-Cancer Therapy	12%
Ambulatory Care Services	8%
Outpatient Services	8%
Inpatient Admitted Care	2%

The headline capacity enhancement requires consideration of the changes to clinical practice and service delivery in comparison to the 19/20 baseline. For example, the increased utilisation of virtual outpatient attendances, mix of oral and IV infusion SACT delivery, introduction of hypofractionation for Radiotherapy Services, outsourcing and outreach settings. This work is ongoing alongside activity to identify efficiencies and developments across all treatment pathways.

Systemic Anti-Cancer Treatment (SACT)

Pre-Covid, SACT day case activity was increasing by approximately 5-8% per annum. This is a nationally recognised figure, and not just at Velindre. However, new Outpatient referrals to Velindre over the last 12 months have been 12% below pre-Covid levels, although considerable variation exists across tumour sites. However, we are still experiencing the underlying growth of 5-8% in SACT demand that was being realised pre Covid in 2019/20 from new and combined treatments. By Quarter 4 2020/21, patient referrals into the SACT service recovered to pre Covid levels.

It is worth noting, that demand for SACT is not only from the new referrals in for SACT, but the ongoing patients are also driving demand. This is because of more treatment options, patients living longer and receiving intermittent SACT regimens, and the increasing use of ‘maintenance’ regimens.

There is a ‘knock on’ impact of the increasing demand on SACT which is seen in Out-patients, and on the Ambulatory Support Unit where treatment related toxicities are assessed and managed

External Beam Radiotherapy

Referrals are predicted to return to Pre Covid (2019-20) levels by March 2022 and predicted to grow to Pre Covid plus 8% by March 2023. This is a higher rate of growth than new outpatients which is indicative of internal increase due to repeat cycles of treatment and increases in combination therapies. The impact varies by tumour site.

The continuous improvement of the radiotherapy pathways to meet revised treatment start targets will continue, however investment will be required to make a step change. This has not been included in the plan for the current year.

Outpatient service

The demand position has identified the biggest challenge in 2022-23 will be in the outpatient volumes with an additional 9000 patient episodes required. This reiterates the need for a transformative approach to the patient pathway to reduce the need for patients to be seen in the outpatient setting, including the implementation of the 'supported self-management' initiative.

Key Programmes of Work 2022 - 2023

The initiatives listed below include a wide range of projects to deliver our ambition, however alongside these there are also an extensive programme of ongoing "business as usual" replacement of equipment, digital systems upgrades and projects that are ongoing.

Meeting Demand

Sustaining and building capacity in all areas of the service to meet the patient demand and the demand pattern to enable us to consult with and treat people in accordance with the appropriate professional standards for care and time to treatment.

Velindre Futures

- Continue to deliver service change each of the directorate service areas; Medical, SACT and Medicines Management, Radiation Services, Integrated Care, Operational Services including Outpatients.
- Primary Care Oncology – exploring where we can provide additional support for primary care, and working in partnership with Primary Care colleagues to strengthen patient pathways and Care Closer to Home.
- Working to meet the Single Cancer Pathway and the delivery of COSC waiting times for Radiotherapy.
- Palliative care – reviewing the service requirements and ongoing service developments aligned with the End of Life Care Board programme, ensuring the ability to meet the internal demand for specialist palliative care services, implementing and embedding Advance Care Planning at the Cancer Centre. For instance, embed electronic Advance & Future Care Planning patient records into healthcare records in patients with palliative care needs.
- Delivery of the pharmacy TrAMMS programme
- Patient support services development including: Strengthening the 24/7 Helpline.
- Increase the range of therapies available to patients during/following their treatment – including pre-hab.

- Outpatient transformation programme – working to modernise the outpatient model of care delivery, including implementing 'supported self-management' for cancer patients with a Values Based Health Care approach (rather than the traditional outpatient model of '*follow up*').

- Disease 'Site Specific Team' (SST) Transformation programme – working with the SSTs and regional partners to ensure that patient pathways are effective, efficient and smooth, and that clinical outcomes and the patients experience of their care are optimised.
- Supporting specific treatment developments identified by SSTs as priorities. These will be delivered through external negotiations e.g. commissioning, and internal programmes of work to tackle gaps in service, access to trials, pathway reviews etc.

Specific major projects

- Digital Healthcare Record (DHCR) (the CANISC replacement) - delivery of the Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP) into all areas within the Trust.
- The Radiotherapy satellite Centre (RSC). Further development of the operating model for the centre including workforce planning
- The Integrated Radiotherapy Solution (IRS)- establish the implementation programme board and work programme with particular focus on requirements for phase 1 replacement of 2 LiNAC at VCC and the RSC.
- The new cancer centre replacing Velindre Hospital (nVCC) - provide the subject matter expertise to inform the next stages of the development.

Supporting projects

- Digital enablement of all VF projects.
- Patient Engagement: Establishing the new ways of working to enable delivery of the aspirations in the new framework.
- Workforce for the Future - further modernise our workforce model to ensure we have all staff operating at the top of their licence, and make the most of advanced practice and consultant roles.
- Working with HEIW and the Cancer Network to ensure that Velindre has a workforce 'fit for the future' with new roles, succession planning and the upskilling staff through development programmes.

Velindre Cancer Centre Service Plan 2022 - 2025

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	1. SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24) Supported by Task and Finish group proposals. Finalise interim facility plan at Neville Hall Hospital. Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing. Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led model of care delivery for SACT Implement staffing review agreed actions.	Implement Neville Hall interim facility return. Develop business case for SACT Consultant Nurse/ Consultant Pharmacist.	Commence booking service review.	Re- establish full service at Neville Hall Hospital in new cancer facility. In line with plans for reduced chair capacity at new cancer centre, begin transition planning with Health Boards.	Agree model and finalise chair capacity plans at Velindre and outreach centres.

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		include review staffing model and assess workforce options.					
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service Begin project to increase Linac capacity to 80 hours (73 currently) Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand. Review demand and capacity for clinical trials requiring capacity Review the Linac transition capacity for IRS implementation.	MRI refurbishment in radiology Brachytherapy action plan delivery Explore dose and fractionation schedules and alternative treatment approaches Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.	Streamline plan complexity for certain palliative scenarios. Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Ongoing review of capacity for IRS implementation plan	Implement Radiotherapy satellite unit in Neville Hall.

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical treatment developments	Programme to review efficiency of existing pathways continues including reduction in variation in ways of working /action plan developed. Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision) Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Develop standard operating procedures for pathway management, building on those developed in Lung Pathways and emerging themes/challenges with SST leads. Engage with WHSSC on PRRT service to deliver patient benefit Active engagement with commissioners with priority treatment development plan and delivery	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal pathways with SST leads. PRRT business case if able to progress Active engagement with commissioners with priority treatment development plan and delivery	Implement agreed pathway and workforce models developed to meet COSC target requirements. Finalise business case and Delivery of PRRT plan Active engagement with commissioners with priority treatment development plan and delivery	IRS implementation to drive pathway improvements through improved visibility of patients on pathways. PPRT established Annual cycle of new treatments to be established	IRS implementation Annual cycle of new treatments to be established
	4 Outpatient Services / Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre Pandemic	The transformation objectives for the SSTs and Outpatient workforce will continue as	Deliver transformation programmes- estate, pathways and workforce	Deliver transformation programmes- estate, pathways and workforce	Engagement on service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		work.(interdependent with Radiotherapy projects) Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinary workforce model. Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing	previously described in quarter 1. This is a fundamental change and improvement programme which will run over 18 months.				

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		more efficient ways of working Maximise use of virtual consultations and embed into 'business as usual'. (50% at present). Establish optimum levels of Phlebotomy provision and notify HBs of changes in access. Provide increased capacity incl. at evenings/weekends to meet demand initially while the more fundamental pathway changes and ways of working are introduced pending service improvement efficiency delivery. Work to reduce demand within the Outpatient setting, including: review					

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		and streamlining of patient pathways and the implementation of the 'supported self-management' model Re-commence the pre Covid Outreach Clinics					
Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5 Digital Health Care Record (CANISC Replacement)	Finalise development Functional testing User Acceptance Testing Data Migration Operational service change planning Training sign off	Testing and training Operational Go Live planning Go Live readiness assessment Go Live run through SOP development	Commence Go Live Phases– dry run Complete Go Live	Review impact of implementation on operational delivery plan phase 2	Phase 2	
	6 Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter. Appoint Radiation Services Programme Manager to lead implementation and	Complete hybrid OBC/FBC and submit to WG and await approval. Prepare recruitment of IRS implementation posts. Award IRS contract once approval of	Commence formal IRS implementation – shadow implementation board stands up as a formal board. Recruit to IRS implementation posts.	LA6 Bunker Refurb complete. Service plans for second machine replacement confirmed. Initial scoping works on TPS/OIS replacement and	1st VCC Linac replacement live. Decommissioning and Refurb of 2nd bunker commences and completes. 2nd VCC Machine live	Installation of 2 standard Linacs and a CT Sim at the Satellite Centre TPS/OIS readiness for cloud confirmed

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**						
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		commence design of 1st bunker. Establish Shadow Implementation Board	capital and revenue funding. Receive vendors detailed implementation plans	LA6 Bunker Decommissioning commences	Phase 1 additional functionality. Plans for Satellite and nVCC confirmed	Work continues to develop TPS / OIS and prepare for cloud services when nVCC goes live. Plans firmed up for Satellite Installation	Plans firmed up for nVCC Installation
	7 Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	Service embedding and review Engagement on service model for nVCC	Transition to nVCC
	8 Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS. Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity Ambulatory Care- increase weekday opening Continue to review the unscheduled care	Immunohematology Service- further pathway work with HBs Ambulatory Care- weekend opening	Immunohematology Service- grow service delivery	Engagement on service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		(SDEC) Ambulatory Care – finalise staff recruitment	patient pathway aligned to the VCC element of AOS. Deliver requirements of national projects e.g. Immuno Oncology				
	9 Palliative Care	Review Cancer Associated Thrombosis clinic service : establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of service delivery and future planning.	Transition to nVCC
	10 Key Treatment Developments – IMN SABR Lutetium PSMA HDR Brachy etc. Clinical team priorities – Gaps in service, e.g. CNS/Therapies. Access to Trials/Research.	Finalise the priority of implementation of key treatments where external funding is required and agree timescales. Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Take forward agreed business cases in a phased approach as agreed. Apply 'Just do it' criteria where appropriate for clinical team Begin development of implementation plans for clinical team priorities requiring	Take forward agreed business cases in a phased approach as agreed. Apply 'Just do it' criteria where Continue the development of implementation plans for clinical team priorities requiring	Take forward agreed business cases in a phased approach as agreed.	Develop enhanced commissioning frameworks/models to support future treatment developments. Engagement on treatment models for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**						
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	MDT attendance / cover arrangements.	Finalise the priority of clinical team priorities.	support/wider discussions.	support/wider discussions.			
	11 Radiotherapy Satellite Centre	Support Strategic case development & review of FBC. Workforce Plan. Finance case. IRS alignment & FBC. FBC scrutiny and approval by service lead & through Boards	FBC approval- WG Implement Arts strategy for RSC Operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment Project Board, Project Team Meetings Operational Model delivery plan preparation	Operational Model delivery plan preparation	Recruitment of additional posts for RSC Review SLA's Review operational model Workforce Training Communications	Linac installation Feb 2024. Acceptance testing March 2024 External commissioning April -2024 Internal commissioning April- June 2024 Staff training June- July 2024 RSC opens- beam on date July 2024
	12 Radiology	Commission reconditioned MRI scanner.	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Engagement on service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		Phase 1 capacity delivery					
Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer	13 Patient treatment helpline	Implement new handover arrangement into SACT service. Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Develop action plan to address issues identified and changes required. Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.	Implement actions identified. Implement any identified telephony systems to allow signposting to all areas.	Implement associated workforce or training plans Roll out new system and ways of working.	Review Helpline developments from 22/23	Ongoing adaptation and development in line with other service changes
	14 Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel Implement patient panel management software programme.	Commence establishment of Patient Engagement Hub and Patient Leadership Group Establish initial Patient Engagement activity for Velindre Futures projects	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	Engagement on service model for nVCC	Transition to nVCC
	15 Establish Primary Care						

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	project under Velindre Futures						
Strategic Priority 4: To be an international leader in research, development, innovation and education	16 R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case Cost(ing and funding agreements in place.	Establish Governance Arrangements for the Hub.	Engagement on service model for R&D for nVCC	Transition to nVCC
	17 TrAMS	Establish VCC programme board and supporting sub groups: 1) Clinical Service Model 2) Clinical Trials via TrAMS 3) Workforce and staff impact. 4) Finance, incl. private patient impact.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Develop detailed implementation plan addressing all areas of risk	Implementation of new service from Spring 2024.
	18 Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and	Review funding streams and commissioning models to facilitate	Continue participation in regional service	Bring forward proposals for therapies development	Engagement on Therapies service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		scope development plan.	prehabilitation service development.				
	19 Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach -'Stabilise and Modernise' Finalise proposals for revised clinical leadership arrangements.	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles to 'kick start' the workforce Advanced Practice Radiographers and Therapeutic Radiographers	Implement Physicians Associate posts. Prepare plan for advanced practice – Non Medical Consultant roles.	Workforce modernisation programme continues		

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	20 Single Cancer Pathway	Focus on front end of the pathway for all tumour sites: Aims to Standardise patient referrals to VCC. Timely receipt of all diagnostic test results and treatment pre-requisites prior to MDT. Improve patient outcomes by early genomic testing where indicated. Develop action plan.	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway: Mapping of Breast Pathway from patient referral to service to treatment commenced. Identify touch points along pathway and potential bottlenecks Measure how currently delivering against the National Optimal Pathways (NOP) Develop action plan.	Commence Action plan implementation.	Roll out Pathway mapping process for Urology, then other tumour sites.	

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer	21 Engagement with HB's	Agree terms of reference and priorities for joint working with each HB. Commence meetings to deliver on these priorities.	Share patient pathway challenges in developing improvement plans. Agree outreach plans for outpatients and SACT with all HBs.			Take lead from partnership board on development of local implementation of clinical models	Implement agreed clinical models in readiness for nVCC.

Blood and Transplant Services

The Welsh Blood Service collects voluntary, non-remunerated blood and blood product donations from the general public and provides advice and guidance regarding appropriate blood product use in Health Boards. Donations are processed and tested at the laboratories based in WBS Head Quarters in Talbot Green, Llantrisant, before distribution to hospitals. We have a Stock Holding Unit (SHU) in Wrexham, North Wales and also have sites in Bangor, North Wales and Dafen, West Wales. The WBS laboratory services also include antenatal patient testing and a reference centre for complex immunohaematology investigations.

It supports the solid organ and stem cell transplant programmes that run out of Cardiff and Vale University NHS Trust and manages the Welsh Bone Marrow Donor Registry, which provides haematopoietic stem cell products nationally and internationally and the UK National External Quality Assurance Scheme for Histocompatibility and Immuno-genetics (NEQAS) (global quality assessment service)

In addition, we hold a wholesaling licence to supply blood-derived medicinal products (both NHS and Commercial for purchase by our customer hospitals).

The service models are supported by strong Research, Development and Innovation (RD&I) derived from within WBS and working closely with other Blood Services across the Home Nation and further afield. Investing our time in supporting and facilitating RD&I is fundamental in ensuring we remain a leading service within the fields of blood component, transplant and transfusion services.

The Trust is committed to ensuring the services we provide meet the high expectations required by patients, donors, staff and partner organisations across health, academia and industry. Our services must be high quality, clinically safe, effective and underpinned by a strong evidence-base.

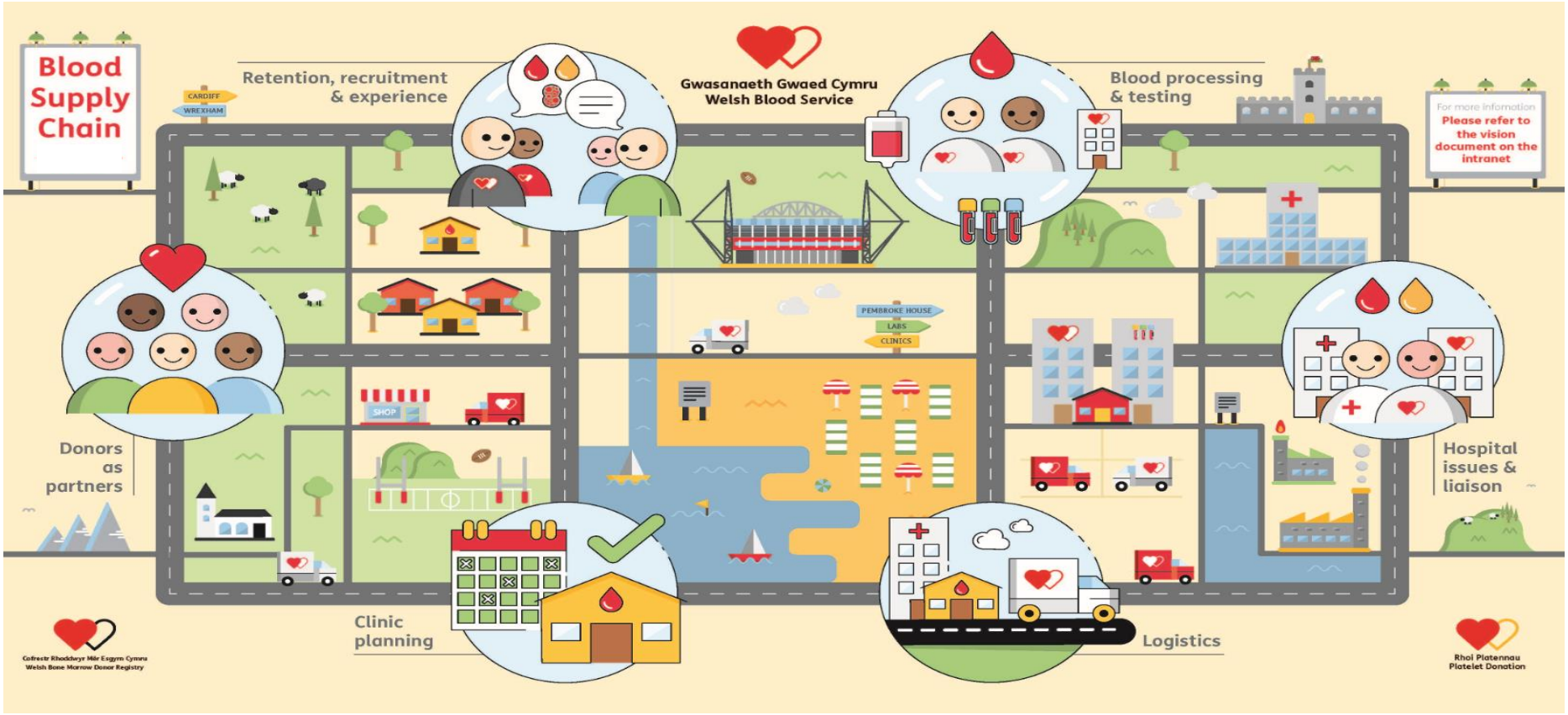
Strong clinical and scientific leadership and governance helps to ensure that the quality of our service remains at the forefront of our decision-making. This assurance is maintained through our commitment to ensuring the services we provide meet the high standards of our regulators and auditors, such as the Medicines and Healthcare Regulatory Agency (MHRA), Human Tissue Authority (HTA), UK Accreditation Services (UKAS) and the Health and Safety Executive (HSE).

The delivery of our blood, transplant and transfusion services requires working in partnership and collaboration with colleagues within our corporate and support functions:

- Digital support is fundamental to the provision of modern services that minimise unnecessary work, maximise efficiency and support clinical safety.
- Data from our Business Intelligence Service is used to support planning of our service delivery and development and provide a means of monitoring performance and measuring our success.
- Strong corporate governance and project structures, provided by our Innovations Hub and business support team, are important in ensuring the successful delivery and continuous improvement.
- Maintaining a safe, sustainable and efficient estates infrastructure from which to run our services and look after our staff, is an essential requirement of WBS and is managed in partnership between our corporate estates team and local facilities team.
- Working with our Workforce and Organisational Development team helps ensure that the well-being of our staff remains an important part of service.
- Strong financial support helps to ensure service are delivered within our agreed financial envelop and we meet our Standing Financial Instructions (SIFs) obligations.

Our clinical model is illustrated by ***Figure 3*****.**

Figure 3 - Our Clinical Model



Our Strategic Priorities

Strategic Priority 1:	**Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality**
Strategic Priority 2:	**Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations**
Strategic Priority 3:	**Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services**
Strategic Priority 4:	**Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services**
Strategic Priority 5:	**Provide, services that are environmentally sustainable and benefit our local communities and Wales**
Strategic Priority 6:	**Be a great organisation with great people dedicated to improving outcomes for patients and donors**

Forecasting Demand for Blood Components and for Blood Products and Platelets

Meeting Demand - Planning assumptions
The following assumptions have been made when forecasting the demand for blood components, blood products and platelets:

- COVID-19 social distancing and IPC measures will remain in place for the length of 2022/23
- No ‘surge’ has been applied, but an uplift of 1% has been applied to the pre-COVID-19 data (this is reflective of the uplift modelled and applied by NHS Blood and Transfusion Service in England)
- Uptake rate is based on 2 years data April 2020 to March 2022 to reflect the ‘booking only’ model in place at this time. There is an assumption only booked appointments will be available i.e. no walk-in appointments
- DNA rates are based on pre-COVID-19 data
- There is an expected post collection loss rate of 4%, which will include losses due to donor screening results, laboratory process and quality monitoring purposes

Figures are subject to external changes which may have a significant impact on how much whole blood and blood components and products are demanded from Hospitals (our customers) throughout the year.

WBS will continue to monitor actual issuing against forecasted issuing throughout the year and will adjust the planned whole blood and platelet collection and the corresponding product manufacturing accordingly, to meet demand.

Meeting Demand for Blood (Red Cells) and components

The Collection Clinic Planning department will aim to schedule clinic sessions to collect enough whole blood to meet the estimated demand during the year.

Based upon our planning assumptions above, we have modelled how much blood we will need to collect from our donors compared to issuing to Health Boards. There is always a challenge in the interpretation of Health Board activity planning and impact on blood demand due to the myriad of factors that influence demand.

The assumptions upon which the forecast data is based, reflects similar modelling to other Blood Services and assumes Health Boards will increase their activity over 'business as usual' at a rate of 1%, attributable to 'surge' activity as a demand projection.

In planning the clinic capacity, as the COVID-19 restrictions are lifting, we have seen donor behaviour revert to closer to pre-pandemic levels, with lower uptake in appointments and higher DNA rates. This is in contrast to donor behaviour at the height of lockdown, which saw a significant rise in uptake and a reduction in DNAs.

Meeting demand for Platelets

Based upon our planning assumptions, we have modelled how many platelets we expect to manufacture, compared to issuing to Health Boards, in order to support safe and effective patient care.

Platelet demand has returned to pre-COVID-19 19 '*business as usual*' levels and will be met through a combination of apheresis derived and the pooling of whole blood platelets. The amount of whole blood required for pooled platelets is accounted for in the above assumptions and is complimented by the production of platelets from apheresis.

The service will flex our production of pooled platelets appropriately to ensure supply chain integrity. However, it is important to note that platelet demand can be volatile due to the nature of the component, the short shelf life (7 days), the blood group complexities as well as the two different manufacturing methods (apheresis and pooled), which in turn can lead to higher wastage levels.

Based upon the above assumptions the plan for 2022/2023 will ensure that we meet demand for blood components and for blood products and platelets.

Key Programmes of Work during 2022 - 2023

Within the IMTP, there are a number of high priority programmes of work, which will require capital investment.

Programme	Deliverable
Talbot Green Infrastructure	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model
WTAIL LIMS	Implement WHAIS LIMS Deliver WLIMS modules for Blood Transfusion (BT)
Laboratory Services Modernisation	Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS
Plasma for Fractionation – medicines	Develop and introduce Plasma For Fractionation - medicine service model for Wales
Occult Hepatitis B Infection in UK Blood Donors	Assess and implement SaBTO recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required
Donor attraction and retention	Develop and implement Donor strategy Use digital operating systems to enhance and support more effective service provision
Service Development and regulation	Develop and implement WBMDR strategy Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required. Deliver WLIMS modules for Blood Transfusion (BT) Implementation of Foetal DNA typing Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions

	Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology
Workforce	• Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning
Infected Blood Inquiry	• The Support UK Infected Blood Inquiry and delivery of its Terms of Reference

Contingency Planning

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups, but this remains difficult to determine as identified above. We are continuing to work closely with the hospital blood banks and service leads for blood transfusion to understand and help manage appropriate demand and meet the required capacity. In further support of effective stock use, the Blood Health National Oversight Group is continuing to provide leadership across Wales.

Contingency plans are being reviewed within the service to enable capacity to be '*flexed*' across the supply chain to support the anticipated increased (surge) demand from Health Boards as they move towards implementing their recovery plans. A risk assessment has been completed modelling additional capacity available with a reduction of social distancing from the current 2meters to 1.5 meters and 1 meter respectively.

For business continuity purposes, and if required, the WBS can call on mutual aid support with the other UK Blood Services or in extreme circumstances would instigate the National Blood Shortage Plan which provides a structured approach to addressing the shortfall in supply.

Welsh Blood Service Plan 2022 - 2025

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	Develop and introduce Plasma For Fractionation - medicine service model for Wales	Scope service need project group established	Business case to Welsh Government	Develop draft service model	Service model approved	SOURCE PLASMA: Service model approved workforce plan developed collection model agreed Proof of Concept Open	SOURCE PLASMA: Sites procured equipment procured workforce recruited
	Develop and implement Donor strategy	Scope service need project structure established draft strategy produced	Consultation on strategy	Implementation plan developed	implementation of eDRM phase 1 to support delivery of implementation plan	Extend eDRM Scope opportunities for digital to support real-time engagement with donors and develop bespoke donor journeys to maximise opportunities for whole	scope processes required to targeted specific donors in line with meeting service needs

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
						blood and stem cell collection	
	Use digital operating systems to enhance and support more effective service provision	Scope opportunities for digital technology to support sharing real time data and transfer of goods between WBS and customers	Establish technology solutions	Identify resources to support implementation	Implementation commence	Continue phased implementation of solution with concurrent process review and re-design as required. Upgrade systems	Continue phased implementation of solution with concurrent process review and re-design as required.
	Develop and implement WBMDR strategy	Scope service need project structure established draft strategy produced	Consultation on strategy	Implementation plan developed	implementation commence	Continued phased implementation	Continued phased implementation review and embed
	Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose	Establish project structure review service models to meet need &	Undertake service/data review in light of COVID and proposed	Complete OCP process in relation to service model	Complete OCP process in relation to service model		

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		undertake service/data review in light of COVID and proposed contract variation	contract variation				
SP2: Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations							
SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services	Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.	Confirm role of WBS with Welsh Government establish project structure	Complete OCP process in relation to service mode	Establish workforce model	Implementation	Input data from pilot into SaBTO review	Implement revised strategy

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification	Undertake procurement	Undertake procurement	Complete USR procurement	Commence phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.
	Implementation of Foetal DNA typing	Engage with Antenatal Screening services to develop implementation plan	Agree implementation plan	Take forward implementation	Take forward implementation	Introduce a new test to the laboratory service, plus additional digital development Deliver service for Foetal D	Embed service
SP5: Provide, services that are environmentally sustainable and benefit our local communities and Wales	Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology	Project to be scoped project structure established phased work plan	Develop implementation plan	Take forward implementation		Continue phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions	Submit OBC for Talbot Green infrastructure Project further implementation of fleet strategy	Procure support to develop FBC further implementation of fleet strategy	Appoint health care planner to develop FBC	FBC submitted to Welsh Government	Phase 1 implementation Capital funding secured phase 2 procurement	Capital funding secured phase 2 procurement
SP6: Be a great organisation with great people dedicated to improving outcomes for patients and donors	Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning	Engagement with teams in relation to Review of clinical services Review of Facilities model Review of BI	Development of service Model paper to be developed for approval	Development of service Model paper to be developed for approval	Implementation plan developed	Realign structure based on review outcome. Developing succession planning and resilience for specialist posts	Implementation of review outcomes, ongoing succession planning and resilience for specialist posts

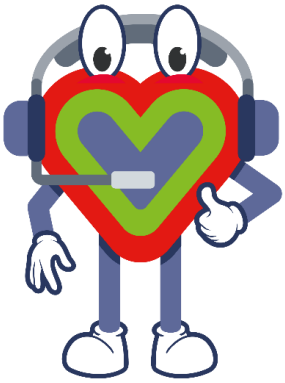
IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS	Scope programme of work Establish project structure	Develop implementation plan	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab	Funding secured	Continue phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.
	Lead the all Wales approach to implementation of Welsh Government Statement of Intent for Advanced therapies	secure funding review structure and develop work plan 2022/23	clinical lead appointed implementation of work plan	implementation of work plan	implementation of work plan	implementation of work plan	implementation of work plan
	Support UK Infected Blood Inquiry and delivery of its Terms of Reference	IBI continues	IBI continues	IBI continues	IBI continues	IBI continues	IBI continues

Part 6

Our Trust-wide Support Functions

We set out how our Trust-wide enabling functions support the delivery of our Plan.

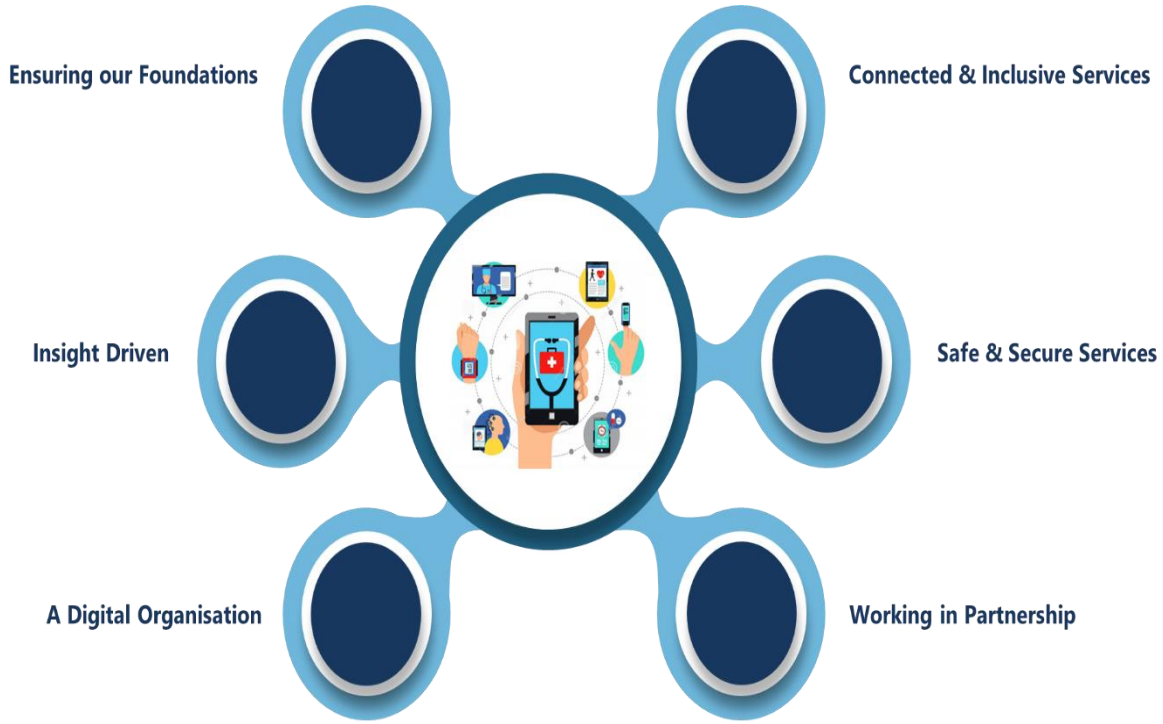
Digital Innovation



These are exciting times when you consider the opportunities ahead for Blood and Cancer Services in Wales. By taking full advantage of digital to support our transformation we have an opportunity to accelerate progress toward our ambitious long-term strategic goals.

One of the most important components of our future success will be how well we embrace the challenge of digital. A new Digital Strategy – "*Enhancing our Future through Digital & Data… Enabling Services of Tomorrow … Today*" – describes our approach to digital in response to the Trust mission to *"Improve Lives"*, and its vision to deliver *'Excellent Care, Inspirational Learning, Healthier People'*.

Our Digital Strategy sets out a number of themes which we will progress to enable high quality and accessible services.



Our digital plan is set out in **Appendix B**

Workforce and Organisational Development

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

As a Trust we value our staff and recognize they are all core to the success of our organization. We have developed a People Strategy for 2032 and our overall aim is to develop our staff to be able to provide the care our patients and donors need now and in the future, support their wellbeing and to recognise and value their diversity as part of a bi-lingual culture.

Our vision is to have:

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

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

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

Our workforce and organisational development priorities are set out in **Appendix B**

Trust Estate and Infrastructure Programmes

The Trust has developed an Estates Strategy for 2032 which sets out a number of strategic aims:

Strategic aim 1: Provide a safe and high quality estate which provides a great experience

Strategic aim 2: Provide healthy buildings and healthier people

Strategic aim 3: Minimise our impact

Strategic aim 4: Use our estate to deliver the maximum benefit and social value to the community

Our estates plan is set out in **Appendix B**

It is supported by an ambitious capital programme which includes:-

- **Development of a New Velindre Cancer Centre in Whitchurch, Cardiff: the** replacement of the existing VCC has been identified as a key commitment within the Welsh Government's '*Programme for Government*'. The Project is one of three pathfinder Projects for the Welsh Governments innovative Mutual Investment Model (MIM) Programme.

- **Development of a Velindre Radiotherapy Satellite Centre at Nevill Hall Hospital: t**he provision of a Radiotherapy Satellite Centre (RSC) has been identified as a key regional development to facilitate timely and effective Radiotherapy services to the South East Wales population. The ambition is to deliver a world-class facility that will provide specialist care for cancer patients from that locality.

- **Programme to re-develop the Welsh Blood and Transplantation Services Facility: t**his Programme sets out a number of strategic developments which will support the provision of high quality, safe, sustainable, efficient services and support the decarbonisation of our estate. It will also provide the foundation for the Laboratory Modernisation programme which will look at a range of new services to support NHS Wales.

Part 7

Our Financial Plan

We set out our 3 Year Financial Plan for 2022 to 2025

Strategic Financial Plan for 2022/23 - 2024/25

Overview of the Financial Plan 1st April 2022 to 31st March 2025

The Trust has had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.

Our Integrated Medium Term Plan (IMTP) for 2022-2025 sets out our Financial Strategy from 1st April 2022 to 31st March 2025, in the context of the COVID-19 pandemic. During this period the Financial Strategy aims to enable the Trust to meet the anticipated demand for services in Covid recovery returning to normalised activity and delivering additionality within the ongoing constraints of COVID-19 response and the inherent unpredictable nature of the pandemic. Recovery from the pandemic is compounded by significant financial challenges due to system wide exceptional cost pressures, which include energy & fuel cost increases, Employers National Insurance uplift (1.25%), living wage and other extraordinary levels of cost inflation. The balanced financial plan assumes Welsh Government income will be provided for these system wide exceptional cost pressures and the ongoing transitional costs of responding to COVID-19 that cannot yet be removed in addition to Commissioner income.

The financial plan for 2022-23 consists of three distinct parts:

Core Plan: Balanced

Brought Forward Deficit:

- Despite the constraints, the Trust aims to continue its Programme of service transformation and improvement, whilst working towards a key financial objective of removing the underlying deficit of £500k carried forward from 2021-22 restoring the Trust to a core financially recurrent balanced position.

- The recurrent carry forward underlying deficit of £500k, which is a consequence of unachieved 2020-21 savings delivery as a result of the pandemic. The deficit mainly relates to radiotherapy and medical staff, as well as increased estates and maintenance costs. This deficit will be removed through use of the 2.8% core uplift (sustainability) funding.

Growth pressures:

- The balance of 2.8% core uplift (sustainability) funding has been used to fund local core service growth and cost pressures of £1,298k and £170k towards the normal National cost pressures of £390k.

Savings Plans:

- The following table summarizes the level of savings we are planning to deliver in 2022-23

- These savings will fund the service growth investment requirements of £934k that commissioners have not agreed to fund and the balance of the savings will fund £366k of the normal National cost pressures of £578k

	2022-23 £000
CIP Planned Savings	750
Income Generation	550
Total Savings / Income Generation	**1,300**
CIP % (of Core LTA)	**2%**

- The core financial plan is balanced excluding exceptional national cost pressures and the ongoing impact of Covid response.

Exceptional National Cost Pressures

- Following the letter from Judith Paget dated 14th March 2022 the Trust is assuming WG funding cover will be provided for the system wide cost pressures which for Velindre includes energy / fuel, and Employers NI

COVID-19

- Currently the Trust has agreed with its commissioners a planning assumption around income to fund the cost of additional capacity the Trust has put in place and any further capacity required to deal with impact of COVID-19 delayed activity. There remains a risk around how this income will flow given significant costs are already in place, but the certainty around the level and timing of activity that will flow from LHBs is uncertain.

- The LTA activity based Income and associated costs are modelled on the following growth in demand assumptions:

Forecast Demand Growth from Prior Year Activity Out-turn			
Service	**22/23**	**23/24**	**24/25**
Radiotherapy	8%	2%	2%
Nuclear Medicine	12%	9%	9%
Radiology Imaging	12%	9%	9%
Preparation & Delivery for Systematic Anti-Cancer Therapy	12%	8%	8%
Ambulatory Care Services	8%	2%	2%
Outpatient Services	8%	2%	2%
Inpatient Admitted Care	2%	2%	2%

- The weekly internal service capacity for 19-20 pre pandemic baseline and 22-23 based on Covid recovery funding are set out in table below:

Weekly Internal Service Capacity		
Service	**19-20 Baseline Capacity**	**22-23 Capacity Based on Covid Recovery Investment**
Outpatients	1,128 attendances	1,353 attendances
SACT	460 cycles of treatment	580 cycles of treatment
Radiotherapy	75 planned patients and 78 hours LINAC daily capacity	77 planned patients and 80 hours LINAC daily capacity

- The headline capacity enhancement requires consideration of the changes to clinical practice and service delivery in comparison to the 19-20 baseline. For example, the increased utilization of virtual outpatient attendances, mix of oral and IV infusion SACT delivery, introduction of hypofractionation for Radiotherapy Services, outsourcing and outreach settings.

- There remain significant Covid response costs relating to covering higher sickness levels, enhanced IPC, social distancing and other income lost. The plan currently assumes WG will provide funding cover for these costs as confirmed by Judith Paget's letter of 14.03.22.

The plan aims to provide services with sufficient capacity to meet demand in support of recovery from the COVID-19 pandemic, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national and / or professional performance standards. In terms of efficiency the Trust will be setting a 2% savings target of £1,300k in 2022-23.

The Trust had been working with Commissioners prior to the pandemic to agree a new contracting model that better reflects the complexity of the services the Trust provides, the resources they consume, and which appropriately funds the Trust for the marginal costs of any over activity. There was agreement that this new model would be implemented in 2020-21.

An important development during the plan period will be the introduction of the new LTA contracting model (subject to commissioner support), suspended in 2020-21 and 2021-22 under the nationally agreed "block contract" arrangement to maintain financial stability during given reduced activity during the pandemic.

National discussions are near finalisation as to the way in which funding will flow through to providers for activity to meet the demand which arises. The Trust took the decision during 2021-22 to make upfront investment in permanent staffing and infrastructure to create additional capacity sufficient to meet forecast demand growth in 2021-22 and into 2022-23. Whilst commissioners have recognised and supported this decision to ensure cancer patients referred to Velindre receive timely care and blood supply across Wales meets demand, this presents a significant financial risk to the Trust as income remains uncertain dependent on

Health Boards ability to create additional capacity for diagnostics and surgery to generate onward referrals to Velindre for specialist cancer treatment.

The financial plan assumes income levels will be commensurate with the Covid internal capacity costs already in place and the additional costs to procure further capacity from Rutherford Cancer Centre (external private provider) that modelling undertaken with HB's and the WG Delivery Unit has forecast will be required. National funding flow principles have recently been firmed up, but not completely finalised. They are anticipated to be in place for the financial year 2022-23, however the Trust has written to HB Chief Executives setting out a proposal for a strategic funding approach to the additional internal capacity the Trust has established to meet their patient demand, irrespective of the activity driven national funding flow principles.

The Trust will progress discussion with commissioners to agree changes required to the contract currencies and prices to reflect the new service models and clinical pathways that are now permanent.

Whilst the Trust is submitting a balanced financial plan there is significant financial risk and challenges to deliver this plan due to the uncertainties around the income it will receive to cover the committed Covid costs and additional Covid commitments required during 2022-23.

The proposed financial plan has been developed using the latest assumptions regarding the Trust's expected income from Commissioners and Welsh Government funding in recovery from the COVID-19 pandemic, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving potential of services.

These assumptions have been discussed and agreed with Commissioners and Trust Board through the IMTP engagement process. WG Director General for H&SS is sighted on the income gap relating to local Covid response costs and exceptional national cost pressures and her letter of the 14.03.22 provides income cover for these costs.

The formal agreement of the Trust income planning assumptions are summarized within respective Commissioner Long Term Agreements for 2022-23 which are to be signed by the 30th June. A summary financial pan for period 2022-23 to 2024-25 is presented in the following table:

Summary of Finanical Plan 2022-25	2022/23		2023/24		2024/25	
	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000
Non Achieved Savings 2022-23	(500)	0	0	0	0	0
b/fwd underlying deficit	**(500)**	**0**	**0**	**0**	**0**	**0**
Revenue						
WG Pay Award & DDRB	2,371	2,371	1,689	1,689	1,787	1,787
WG Pay Award Commissioner funding (per WG Matrix)	81	81	81	81	81	81
WG Increase in Employer Pension Contribution	2,743	2,743	2,798	2,798	2,854	2,854
WG Funding for Extra Ordinary Cost Pressures	1,150	550	600	0	0	0
WG Covid Programme Funding (Mass Vacc and PPE)	710	0	0	0	0	0
WG Assumed Covid Response Funding (Not in Commissioner plans)	1,394	697	0	0	0	0
Covid Funding Via Commissioners	6,056	6,056	0	0	0	0
2.8% Recurrent LTA Core Uplift (1.5% 23/24 & 0.75% 24/25)	1,968	1,968	1,104	1,104	591	591
Assumed LTA Income Growth (Inc Pay Award Pass through)	12,371	12,371	10,843	10,843	12,027	12,027
LTA Service Growth Investment	1,772	1,772	511	511	1,696	983
Total Revenue	**30,616**	**28,609**	**17,626**	**17,026**	**19,036**	**18,323**
In year Changes to Operation Cost Base						
Pay Award/ Pension/ Increments	(5,341)	(5,341)	(4,704)	(4,704)	(4,858)	(4,858)
LTA Service Growth Investment	(2,706)	(2,706)	(1,219)	(1,219)	(1,696)	(983)
VV NICE Drug Growth	(10,695)	(10,695)	(9,000)	(9,000)	(10,000)	(10,000)
WBS Contract Price/ Inflation	(1,676)	(1,676)	(1,843)	(1,843)	(2,027)	(2,027)
Exceptional National Cost Pressures	(1,150)	(550)	(600)	0	0	0
General Cost Pressures	(578)	(578)	(206)	(206)	(200)	(200)
Local Cost Pressures	(1,110)	(1,110)	(1,254)	(854)	(1,455)	(1,055)
Covid Impact 2022-23	(8,160)	(6,753)	0	0	0	0
Total In Year Changes to Cost Base	**(31,416)**	**(29,409)**	**(18,826)**	**(17,826)**	**(20,236)**	**(19,123)**
Net Opening Balance before Savings	**(1,300)**	**(800)**	**(1,200)**	**(800)**	**(1,200)**	**(800)**
Savings Plan	750	600	700	500	700	450
Net Income Generation	550	200	500	300	500	350
Net Opening Balance	**0**	**0**	**0**	**0**	**0**	**0**

Income Assumptions

Income Assumptions and extent of alignment with commissioner & WG plans

The following are the income growth assumptions the Trust has made to meet the COVID-19 recovery and response costs, new inflationary and cost growth pressures in 2022-23:

- Commissioners will uplift LTA values by 2.8% which amounts to £1,968k core uplift in 2022-23, 1.5% (£1,104k) 2023-24 and 0.75% (£591k) in 2024-25 in line with the HB Allocation Letter.
- WG will fund the Trust directly the 2022-23 pay award costs for Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB), once nationally agreed.
- Commissioners will pass through as additional income to the LTA the 2021-22 Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB) costs as per the WG Pay award matrix.
- The Trust has applied a planning assumption for the new pay deal of 3% uplift in 2022-23 and 2% in both 2023-24 and 2024-25, but it is assumed WG will fund the actual costs once future pay deals are agreed.
- The Trust will continue to receive pay award funding for being a provider per the pay matrix which is currently assumed at £81k for each year.

- The cost increase in employer's pension contributions from 14.3% to 20.6% will continue to be paid by WG for the period of the plan.
- Following the issue of the Director General of H&SS letter on 14.03.22 the Trust is assuming that funding cover will be provided by WG for the Exceptional National Pressures estimated cost of £1,150k, which includes the forecast increase in energy / fuel currently estimated at £600k although there is a risk this could increase due to the conflict between Russia and Ukraine and additional employers NI contributions (1.25%) c£550k. The Trust is assuming WG will provide funding cover for the actual 2022-23 Exceptional National costs outturn, given the uncertainty around the energy / fuel cost forecast.
- If WG identifies additional funding to HBs above the 2.8% core uplift, the Trust will receive a % uplift of the same to its LTA values.
- The Trust anticipates that the full amount of identified income requirement in relation to COVID-19 response and recovery costs will be provided by commissioners and WG.

    - Following the issue of Director General of H&SS letter of 14.03.22 the Trust is assuming WG will provide financial cover for the Covid response costs it incurs in 2022-23. However, whilst commissioners have confirmed they have identified funding in their financial plans for Velindre Covid Recovery internal capacity, which the Trust has put in place with a cost of £4,400k for staffing & infrastructure, it is essential that this funding is passed to the Trust irrespective of the activity HBs refer to the Trust.

    - Beyond the existing internal capacity already in place, it is anticipated that external outsourced capacity will be required to meet projected demand. The maximum anticipated utilisation cost is forecast at £4,150k for a full year of service delivery, however income will be recovered from commissioners commensurate with the cost of actual activity outsourced. The Trust is assuming that Commissioner's financial plans will provide income cover up to the forecast cost in order that the Trust can meet cancer treatment times for their patients and avoid breaches. It is not clear if commissioners have identified funding in their financial plans for this external capacity.

- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs VCC uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to £10,695k increase in 2022-23, £9,000k increase in 2023-24 and £10,000k increase in 2024-25.
- The Trust will receive pass through income from LHBs to cover the cost of wholesale blood derived products WBS supplies to them. The forecast annual cost growth for 2022-23 has been calculated based an estimated 10% volume growth and general price inflation totalling (£1,676k).
- The Trust will be submitting a business case to seek funding from the WG Value Based Healthcare (VBHC) fund and will be discussing with HEIW proposals around its needs in relation to the additional funding for Workforce, Education and Training, although no income is currently reflected within the IMTP as the Trust is still developing its plans.
- WG has confirmed funding of the WBS business case costs for Occult Hep B Core Testing.

- WG will fund the WBS Plasma for Medicines (Fractionation) business case costs should WG decide to progress with this service development
- The Trust will receive additional income from commissioners to cover any new service developments they agree to invest in, should funding not be agreed, developments and infrastructure will not be implemented, and costs will need to be mitigated or removed. These key service infrastructure, quality improvement, activity growth and cost pressures have been shared with Commissioners including:

	2022/23			Incremental Income			
LTA Service Growth Investment	**LHB** **£000**	**WHSCC** **£000**	**TOTAL** **£000**	**IMTP Total 2023/24 £000**	**IMTP Total 2024/25 £000**	**IMTP Total 2025/26 £000**	**IMTP Total 2026/27 £000**
TCS Service Development Acute Oncology Services	714		714	260	34	0	0
TCS Service Development Integrated Radiotherapy Solution	287		287	347	0	619	0
SACT Medicine Infrastructure Financial impacts (MIFs) 2021-22	100		100	100	100	100	100
Radiotherapy Service Implementation	361		361	361	0	0	0
Stereotactic Ablative Body Radiotherapy (SABR) for Oligometastatic Disease and Hepatocellular Carcinoma (HCC)		208	208	0	0	0	0
High Dose Brachytherapy for Prostate Cancer		286	286	0	0	0	0
EU Directive on In Vitro Diagnostic Device (IVDD/IVDR) Regulation		750	750	0	0	0	0
TCS Radiotherapy Satellite Centre - Transition Cost				79	634	0	0
TCS Radiotherapy Satellite Centre - Fixed Cost Fee				72	928	0	0
TCS Radiotherapy Satellite Centre - Predicted Marginal Activity Growth					Marginal Income for activity growth via LTA		
TCS nVCC OBC Planned Recurrent Funding Requirement						2,709	903
TCS nVCC OBC Planned Transition Funding Requirement						1,558	519
TCS Outreach Programme				Planning work ongoing with LHBs to identify requirements			
Total Service Improvement & Growth	**1,462**	**1,244**	**2,706**	**1,219**	**1,696**	**4,986**	**1,522**
Commissioner Funding in IMTP	**814**	**958**	**1,772**	**511**	**1,696**	**4,367**	**1,522**
Trust Funding from 2.8% Core LTA Uplift income	**648**	**286**	**934**	**708**	**0**	**619**	**0**
Total	**1,462**	**1,244**	**2,706**	**1,219**	**1,696**	**4,986**	**1,522**

Pay Related Cost Assumptions:

- Pay Inflation funding received will cover the cost growth:
  - For staff on **Agenda for Change** Terms & Conditions Trust planning assumed **3%** pay cost increase for 2022-23, 2% for both 2023-24 and 2024-25.
  - For staff on **Doctors & Dentists** Review Body Terms & Conditions assumed an average **3%** pay cost increase for 2022-23, and 2% for 2023-24 and 2024-25.

- The increase in NI rates (1.25%) will be funded by WG, current planning assumptions assume the cost for 2022-23 will be c£550k.
- The employers pension contributions cost increase 14.38% to 20.6% will continue to be paid directly by Welsh Government. The 2022-23 cost estimate for Velindre Trust Core (Excluding NWSSP & NWIS) is £2,743k, 2023-24 £2,798k and 2024-25 £2,854k.

Non Pay Related Cost Assumptions

- The average % growth in spend on NICE/HCD and latest Velindre Horizon Scanning Group has been used to estimate a c£10,965k growth in cost for 2022-23 and £9,000k growth in 2023-24 and £10,000k in 2024-25 as agreed with our Commissioners.
- Wholesale blood products cost and volume growth has been included as £1,676k for 2022-23 which is 10% increase. Price and volume growth figures are very uncertain due to the difficulties in forecasting the recovery from the COVID-19 pandemic but assumed income will match expenditure incurred.
- The exceptional National Cost Pressures of £1,150k have been categorised as a forecasted increase in energy / fuel price currently estimated at £600k although a risk this may rise further, additional employers NI contributions c£550k.
- The normal national cost pressures have been estimated at £578k, which includes WRP contribution, Microsoft 365, national IT system projects costs. However, this also includes £180k for Brexit / Covid price inflation and £89k for living wage which the Trust does not consider are normal national cost pressures, but which are not included in the Director General for HSS letter providing funding cover.
- Non-pay inflationary pressures and local cost & growth pressures have been specifically identified for 2022-23.
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 2.8% (£90k) have been assumed for 2022-23 on the basis of that a 2.8% core funding uplift to LTA values is passed through to the Trust.

Local core service growth and cost pressures

The Trust has undertaken a robust review of its local core service growth and cost pressures, which has resulted in a number being removed or costs reduced. The remaining pressures are key to delivering against a number of key service improvement objectives or are unavoidable cost pressures:

Local Cost Pressures	Rec / Non-Rec	IMTP Total 2022/23 £000	Rationale for Investment	Benefits / Impact
Enhanced Medical On-call on-Site Clinical Care	Rec	200	Nuffield Report recommendation to stabilse USC	Improved service quality, safety and outcomes
Radiology capacity & enhanced model investment -to achieve Single Cancer Pathway	Rec	200	Nuffield Report recommendation to enhance diagnostic capacity / SCP delivery	Increased capacity & Improved service quality, safety and outcomes

Local Cost Pressures	Rec / Non-Rec	IMTP Total 2022/23 £000	Rationale for Investment	Benefits / Impact
Contract Maintenance & Support and license Costs (above Inflation)	Rec	100	Unavoidable maintenance contract (Medical Physics & Pharmacy) cost pressures and Software for Clinical Coding 3m medicore license	Maintain core clinical systems required for service delivery
Palliative Care	Rec	106	Nuffield Report recommendation to stabalise palliative care	Improved service quality, safety and outcomes
NHS SLA Inflation	Rec	110	Required pass through 2.8% core uplift	Maintain essential support services
NWSSP ESR Recharge	Rec	18	National System upgrade	Maintain essential workforce management system
Loss of Rutherford Proton Beam Therapy SLA income	Rec	140	Unavoidable service reduction due to limited activity referred by WHSSC	Services funded through Rutherford income lost have either required new funding from 2.8% uplift or savings delivery replace
Allocate - E - Rostering & E-Job Planning Services	Rec	55	Improved workforce management & Job Planning	Improved workforce management & Job Planning
Navigator Roles	Rec	96	Nuffield Report recommendation	Improved patient experience, service quality, safety and outcomes
Regulatory Compliance - Blood sample archiving	Rec	28	Regulatory compliance	Reduced risk of clinical negligence / claims
NDR Vx Rail revenue licensing	Rec	60	Required for National Data Resource	Better integrated information to improve clinical care and business management
Employment Law Advice LR Block Charging	Rec	10	NWSSP Legal services cost increase	Improved legal services - reduced risks and associated costs
Premises Related Costs (e.g Rates, Rents)	Rec	75	Unavoidable cost pressures	Maintains current estate requirement whilst review undertaken to assess requirement
Apheresis Contract - introduce hardware costs	Rec	40	Unavoidable cost pressures	Ensure maintenance of blood & plasma supply
Other	Rec	60	Unavoidable cost pressures	
Total Local Cost Pressures		**1,298**		

Normal National Cost Pressures

These normal national cost pressures are funded in part by the 2.8% core uplift (sustainability) funding and in part from savings delivery:

Normal National Cost Pressures	Recurrent / Non-Recurrent	2022/23 £000
Microsoft 365 new contract licenses	Rec	74
RISP - All Wales Business Case	Non Rec (22-23 to 24-25)	21
LINC - All Wales Business Case	Non Rec (22-23 to 24-25)	115
WRP Additional Contribution	Rec	99
Brexit/ Covid Price Inflation	Rec	180
Living Wage Increase (Non CHC)	Rec	89
Total National Cost Pressures		**578**

Exceptional National Cost Pressures

The financial plan assumes that additional funding will be provided by WG to cover these exceptional unavoidable system wide cost pressures:

Exceptional National Cost Pressures	Recurrent / Non-Recurrent	2022/23 £000
Energy / Fuel Increases	Non Rec (22/23 & 24/25)	600
Employers NI (Health & Social Care Levy)	Rec	550
Total National Cost Pressures		**1,150**

Other Assumptions

- Prioritised service developments will be submitted to commissioners as a business case for funding consideration.
- Expectation is other cost pressures are avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be delivered to fund them.

Planned Savings

The following table summarizes the level of savings the Trust is planning to deliver in 2022-23:

	2022-23 £000
CIP Planned Savings	750
Income Generation	550
Total Savings / Income Generation	1,300
CIP % (of Core LTA)	2%

Saving Theme	Saving Description	Division	Recurrent	Non Recurrent	TOTAL	Scheme Type
			£'000s	£'000s	£'000s	
Laboratory and Collection Model Efficiencies - efficiencies generated via optimised operating models	Reduced establishment resultant from model enhancement	WBS	50	-	50	Pay
Laboratory and Collection Model Efficiencies - efficiencies generated via optimised operating models	Reduced service delivery costs resultant from model enhancement	WBS	50	-	50	Non Pay
Maximising Income Opportunities - attracting additional non NHS income	Sales of expertise and bi-products into Research	WBS	50	50	100	Income
Stock Management - Non Recurrent Benefits of Stock Management	Reduced stock holding and waste via optimised stock management	WBS	100	150	250	Non Pay
Procurement - Supply Chain cost reductions	Contracting cost reductions	WBS	50	-	50	Non Pay
Service Redesign – efficiencies generated via optimised operating models, options for consideration of cessation of services and their respective consequences.	Reduced establishment resultant from model enhancement	VCC	100	-	100	Pay
Supportive Structures - efficiencies generated via optimised support services, enabled by rationalisation/centralisation/digitisation	Reduced establishment resultant from model enhancement	VCC	100	-	100	Pay
Maximising Income Opportunities - Private Patient Services	Increased volumes of private patients, fee restructure and enhanced debt recovery	VCC	150	100	250	Income
Maximising Income Opportunities - attracting additional non NHS income	Utilisation of new external funding. Enhanced cost recovery	VCC	-	200	200	Income
Procurement - Supply Chain cost reductions	Contracting cost reductions	VCC	50	-	50	Non Pay
Establishment Control	Reduced establishment resultant from model enhancement	CORP	100	-	100	Pay
Total			**800**	**500**	**1,300**	

Green RAG Rated Schemes			100	350	450	
Amber RAG Rated Schemes			500	150	650	
Red RAG Rated Schemes			200	-	200	
Total			**800**	**500**	**1,300**	

Covid

The total Trust Covid funding requirement for 2022-23 as presented in the tables below is £8,160k. The Trust has received confirmation that the £710k National response programme costs relating to both Mass Vaccination (£375K) and PPE (£335k) will be funded directly by WG, whilst our Commissioners have included £6,056k within their financial plans for Covid Recovery capacity costs. The Director General for HSS letter of 14.03.22 has provided funding cover for the estimated costs for 2022-23 of £1,394k, which is in relation to local Covid response (enhanced Infection Prevention Control (IPC) measures, Covid related sickness and social distancing measures).

Covid Funding Requirement 2022-23	**WG £000**	**LHB £000**	**WHSSC £000**	**Total £000**
Mass Vaccination	375	-	-	375
PPE	335	-	-	335
Subtotal Covid Programme Funding	**710**	**-**	**-**	**710**
Covid Recovery & Response Funding	1,394	2,880	3,176	7,450
Subtotal Covid Recovery and Response Funding	**1,394**	**2,880**	**3,176**	**7,450**

Total Covid Funding Requirement 2022-23	**2,104**	**2,880**	**3,176**	**8,160**

In addition to the COVID funding requirements described, the following tables highlight the potential utilisation of outsourced capacity required to meet demand, above investments made for enhanced internal capacity via COVID Recovery.

2022-23 Annual Forecast Activity Demand and Internal / External Capacity Requirement					
Service	**Forecast Demand (Patient Nos.)**	**Internal Capacity (Patients Nos.)**	**Capacity Shortfall (Patient Nos.)**	**External Capacity (Patients Nos.)**	**Remaining Capacity Gap (+'ve shortfall / –'ve headroom) (Patients Nos.)**
Radiotherapy (With Enhanced IPC Measures)	4212	3692	520	520	0
Radiotherapy (No Enhanced IPC Measures)	4212	4004	208	520	-312

Service	Forecast Demand (Annual Patient Cycles)	Internal Capacity (Annual Patient Cycles)	Capacity Shortfall (Annual Patient Cycles)	External Capacity (Annual Patient Cycles)	Remaining Capacity Gap Gap (+'ve shortfall / –'ve headroom) (Annual Patient Cycles)
SACT Delivery	32240	30160	2080	2496	-416
Total	**40664**	**37856**	**2808**	**3536**	**-728**

It should be noted that this highlights that the annual forecast additional outsourced capacity may not fully be required, however this is dependent on demand and internal capacity assumptions being fulfilled.

2022-23 Annual Forecast Investment for Internal / External Capacity at Maximum Utilisation			
Service	**Internal Capacity (£'000)**	**External Capacity (£'000)**	**Total Capacity (£'000)**
Radiotherapy	1,592	2,900	4,492
SACT Prep & Delivery	1,207	1,250	2,222
Outpatients	698	0	698
Total	**3,497**	***4,150**	**7,647**

It should be noted that a proportion of Outpatient activity are SACT treatment appointments contributing to internal capacity.

**The £4,150 external capacity for outsourcing is not included with the summary of financial plan table on page 5 or within the MDS tables, however, is a requirement for the Trust which is based on the maximum cost exposure.*

The £3,487k internal additional Covid recovery capacity cost is included within the Covid Recovery & Response Funding requirement of £7,450k within the LHB and WHSSC figures

Contracting Model

The National Funding Flows discussion will determine the contracting arrangements for 2022-23, it is assumed that these temporary measures will be sufficient to meet the costs of delivery.

The Trust will continue to work with Commissioners to agree the process and timing of when the new model will go live. Consequences of the post COVID-19 "new normal" service delivery models and clinical pathways will require a review of the contract currencies and associated cost pools to ensure their appropriateness, monitoring of contract performance during 2022-23 will inform the prioritization of areas for review.

Financial Risks and Opportunities

There are a number of financial risks that could impact on the successful delivery of the plan. The Trust recognises this and is taking appropriate actions as set out below, in order to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Worst Case £'000	Best Case £'000	Risk Mitigation
Financial Plan Outturn	**0**	**0**	
Full Covid funding not flowing from Commissioners	TBC	0	Trust still in discussion with commissioners around strategic principles for funding Covid recovery capacity already in place in stead off national funds flow mechanism
Costs of service delivery for outsourced activity beyond internal planned volumes	(4,150)	0	Based on modelling of demand the additional covid recovery internal capacity established at Velindre and reinstated via HB outreach will be exhausted, outsourcing of activity to the Rutherford Cancer Centre will be required incurring a premium cost. This is the maximum cost exposure. There is a risk that Commissioners will not fund this cost.
Non-delivery of amber / red saving schemes	(850)	0	Service to urgently review savings schemes that are classified as red or amber with a view to turn green or find replacement schemes
Further rise in energy prices	(600)	0	Will form part of all Wales approach, reviewed and mitigated by EPRMG group.
Delayed implementation of Integrated Radiotherapy Solution (IRS)	(250)	0	Review Divisional budgets to absorb costs for up to 6 months prior to implementation.
Management of operational Pressures	(250)	0	Further Operational cost pressures to be mitigated at divisional level
Microsoft Agreement (Increase above figure included within Plan)	(126)		Inflated figures recently provided by DHCW with challenge from Trust on rationale for increase.
Total Risks	**(6,226)**	**0**	
Key Financial Opportunities	**Worst Case £'000**	**Best Case £'000**	**Opportunity application and action**
Covid Cost Reduction	TBC	TBC	Mitigation from plan by reducing Covid related expenditure
Further vacancy turnover savings above the vacancy factor held in divisions	200	400	Used to provide non-rec savings against savings schemes that are either amber or red.
Emergency Reserve	500	500	Reserve held for emergency expenditure but could be released to support position if no unforeseen costs materialise.
Total Opportunities	**700**	**0**	
Net Financial Risk	**(5,526)**	**900**	

Capital Plans for the Trust

The focus of the capital investment Programme it to maintain a high quality environment in which to collect, transport, process & supply blood, treat cancer patients and provide modern treatment equipment.

£69.7m of the capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All Wales Capital Fund. £24.981m has been submitted and agreed to date in relation to TCS (£23.902m), Fire Safety (£0.500m), and the Digital Cancer project (£0.579m). Further schemes to be considered for approval include additional TCS requirement of (£3.795m), Integrated Radiotherapy Solution (IRS) (£37.929m), WBS HQ infrastructure (£22.500m), Ventilation (£2.491m), VCC Outpatients (£1.2500m), WBS Hemoflows (£0.224m), WBS Fleet Replacement over the next four years totaling (£1.236m). Scalp Cooler Upgrade (£0.250n) and Plasma Fractionation with costs to be confirmed.

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

Summary of Capital Plans & Approved Funding	**2022-23 £m**	**2023-24 £m**	**2024-25 £m**	**2025-26 £m**	**2026-27 £m**	**Total All Wales Schemes £m**
Proposed All Wales Schemes	6.360	23.502	22.437	13.873	3.503	69.675
Proposed Discretionary Schemes	1.454	1.454	1.454	1.454	1.454	
Total Capital Schemes Proposed	**7.814**	**24.956**	**23.891**	**15.327**	**4.957**	
All Wales Schemes Funding Approved	**24.981**	**0.000**	**0.000**	**0.000**	**0.000**	
Total Capital Plans	**32.795**	**24.956**	**23.891**	**15.327**	**4.957**	

Part 8

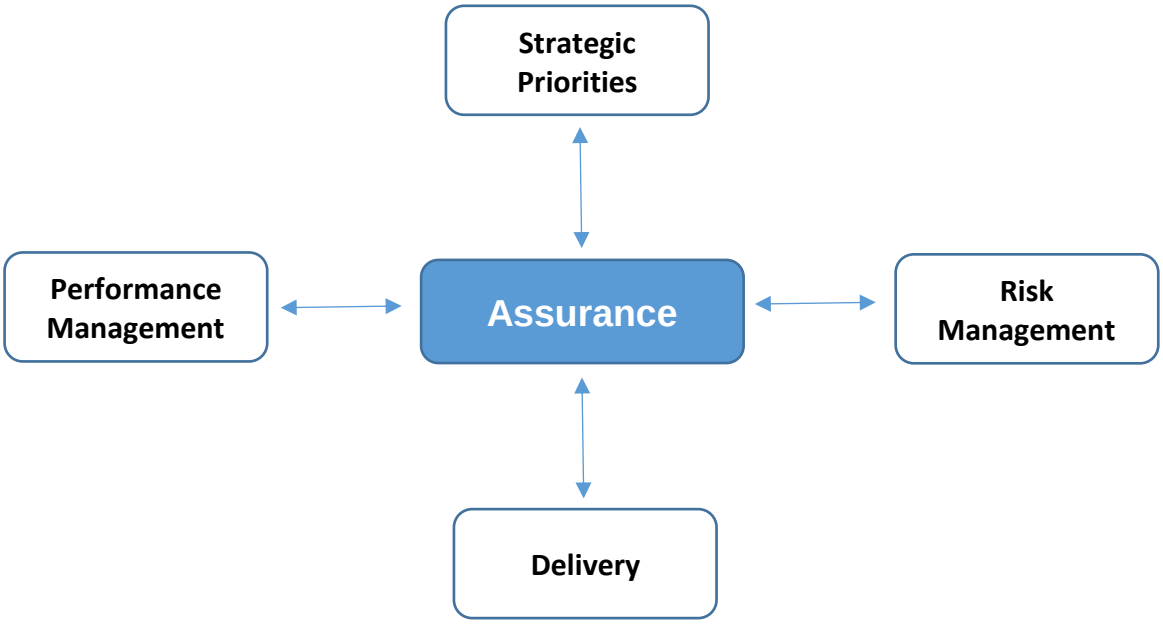
Our Performance Management Framework

We set out how we will manage the delivery of our plan and monitor progress in delivering the changes we wish to see.

Managing the Delivery of our Plan

We utilise an Integrated Framework to manage the delivery of service and strategic plans. This ensures that there is a '*golden thread*' that links all organisational plans and priorities, risk, delivery and measurement into an overall system of assurance.

Integrated Performance, Risk and Assurance Framework



Plans and priorities - Our strategic aims and priorities are set out within our strategies and translated into specific objectives and actions within this plan.

Delivery - The focus of delivery are the divisional service plans which set out the actions we will take to deliver the identified priorities and objectives.

Performance Measures - We use a range of quantitative and qualitative information to allow us to monitor our progress.

Risk Management - We assess the risk of achievement against each of our strategic aims, priorities and objectives as part of the planning process.

Performance Management Framework

We use a robust framework to support our staff in achieving the improvements required and in delivering our plan. The system is based upon four main elements:

- A clear set of aims, objectives, plans and supporting actions to improve quality
- A range of performance measures
- A regular process of monitoring and review
- A process of escalation/action if we are not on track to achieve our aims.

However, and despite the robust existing arrangements, a key priority for us during 2022 – 2023 will be further enhance our Performance Management Framework (PMF).

This is in line with the Welsh Governments introduction of quality statements in '*A Healthier Future for Wales' (2018 to 2030)'*, and has been described in the National Clinical Framework, as the next level of national planning for specific clinical services. It forms part of the enhanced focus on quality in healthcare delivery that was put forward in A Healthier Wales and the Quality and Safety Framework (QSF).

Governance Arrangements

The Board is accountable for governance and internal control of those services directly managed and for services delivered via hosting arrangements. The Board discharges its responsibilities through its Committees and scheme of delegation.

Delivering our Plan

Our plan sets out a clear set of milestones and trajectories that are owned by the Board who will receive a regular assessment of progress against the plan. Responsibility for delivering the plan is discharged to the divisional Senior Management teams who manage the detailed progress of service objectives and their associated performance and risks. Regular meetings between the divisions and the Executive Directors will take a more strategic overview of progress.

Whilst the plan objectives and related performance will be scrutinised by the most appropriate committee, the Planning and Performance Committee will assume overall responsibility for challenging plan progress and providing assurance to the Board.

Commissioning Arrangements

Health Boards are responsible for commissioning cancer and blood services from the Trust. However, there is a common view that the current arrangements are not sufficient to meet the future needs of the Trust in delivering services on behalf of our commissioners and the patients and donors who use them. We are therefore committed to working with our Health Board partners and the Welsh Government to develop a planning, commissioning and funding framework that provides us with the greatest opportunity to achieve our ambitions and achieve the levels of excellence that people can be proud of.

Implementation: How will we measure success?

We will track implementation of our plan through a small number of key metrics and strategic markers, which will be underpinned by more detailed reporting. The following metrics will be used to monitor and track implementation as they:

- **Provide a headline picture against our strategies and plans as a whole.** Identifying a small number of headline metrics allows for a simple mechanism to track progress and report to our patients, donors, staff and partners.

- **Includes a mixture of process, output and outcome measures.** This allows us to track specific actions in the short-term (process and output measures) and ensure they are translating into real change in the longer-term (outcomes and benefits).

Part 9

Appendices

Trust Programmes and Trust Support Functions Key Deliverables and the Welsh Government Minimum Data Set

APPENDIX A

Trust Programmes – Key Deliverables 2022 to 2025

[Attached separately]

APPENDIX B

Trust-wide Support Functions – Key Deliverables 2022 to 2025

[Attached separately]

APPENDIX C

Velindre University NHS Trust Minimum Data Sets (MDS) Welsh Government Return

[Attached separately]

Final Submission to Welsh Government

Velindre University NHS Trust

Integrated Medium Term Plan

2022/23 to 2024/25

(1st April 2022 to 31st March 2025)

CONTENTS

Introduction

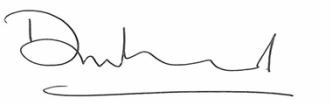
We are delighted to present the Velindre University NHS Trust Integrated Medium Term Plan (IMTP) for 2022 - 2025. The IMTP builds upon the excellent work undertaken by teams from across the Trust, working with our many partners, to develop a set of ambitious priorities, which build on our strengths and which will result in people who use our services receiving excellent care, service and support. This IMTP sets out our plans in three distinct areas.

Firstly, the plan sets out our commitment to delivering high quality, safe services which provide an excellent experience and outlines how we deliver this in context of the living with COVID-19. It describes what services we will provide, where they will be provided from and how we will meet the expected increase in demand for services over the coming years. The foundation of our services will be work we are progressing on our clinical and scientific plans and value-based healthcare.

Secondly, the plan identifies our priorities related to the implementation of enhanced models of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, receive a wider range of information services digitally, and have access to a trials and other services provided by our partners which may add value for them. We will also seek to significantly develop our buildings and upgrade our equipment by 2025 and this, together with our clinical and sustainability plans, will provide us with the opportunity to deliver a carbon Net Zero organisation and a range of wider benefits to support the development of thriving and resilient communities across Wales.

The third area, and related priorities, signal the continued strategic development of the Trust and its transformation into new and potentially exciting areas of work in accordance with the challenge laid down by 'A Healthier Wales'. This will see us explore opportunities across the health and social care system to identify areas where we can further support our partners in achieving outcomes and benefits for the populations we serve.

The plan we have set out demonstrates the exciting times ahead of Velindre University NHS Trust. We look forward to working with our staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.



Professor Donna Mead OBE
Chair

Steve Ham
Chief Executive Officer

The Structure of Our Plan

Part 1: **Organisation Overview** – providing an overview of Velindre University NHS Trust and the services we provide

Part 2: **The Context for Service Delivery** – making sense of our environment, our commitment to quality and the challenges we face

Part 3: **How will we respond**? – setting out the main strategic priorities for 2022 to 2025

Part 4: **Translating our priorities into high quality services** – describing our service delivery framework for Strategic Trust Programmes

Part 5: **Our Service Delivery Plans** – our Velindre Cancer Centre and Welsh Blood & Transplant Service delivery plans for 2022 to 2025

Part 6: **Our Trust-wide Support Functions** – setting out how our Trust-wide enabling functions support the delivery of our Plan

Part 7: **Our Strategic Financial Plan** – laying out our 3 Year Financial Plans for 2022 to 2025

Part 8: **Our Performance Management Framework** – explaining how we will manage the delivery of our plan and monitor progress

Part 9: **Appendices** (separate attachments) Velindre Cancer Centre & Welsh Blood Service Key IMTP Deliverables and Minimum Data Set

Part 1

Organisation Overview

An overview of Velindre University NHS Trust and the services we provide

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

Overview of Our Services

The Trust was established in 1994 and is one of eleven statutory NHS organisations in Wales. We provide a range of specialist services at the national and regional level.

Non-surgical tertiary oncology services

Our Trust provides non-surgical tertiary oncology services to patients covering South East Wales, working closely with local partners in ensuring services are offered at appropriate locations, in line with best practice standards. An increasing number of services are delivered on an outreach basis. Our specialist treatment, teaching and research work serves a population of 1.7million.

Blood and Transplant Services

The Trust also delivers a range of essential and highly specialised services including the collection and production of blood and blood components to treat patients; and supporting the transplant programmes through our Welsh transplantation and immunogenetics laboratory services.

Hosted Services

Our Trust is responsible for hosting the following organisations on behalf of the Welsh Government and NHS Wales:

- **NHS Wales Shared Services Partnership (NWSSP):** who provide a wide range of support services to NHS Wales including procurement, recruitment and wider back office services

- **Health Technology Wales (HTW):** a national body working to improve the quality of care in Wales. It collaborates with partners across health, social care and the technology sectors to identify, appraise and advising on the adoption of technology or models of care to ensure an all-Wales approach.

Part 2

The Operating Environment

Making sense of our environment, our commitment to quality and the challenges we face

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

Our commitment to Quality and Safety: our golden thread

Healthcare is changing rapidly, locally, nationally and globally and the pace of change will continue to intensify as we seek to respond the challenges across the healthcare system and continue to respond to the Covid-19 pandemic. Our Trust strategy '*Destination 2032*' sets out our commitment to quality and safety:

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: A leading provider of exceptional clinical services that always meet, and routinely exceed, expectations

In respect of these goals, we will ensure that putting our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving; is the '*golden thread*' throughout our organisation. Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve. The Trust is in the process of delivering a range of transformational changes across its cancer, blood and transplant services which will provide better care, enhanced clinical experiences and improved outcomes. We are committed to ensuring that quality, safety and experience is at the centre of all changes. This includes knowing '*what good looks like*' across all services and always striving to achieve this as well as pushing forwards these quality boundaries. We will also seek to continually obtain real time experience feedback as well as obtaining regular patient, donor and staff engagement to which will help to inform and influence decision-making. We are also committed to providing kindness and compassion when delivering care and services and to acting in an open and transparent manner at all times; this includes a willingness to learn when things don't go as planned.

Our Trust has a strong track record of patient safety and quality improvement in all services we deliver across the Trust. We will further build on this and embrace all opportunities for improvement across the organisation, which are strengthened by the clear requirements set out with the Health and Social Care (Quality and Engagement) (Wales) Act 2021; the Welsh Governments Quality Framework (2021); The National Clinical Plan (2021); The Healthcare Standards for Wales (2015); Wales Cancer Plan (2021); and Blood Health Plan (2017). We aspire to be leading the way in respect of Quality, Safety & experience and have a clear plan over the next three which will help us make continued progress.

The scale and pace of change required will not be possible without the development of our multi-professional clinical, scientific, medical, and nursing professional leaders. We are developing a strong cadre of clinical leaders at all levels (service delivery level

to Board) who will help to drive the required clinical transformation and quality improvement forward.

This will need to be supported by high quality integrated digital, business intelligence and informatics systems to provide us with clinically driven, outcome and patient / donor focussed triangulated data and information to provide meaningful insight into our clinical decision-making, service delivery and how we are learning and improving. This will include significantly enhancing the Trusts Performance Management Framework ensuring it is focussing on the golden thread of quality, safety and experience. Our Chief Clinical Information Officer and Chief Nursing Information Officer will work with technical specialists to guide us.

The Trust will also further strengthen our quality improvement infrastructure through working with Improvement Cymru.

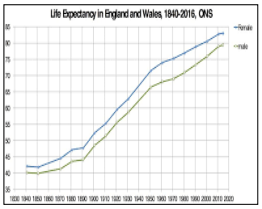
The Trusts Quality, Safety and experience infrastructure will be greatly enhanced through the development of '*Quality Hubs*' utilising an integrated governance approach from departmental level to Board.

Whilst we are proud of what we have achieved to date, we are excited by the future. This IMTP has been developed with quality, safety and experience at its centre and will work with all partners to secure the best possible outcomes over the coming three years.

The main drivers facing the NHS its partners

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

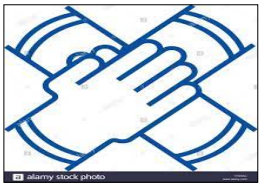
People's expectations are changing with the reasonable expectation that our services will be personalised to their needs. This is challenging us to think differently about how we can modernise and improve the way people access care and the quality and experience of it.



There are significant differences in healthy life expectancy and quality of life across different areas within Wales, with recent data suggesting that this gap is widening.

Attracting, training, supporting and retaining the right workforce is one of our biggest challenges and a key challenge across the NHS.

Digital technology, innovation and artificial intelligence are creating opportunities to transform the delivery of our services as well as opportunities to personalise our services so that we can make them more effective, efficient and valuable to people.



The Trust has been growing opportunities to collaborate across our regional health system and wider networks to join up care, share learning and improve outcomes.

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

Policy Context: responding to the drivers

Local Context

Current Performance:

- Waiting times
- Clinical outcomes (post COVID-19)
- Quality and safety
- Patient and donor experience
- SWOT analysis
- Financial delivery
- Workforce (post COVID-19 wellbeing)

Local Drivers:

- Patient and donor outcomes
- Health inequalities
- Population changes
- Surge recovery demand
- Increasing complexity
- Commissioner priorities
- Patient, donor and carer experience
- Addressing the 'five harms' & COVID-19 guidance

National Context

Statutory Duties and Key Policies:

- A Healthier Wales 2018
- Well Being of Future Generations Act (2015)
- Health and Social Care (Quality and Engagement (Wales) Act 2020
- Public Health Wales Act (2017)
- Social Services and Well-being Act (2014)
- Nurse Levels (Wales) Act (2016)
- Equalities Act 2010
- Welsh Language (Wales) Measure (2011)
- Equality Act (2010)
- Health & Safety at Work Act (1974)
- Socio-economic Duty 2021
- A Healthier Wales
- Prudent Health Care/Value Based Health Care
- Working Differently- Working Together
- De-carbonisation strategy
- WG Digital strategy
- National Clinical Plan (2021)

What do our Local Health Board partners require from us?

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
NHS Wales Information Services	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality

Engagement with people who use our services to design them in partnership

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

There are a number of ways used to listen, discuss and learn about our services.

Cancer Services - Non-surgical Tertiary Oncology

Our service plans respond to feedback from patients and donors, their families and carers, Velindre staff, Health Boards, third sector and other partners. A range of engagement events and workshops have been undertaken with key stakeholders over the last 12 months.

Social Media continues to offer a productive two-way conversation tool with our online cancer community. This helps us to listen and respond to compliments, queries and concerns. Our Patient Advice and Liaison Service is able to respond in a timely and efficient manner, capturing mini-stories and signposting to wider online surveys.

Blood and Transplant Services

The Blood Service also has daily interactions with members of its community of donors. We are committed to listening to our donors and we do this by circulating a comprehensive survey to every donor that enters a donation session each month.

The service operates a dedicated donor contact centre which exists to inform, educate and assist donors in contributing to the health of the nation by donating their blood, platelets or bone marrow. The service also engages existing and prospective donors through its donor engagement team. This team uses social media, the press, the website and face-to-face interactions to promote blood, platelet and bone marrow donations in Wales.

The engagement department is present in the communities of Wales, building close links and partnerships with community groups, sports teams, businesses, education providers and other socially engaged groups that have an influence in their localities. The engagement team is also committed to having a presence at the high profile national events that occur each year across Wales, such as the National Eisteddfod.

What are the challenges we face?

At an organisational level ……..

Providing high quality services as we manage and transition out of Covid-19: returning to '*business as usual*': In March 2020, Covid 19 arrived in the United Kingdom and fundamentally changed the lives of the population during the pandemic and as we seek to move to an endemic state; living with Covid-19. The impact of people's health and well-being in Wales has, and will continue to be, profound in range of ways. At the societal level, within healthcare and across the wider public services the current environment remains highly complex regarding the pandemic, as is the ability to plan and deliver services of the highest quality. The move towards re-establishing '*business as usual*' during 2022/2023 will continue to be challenging as we learn to live with Covid-19 whilst also finding solutions to some of its direct impacts e.g. increased staff sickness.

Service delivery is complex: Our frontline services face a number of challenges with the blood and transplant service working to maintain a healthy donor base, meet the national demand for blood and maintaining regulatory compliance. The non-surgical tertiary oncology service faces increasing demand, accentuated by Covid-19; the challenge of providing capacity to see patients quickly; and the need to keep pace with new treatments and continuously improved levels of quality, safety and experience.

Maintaining a healthy workforce: The commitment, resilience and professionalism of our staff has been remarkable over the last two years. However, there are direct costs to this, with staff becoming unwell due to COVID-19 and the impact it's having on their mental well-being. As we move to an endemic position, our staff will be required to continue to provide high quality care to more patients and donors as we work hard to reduce any backlogs and reduce any waits.

Developing a sustainable workforce: The NHS workforce across the UK is fragile with shortages in a number of areas/specialisms. These are particularly acute in a number of services provided by the Trust e.g. a shortage of oncologists, physicists and scientists.

Delivering key transformation programmes: The Trust is currently delivering a number of highly complex transformation programmes including the Transforming Cancer Services Programme and the Welsh Blood Service Lab Modernisation and Infrastructure Programmes. The level of change required is significant and the risk to delivery has increased as a result of the direct and indirect impact of COVID-19.

Working effectively as a partner across the system: The Trust is a provider of specialist services at a regional and national level which enables strategic step change in the quality and experience of services to be achieved by the healthcare system at scale. It also brings challenges, including the need to manage numerous relationships with commissioner organisations.

Decarbonisation and Net Zero: The NHS is committed to transitioning from an ill-health service to a well-being service. As one of the largest carbon emitters, the delivery of carbon net zero is essential. It will require careful planning, huge cultural and behavioural change and capital investment; at a significant scale.

Sustainability and wider social value:
The Trust is fully committed to making a wider contribution to the communities it serves to deliver a thriving and prosperous Wales. The Welsh Governments policy requires the Trust to think innovatively about how it can maximise the social value it can generate as an Anchor Institution in accordance with key policies such as the Foundational Economy. This is a relatively new area to explore for the Trust with limited resources to apply outside of core service delivery.

Funding: The medium-term funding position for the NHS is a challenging one, both in revenue and capital terms. Redesigned models of care, using technology and different skills will see improved levels of productivity and efficiency. However, this may be insufficient to deliver the levels of service quality and change over the next three years.

So what does all this mean for the Trust, the services we provide and our 2022 – 2025 plan?

The next three years will undoubtedly provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to support us in taking the learning from the pandemic to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Whilst this plan sets out our initial view of the 2022 – 2025 period, its primary focus is on the 2022 -2023 period given the level of uncertainty across the globe regarding Covid-19 and its impact. Our focus during this period will be on:

Delivering the fundamental cornerstones of healthcare provision
These include:

- Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework

and the National Clinical Framework to provide services of the highest possible quality
- Delivering services that meet the national clinical quality and safety standards and provide an excellent experience
- Treating patients as quickly as possible
- Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales
- Delivering services which are '*COVID safe*' and reducing / eliminating (as far as is possible) the 5 harms from COVID. This will see us:
    - Focusing on infection prevention control standards
    - Responding quickly and robustly to Public Health Wales/Welsh Government guidelines and translating it into safe operational service delivery
    - Continuing to manage the challenges presented by nosocomial transmission
- Developing agile and flexible capacity plans which allow us to respond quickly to the challenges presented by Covid-19 and its related impacts
- Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past two years
- Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working

We have a number of important strategic areas of work. These include:

Improving population Outcomes and reducing inequalities

The Trust will work with our Local Health Board and wider partners to identify opportunities where we can support the improvement of public health and population outcomes through primary and primary and secondary prevention. This will focus on a number of areas:

- Improving access to our services to increase uptake and reduce inequalities and ill-health
- Strengthening our decision-making (systems/processes/culture) regarding the Equality Impact Assessment and Socio-Economic Duty to consciously address poor outcomes and inequalities in the communities we serve
- Working with our health partners where it is clear and compelling that we can add value and make a difference
- Developing a range of strategies and plans that enable us to help our staff to improve their health and well-being
- Secondary prevention: making the most of the opportunities of '*every contact counts'* with patients, donors, partners to support them in improving their health and well-being.

Regional working, partnerships and collaboration to improve outcomes

The Trust will:

- Work with Local Health Board partners to strengthen the Cancer Collaborative Leadership Group and to lead on the delivery of improving cancer outcomes for patients in South East Wales
- Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales
- Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales

System leadership

The Trust will continue to develop our system leadership role in Wales in areas where we can add value. Our initial focus will be on developing the contribution we can make in:

- Working with Health Boards, the Cancer Collaborative Leadership Group and wider partners to improve cancer services
- Working with Health Boards to deliver the National Blood Health Plan
- Working with Health Boards, universities and commercial partners to deliver a range of cutting edge research, development and innovation

Delivery of Transformation Programmes

Non-surgical tertiary oncology Services

The Trust will progress a number of key areas of work within the Transforming Cancer Services Programme and Velindre Futures programmes:

- Implementation of the Nuffield Trust recommendations including:
    - Delivery of the Acute Oncology Service regional model
    - Implementation of revised pathways for unscheduled care
    - Development of a phased implementation plan for the V@UHW research hub

Development of the infrastructure to support regional cancer services including:

- Award of the contract for the Integrated Radiotherapy Solution and implementation of 2 LINACS at the Velindre Cancer Centre
- Completion of the enabling works for the new Velindre Cancer Centre
- Completion of the competitive dialogue for the new Velindre Cancer Centre and identification of the preferred bidder
- Work in partnership with our Local Health Boards to secure approval of the final business case for the radiotherapy satellite centre in Nevill Hall, Abergavenny

Blood and Transplant Services

The Trust will progress a number of key areas of work within blood and transplant services including:

- Laboratory Modernisation programme
    - Scoping and planning of the future laboratory services plan
    - Refurbishment of Talbot Green facility and carbon reduction
- Plasma for Fractionation: developing the case for change and delivery programme

Research, development and innovation

The Trust will continue to drive our research, development and innovation ambition for our patients and donors and focus on

- Implementing our Cancer R&D Ambitions Strategy 2021-2031
- Building on our Welsh Blood Service R&D Strategy
- Embedding our Innovation Plan
- Developing our national and international RD&I Partnerships

Mental Health and emotional well-being/supporting the workforce (WG)

The Trust will continue our programme of work to support the physical, mental and emotional well-being of our staff across a number of areas:

- Promoting healthier lifestyle choices including healthier food options, access to physical activities, and support to reduce and stop smoking
- Providing accessible information and resources on physical health and well-being for people who experience mental health problems
- Delivering staff training on mental health issues
- Increasing access to the Employee Assistance Programme and other support and counselling services
- Establishing a part-time dementia liaison nurse position within the Trust
- Providing a programme of mental health awareness training for all staff, with a proposal for Mental Health Awareness to become a mandated module in the Trust's core management training framework
- Providing a range of other initiatives and schemes to support well-being such as Menopause Café

Decarbonisation

The Trust will focus on delivering the first stages of our journey to Net Zero. This will include:

- Infrastructure: we will develop a range of green infrastructure including:
    - Submitting an outline business cases to refurbish/decarbonise the Welsh Blood Service, Llantrisant facility
    - A full business case for the radiotherapy satellite centre in Nevill Hall; and identifying a preferred partner for the new Velindre Cancer Centre (where we have an ambition to be the Greenest Hospital in the United Kingdom)

Part 3

How will The Trust respond?

In this chapter we set out the main strategic priorities for 2022 to 2025.

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Velindre University NHS Trust

Destination 2032: our view of the future

In response to the operating environment, the Trust has undertaken a strategic refresh to set out the future direction for the Trust over the next 5 -10 years. In January 2022, the Trust Board approved our 10 year strategy '*Destination 2032*' which sets out the framework for the Trusts' development.

Our purpose: To improve lives

Our vision: Excellent care, Inspirational Learning, Healthier People

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

Our strategy will support us in:

- Focusing on delivering excellence in our core clinical services
- Placing quality and safety at the centre of everything we do
- Developing our clinical, scientific and healthcare professional leadership
- Becoming world leaders in specific areas of research, development and innovation
- Expanding our culture of learning across staff, students and the communities we work with
- Delivering carbon net zero operations and wider benefits and social value for our communities
- Moving towards a future which will see us becoming a valued partner in the prevention, public health and wider social policy areas; helping to find solutions to deep-seated problems in Wales such as poverty and deprivation

To deliver our strategic goals by 2032, we have refreshed our key service strategies:

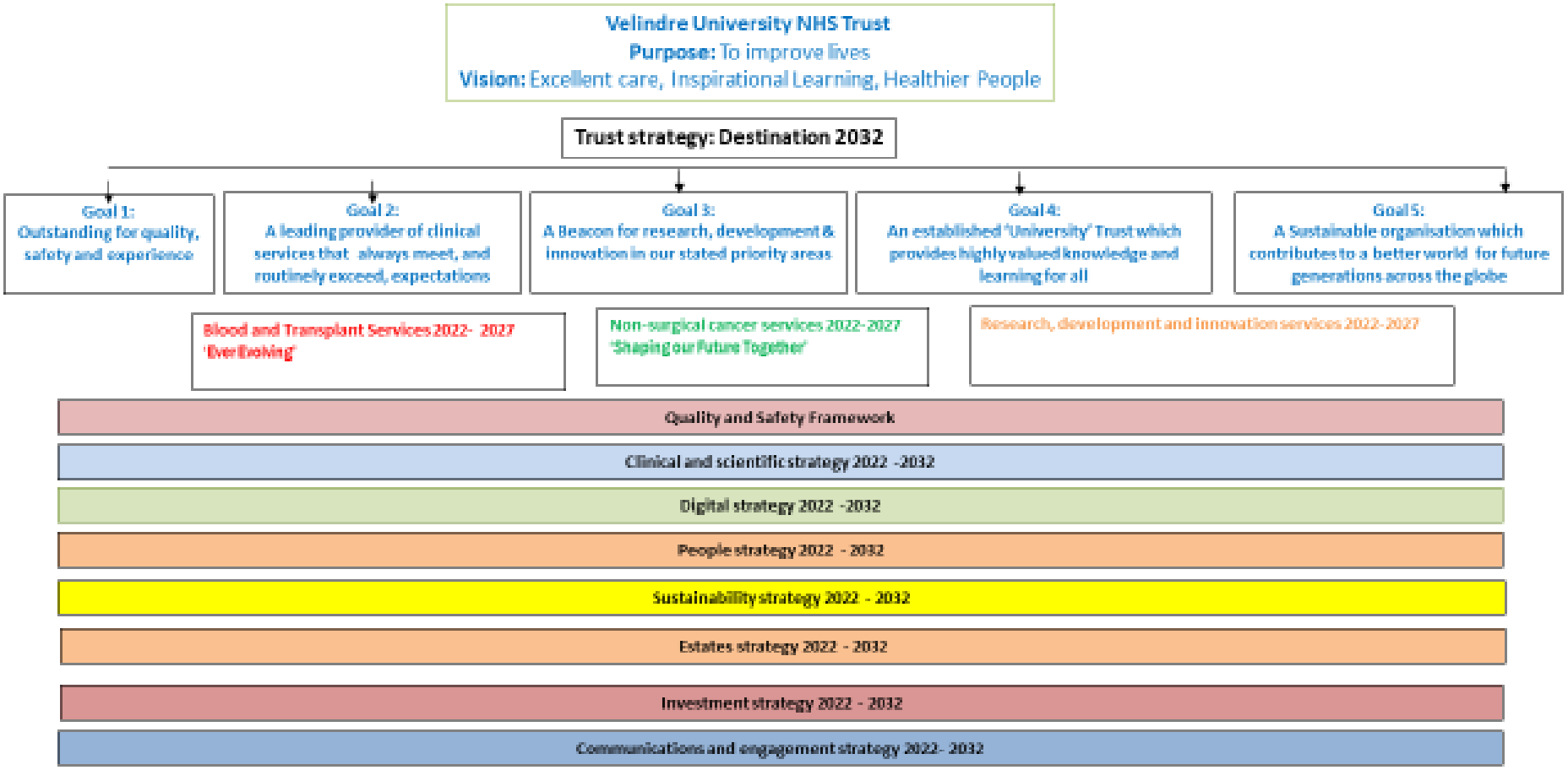
- Welsh Blood Service Strategy 2022 – 2027
- Velindre Cancer Strategy 2022 -2027

These are supported by a range of refreshed enabling strategies / frameworks including:

- Quality and Safety Framework
- Clinical and Scientific Strategy (being developed)
- Sustainability Strategy
- People Strategy
- Digital Strategy
- Estates Strategy

Our strategic refresh provides the Trust with a clear line of sight between our Purpose, Vision, Strategic Goals and the priorities contained within our Integrated Medium Term Plan (***see Figure 1***). This will provide us with the ability to effectively prioritise our activities and resources over the coming years.

Figure 1 Our Purpose Vision and Destination to 2032



Trust priorities for 2022 – 2025

Our Trust strategy '*Destination 2032*' identifies a number of priorities which will support us in achieving our goals. In light of the current operating environment and the impact of Covid-19, our priorities are focused on 2022/2023.

Strategic Goal 1: Outstanding for quality, safety and experience
Key priorities:

- Implementing the requirements of the Health and Social Care Quality and Engagement Act
- Implementation of all infection, prevention and control requirements
- Implementing a quality and safety management framework which will drive every action we take and decision we make
- Implementing the National Clinical Framework for the services provided by the Trust
- Development of a targeted and innovative value based healthcare programme to drive quality, safety and experience of services

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

- Recovery from Covid-19 with the recommencement of all core services and reduction of any patient backlog
- Developing clinical service models which support sustainability e.g. more care at home and locally Implementing our sustainability strategy
- Implementing the National Clinical Framework for the services provided by the Trust
- Improving our engagement processes with our donors and patients to support service design, delivery and improvement
- Development of a sustainable workforce plan to meet the needs of today and the future
- Supporting our staff in maintaining their health and well-being
- Reducing health inequalities in the services we provide

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

- Implementation of our research strategies
- Implementation of our innovation plan
- Increasing the number of staff routinely involved in R, D & I
- Developing a culture of curiosity and supporting infrastructure and facilities to support research, development and innovation

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

Key priorities:

- Increasing the number of staff involved in formal learning
- Development of a programme for learners aligned to the needs of our business and that of our partners
- Improved facilities and digital resources to improve the learning experience
- Development of learning opportunities for learning in specialist areas with initial focus on developing the School of Oncology

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

Key priorities:

- Decarbonisation of our business
- Implementation of our sustainability strategy
- Development of education and training programme to provide staff with the knowledge to make sustainable-based decisions in work and at home
- Implementation of all equalities and diversity requirements including the Welsh Language Act
- Development of our role as an anchor organization within the communities we serve to generate broader social value

The Trust priorities are delivered through a range of organisational and service plans for non-surgical oncology tertiary cancer services and blood and transplant services.

Part 4

Translating our priorities into high quality services

We describe our service delivery framework for Strategic Trust Programmes

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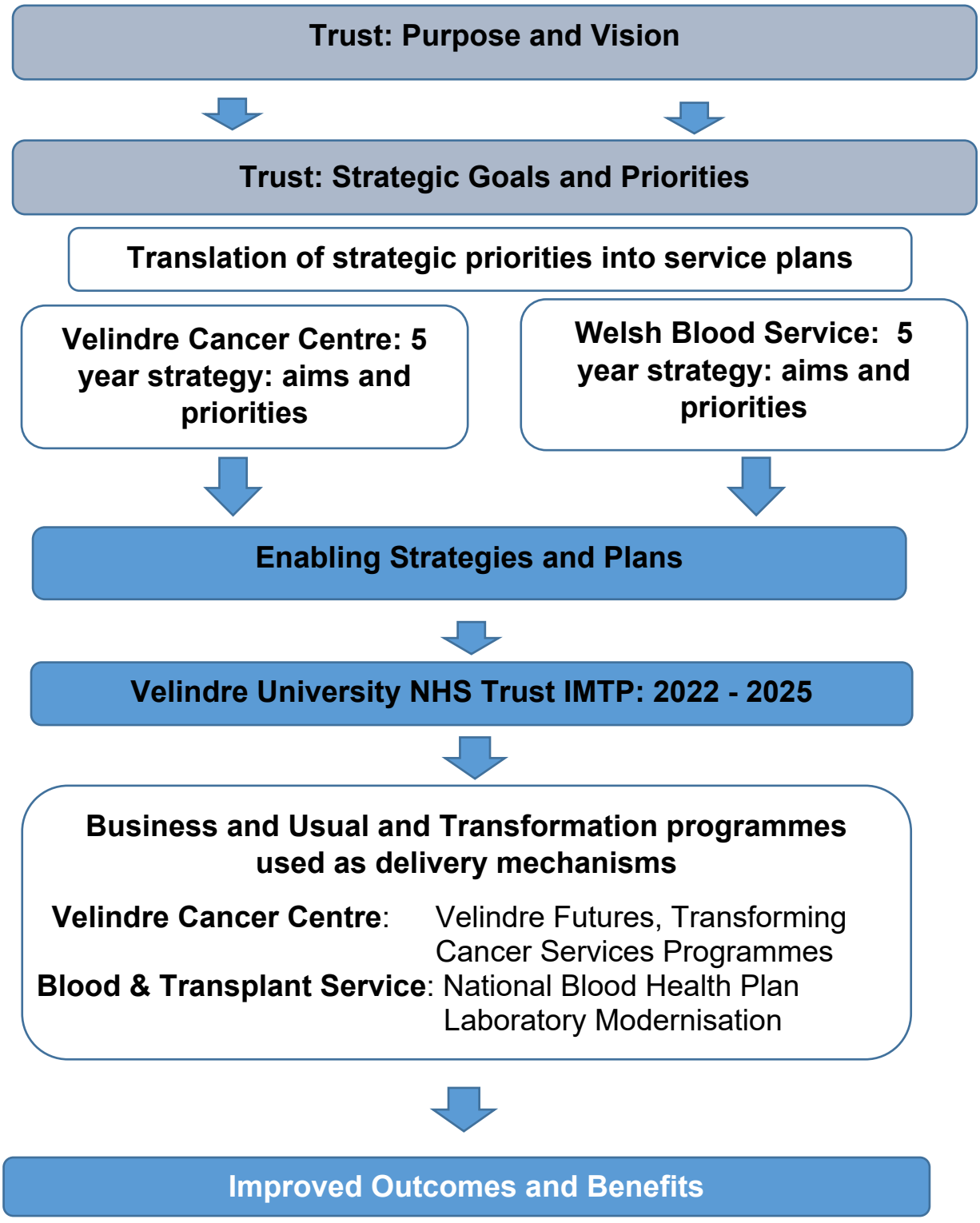
Our Strategic Delivery Framework

Our strategic delivery framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation.



Trust Programmes

There are a range of programmes that we will progress at an organisational level, embedding them into the services that we deliver. These include:

Clinical Quality and Safety - delivery of the Health and Social Care (Quality and Engagement) (Wales) Act 2021 & National Quality Framework

Quality, safety and experience as our golden thread are in fundamental in everything we do. The Trust will fully implement the Act and Framework requirements. This requires further strengthening our core foundations across all areas of the organisation. We will work with patients, donors, staff and partners to:

- Define what '*good looks li*ke' across all services - measure, assess and report against this in an open & transparent manner (Duty of Quality) – aligning this to the revised Trust Performance Management Framework
- Monitor patient / donor outcomes and experience '*en masse*' to continually improve what we do
- Be able to demonstrate publically the learning & improvement that has taken place (Duty of Quality)
- Further improve how we investigate and learn from '*things that go wrong*', incidents, concerns, inquests etc.
- Roll out investigation training to all involved in investigations
- Fully implement the duty of candour requirements
- Develop integrated Quality Hubs – Trust wide and within each Division to enhance governance oversight at all levels
- Implement the CIVICA system across WBS and VCC
- Further enhance our multi-professional clinical audit mechanisms including fully role out '*Tenable*' Nurse Audit system
- Mainstream the 15 step challenge process into Independent members assurance mechanisms
- Fully implement the Medical Examiner process and revise mortality review processes
- Ensure full implementation of revised cleaning standards

Sustainability: Delivering value and decarbonisation

Our Sustainability Strategy '*Destination 2032*' sets out a clear ambition for the organisation over the coming years with the following aims:

- Deliver sustainable services which add wider social value for the communities we serve
- To be recognised as an exemplar organisation in relation to the delivery of the Well-Being of Future Generations Act
- Deliver Biodiversity Net Gain and enjoyment of our green spaces to improve health and well-being
- To be Carbon Neutral by 2030
- Use resources efficiently: zero waste to landfill by 2025 and reduced consumption of energy and water

It provides a roadmap for us to maximise our contribution to our communities and to mitigate our impact on the planet whilst delivering high quality services for our donors, patients and carers. It is supported by a decarbonisation plan which will allow us to deliver Carbon Net Zero.

Value-Based Healthcare:

The Welsh Government and NHS Wales has set out on an ambitious and exciting journey which focuses on the delivery of high quality patient outcomes through improving patients involvement in decision-making using the best evidence available; avoiding unnecessary variation in care and by being innovative in determining who to best use resources in order to improve overall outcomes.

The financial strategy for Velindre University NHS Trust aims to be an enabler to the clinical, service, workforce, digital & estates plans, which set out how the Trust, in conjunction with National Public Health Service for Wales (NPHSW), its commissioners and Welsh Health Specialised Services Commissioner (WHSSC), will:

- Address cancer population healthcare needs and specialist cancer service delivery requirements
- Deliver the Laboratory modernisation programme & infrastructure improvements in the Welsh Blood Service, support implementation of the Blood Health Plan for Wales and continuous improvement in technology and practice in transplant services

The financial strategy is designed to support the Trust in meeting the aims of '*A Healthier Wales*" and '*Wellbeing of Future Generations Act*'. Our approach aims to meet the '*quadruple aims*' of improved population health and wellbeing; better

quality and more accessible health and social care services; higher value health and social care; and a motivated and sustainable health and social care workforce as well as sustainable development principles contained in the Act. Whilst the Trust is at an early stage in its VBHc journey, as evidenced through our self-assessment, it we are keen to move at pace to deliver on some of the key objectives with its 3 strategic priorities for VBHc:

- Culture, Socialisation and Education
- Measurement of Outcomes & Cost in a meaningful way
- Prudent Healthcare and Service Prioritisation

The Board has agreed:

- To adopt VBHc as a way of improving the outcomes for its patients and donors
- That the Trust Executive lead for delivering VBHc is the Director of Finance (DoF)
- That our approach to VBHc will not be the creation of a separate programme of work, but to embed value and prudent principles within the existing clinical & service delivery teams and business mechanisms

- In parallel the DoF has initiated the following approach to VBHc:
  - Leading a wider debate around what value is and what it means at the Board, Executive Management Board, Divisional SMTs, Innovation Forum and Clinical Improvement Group
  - Engaging with the National VBHc team and the FDU to provide advice & support on the Trust's approach

- Recognising the need for all staff within the Trust to consider value as part of their every-day work, we intend to:
  - Embed value and prudent healthcare principles at the centre of the work of the Trusts cancer SSTs, Velindre Futures, clinical audit, quality & safety and improvement / transformation teams.
  - Invest in a dedicated expert VBHc role, additional Digital and BI posts and a project management structure to support the embedding of value principles by building capacity & capability and changing behaviour. This resource requirement will form part of the Trust business Case submission to WG against the £5m VBHc fund.
  - Identify and deliver some quick wins where the application of value principles can improve services for patients and donors with better outcomes and / or experience

The Trust VBHc Strategic priorities, key objectives and specific actions are set out in the VBHc template at *Appendix A.*

VCC Four Components of plans to Improve Value

Within VCC Tertiary services: removing waste & variation and improving the technical efficiency of its services.

Across the South East Wales region: working with partners through the Collaborative Commissioning Leadership Group, HB / Trust Cancer Partnership Boards and HB Cancer Boards to improve cancer pathways and focus around linking outcomes & cost, prehabilitation, prevention and improving outcomes.

Optimise the clinical delivery model: through workforce redesign that places duties with appropriate roles, for example, non-medical outlining and prescribing whilst maintaining the highest standards of clinical care and patient outcomes.

PROMs & PREMs rollout: ensuring effective capture of data for the Trust tertiary services and across the wider cancer pathways through patient engagement work, PhD student work to collate the current PROM data collection by clinical teams and to digitise and store this data in the Trust data warehouse to feed into SST dashboards, together with clinical data, patient level cost data and clinical audit data.

Use of Digital to Drive value: by creating and connecting a digital cancer services community in South East Wales that will transcend organisations and form the digital environment to enable data collection for service improvement & transformation to be facilitated.

WBS plans to Improve Value

Strategic priorities for the Welsh Blood Service are aligned with the NHS Wales Blood Health Plan in '*supporting individuals to manage their health and wellbeing, avoiding unnecessary intervention, using evidence and transparent data to drive service planning and improvement to reduce unnecessary variation and to avoid harm, placing safety and quality at the core of patient care*'. The spirit and substance of these priorities support the delivery of value based prudent healthcare.

Specific objectives include changes in practice to meet service development needs, including the potential development of a new plasma for fractionation service, subject to Ministerial approval, establishment of an Occult Hep B testing service, a programme for Laboratory Modernisation, and a reduction of variation in the usage of intravenous immunoglobulins (IVIG), ensuring continuity of patient care in an efficient and effective way. Additionally, a key objective is in the development of an increasingly prudent & sustainable supply chain flexible to match patient demand in Wales, with the ambition to optimise supply chain efficiency whilst maintaining and

improving donor experience and care, alongside positive outcomes and the avoidance of harm for patients.

Trust wide Infrastructure for Value – Digital, BI & Project Management

Ensuring that there is insightful business intelligence to aid service planning and re-design is key to support the debate for alternative models of care or delivery platforms, to improve patient reported outcome measures and experience as well as securing sustainability, efficiency and value. Across the Trust there is a need for investment in Business Intelligence and other infrastructure. This is an investment priority that the Trust will progress through a Business Case to Welsh Government against the £5m VBHc fund.

The Financial Strategy will evolve over the term of the plan to support the Trust in its strategic ambitions for both cancer and blood services to be health sector leaders in these fields. A key aspect of the Financial Strategy will involve a review of how the Trust spends the total income that it receives annually. Initially this review will focus on traditional assessment of efficiency & effectiveness, but as we are able to link the cost of service delivery with appropriate outcome measures a more appropriate assessment of value will be undertaken to enable the Trust clinicians to make informed decisions around the prioritisation, allocation and distribution of its resources.

A key part of the Financial Strategy for Velindre Cancer Centre (VCC) is the application of the new contracting model following the 2022-23 interim national funding flow protection mechanism. There will need to be work undertaken with the Trust clinicians to review the currencies and costs to and amend the model to reflect any permanent changes to clinical pathways that have been added as a result of the Covid pandemic. These changes will require agreement from HB clinicians and commissioners. The Trust financial plan assumes that this go live date will be agreed by HBs and will be operating within the agreed all Wales Funds Flow model whist the impact of the pandemic continue to affect normal activity flows and levels.

The new costing and contracting model will also enable clinicians and managers to have a better understanding of the costs of their services and how those costs change with activity and case mix complexity. We have undertaken a major piece of work with the FDU to benchmark VCC services with the two other cancer centres in Wales. The next phase of this work will be to bring this cost information together with non-financial information to provide context and help explain cost differences. This benchmarking data will provide focus in identifying areas of inefficiency and waste.

The Trust plans to implement the Trust costing system in WBS to help the service understand in more detail the cost of each part of the blood supply chain and identify where there are inefficiencies. The Blood Supply Chain 2020 programme of work has already mapped processes in detail and identified key areas for change some of which have been implemented and others planned for implementation. WBS already participates in a European benchmarking club for blood services, which together with the new cost information will help the service identify areas of inefficiency and waste.

Research, Development and Innovation:

In line with the Trusts' Strategic goal to be ***"A beacon for research, development and innovation"***, we are committed to building on our excellent national and international reputation, based on successful delivery and management of a wide portfolio of research, development and innovation and a firm commitment to partnership working. The overarching prioritisation of research and innovation within the Trust is clear and embedded within the two divisions: Velindre Cancer Centre and the Welsh Blood Service, both of which are focused in their approach and have developed robust research strategies and plans for innovation. Patients and donors remain at the centre of this activity and through the 4 key priorities identified below, we seek to radically improve access to research and innovation whilst building a sustainable and capable clinical and scientific workforce for the future.

Velindre Cancer Centre has a key role to play in the cancer research network in South East Wales (SEW). It provides an important link between the 3 University Health Boards in the region (Cardiff & Vale, Aneurin Bevan and Cwm Taf Morgannwg UHBs) for collaborative clinical cancer research, offering opportunities for patients to access clinical trials and a range of other research studies, either at Velindre Cancer Centre (VCC) itself or in outreach facilities at the UHBs. Velindre is also in a prime position to provide the crucial connection between laboratory cancer researchers and patients, enabling research to '*bridge the translational gap*' and bring new discoveries from the laboratory to the clinic for patient benefit. The development of a new state of the art Velindre Cancer Centre brings with it opportunities for both clinical and non-clinical research and innovation, which are being explored and will contribute to the design and facilities of the new build.

The Welsh Blood Service is a unique organisation within the Welsh healthcare system, with the capacity to perform research and to implement and disseminate evidence-based innovations and new technologies on an all Wales basis, in order to advance donor care and our reputation for transfusion and transplantation medicine.

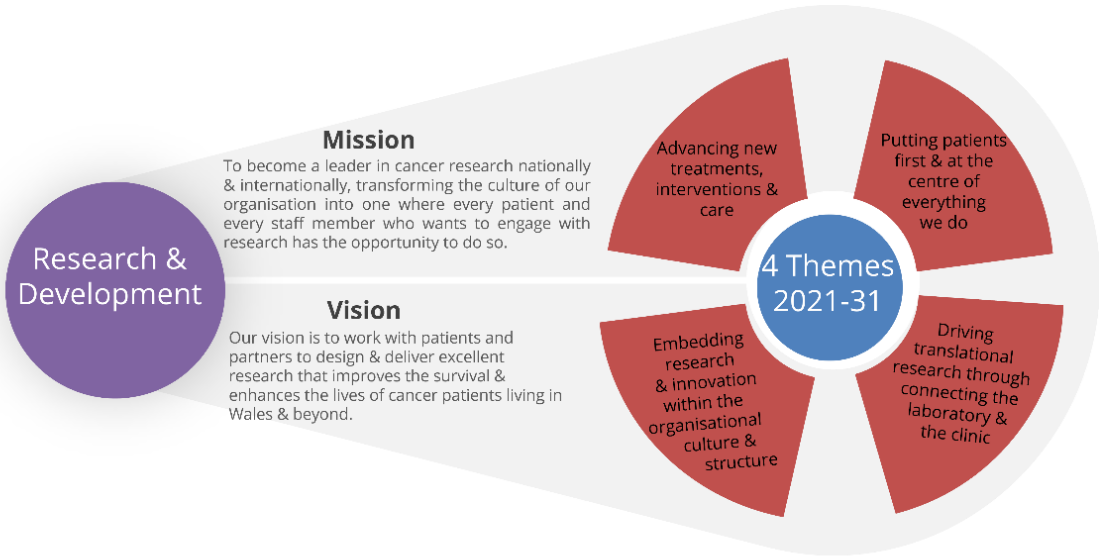
It is an exciting time for research and innovation at the Trust in 4 key Strategic Priority areas.

Our Priorities:

Strategic Priority 1: The Trust will drive forward the implementation of its Cancer Research and Development Ambitions 2021-2031

Overarching Cancer Research & Development Ambitions 2021-31 developed by multidisciplinary research leads from the Cancer Centre, University partners and Patient and Public representatives received approval from the Trust Board in March 2021.

These describe our vision, mission and aims for future Cancer Research at Velindre that will be delivered through research in 4 interconnected strategic themes.



Our vision is to work with patients and partners to design and deliver excellent research that improves the survival and enhances the lives of patients and their families.

Our mission is to become a leader in cancer research nationally and internationally, transforming the culture of our organisation into one where every patient, family and staff member who wants to engage with research has the opportunity to do so.

To enable this, we will work with our NHS and academic partners, with a shared strategic focus and collaborative ethos.

Our Aims are to:

- Enhance **patient experience** and care
- Improve **patient outcomes** and reduce variation
- Accelerate the **implementation** of new discoveries into the clinic
- Demonstrate the **impact** of our research on patients and the NHS
- Build research **capacity and capability** at Velindre & across SE Wales.

Our Research Themes:

- **Putting patients first and at the centre of everything we do**: patients will help set the research agenda and we aim to increase opportunities for patients and their families to take part in research, so that within 10 years most of our patients are offered research and innovation opportunities at some point in their cancer journey.
- **Advancing new treatments**, **interventions and care:** We will lead and take part in well-designed Clinical Trials and other research studies, providing the evidence base required to bring new, improved treatments and interventions into the clinic to enhance patient care. Research that is led from Wales will be prioritised and new infrastructure for research delivery will be developed, including a Tripartite Cardiff Cancer Research Hub for Early Phase and Translational research delivery on the University Hospital of Wales (UHW) site and a firm footprint for research at the new Velindre Cancer Centre, particularly to enable cutting-edge radiotherapy research.
- **Driving translational research** through connecting the laboratory and clinic: We will work closely with our academic (university) partners to enable translational ('*bench to bedside*') research, bringing new discoveries (novel drugs, imaging techniques and/or technological advances) through from the laboratory to the clinic to benefit patients. We will also enable reverse translation ('*bedside to bench*') research where patient samples/scans and/or data are taken back to the laboratory to generate new knowledge. Developing Clinical Academic posts that link across clinical-academic boundaries will be key to success in this theme.
- **Embedding research and innovation within the organisational culture:** We will establish an organisational culture that values research and build capacity and capability within the multi-disciplinary workforce, providing dedicated ring-fenced time and training opportunities for staff from all disciplines who wish to engage with research. The appointment in 2020 of a Velindre Professor of Nursing and Interdisciplinary Research is important in this endeavour.
- A newly appointed implementation team will map out and lead this work. Our research will be facilitated by a governance and enabling infrastructure, supported by a communication, engagement and funding strategy and delivered by an agile research workforce. Close collaboration with our regional NHS and Academic partners and engagement across different sectors will be key to success (see Strategic Priority 4).

Strategic Priority 2: The Trust will maximise the Research and Development ambitions of the Welsh Blood Service

The Welsh Blood Service has an established Research and Development (R&D) strategy, developed in collaboration with our staff, scientists, clinicians, academia and other UK blood services. Our aims are to drive improvement, increase our

research activity, be open to collaboration and build our reputation for research & development, in order to improve donor and patient health.
We will continue to develop our 4 Welsh Blood Service R&D themes which are:

- **Transplantation**: including solid organ and stem cell transplants
- **Donor Care and Public Health**: including donor recruitment and retention strategies, aiming to enhance their experience and continued engagement.
- **Products**: including blood components, immuno-haematology, manufacturing and quality management.
- **Therapies**: including preparation of cellular and blood therapies for research.
- We will also honour the expectation of our staff that R&D is an embedded function that is part of an evidence based, first class service, delivered with pride. We will also maximise opportunities to improve and expand the services at WBS, through feasible and evidence-based R&D.

The Welsh Blood Service R&D team will continue to grow commercial R&D opportunities and the significant potential of our Component Development Lab. We will continue to actively seek strong academic and professional R&D partners, nationally and internationally. These will include high quality networks such as the international BEST Collaborative and the European Blood Alliance. We will leverage these partnerships to further explore the potential of Advanced Therapies aligned to our unique Service. Finally, we will continue to build the capacity and capability of our workforce and to embed a positive culture around R&D activity.

Strategic Priority 3: The Trust will implement the Velindre Innovation Plan
In partnership with the Welsh Government Health and Care Innovation Team and the Velindre Charity, a new dedicated Velindre Innovation infrastructure is being established to develop a plan that will deliver a step change improvement in the quality and quantity of multi-disciplinary and multi-partner innovation to achieve our Trust's purpose to improve lives. In the '©Velindre 7P Value-Based Innovation Plan' we will set out a clear structure for delivering the Trust's innovation ambition.

In the plan we will have a clear **Purpose** and definition of innovation. We will have agreed innovation **Priorities** and themes that will including emerging technology and informatics, commercialisation, workforce, engagement, arts & creativity, new hospital design, sustainability and future generations and social innovation with community benefit. At the Velindre Cancer Service, these will also include patient outcomes and patient experience, primary & community oncology care, diagnostics, advanced cancer treatments and therapies, supportive care and palliative care. At the Welsh Blood Service these will include, plasma fractionation, donor engagement, experience and care, components and products, stem cell and transplant, along with advanced blood-based therapies and innovative logistics.
We will have a clear **Process** for triaging and accelerating innovation. We will have a strong **Platform** for delivering innovation that will include the right people and

culture, flexible and responsive innovation funding, toolkits, and a responsive IP protection procedure. To increase our capability and capacity we will have strong **Partnerships** that will include the Welsh Government and NHS Wales Innovation Leads and RIIC Networks, HTW, LSH, Bevan, academia, industry and the third sector. We will build an innovation premium through awards, targeted promotion, **Publication** and delivering value through a **Performance** framework, aligned to the Welsh Government's new Innovation Strategy and Programme.

Strategic Priority 4: The Trust will maximise collaborative opportunities locally, nationally and internationally

Across the Health Boards we will work with our colleagues to maximise research opportunities for our patients and donors. This will include the Velindre@ Programme which aims to evolve the research infrastructure across South-East Wales, enabling local access to clinical research. The specific tripartite partnership with C&V UHB and Cardiff University to develop the Cardiff Cancer Research Hub will provide a safe environment to provide cutting edge and complex advanced therapies for patients and enable translational research in collaboration with Advanced Therapies Wales and our Haematology and University colleagues.

We will also work with scientists within Cardiff and beyond to bring new therapies into the clinic for the very first time as well as generating reverse translation opportunities involving both systemic therapy and radiotherapy. Moreover, we will increase the number of Velindre Chief Investigators who can collaborate with the Centre for Trials Research (CTR) in Cardiff University. Through interactions with the Cardiff Experimental Cancer Research Centre (ECMC), the Wales Cancer Research Centre (WCRC), and Health and Care Research Wales (HCRW), we will maximise research opportunities across all fields of cancer research including early diagnosis, interventional therapies and palliative and supportive care.

In addition, with the All Wales Medical Genomics Service, we will become the only hub in the UK to offer a 500 gene panel to all new metastatic cancer diagnoses, providing outstanding potential for precision medicine research opportunities with all our patients.

Nationally we will continue to work with our colleagues across the UK, including the National Cancer Research Institute (NCRI). We will also develop our already healthy relationship with the third sector, industry partners and contract research organisations (CROs) to both deliver commercial research and to collaborate in the design and delivery of clinical trials with Velindre University NHS Trust acting as Sponsor.

We will strengthen our Academic Partnership Board with multiple HEI partners across Wales to help us to shape our Trust University Status whilst ensuring that

multi-professional development of research and innovation remains central to this agenda. Lastly, and most importantly, we will work with patients and the public through PPI to ensure that the research we develop and offer is relevant to their needs.

Conclusion

Healthcare research is vital for patients, donors and the NHS. It underpins the evidence needed to provide the best care and services for patients and donors, improves outcomes, underpins innovation and service improvements, improves efficiency and effectiveness and motivates, attracts and retains staff. The work in each of the 4 Strategic Priority areas detailed above will be coordinated and focused to enhance the Trusts' reputation for RD&I, maximise opportunities to collaborate with partners and ultimately to benefit our patients and donors.

System Leadership and Regional Partnership Working

The development of leadership roles, partnerships and collaboration are vital in NHS Wales achieving the best outcomes for the population we serve. The Trust is a partners in a number of exciting programmes of work which we will continue to pursue. These include:

Cancer Services

The development of the cancer system across South East Wales and the implementation of the Nuffield Trust recommendations.

Development of Acute Oncology Services Across South East Wales

Acute oncology (AO) ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting.

Development of a Cardiff Cancer Research Hub

Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) have a shared ambition to work in partnership together and with other partners to develop a Cardiff Cancer Research Hub.

Blood and Transplantation

Advanced Therapies Wales (ATW)

The Programme was established in 2019 on behalf of the Welsh Government after the publication of their Advanced Therapies Statement of Intent (SOI). The Programme is part of the Precision Medicine initiative within the Health and Social Services Group. The SOI outlines the challenges, opportunities and actions necessary to develop a sustainable strategic approach to developing the Advanced Therapy Medicinal Products (ATMP) sector in Wales.

Funding for the Programme is through an annual non-recurring basis from Welsh Government, with ATMP treatment funded through specific Welsh Government funding allocated to Welsh Health Specialised Services Committee.

COVID 19 has had a significant impact on progressing the ATMP agenda across Wales and the UK with much of the work in relation to ATMPs and clinical trials being paused.

As we move into 2022/23, we have taken the opportunity to review the programme expectations, structure and work plan. The appointment of a clinical lead to the Programme will provide clinical leadership, specialist clinical knowledge and experience of regenerative medicine and ATMPs, support, advice and guidance to the Programme and the wider NHS Wales service.

Focus will continue to be on supporting the developing of Clinical trials in Wales and facilitating a collaborative approach to research and development with the Cardiff Cancer Research Hub, a tripartite partnership between Velindre University NHS Trust (VUNHST), Cardiff and Vale UHB (CVUHB) and Cardiff University (CU) is driving the development of a Cardiff Cancer Research Hub (CCRH) and the Clinical Research Hub, established by Cardiff and Vale UHB (the main tertiary services provider in Wales) to provide the opportunity for key stakeholders, including Health and Care Research Wales (HCRW), the Cell and Gene Catapult, health and academia to work together to implement new clinical studies for the population of Wales.

There will also be a focus on working with WHSSC and Health Boards in Wales to support the implementation of NICE approved ATMP treatments for the Welsh population. As ATMPs are classified as highly specialised because of the small number of patients diagnosed with these conditions, the delivery of these services is normally through a very small number of specialist centres, which may require specialist accreditation, equipment or highly trained and skilled workforce. Where possible the preference is to treat people in Wales. However, it is recognised that this is not always beneficial to the Patient or economically viable and accessing the best care for patient may mean some patient having to travel out of their local areas, and in some cases having to travel to England for treatment.

Plasma Derived Medicinal Products

Over the past 5+ years there have been sustained annual increases in the global demand for Plasma Derived Medicinal products (PDMP's), in particular Immunoglobulin (IG). As a result, all UK blood services have devoted resource to scoping out potential plasma collection programs to improve availability of IG. The Welsh Blood service will work in collaboration with other UK services to be able

achieve sufficient volumes of plasma to be able to negotiate with the pharmaceutical industry.

WBS is working with the Welsh Government to determine these arrangements and what the implementation of any associated work programme would be over the next 3-5 years, including agreeing of the annual Welsh demand for plasma-derived Immunoglobulins that WBS would seek to contribute. The work will be delivered through a Wales Programme Board linking to the other UK nations as the work progresses and final agreements on a model are made. Through the early part of 2022/23 the ongoing UK discussions will take place with the implementation programme establishing later in the year.

The action plans for our Trust programmes are set out in *Appendix A*.

Part 5

Our Service Delivery Plans

Our Velindre Cancer Centre and Welsh Blood & Transplant Service delivery plans for 2022 to 2025

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

Our clinical services

Cancer Services Non-surgical Tertiary Oncology

Our cancer services have inevitably been disrupted as a result of COVID-19. From a range of causes, from changes in public access to general practice for diagnosis, changes in screening services and onward referrals through secondary care to the impact on our VCC elements of patient pathways. The impact of social distancing and other infection prevention control interventions, as well as the centralisation of services from LHBs to the VCC site have all impacted on the patient flow, site use and how we provide the services our patients need. We adapted our '*Clinical Model*' based on professional guidance and established a set of clinical principles to inform patient treatment decisions and choices.

The introduction of virtual consultation methods, the extension of SACT delivery with additional service through the mobile unit with Tenovus and the expansion of the SACT homecare service as well as increasing radiotherapy capacity through a partnership agreement with the independent sector are all adaptations that will need to be sustained in the medium term to enable us to meet the projected increase in demand and changes in patient need as we work with our Health Board partners to continue the recovery from the pandemic alongside delivering our ambition for the further development of cancer services in South East Wales.

The cancer centre has an ambitious programme of change that was planned and underway prior to the pandemic and which has been maintained wherever possible alongside the service changes implemented to manage services through the pandemic. This includes major work programmes such as the CaNISC replacement (DHCR) and work to support the new Velindre Cancer Centre (nVCC) development as well as initiatives to deliver on our ambitions for individual services that make up our overall support for patients on the whole of their care pathway. This includes substantial changes in elements of service provision for Outpatients, SACT, and radiotherapy as well as plans to further develop our active engagement and support to primary care, palliative care and therapies. This list is not exhaustive.

The leadership and co-ordination of this work through the Velindre Futures initiative continues. In addition, the delivery of the VCC elements of regional programmes such as the Acute Oncology Service, the recommendations of the Nuffield Report dovetail with the VF initiatives wider service modernisation and transformation projects.

The move to implementation phase of the Integrated Radiotherapy Solution, which is currently in procurement, also provides a further key work programme that is crucial for the continued delivery of radiotherapy service as well as enabling the new

Radiotherapy Satellite Centre at Neville Hall. Together these changes form an agenda of unprecedented change for Velindre cancer services. They will be delivered alongside the repatriation of services back to Health Boards following the centralised delivery at VCC that was established during the pandemic as well as growing service capacity to meet the patient demand that has been supressed in the past two years.

The delivery of our plan for 2022/23, and the subsequent years, will be dependent on the recovery plans of health board partners and the ongoing pandemic situation and associated population interventions. The development of outreach services to meet the Transforming Cancer Services model will also form a key element of our service plans as we move towards the transition to the move to the new Velindre Cancer Centre.

Our Priorities for 2022 -2025

The Cancer Strategy 'Shaping our Future Together' 2016-2026 sets out the strategic priorities.

Strategic Priority 1:	**Equitable and consistent care, no matter where; meeting increasing demand.**
Strategic Priority 2:	**Access to state-of-the-art, world-class, evidence-based treatments**
Strategic Priority 3:	**Improving care and support for patients to live well through and beyond cancer**
Strategic Priority 4:	**To be an international leader in research, development, innovation and education**
Strategic Priority 5:	**To work in partnership with stakeholders to improve prevention and early detection of cancer.**

The five strategic priorities and the key programmes of work that underpin these priorities continue in the main to be those commenced prior to the pandemic, including the Transforming Cancer Services projects such as the delivery of the Integrated Radiotherapy Solution, the Radiotherapy Satellite Centre and delivering the nVCC including planning transition to the new site. Wider ongoing service transformation delivered through the Velindre Futures initiative and the delivery of the replacement for CaNISC are also a priority.

Alongside this work, the sustainable delivery of our services for patients and providing sufficient capacity continues to be our primary focus. Our capacity challenge will not only be in the delivery of treatment by SACT or radiotherapy, but also in the other

services that support patient care including radiology, therapies, pharmacy and palliative care.

This requires the delivery of outpatient and SACT services at local hospital sites in collaboration with LHBs as well as expanding capacity across our full range of services on site at the cancer centre. This will enable us to plan to meet expected levels of demand, following reduced numbers of patient entering cancer pathways during the pandemic. For radiotherapy services the capacity challenge is limited by our LINAC fleet and availability of third party capacity.

In addition to this, we will continue to deliver a number of key business critical initiatives. These all require fundamental changes in systems, processes and ways of working and have the potential to have significant operational impact.

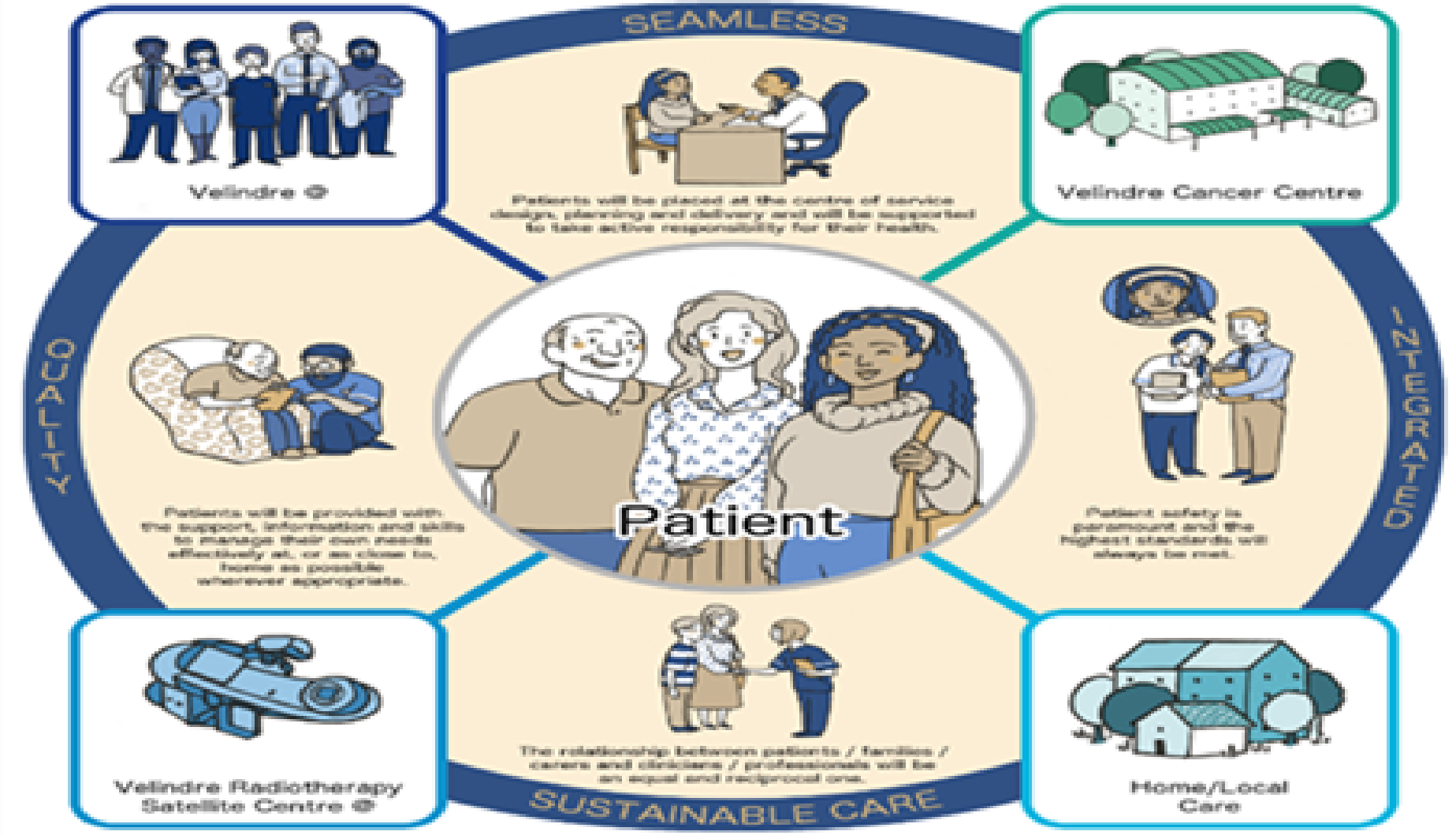
Velindre Futures will be the vehicle through which we will deliver the changes we need to meet service change aspirations including the VCC element of the regional work and the implementation phases of the TCS programme. Established in 2020, Velindre Futures is a clinically led initiative that directs the development of the clinical model and future service configuration, working in partnership and collaboration with staff, patients and carers and the public. It will ensure that the Cancer Centre systems and processes remain fit for purpose and patient centred, now and in the future. It will enable the VCC aspects of regional collaborative working.

It considers the Velindre System; a series of networked services for patients that ensures an integrated regional approach. Through this initiative we will both shape and deliver these aspirations and inform strategic discussions internally and across the region through a clear, planned and managed programme of service change to take us to where we want to be.

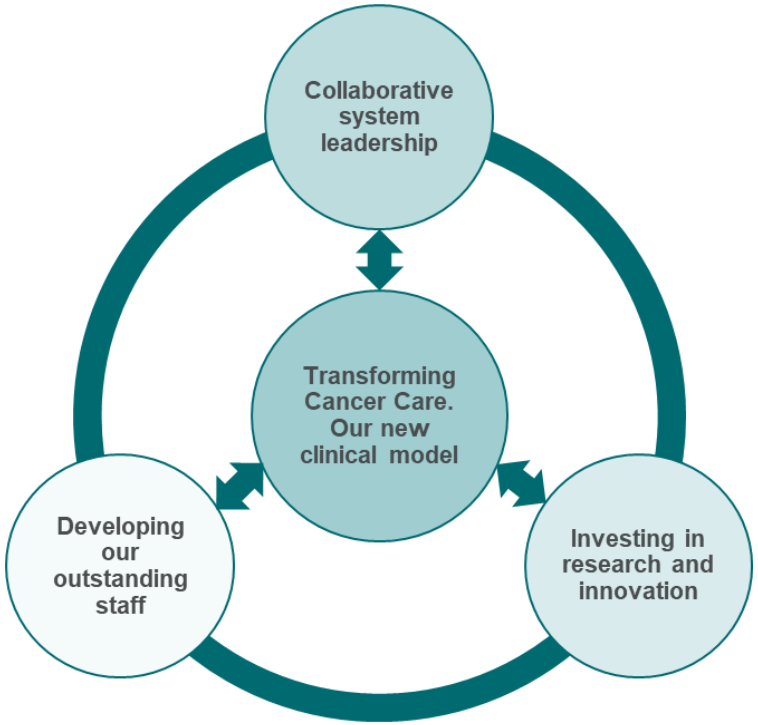
Through 2022 and beyond, the Velindre Futures work programme will ensure the delivery of the key recommendations identified alongside the existing service changes planned.

This is an ambitious programme of work that will be prioritised and delivered through 2022-25 as we continue to focus on increasing capacity to manage demand increases. Core to service change is ensuring that the voice of the patient, their carers, families and the public are involved in shaping what we do. To enable this, a new framework for engaging with patients and the public will be developed to draw on best practice and set our expectations and ideas **(*see Figure 2*).**

Figure 2 - Our Clinical Model



Our Approach



Collaborative System Leadership:

- Play a lead role in the development of a system wide approach to cancer services in the region through the Cancer Collaborative Leadership Group.
- Continue to lead and contribute to key areas of care and research, including through embedding our new clinical model, both nationally and internationally.
- Support the development of the diagnostic network and single cancer pathway as key enablers of service transformation.
- Support the development of integrated health and social care and research models across south Wales/Wales.

Investing in research and innovation:

- Increase participation in clinical trials, Velindre sponsored studies, and become renowned for qualitative research.
- Developing a research network across South East Wales with our LHB and University partners.
- Lead the research and innovation agenda through taking an active leadership role in partnership with universities, commercial partners and the Research Network.
- Increase our opportunities to be at the forefront of innovation.

Developing our outstanding staff:

- Developing our clinical, scientific, nursing and allied health professional leadership capability
- A consistent approach to quality improvement through the Quality and Safety Framework.
- Developing a comprehensive approach to Education and Training.
- A focus on engaging and empowering staff.
- New workforce skills and leadership development to meet our workforce challenges.

Velindre Cancer Centre: How we will Meet Our Challenges

The Challenge…	We will meet this by…
Cancer Incidence is Increasing	✓ Expanding our role in the early diagnosis of cancer ✓ Promoting effective public health messages – making every contact count
There Continues to be Variation in Outcomes Throughout Wales	✓ Delivering more services of consistent quality in outreach settings closer to patients' homes ✓ Delivering a Radiotherapy satellite centre, in collaboration with Aneurin Bevan University Health Board ✓ Leading on the standardisation of Acute Oncology Services across and the development of a Cancer of the Unknown Primary service across SE Wales
There is a Gap Between Forecast Demand and Supply Which We Need to Close	✓ Continuing to implement techniques which are resource neutral or that deliver efficiencies elsewhere in the process ✓ Developing a robust, flexible, highly skilled and responsive workforce ✓ Rationalising treatment pathways and identifying efficiencies
Treatments are Becoming More Complex and New Advances are Continuously Emerging	✓ Ensuring, in collaboration with health board partners, that sufficient linear accelerator capacity is available to accommodate new techniques ✓ Effective horizon scanning
More People are Living With and Beyond Cancer	✓ Ensuring timely access to robust, high quality Clinical Psychology and Therapies services

Our priorities for 2022 – 2025
We have identified a range of key deliverables:

Strategic Priority 1: To meet increasing demand

- Reduce patient backlog and waiting times
- Provide safe services in a Covid environment:
    - Achieve Covid/flu vaccination requirements
- Implementation of the Single Cancer Pathway and transition to COSC standard
- Implementation of quality and safety framework, assurance and reporting tools
- Delivery of clinical audit programme
- Deliver quality improvements in Brachytherapy service
- Delivery of quality and safety requirements and Healthcare Associated Infections/Infection Prevention Control Requirements
- Delivery of next phase of Velindre Futures / TCS Programme:
    - Implementation of unscheduled care pathways
    - Implementation of regional acute oncology service model
    - Implementation of V@UHW Research hub: phase 1
    - Agreement of V@ CTM and AB service model and phased implementation
    - Complete competitive dialogue for the new Velindre Cancer Centre
- Development of sustainable workforce model and agreement for funding with LHB to support transition to improved clinical model and stepped change in capacity

Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments

- Identify and secure additional capacity to deliver radiotherapy and SACT requirements
- Deliver infrastructure phase of TCS Programme:
    - Award Integrated Radiotherapy Solution contract
    - Secure approval of full business case for the radiotherapy satellite centre in Nevill Hall
    - Implementation of 2 new linear accelerators in Velindre Cancer Centre
    - Identification of V@ outreach requirements in LHB models/facilities

Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer

- Enhance our self-assessment unit to improve access and support for patients with acute needs
- Increase the range of holistic therapies available to patients during/following their treatment
- Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners
- Patient self-management programmes
- End of life/palliative care

Strategic Priority 4: To be an international leader in research, development, innovation and education • Implementation of Research and Development strategy (year 1) • Implementation of V@UHW Research hub: phase 1 • Progress a range of strategic partnerships to take innovation to market
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early detection of cancer • Deliver our secondary prevention programme to support patients in improving their health and well-being • Deliver our McMillan primary care programme to support improved detection and diagnosis of cancer

Forecasting Demand & Capacity to Deliver Services

The demand for cancer services is comprised of care for patients newly diagnosed with cancer as well as new cycles of treatment for existing patients e.g. patients with metastatic disease requiring further cycles of treatment over time and the availability of new treatment regimens.

Demand for non-surgical cancer services at VCC has been increasing steadily over recent years. Notwithstanding the COVID-19 pandemic, demand for our services was predicted to increase by between 2%-5% which was derived based upon growth, improved access and increasing treatment complexity.

The demand forecast for 2022/23 and beyond uses this pre pandemic baseline supplemented with additional data from a major exercise we have led in conjunction with our LHBs, the Wales Cancer Network, Improvement Cymru and the Welsh Government Delivery Unit to develop a model to guide to identify new patient demand.

The demand modelling initially focused on using historic flows of patients from primary care to diagnosis and to treatment to develop a predictive model that to determine external demand from new patient referrals. This informs tactical decisions on timing of implementation of capacity changes likely to be required, with forecasting of actual demand over the next 16 weeks and informing capacity plans for next 12 months. We have used this to quantify capacity requirements for 2022/23 and beyond.

We recognise the pattern with which patients that have not yet presented will come forward is unknown and will be dependent on actions taken by Health Boards to develop their service capacity including diagnostics. This is variable between geographic areas and by patient tumour site. We will continue to use this model to review demand and going forward.

The table below provides a summary of the planning assumptions that underpin the capacity and delivery plan for 2022/23

Growth in service above the 2021 - 2022 baseline

Service	22/23
Radiotherapy	8%
Nuclear Medicine	12%
Radiology Imaging	12%
Preparation & Delivery for Systematic Anti-Cancer Therapy	12%
Ambulatory Care Services	8%
Outpatient Services	8%
Inpatient Admitted Care	2%

The headline capacity enhancement requires consideration of the changes to clinical practice and service delivery in comparison to the 19/20 baseline. For example, the increased utilisation of virtual outpatient attendances, mix of oral and IV infusion SACT delivery, introduction of hypofractionation for Radiotherapy Services, outsourcing and outreach settings. This work is ongoing alongside activity to identify efficiencies and developments across all treatment pathways.

Systemic Anti-Cancer Treatment (SACT)

Pre-Covid, SACT day case activity was increasing by approximately 5-8% per annum. This is a nationally recognised figure, and not just at Velindre. However, new Outpatient referrals to Velindre over the last 12 months have been 12% below pre-Covid levels, although considerable variation exists across tumour sites. However, we are still experiencing the underlying growth of 5-8% in SACT demand that was being realised pre Covid in 2019/20 from new and combined treatments. By Quarter 4 2020/21, patient referrals into the SACT service recovered to pre Covid levels.

It is worth noting, that demand for SACT is not only from the new referrals in for SACT, but the ongoing patients are also driving demand. This is because of more treatment options, patients living longer and receiving intermittent SACT regimens, and the increasing use of ‘maintenance’ regimens.

There is a ‘knock on’ impact of the increasing demand on SACT which is seen in Out-patients, and on the Ambulatory Support Unit where treatment related toxicities are assessed and managed

External Beam Radiotherapy

Referrals are predicted to return to Pre Covid (2019-20) levels by March 2022 and predicted to grow to Pre Covid plus 8% by March 2023. This is a higher rate of growth than new outpatients which is indicative of internal increase due to repeat cycles of treatment and increases in combination therapies. The impact varies by tumour site.

The continuous improvement of the radiotherapy pathways to meet revised treatment start targets will continue, however investment will be required to make a step change. This has not been included in the plan for the current year.

Outpatient service
The demand position has identified the biggest challenge in 2022-23 will be in the outpatient volumes with an additional 9000 patient episodes required. This reiterates the need for a transformative approach to the patient pathway to reduce the need for patients to be seen in the outpatient setting, including the implementation of the 'supported self-management' initiative.

Key Programmes of Work 2022 - 2023

The initiatives listed below include a wide range of projects to deliver our ambition, however alongside these there are also an extensive programme of ongoing "business as usual" replacement of equipment, digital systems upgrades and projects that are ongoing.

Meeting Demand

Sustaining and building capacity in all areas of the service to meet the patient demand and the demand pattern to enable us to consult with and treat people in accordance with the appropriate professional standards for care and time to treatment.

Velindre Futures

- Continue to deliver service change each of the directorate service areas; Medical, SACT and Medicines Management, Radiation Services, Integrated Care, Operational Services including Outpatients.
- Primary Care Oncology – exploring where we can provide additional support for primary care, and working in partnership with Primary Care colleagues to strengthen patient pathways and Care Closer to Home.
- Working to meet the Single Cancer Pathway and the delivery of COSC waiting times for Radiotherapy.
- Palliative care – reviewing the service requirements and ongoing service developments aligned with the End of Life Care Board programme, ensuring the ability to meet the internal demand for specialist palliative care services, implementing and embedding Advance Care Planning at the Cancer Centre. For instance, embed electronic Advance & Future Care Planning patient records into healthcare records in patients with palliative care needs.
- Delivery of the pharmacy TrAMMS programme
- Patient support services development including: Strengthening the 24/7 Helpline.
- Increase the range of therapies available to patients during/following their treatment – including pre-hab.

- Outpatient transformation programme – working to modernise the outpatient model of care delivery, including implementing 'supported self-management' for cancer patients with a Values Based Health Care approach (rather than the traditional outpatient model of '*follow up*').

- Disease 'Site Specific Team' (SST) Transformation programme – working with the SSTs and regional partners to ensure that patient pathways are effective, efficient and smooth, and that clinical outcomes and the patients experience of their care are optimised.
- Supporting specific treatment developments identified by SSTs as priorities. These will be delivered through external negotiations e.g. commissioning, and internal programmes of work to tackle gaps in service, access to trials, pathway reviews etc.

Specific major projects

- Digital Healthcare Record (DHCR) (the CANISC replacement) - delivery of the Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP) into all areas within the Trust.
- The Radiotherapy satellite Centre (RSC). Further development of the operating model for the centre including workforce planning
- The Integrated Radiotherapy Solution (IRS)- establish the implementation programme board and work programme with particular focus on requirements for phase 1 replacement of 2 LiNAC at VCC and the RSC.
- The new cancer centre replacing Velindre Hospital (nVCC) - provide the subject matter expertise to inform the next stages of the development.

Supporting projects

- Digital enablement of all VF projects.
- Patient Engagement: Establishing the new ways of working to enable delivery of the aspirations in the new framework.
- Workforce for the Future - further modernise our workforce model to ensure we have all staff operating at the top of their licence, and make the most of advanced practice and consultant roles.
- Working with HEIW and the Cancer Network to ensure that Velindre has a workforce 'fit for the future' with new roles, succession planning and the upskilling staff through development programmes.

Velindre Cancer Centre Service Plan 2022 - 2025

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
Strategic Priority 1: Access to equitable and consistent care, no matter where; To meet increasing demand	1. SACT Capacity Plan	Maintain high level of chair utilisation at VCC to support capacity growth. (see 2023/24) Supported by Task and Finish group proposals. Finalise interim facility plan at Neville Hall Hospital. Commence contract with third party provider to deliver SACT chair capacity while Neville Hall is progressing. Commence the SACT Improvement / Transformation programme to develop a robust service which is 'fit for the future' to	Implement programme to attract and retain SACT trained staff, and increase nurse led 'protocol' clinics to shift to a greater nurse led model of care delivery for SACT Implement staffing review agreed actions.	Implement Neville Hall interim facility return. Develop business case for SACT Consultant Nurse/ Consultant Pharmacist.	Commence booking service review.	Re- establish full service at Neville Hall Hospital in new cancer facility. In line with plans for reduced chair capacity at new cancer centre, begin transition planning with Health Boards.	Agree model and finalise chair capacity plans at Velindre and outreach centres.

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		include review staffing model and assess workforce options.					
	2. Radiation Services Capacity Plan	Maximise Rutherford contract – revised service Begin project to increase Linac capacity to 80 hours (73 currently) Complete Brachytherapy Peer Review and submit Business Case for additional planned capacity to meet demand. Review demand and capacity for clinical trials requiring capacity Review the Linac transition capacity for IRS implementation.	MRI refurbishment in radiology Brachytherapy action plan delivery Explore dose and fractionation schedules and alternative treatment approaches Agree the position on temporary/mobile/ fully commissioned leased bunkers while IRS process takes down fleet.	Streamline plan complexity for certain palliative scenarios. Finalise proposals for capacity increase to 80 hours	Implement 80 hours Linac capacity	Ongoing review of capacity for IRS implementation plan	Implement Radiotherapy satellite unit in Neville Hall.

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	3. Radiotherapy Pathway/COSC target achievement and radiotherapy clinical treatment developments	Programme to review efficiency of existing pathways continues including reduction in variation in ways of working /action plan developed. Engage with WHSSC on PRRT service to deliver patient benefit (awaiting WHSSC decision) Review proposed RT treatment developments including IMRT to establish capacity and commissioning approach	Develop standard operating procedures for pathway management, building on those developed in Lung Pathways and emerging themes/challenges with SST leads. Engage with WHSSC on PRRT service to deliver patient benefit Active engagement with commissioners with priority treatment development plan and delivery	Evaluate roles for advanced practice particularly Non-Medical Outliners in optimal pathways with SST leads. PRRT business case if able to progress Active engagement with commissioners with priority treatment development plan and delivery	Implement agreed pathway and workforce models developed to meet COSC target requirements. Finalise business case and Delivery of PRRT plan Active engagement with commissioners with priority treatment development plan and delivery	IRS implementation to drive pathway improvements through improved visibility of patients on pathways. PPRT established Annual cycle of new treatments to be established	IRS implementation Annual cycle of new treatments to be established
	4 Outpatient Services / Medical Directorate	SST and Outpatient Transformation programmes to commence building on pre Pandemic	The transformation objectives for the SSTs and Outpatient workforce will continue as	Deliver transformation programmes- estate, pathways and workforce	Deliver transformation programmes- estate, pathways and workforce	Engagement on service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		work.(interdependent with Radiotherapy projects) Rolling programme of SST 'supportive reviews' to commence to work to ensure that pathways are effective, efficient and smooth, and to inform modernisation of the multidisciplinary workforce model. Commence workforce modelling and planning within the SSTs and Outpatient teams (and link to radiotherapy); maximising opportunities for enhancing skill mix and embracing	previously described in quarter 1. This is a fundamental change and improvement programme which will run over 18 months.				

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		more efficient ways of working Maximise use of virtual consultations and embed into 'business as usual'. (50% at present). Establish optimum levels of Phlebotomy provision and notify HBs of changes in access. Provide increased capacity incl. at evenings/weekends to meet demand initially while the more fundamental pathway changes and ways of working are introduced pending service improvement efficiency delivery. Work to reduce demand within the Outpatient setting, including: review					

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		and streamlining of patient pathways and the implementation of the 'supported self-management' model Re-commence the pre Covid Outreach Clinics					
Strategic Priority 2: Access to state-of-the-art, world-class, evidence-based treatments	5 Digital Health Care Record (CANISC Replacement)	Finalise development Functional testing User Acceptance Testing Data Migration Operational service change planning Training sign off	Testing and training Operational Go Live planning Go Live readiness assessment Go Live run through SOP development	Commence Go Live Phases– dry run Complete Go Live	Review impact of implementation on operational delivery plan phase 2	Phase 2	
	6 Integrated Radiotherapy Solution	Complete Tender Evaluation and Identify Winning Bidder, issue standstill letter. Appoint Radiation Services Programme Manager to lead implementation and	Complete hybrid OBC/FBC and submit to WG and await approval. Prepare recruitment of IRS implementation posts. Award IRS contract once approval of	Commence formal IRS implementation – shadow implementation board stands up as a formal board. Recruit to IRS implementation posts.	LA6 Bunker Refurb complete. Service plans for second machine replacement confirmed. Initial scoping works on TPS/OIS replacement and	1st VCC Linac replacement live. Decommissioning and Refurb of 2nd bunker commences and completes. 2nd VCC Machine live	Installation of 2 standard Linacs and a CT Sim at the Satellite Centre TPS/OIS readiness for cloud confirmed

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025								
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**						
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		commence design of 1st bunker. Establish Shadow Implementation Board	capital and revenue funding. Receive vendors detailed implementation plans	LA6 Bunker Decommissioning commences	Phase 1 additional functionality. Plans for Satellite and nVCC confirmed	Work continues to develop TPS / OIS and prepare for cloud services when nVCC goes live. Plans firmed up for Satellite Installation	Plans firmed up for nVCC Installation
	7 Acute Oncology Service- local delivery	Recruit ANPs and other staff	Pathway design with region	Pathway implementation	Pathway implementation	Service embedding and review Engagement on service model for nVCC	Transition to nVCC
	8 Integrated care	Scope bed plans/model for assessment unit aligned to the VCC element of AOS. Develop plans for delivering national projects e.g. Immuno Oncology (SDEC) Immunohematology Service – Recruit staff	Immunohematology Service Increase capacity Ambulatory Care- increase weekday opening Continue to review the unscheduled care	Immunohematology Service- further pathway work with HBs Ambulatory Care- weekend opening	Immunohematology Service- grow service delivery	Engagement on service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		(SDEC) Ambulatory Care – finalise staff recruitment	patient pathway aligned to the VCC element of AOS. Deliver requirements of national projects e.g. Immuno Oncology				
	9 Palliative Care	Review Cancer Associated Thrombosis clinic service : establish working SLA with Oncology	Undertake Peer Review as planned	Review of Chronic pain service.	Preparing the move from CANISC (No solution yet identified)	Review of service delivery and future planning.	Transition to nVCC
	10 Key Treatment Developments – IMN SABR Lutetium PSMA HDR Brachy etc. Clinical team priorities – Gaps in service, e.g. CNS/Therapies. Access to Trials/Research.	Finalise the priority of implementation of key treatments where external funding is required and agree timescales. Commence business case developments for agreed treatments in phased approach according to priority and timetable agreed.	Take forward agreed business cases in a phased approach as agreed. Apply 'Just do it' criteria where appropriate for clinical team Begin development of implementation plans for clinical team priorities requiring	Take forward agreed business cases in a phased approach as agreed. Apply 'Just do it' criteria where Continue the development of implementation plans for clinical team priorities requiring	Take forward agreed business cases in a phased approach as agreed.	Develop enhanced commissioning frameworks/models to support future treatment developments. Engagement on treatment models for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	MDT attendance / cover arrangements.	Finalise the priority of clinical team priorities.	support/wider discussions.	support/wider discussions.			
	11 Radiotherapy Satellite Centre	Support Strategic case development & review of FBC. Workforce Plan. Finance case. IRS alignment & FBC. FBC scrutiny and approval by service lead & through Boards	FBC approval- WG Implement Arts strategy for RSC Operational model development aligned to IRS	Ongoing liaison with ABUHB regarding build, IRS alignment Project Board, Project Team Meetings Operational Model delivery plan preparation	Operational Model delivery plan preparation	Recruitment of additional posts for RSC Review SLA's Review operational model Workforce Training Communications	Linac installation Feb 2024. Acceptance testing March 2024 External commissioning April -2024 Internal commissioning April- June 2024 Staff training June- July 2024 RSC opens- beam on date July 2024
	12 Radiology	Commission reconditioned MRI scanner.	Review Radiology demand and align to capacity plan		Full additional capacity plan is delivered	Engagement on service model for nVCC	Transition to nVCC

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Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
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		Q1	**Q2**	**Q3**	**Q4**		
		Phase 1 capacity delivery					
Strategic Priority 3: Improving care and support for patients to live well through and beyond cancer	13 Patient treatment helpline	Implement new handover arrangement into SACT service. Commence review of service functionality and fitness for purpose. Engage with digital team to explore system capability and options for future.	Develop action plan to address issues identified and changes required. Engage with stakeholders at VCC and externally in developing plans to ensure all calls are appropriately directed from 1st contact.	Implement actions identified. Implement any identified telephony systems to allow signposting to all areas.	Implement associated workforce or training plans Roll out new system and ways of working.	Review Helpline developments from 22/23	Ongoing adaptation and development in line with other service changes
	14 Implementation of patient engagement strategy to strengthen our conversations with patients, families and wider partners	Commence Patient panel Implement patient panel management software programme.	Commence establishment of Patient Engagement Hub and Patient Leadership Group Establish initial Patient Engagement activity for Velindre Futures projects	Patient Leadership Group recruitment and training	Continue to develop Group, staff team and patient engagement delivery. Includes underpinning nVCC.	Engagement on service model for nVCC	Transition to nVCC
	15 Establish Primary Care						

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	project under Velindre Futures						
Strategic Priority 4: To be an international leader in research, development, innovation and education	16 R & D Hub (Development at UHW)	Progress the clinical scientist and clinical academic business cases.	Progress the clinical scientist and clinical academic business cases.	Business case Cost(ing and funding agreements in place.	Establish Governance Arrangements for the Hub.	Engagement on service model for R&D for nVCC	Transition to nVCC
	17 TrAMS	Establish VCC programme board and supporting sub groups: 1) Clinical Service Model 2) Clinical Trials via TrAMS 3) Workforce and staff impact. 4) Finance, incl. private patient impact.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Progress programme aims and objectives through full engagement externally and internally.	Develop detailed implementation plan addressing all areas of risk	Implementation of new service from Spring 2024.
	18 Therapies incl. collaborative work across region	Participate in regional Prehabilitation programme and	Review funding streams and commissioning models to facilitate	Continue participation in regional service	Bring forward proposals for therapies development	Engagement on Therapies service model for nVCC	Transition to nVCC

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		scope development plan.	prehabilitation service development.				
	19 Workforce Modernisation:	Establish a workforce modernisation programme – with a 2 phased approach -'Stabilise and Modernise' Finalise proposals for revised clinical leadership arrangements.	Align workforce plans for regional developments e.g. AOS, RSC. Advanced practice plan the potential for 'pump priming' advanced practice roles to 'kick start' the workforce Advanced Practice Radiographers and Therapeutic Radiographers	Implement Physicians Associate posts. Prepare plan for advanced practice – Non Medical Consultant roles.	Workforce modernisation programme continues		

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	20 Single Cancer Pathway	Focus on front end of the pathway for all tumour sites: Aims to Standardise patient referrals to VCC. Timely receipt of all diagnostic test results and treatment pre-requisites prior to MDT. Improve patient outcomes by early genomic testing where indicated. Develop action plan.	Develop dashboards and pathway data to make all patients' pathway points visible.	Focus on whole Breast Pathway: Mapping of Breast Pathway from patient referral to service to treatment commenced. Identify touch points along pathway and potential bottlenecks Measure how currently delivering against the National Optimal Pathways (NOP) Develop action plan.	Commence Action plan implementation.	Roll out Pathway mapping process for Urology, then other tumour sites.	
Strategic Priority 5: To work in partnership with stakeholders to improve prevention and early	21 Engagement with HB's	Agree terms of reference and priorities for joint working with each HB. Commence meetings to deliver on these priorities.	Share patient pathway challenges in developing improvement plans. Agree outreach plans for outpatients and SACT with all HBs.			Take lead from partnership board on development of local implementation of clinical models	Implement agreed clinical models in readiness for nVCC.

IMTP Strategic Priorities VCC Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables/Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
detection of cancer							

Blood and Transplant Services

The Welsh Blood Service collects voluntary, non-remunerated blood and blood product donations from the general public and provides advice and guidance regarding appropriate blood product use in Health Boards. Donations are processed and tested at the laboratories based in WBS Head Quarters in Talbot Green, Llantrisant, before distribution to hospitals. We have a Stock Holding Unit (SHU) in Wrexham, North Wales and also have sites in Bangor, North Wales and Dafen, West Wales. The WBS laboratory services also include antenatal patient testing and a reference centre for complex immunohaematology investigations.

It supports the solid organ and stem cell transplant programmes that run out of Cardiff and Vale University NHS Trust and manages the Welsh Bone Marrow Donor Registry, which provides haematopoietic stem cell products nationally and internationally and the UK National External Quality Assurance Scheme for Histocompatibility and Immuno-genetics (NEQAS) (global quality assessment service)

In addition, we hold a wholesaling licence to supply blood-derived medicinal products (both NHS and Commercial for purchase by our customer hospitals).

The service models are supported by strong Research, Development and Innovation (RD&I) derived from within WBS and working closely with other Blood Services across the Home Nation and further afield. Investing our time in supporting and facilitating RD&I is fundamental in ensuring we remain a leading service within the fields of blood component, transplant and transfusion services.

The Trust is committed to ensuring the services we provide meet the high expectations required by patients, donors, staff and partner organisations across health, academia and industry. Our services must be high quality, clinically safe, effective and underpinned by a strong evidence-base.

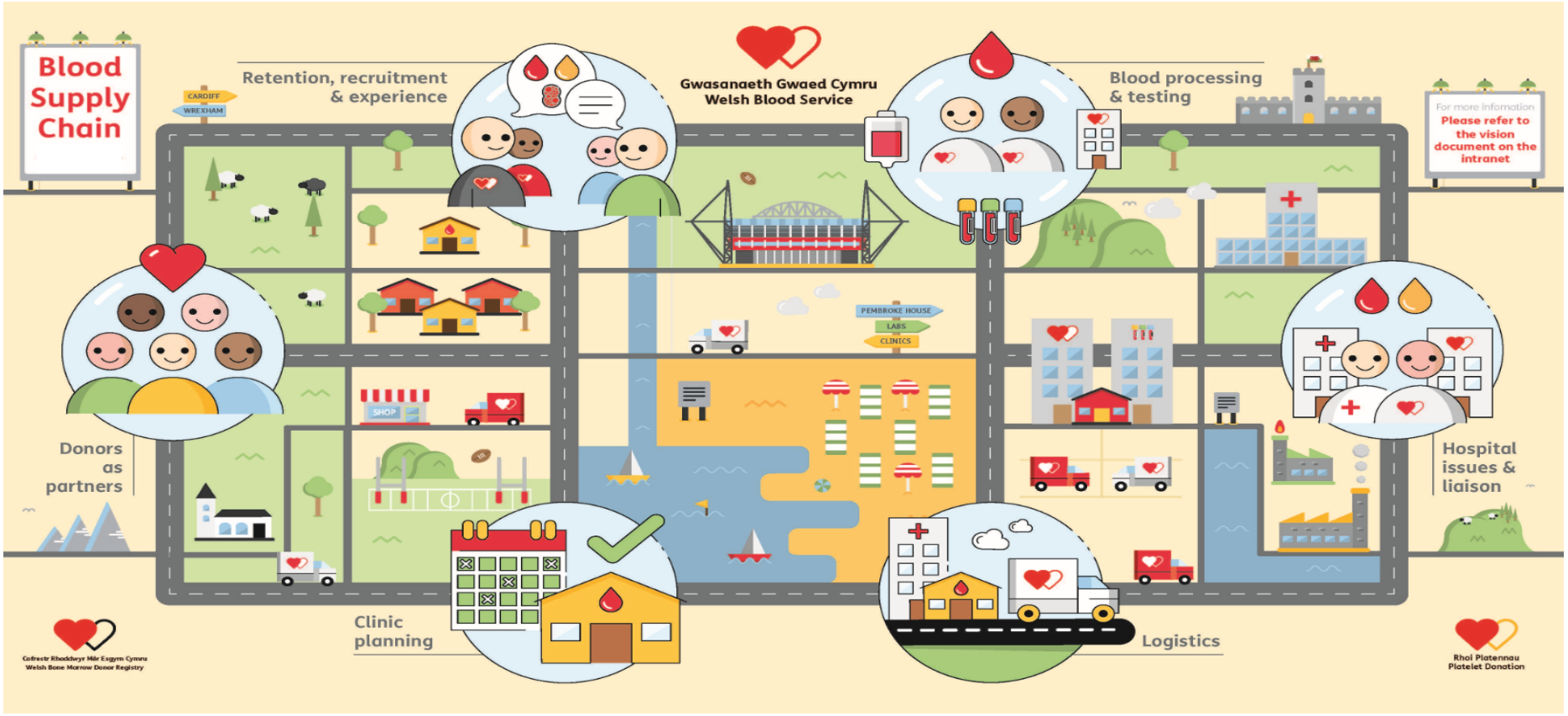
Strong clinical and scientific leadership and governance helps to ensure that the quality of our service remains at the forefront of our decision-making. This assurance is maintained through our commitment to ensuring the services we provide meet the high standards of our regulators and auditors, such as the Medicines and Healthcare Regulatory Agency (MHRA), Human Tissue Authority (HTA), UK Accreditation Services (UKAS) and the Health and Safety Executive (HSE).

The delivery of our blood, transplant and transfusion services requires working in partnership and collaboration with colleagues within our corporate and support functions:

- Digital support is fundamental to the provision of modern services that minimise unnecessary work, maximise efficiency and support clinical safety.
- Data from our Business Intelligence Service is used to support planning of our service delivery and development and provide a means of monitoring performance and measuring our success.
- Strong corporate governance and project structures, provided by our Innovations Hub and business support team, are important in ensuring the successful delivery and continuous improvement.
- Maintaining a safe, sustainable and efficient estates infrastructure from which to run our services and look after our staff, is an essential requirement of WBS and is managed in partnership between our corporate estates team and local facilities team.
- Working with our Workforce and Organisational Development team helps ensure that the well-being of our staff remains an important part of service.
- Strong financial support helps to ensure service are delivered within our agreed financial envelop and we meet our Standing Financial Instructions (SIFs) obligations.

Our clinical model is illustrated by ***Figure 3*****.**

Figure 3 - Our Clinical Model



Our Strategic Priorities

Strategic Priority 1:	**Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality**
Strategic Priority 2:	**Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations**
Strategic Priority 3:	**Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services**
Strategic Priority 4:	**Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services**
Strategic Priority 5:	**Provide, services that are environmentally sustainable and benefit our local communities and Wales**
Strategic Priority 6:	**Be a great organisation with great people dedicated to improving outcomes for patients and donors**

Forecasting Demand for Blood Components and for Blood Products and Platelets

Meeting Demand - Planning assumptions
The following assumptions have been made when forecasting the demand for blood components, blood products and platelets:

- COVID-19 social distancing and IPC measures will remain in place for the length of 2022/23
- No ‘surge’ has been applied, but an uplift of 1% has been applied to the pre-COVID-19 data (this is reflective of the uplift modelled and applied by NHS Blood and Transfusion Service in England)
- Uptake rate is based on 2 years data April 2020 to March 2022 to reflect the ‘booking only’ model in place at this time. There is an assumption only booked appointments will be available i.e. no walk-in appointments
- DNA rates are based on pre-COVID-19 data
- There is an expected post collection loss rate of 4%, which will include losses due to donor screening results, laboratory process and quality monitoring purposes

Figures are subject to external changes which may have a significant impact on how much whole blood and blood components and products are demanded from Hospitals (our customers) throughout the year.

WBS will continue to monitor actual issuing against forecasted issuing throughout the year and will adjust the planned whole blood and platelet collection and the corresponding product manufacturing accordingly, to meet demand.

Meeting Demand for Blood (Red Cells) and components

The Collection Clinic Planning department will aim to schedule clinic sessions to collect enough whole blood to meet the estimated demand during the year.

Based upon our planning assumptions above, we have modelled how much blood we will need to collect from our donors compared to issuing to Health Boards. There is always a challenge in the interpretation of Health Board activity planning and impact on blood demand due to the myriad of factors that influence demand.

The assumptions upon which the forecast data is based, reflects similar modelling to other Blood Services and assumes Health Boards will increase their activity over 'business as usual' at a rate of 1%, attributable to 'surge' activity as a demand projection.

In planning the clinic capacity, as the COVID-19 restrictions are lifting, we have seen donor behaviour revert to closer to pre-pandemic levels, with lower uptake in appointments and higher DNA rates. This is in contrast to donor behaviour at the height of lockdown, which saw a significant rise in uptake and a reduction in DNAs.

Meeting demand for Platelets

Based upon our planning assumptions, we have modelled how many platelets we expect to manufacture, compared to issuing to Health Boards, in order to support safe and effective patient care.

Platelet demand has returned to pre-COVID-19 19 '*business as usual*' levels and will be met through a combination of apheresis derived and the pooling of whole blood platelets. The amount of whole blood required for pooled platelets is accounted for in the above assumptions and is complimented by the production of platelets from apheresis.

The service will flex our production of pooled platelets appropriately to ensure supply chain integrity. However, it is important to note that platelet demand can be volatile due to the nature of the component, the short shelf life (7 days), the blood group complexities as well as the two different manufacturing methods (apheresis and pooled), which in turn can lead to higher wastage levels.

Based upon the above assumptions the plan for 2022/2023 will ensure that we meet demand for blood components and for blood products and platelets.

Key Programmes of Work during 2022 - 2023

Within the IMTP, there are a number of high priority programmes of work, which will require capital investment.

Programme	Deliverable
Talbot Green Infrastructure	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model
WTAIL LIMS	Implement WHAIS LIMS Deliver WLIMS modules for Blood Transfusion (BT)
Laboratory Services Modernisation	Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS
Plasma for Fractionation – medicines	Develop and introduce Plasma For Fractionation - medicine service model for Wales
Occult Hepatitis B Infection in UK Blood Donors	Assess and implement SaBTO recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required
Donor attraction and retention	Develop and implement Donor strategy Use digital operating systems to enhance and support more effective service provision
Service Development and regulation	Develop and implement WBMDR strategy Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required. Deliver WLIMS modules for Blood Transfusion (BT) Implementation of Foetal DNA typing Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient

	and effective management of regulatory compliance and maximising digital technology
Workforce	• Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning
Infected Blood Inquiry	• The Support UK Infected Blood Inquiry and delivery of its Terms of Reference

Contingency Planning

Work is ongoing through the Blood Health Team and Collections Team to align the collection profile with demand for specific blood groups, but this remains difficult to determine as identified above. We are continuing to work closely with the hospital blood banks and service leads for blood transfusion to understand and help manage appropriate demand and meet the required capacity. In further support of effective stock use, the Blood Health National Oversight Group is continuing to provide leadership across Wales.

Contingency plans are being reviewed within the service to enable capacity to be '*flexed*' across the supply chain to support the anticipated increased (surge) demand from Health Boards as they move towards implementing their recovery plans. A risk assessment has been completed modelling additional capacity available with a reduction of social distancing from the current 2meters to 1.5 meters and 1 meter respectively.

For business continuity purposes, and if required, the WBS can call on mutual aid support with the other UK Blood Services or in extreme circumstances would instigate the National Blood Shortage Plan which provides a structured approach to addressing the shortfall in supply.

Welsh Blood Service Plan 2022 - 2025

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
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		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
SP1: Provide an efficient and effective collection Service, facilitating the best experience for the donor, and ensuring blood products and stem cells are safe and high quality and modern	Develop and introduce Plasma For Fractionation - medicine service model for Wales	Scope service need project group established	Business case to Welsh Government	Develop draft service model	Service model approved	SOURCE PLASMA: Service model approved workforce plan developed collection model agreed Proof of Concept Open	SOURCE PLASMA: Sites procured equipment procured workforce recruited
	Develop and implement Donor strategy	Scope service need project structure established draft strategy produced	Consultation on strategy	Implementation plan developed	implementation of eDRM phase 1 to support delivery of implementation plan	Extend eDRM Scope opportunities for digital to support real-time engagement with donors and develop bespoke donor journeys to maximise opportunities for whole	scope processes required to targeted specific donors in line with meeting service needs

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
						blood and stem cell collection	
	Use digital operating systems to enhance and support more effective service provision	Scope opportunities for digital technology to support sharing real time data and transfer of goods between WBS and customers	Establish technology solutions	Identify resources to support implementation	Implementation commence	Continue phased implementation of solution with concurrent process review and re-design as required. Upgrade systems	Continue phased implementation of solution with concurrent process review and re-design as required.
	Develop and implement WBMDR strategy	Scope service need project structure established draft strategy produced	Consultation on strategy	Implementation plan developed	implementation commence	Continued phased implementation	Continued phased implementation review and embed
	Review blood collection clinic model in light of COVID changes to ensure the service model moving forward remains fit for purpose	Establish project structure review service models to meet need &	Undertake service/data review in light of COVID and proposed	Complete OCP process in relation to service model	Complete OCP process in relation to service model		

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
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		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
		undertake service/data review in light of COVID and proposed contract variation	contract variation				
SP2: Meet the patient demand for blood and blood products through faciltiating the most appropriate use across Health organisations							
SP3: Provide safe, high quality and the most advanced manufacturing, distrbution and testing laboratory services	Assess and implement SaBTO (guidelines 2021 release date) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required.	Confirm role of WBS with Welsh Government establish project structure	Complete OCP process in relation to service mode	Establish workforce model	Implementation	Input data from pilot into SaBTO review	Implement revised strategy

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
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		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
SP4: Provide safe, high quality and the most advanced diagnostic, transplant and transfusion services	Deliver WLIMS modules for Blood Transfusion (BT)	Scope service specification	Undertake procurement	Undertake procurement	Complete USR procurement	Commence phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.
	Implementation of Foetal DNA typing	Engage with Antenatal Screening services to develop implementation plan	Agree implementation plan	Take forward implementation	Take forward implementation	Introduce a new test to the laboratory service, plus additional digital development Deliver service for Foetal D	Embed service
SP5: Provide, services that are environmentally sustainable and benefit our local communities and Wales	Establish a quality assurance modernisation programme to develop and implement strategy which support more efficient and effective management of regulatory compliance and maximising digital technology	Project to be scoped project structure established phased work plan	Develop implementation plan	Take forward implementation		Continue phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.

IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	Develop an estate and supporting infrastructure service model which delivers improved energy efficiency and reduction of carbon emissions	Submit OBC for Talbot Green infrastructure Project further implementation of fleet strategy	Procure support to develop FBC further implementation of fleet strategy	Appoint health care planner to develop FBC	FBC submitted to Welsh Government	Phase 1 implementation Capital funding secured phase 2 procurement	Capital funding secured phase 2 procurement
SP6: Be a great organisation with great people dedicated to improving outcomes for patients and donors	Develop a sustainable workforce model for WBS which provides leadership, resilience and succession planning	Engagement with teams in relation to Review of clinical services Review of Facilities model Review of BI	Development of service Model paper to be developed for approval	Development of service Model paper to be developed for approval	Implementation plan developed	Realign structure based on review outcome. Developing succession planning and resilience for specialist posts	Implementation of review outcomes, ongoing succession planning and resilience for specialist posts

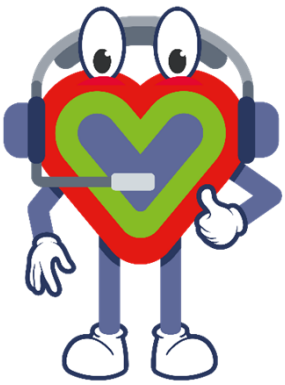
IMTP Strategic Priorities WBS Service Delivery Framework 2022 to 2025							
Strategic Priorities 2022/23 to 2024/25	**Key Deliverables / Objectives**	**Key Specific Actions and 2022/25 Timescales**					
		2022/23				**2023/24**	**2024/25**
		Q1	**Q2**	**Q3**	**Q4**		
	Establish a laboratory modernisation programme to review and develop service processes, practices and workforce requirements which support an efficient and effective service model across all laboratories in WBS	Scope programme of work Establish project structure	Develop implementation plan	Business case submitted to WHSSC to support implementation of new standards and guidance in component development lab	Funding secured	Continue phased implementation of solution with concurrent process review and re-design as required.	Continue phased implementation of solution with concurrent process review and re-design as required.
	Lead the all Wales approach to implementation of Welsh Government Statement of Intent for Advanced therapies	secure funding review structure and develop work plan 2022/23	clinical lead appointed implementation of work plan	implementation of work plan	implementation of work plan	implementation of work plan	implementation of work plan
	Support UK Infected Blood Inquiry and delivery of its Terms of Reference	IBI continues	IBI continues	IBI continues	IBI continues	IBI continues	IBI continues

Part 6

Our Trust-wide Support Functions

We set out how our Trust-wide enabling functions support the delivery of our Plan.

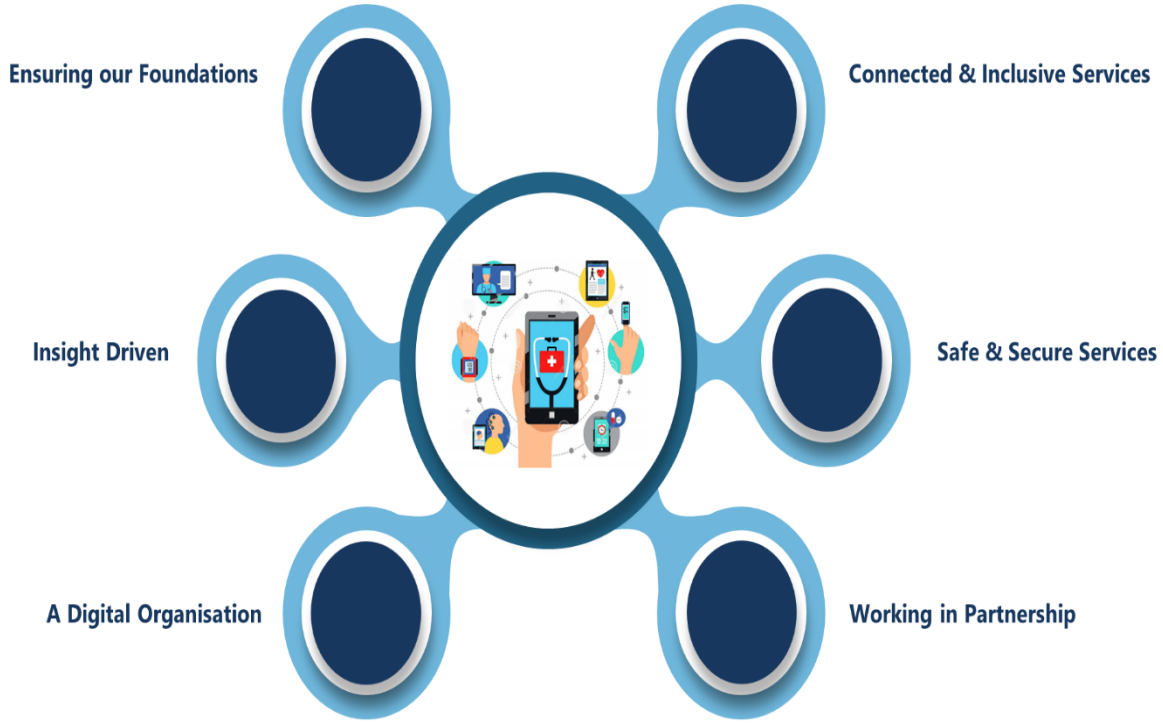
Digital Innovation



These are exciting times when you consider the opportunities ahead for Blood and Cancer Services in Wales. By taking full advantage of digital to support our transformation we have an opportunity to accelerate progress toward our ambitious long-term strategic goals.

One of the most important components of our future success will be how well we embrace the challenge of digital. A new Digital Strategy – "*Enhancing our Future through Digital & Data… Enabling Services of Tomorrow … Today*" – describes our approach to digital in response to the Trust mission to *"Improve Lives"*, and its vision to deliver *'Excellent Care, Inspirational Learning, Healthier People'*.

Our Digital Strategy sets out a number of themes which we will progress to enable high quality and accessible services.



Our digital plan is set out in **Appendix B**

Workforce and Organisational Development

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

As a Trust we value our staff and recognize they are all core to the success of our organization. We have developed a People Strategy for 2032 and our overall aim is to develop our staff to be able to provide the care our patients and donors need now and in the future, support their wellbeing and to recognise and value their diversity as part of a bi-lingual culture.

Our vision is to have:

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

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

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

Our workforce and organisational development priorities are set out in **Appendix B**

Trust Estate and Infrastructure Programmes

The Trust has developed an Estates Strategy for 2032 which sets out a number of strategic aims:

Strategic aim 1: Provide a safe and high quality estate which provides a great experience

Strategic aim 2: Provide healthy buildings and healthier people

Strategic aim 3: Minimise our impact

Strategic aim 4: Use our estate to deliver the maximum benefit and social value to the community

Our estates plan is set out in **Appendix B**

It is supported by an ambitious capital programme which includes:-

- **Development of a New Velindre Cancer Centre in Whitchurch, Cardiff: the** replacement of the existing VCC has been identified as a key commitment within the Welsh Government's '*Programme for Government*'. The Project is one of three pathfinder Projects for the Welsh Governments innovative Mutual Investment Model (MIM) Programme.

- **Development of a Velindre Radiotherapy Satellite Centre at Nevill Hall Hospital: t**he provision of a Radiotherapy Satellite Centre (RSC) has been identified as a key regional development to facilitate timely and effective Radiotherapy services to the South East Wales population. The ambition is to deliver a world-class facility that will provide specialist care for cancer patients from that locality.

- **Programme to re-develop the Welsh Blood and Transplantation Services Facility: t**his Programme sets out a number of strategic developments which will support the provision of high quality, safe, sustainable, efficient services and support the decarbonisation of our estate. It will also provide the foundation for the Laboratory Modernisation programme which will look at a range of new services to support NHS Wales.

Part 7

Our Financial Plan

We set out our 3 Year Financial Plan for 2022 to 2025

Strategic Financial Plan for 2022/23 - 2024/25

Overview of the Financial Plan 1st April 2022 to 31st March 2025

The Trust has had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.

Our Integrated Medium Term Plan (IMTP) for 2022-2025 sets out our Financial Strategy from 1st April 2022 to 31st March 2025, in the context of the COVID-19 pandemic. During this period the Financial Strategy aims to enable the Trust to meet the anticipated demand for services in Covid recovery returning to normalised activity and delivering additionality within the ongoing constraints of COVID-19 response and the inherent unpredictable nature of the pandemic. Recovery from the pandemic is compounded by significant financial challenges due to system wide exceptional cost pressures, which include energy & fuel cost increases, Employers National Insurance uplift (1.25%), living wage and other extraordinary levels of cost inflation. The balanced financial plan assumes Welsh Government income will be provided for these system wide exceptional cost pressures and the ongoing transitional costs of responding to COVID-19 that cannot yet be removed in addition to Commissioner income.

The financial plan for 2022-23 consists of three distinct parts:

Core Plan: Balanced

Brought Forward Deficit:

- Despite the constraints, the Trust aims to continue its Programme of service transformation and improvement, whilst working towards a key financial objective of removing the underlying deficit of £500k carried forward from 2021-22 restoring the Trust to a core financially recurrent balanced position.

- The recurrent carry forward underlying deficit of £500k, which is a consequence of unachieved 2020-21 savings delivery as a result of the pandemic. The deficit mainly relates to radiotherapy and medical staff, as well as increased estates and maintenance costs. This deficit will be removed through use of the 2.8% core uplift (sustainability) funding.

Growth pressures:

- The balance of 2.8% core uplift (sustainability) funding has been used to fund local core service growth and cost pressures of £1,298k and £170k towards the normal National cost pressures of £390k.

Savings Plans:

- The following table summarizes the level of savings we are planning to deliver in 2022-23

- These savings will fund the service growth investment requirements of £934k that commissioners have not agreed to fund and the balance of the savings will fund £366k of the normal National cost pressures of £578k

	2022-23 £000
CIP Planned Savings	750
Income Generation	550
Total Savings / Income Generation	**1,300**
CIP % (of Core LTA)	**2%**

- The core financial plan is balanced excluding exceptional national cost pressures and the ongoing impact of Covid response.

Exceptional National Cost Pressures

- Following the letter from Judith Paget dated 14th March 2022 the Trust is assuming WG funding cover will be provided for the system wide cost pressures which for Velindre includes energy / fuel, and Employers NI

COVID-19

- Currently the Trust has agreed with its commissioners a planning assumption around income to fund the cost of additional capacity the Trust has put in place and any further capacity required to deal with impact of COVID-19 delayed activity. There remains a risk around how this income will flow given significant costs are already in place, but the certainty around the level and timing of activity that will flow from LHBs is uncertain.

- The LTA activity based Income and associated costs are modelled on the following growth in demand assumptions:

Forecast Demand Growth from Prior Year Activity Out-turn			
Service	**22/23**	**23/24**	**24/25**
Radiotherapy	8%	2%	2%
Nuclear Medicine	12%	9%	9%
Radiology Imaging	12%	9%	9%
Preparation & Delivery for Systematic Anti-Cancer Therapy	12%	8%	8%
Ambulatory Care Services	8%	2%	2%
Outpatient Services	8%	2%	2%
Inpatient Admitted Care	2%	2%	2%

- The weekly internal service capacity for 19-20 pre pandemic baseline and 22-23 based on Covid recovery funding are set out in table below:

Weekly Internal Service Capacity		
Service	**19-20 Baseline Capacity**	**22-23 Capacity Based on Covid Recovery Investment**
Outpatients	1,128 attendances	1,353 attendances
SACT	460 cycles of treatment	580 cycles of treatment
Radiotherapy	75 planned patients and 78 hours LINAC daily capacity	77 planned patients and 80 hours LINAC daily capacity

- The headline capacity enhancement requires consideration of the changes to clinical practice and service delivery in comparison to the 19-20 baseline. For example, the increased utilization of virtual outpatient attendances, mix of oral and IV infusion SACT delivery, introduction of hypofractionation for Radiotherapy Services, outsourcing and outreach settings.

- There remain significant Covid response costs relating to covering higher sickness levels, enhanced IPC, social distancing and other income lost. The plan currently assumes WG will provide funding cover for these costs as confirmed by Judith Paget's letter of 14.03.22.

The plan aims to provide services with sufficient capacity to meet demand in support of recovery from the COVID-19 pandemic, whilst targeting improved levels of efficiency and productivity alongside sustained delivery against national and / or professional performance standards. In terms of efficiency the Trust will be setting a 2% savings target of £1,300k in 2022-23.

The Trust had been working with Commissioners prior to the pandemic to agree a new contracting model that better reflects the complexity of the services the Trust provides, the resources they consume, and which appropriately funds the Trust for the marginal costs of any over activity. There was agreement that this new model would be implemented in 2020-21.

An important development during the plan period will be the introduction of the new LTA contracting model (subject to commissioner support), suspended in 2020-21 and 2021-22 under the nationally agreed "block contract" arrangement to maintain financial stability during given reduced activity during the pandemic.

National discussions are near finalisation as to the way in which funding will flow through to providers for activity to meet the demand which arises. The Trust took the decision during 2021-22 to make upfront investment in permanent staffing and infrastructure to create additional capacity sufficient to meet forecast demand growth in 2021-22 and into 2022-23. Whilst commissioners have recognised and supported this decision to ensure cancer patients referred to Velindre receive timely care and blood supply across Wales meets demand, this presents a significant financial risk to the Trust as income remains uncertain dependent on

Health Boards ability to create additional capacity for diagnostics and surgery to generate onward referrals to Velindre for specialist cancer treatment.

The financial plan assumes income levels will be commensurate with the Covid internal capacity costs already in place and the additional costs to procure further capacity from Rutherford Cancer Centre (external private provider) that modelling undertaken with HB's and the WG Delivery Unit has forecast will be required. National funding flow principles have recently been firmed up, but not completely finalised. They are anticipated to be in place for the financial year 2022-23, however the Trust has written to HB Chief Executives setting out a proposal for a strategic funding approach to the additional internal capacity the Trust has established to meet their patient demand, irrespective of the activity driven national funding flow principles.

The Trust will progress discussion with commissioners to agree changes required to the contract currencies and prices to reflect the new service models and clinical pathways that are now permanent.

Whilst the Trust is submitting a balanced financial plan there is significant financial risk and challenges to deliver this plan due to the uncertainties around the income it will receive to cover the committed Covid costs and additional Covid commitments required during 2022-23.

The proposed financial plan has been developed using the latest assumptions regarding the Trust's expected income from Commissioners and Welsh Government funding in recovery from the COVID-19 pandemic, the likely cost pressures facing the Trust, both pay and non-pay inflation, and realistic, but challenging view of the cost saving potential of services.

These assumptions have been discussed and agreed with Commissioners and Trust Board through the IMTP engagement process. WG Director General for H&SS is sighted on the income gap relating to local Covid response costs and exceptional national cost pressures and her letter of the 14.03.22 provides income cover for these costs.

The formal agreement of the Trust income planning assumptions are summarized within respective Commissioner Long Term Agreements for 2022-23 which are to be signed by the 30th June. A summary financial pan for period 2022-23 to 2024-25 is presented in the following table:

Summary of Finanical Plan 2022-25	2022/23		2023/24		2024/25	
	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000	In Year Effect £000	FYE of Recurring £000
Non Achieved Savings 2022-23	(500)	0	0	0	0	0
b/fwd underlying deficit	**(500)**	**0**	**0**	**0**	**0**	**0**
Revenue						
WG Pay Award & DDRB	2,371	2,371	1,689	1,689	1,787	1,787
WG Pay Award Commissioner funding (per WG Matrix)	81	81	81	81	81	81
WG Increase in Employer Pension Contribution	2,743	2,743	2,798	2,798	2,854	2,854
WG Funding for Extra Ordinary Cost Pressures	1,150	550	600	0	0	0
WG Covid Programme Funding (Mass Vacc and PPE)	710	0	0	0	0	0
WG Assumed Covid Response Funding (Not in Commissioner plans)	1,394	697	0	0	0	0
Covid Funding Via Commissioners	6,056	6,056	0	0	0	0
2.8% Recurrent LTA Core Uplift (1.5% 23/24 & 0.75% 24/25)	1,968	1,968	1,104	1,104	591	591
Assumed LTA Income Growth (Inc Pay Award Pass through)	12,371	12,371	10,843	10,843	12,027	12,027
LTA Service Growth Investment	1,772	1,772	511	511	1,696	983
Total Revenue	**30,616**	**28,609**	**17,626**	**17,026**	**19,036**	**18,323**
In year Changes to Operation Cost Base						
Pay Award/ Pension/ Increments	(5,341)	(5,341)	(4,704)	(4,704)	(4,858)	(4,858)
LTA Service Growth Investment	(2,706)	(2,706)	(1,219)	(1,219)	(1,696)	(983)
VV NICE Drug Growth	(10,695)	(10,695)	(9,000)	(9,000)	(10,000)	(10,000)
WBS Contract Price/ Inflation	(1,676)	(1,676)	(1,843)	(1,843)	(2,027)	(2,027)
Exceptional National Cost Pressures	(1,150)	(550)	(600)	0	0	0
General Cost Pressures	(578)	(578)	(206)	(206)	(200)	(200)
Local Cost Pressures	(1,110)	(1,110)	(1,254)	(854)	(1,455)	(1,055)
Covid Impact 2022-23	(8,160)	(6,753)	0	0	0	0
Total In Year Changes to Cost Base	**(31,416)**	**(29,409)**	**(18,826)**	**(17,826)**	**(20,236)**	**(19,123)**
Net Opening Balance before Savings	**(1,300)**	**(800)**	**(1,200)**	**(800)**	**(1,200)**	**(800)**
Savings Plan	750	600	700	500	700	450
Net Income Generation	550	200	500	300	500	350
Net Opening Balance	**0**	**0**	**0**	**0**	**0**	**0**

Income Assumptions

Income Assumptions and extent of alignment with commissioner & WG plans

The following are the income growth assumptions the Trust has made to meet the COVID-19 recovery and response costs, new inflationary and cost growth pressures in 2022-23:

- Commissioners will uplift LTA values by 2.8% which amounts to £1,968k core uplift in 2022-23, 1.5% (£1,104k) 2023-24 and 0.75% (£591k) in 2024-25 in line with the HB Allocation Letter.
- WG will fund the Trust directly the 2022-23 pay award costs for Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB), once nationally agreed.
- Commissioners will pass through as additional income to the LTA the 2021-22 Agenda for Change (AfC) and Doctor & Dentist Review Body (DDRB) costs as per the WG Pay award matrix.
- The Trust has applied a planning assumption for the new pay deal of 3% uplift in 2022-23 and 2% in both 2023-24 and 2024-25, but it is assumed WG will fund the actual costs once future pay deals are agreed.
- The Trust will continue to receive pay award funding for being a provider per the pay matrix which is currently assumed at £81k for each year.

- The cost increase in employer's pension contributions from 14.3% to 20.6% will continue to be paid by WG for the period of the plan.
- Following the issue of the Director General of H&SS letter on 14.03.22 the Trust is assuming that funding cover will be provided by WG for the Exceptional National Pressures estimated cost of £1,150k, which includes the forecast increase in energy / fuel currently estimated at £600k although there is a risk this could increase due to the conflict between Russia and Ukraine and additional employers NI contributions (1.25%) c£550k. The Trust is assuming WG will provide funding cover for the actual 2022-23 Exceptional National costs outturn, given the uncertainty around the energy / fuel cost forecast.
- If WG identifies additional funding to HBs above the 2.8% core uplift, the Trust will receive a % uplift of the same to its LTA values.
- The Trust anticipates that the full amount of identified income requirement in relation to COVID-19 response and recovery costs will be provided by commissioners and WG.

    - Following the issue of Director General of H&SS letter of 14.03.22 the Trust is assuming WG will provide financial cover for the Covid response costs it incurs in 2022-23. However, whilst commissioners have confirmed they have identified funding in their financial plans for Velindre Covid Recovery internal capacity, which the Trust has put in place with a cost of £4,400k for staffing & infrastructure, it is essential that this funding is passed to the Trust irrespective of the activity HBs refer to the Trust.

    - Beyond the existing internal capacity already in place, it is anticipated that external outsourced capacity will be required to meet projected demand. The maximum anticipated utilisation cost is forecast at £4,150k for a full year of service delivery, however income will be recovered from commissioners commensurate with the cost of actual activity outsourced. The Trust is assuming that Commissioner's financial plans will provide income cover up to the forecast cost in order that the Trust can meet cancer treatment times for their patients and avoid breaches. It is not clear if commissioners have identified funding in their financial plans for this external capacity.

- The Trust will receive pass through income from commissioners to cover the cost of NICE / High-Cost drugs VCC uses in delivering cancer care. The forecast annual cost growth has been estimated using historic trends and the latest horizon scanning, this amounts to £10,695k increase in 2022-23, £9,000k increase in 2023-24 and £10,000k increase in 2024-25.
- The Trust will receive pass through income from LHBs to cover the cost of wholesale blood derived products WBS supplies to them. The forecast annual cost growth for 2022-23 has been calculated based an estimated 10% volume growth and general price inflation totalling (£1,676k).
- The Trust will be submitting a business case to seek funding from the WG Value Based Healthcare (VBHC) fund and will be discussing with HEIW proposals around its needs in relation to the additional funding for Workforce, Education and Training, although no income is currently reflected within the IMTP as the Trust is still developing its plans.
- WG has confirmed funding of the WBS business case costs for Occult Hep B Core Testing.

- WG will fund the WBS Plasma for Medicines (Fractionation) business case costs should WG decide to progress with this service development
- The Trust will receive additional income from commissioners to cover any new service developments they agree to invest in, should funding not be agreed, developments and infrastructure will not be implemented, and costs will need to be mitigated or removed. These key service infrastructure, quality improvement, activity growth and cost pressures have been shared with Commissioners including:

	2022/23			Incremental Income			
LTA Service Growth Investment	**LHB** **£000**	**WHSCC** **£000**	**TOTAL** **£000**	**IMTP Total 2023/24 £000**	**IMTP Total 2024/25 £000**	**IMTP Total 2025/26 £000**	**IMTP Total 2026/27 £000**
TCS Service Development Acute Oncology Services	714		714	260	34	0	0
TCS Service Development Integrated Radiotherapy Solution	287		287	347	0	619	0
SACT Medicine Infrastructure Financial impacts (MIFs) 2021-22	100		100	100	100	100	100
Radiotherapy Service Implementation	361		361	361	0	0	0
Stereotactic Ablative Body Radiotherapy (SABR) for Oligometastatic Disease and Hepatocellular Carcinoma (HCC)		208	208	0	0	0	0
High Dose Brachytherapy for Prostate Cancer		286	286	0	0	0	0
EU Directive on In Vitro Diagnostic Device (IVDD/IVDR) Regulation		750	750	0	0	0	0
TCS Radiotherapy Satellite Centre - Transition Cost				79	634	0	0
TCS Radiotherapy Satellite Centre - Fixed Cost Fee				72	928	0	0
TCS Radiotherapy Satellite Centre - Predicted Marginal Activity Growth					Marginal Income for activity growth via LTA		
TCS nVCC OBC Planned Recurrent Funding Requirement						2,709	903
TCS nVCC OBC Planned Transition Funding Requirement						1,558	519
TCS Outreach Programme				Planning work ongoing with LHBs to identify requirements			
Total Service Improvement & Growth	**1,462**	**1,244**	**2,706**	**1,219**	**1,696**	**4,986**	**1,522**
Commissioner Funding in IMTP	**814**	**958**	**1,772**	**511**	**1,696**	**4,367**	**1,522**
Trust Funding from 2.8% Core LTA Uplift income	**648**	**286**	**934**	**708**	**0**	**619**	**0**
Total	**1,462**	**1,244**	**2,706**	**1,219**	**1,696**	**4,986**	**1,522**

Pay Related Cost Assumptions:

- Pay Inflation funding received will cover the cost growth:
  - For staff on **Agenda for Change** Terms & Conditions Trust planning assumed **3%** pay cost increase for 2022-23, 2% for both 2023-24 and 2024-25.
  - For staff on **Doctors & Dentists** Review Body Terms & Conditions assumed an average **3%** pay cost increase for 2022-23, and 2% for 2023-24 and 2024-25.

- The increase in NI rates (1.25%) will be funded by WG, current planning assumptions assume the cost for 2022-23 will be c£550k.
- The employers pension contributions cost increase 14.38% to 20.6% will continue to be paid directly by Welsh Government. The 2022-23 cost estimate for Velindre Trust Core (Excluding NWSSP & NWIS) is £2,743k, 2023-24 £2,798k and 2024-25 £2,854k.

Non Pay Related Cost Assumptions

- The average % growth in spend on NICE/HCD and latest Velindre Horizon Scanning Group has been used to estimate a c£10,965k growth in cost for 2022-23 and £9,000k growth in 2023-24 and £10,000k in 2024-25 as agreed with our Commissioners.
- Wholesale blood products cost and volume growth has been included as £1,676k for 2022-23 which is 10% increase. Price and volume growth figures are very uncertain due to the difficulties in forecasting the recovery from the COVID-19 pandemic but assumed income will match expenditure incurred.
- The exceptional National Cost Pressures of £1,150k have been categorised as a forecasted increase in energy / fuel price currently estimated at £600k although a risk this may rise further, additional employers NI contributions c£550k.
- The normal national cost pressures have been estimated at £578k, which includes WRP contribution, Microsoft 365, national IT system projects costs. However, this also includes £180k for Brexit / Covid price inflation and £89k for living wage which the Trust does not consider are normal national cost pressures, but which are not included in the Director General for HSS letter providing funding cover.
- Non-pay inflationary pressures and local cost & growth pressures have been specifically identified for 2022-23.
- Non-pay Inflationary uplifts on Welsh NHS SLAs of 2.8% (£90k) have been assumed for 2022-23 on the basis of that a 2.8% core funding uplift to LTA values is passed through to the Trust.

Local core service growth and cost pressures

The Trust has undertaken a robust review of its local core service growth and cost pressures, which has resulted in a number being removed or costs reduced. The remaining pressures are key to delivering against a number of key service improvement objectives or are unavoidable cost pressures:

Local Cost Pressures	Rec / Non-Rec	IMTP Total 2022/23 £000	Rationale for Investment	Benefits / Impact
Enhanced Medical On-call on-Site Clinical Care	Rec	200	Nuffield Report recommendation to stabilse USC	Improved service quality, safety and outcomes
Radiology capacity & enhanced model investment -to achieve Single Cancer Pathway	Rec	200	Nuffield Report recommendation to enhance diagnostic capacity / SCP delivery	Increased capacity & Improved service quality, safety and outcomes

Local Cost Pressures	Rec / Non-Rec	IMTP Total 2022/23 £000	Rationale for Investment	Benefits / Impact
Contract Maintenance & Support and license Costs (above Inflation)	Rec	100	Unavoidable maintenance contract (Medical Physics & Pharmacy) cost pressures and Software for Clinical Coding 3m medicore license	Maintain core clinical systems required for service delivery
Palliative Care	Rec	106	Nuffield Report recommendation to stabalise palliative care	Improved service quality, safety and outcomes
NHS SLA Inflation	Rec	110	Required pass through 2.8% core uplift	Maintain essential support services
NWSSP ESR Recharge	Rec	18	National System upgrade	Maintain essential workforce management system
Loss of Rutherford Proton Beam Therapy SLA income	Rec	140	Unavoidable service reduction due to limited activity referred by WHSSC	Services funded through Rutherford income lost have either required new funding from 2.8% uplift or savings delivery replace
Allocate - E - Rostering & E-Job Planning Services	Rec	55	Improved workforce management & Job Planning	Improved workforce management & Job Planning
Navigator Roles	Rec	96	Nuffield Report recommendation	Improved patient experience, service quality, safety and outcomes
Regulatory Compliance - Blood sample archiving	Rec	28	Regulatory compliance	Reduced risk of clinical negligence / claims
NDR Vx Rail revenue licensing	Rec	60	Required for National Data Resource	Better integrated information to improve clinical care and business management
Employment Law Advice LR Block Charging	Rec	10	NWSSP Legal services cost increase	Improved legal services - reduced risks and associated costs
Premises Related Costs (e.g Rates, Rents)	Rec	75	Unavoidable cost pressures	Maintains current estate requirement whilst review undertaken to assess requirement
Apheresis Contract - introduce hardware costs	Rec	40	Unavoidable cost pressures	Ensure maintenance of blood & plasma supply
Other	Rec	60	Unavoidable cost pressures	
Total Local Cost Pressures		**1,298**		

Normal National Cost Pressures

These normal national cost pressures are funded in part by the 2.8% core uplift (sustainability) funding and in part from savings delivery:

Normal National Cost Pressures	Recurrent / Non-Recurrent	2022/23 £000
Microsoft 365 new contract licenses	Rec	74
RISP - All Wales Business Case	Non Rec (22-23 to 24-25)	21
LINC - All Wales Business Case	Non Rec (22-23 to 24-25)	115
WRP Additional Contribution	Rec	99
Brexit/ Covid Price Inflation	Rec	180
Living Wage Increase (Non CHC)	Rec	89
Total National Cost Pressures		**578**

Exceptional National Cost Pressures

The financial plan assumes that additional funding will be provided by WG to cover these exceptional unavoidable system wide cost pressures:

Exceptional National Cost Pressures	Recurrent / Non-Recurrent	2022/23 £000
Energy / Fuel Increases	Non Rec (22/23 & 24/25)	600
Employers NI (Health & Social Care Levy)	Rec	550
Total National Cost Pressures		**1,150**

Other Assumptions

- Prioritised service developments will be submitted to commissioners as a business case for funding consideration.
- Expectation is other cost pressures are avoided/mitigated as far as possible. Where costs are unavoidable additional savings will be delivered to fund them.

Planned Savings

The following table summarizes the level of savings the Trust is planning to deliver in 2022-23:

	2022-23 £000
CIP Planned Savings	750
Income Generation	550
Total Savings / Income Generation	1,300
CIP % (of Core LTA)	2%

Saving Theme	Saving Description	Division	Recurrent	Non Recurrent	TOTAL	Scheme Type
			£'000s	£'000s	£'000s	
Laboratory and Collection Model Efficiencies - efficiencies generated via optimised operating models	Reduced establishment resultant from model enhancement	WBS	50	-	50	Pay
Laboratory and Collection Model Efficiencies - efficiencies generated via optimised operating models	Reduced service delivery costs resultant from model enhancement	WBS	50	-	50	Non Pay
Maximising Income Opportunities - attracting additional non NHS income	Sales of expertise and bi-products into Research	WBS	50	50	100	Income
Stock Management - Non Recurrent Benefits of Stock Management	Reduced stock holding and waste via optimised stock management	WBS	100	150	250	Non Pay
Procurement - Supply Chain cost reductions	Contracting cost reductions	WBS	50	-	50	Non Pay
Service Redesign – efficiencies generated via optimised operating models, options for consideration of cessation of services and their respective consequences.	Reduced establishment resultant from model enhancement	VCC	100	-	100	Pay
Supportive Structures - efficiencies generated via optimised support services, enabled by rationalisation/centralisation/digitisation	Reduced establishment resultant from model enhancement	VCC	100	-	100	Pay
Maximising Income Opportunities - Private Patient Services	Increased volumes of private patients, fee restructure and enhanced debt recovery	VCC	150	100	250	Income
Maximising Income Opportunities - attracting additional non NHS income	Utilisation of new external funding. Enhanced cost recovery	VCC	-	200	200	Income
Procurement - Supply Chain cost reductions	Contracting cost reductions	VCC	50	-	50	Non Pay
Establishment Control	Reduced establishment resultant from model enhancement	CORP	100	-	100	Pay
Total			**800**	**500**	**1,300**	

Green RAG Rated Schemes			100	350	450	
Amber RAG Rated Schemes			500	150	650	
Red RAG Rated Schemes			200	-	200	
Total			**800**	**500**	**1,300**	

Covid

The total Trust Covid funding requirement for 2022-23 as presented in the tables below is £8,160k. The Trust has received confirmation that the £710k National response programme costs relating to both Mass Vaccination (£375K) and PPE (£335k) will be funded directly by WG, whilst our Commissioners have included £6,056k within their financial plans for Covid Recovery capacity costs. The Director General for HSS letter of 14.03.22 has provided funding cover for the estimated costs for 2022-23 of £1,394k, which is in relation to local Covid response (enhanced Infection Prevention Control (IPC) measures, Covid related sickness and social distancing measures).

Covid Funding Requirement 2022-23	WG £000	LHB £000	WHSSC £000	Total £000
Mass Vaccination	375	-	-	375
PPE	335	-	-	335
Subtotal Covid Programme Funding	**710**	**-**	**-**	**710**
Covid Recovery & Response Funding	1,394	2,880	3,176	7,450
Subtotal Covid Recovery and Response Funding	**1,394**	**2,880**	**3,176**	**7,450**

Total Covid Funding Requirement 2022-23	**2,104**	**2,880**	**3,176**	**8,160**

In addition to the COVID funding requirements described, the following tables highlight the potential utilisation of outsourced capacity required to meet demand, above investments made for enhanced internal capacity via COVID Recovery.

2022-23 Annual Forecast Activity Demand and Internal / External Capacity Requirement					
Service	**Forecast Demand (Patient Nos.)**	**Internal Capacity (Patients Nos.)**	**Capacity Shortfall (Patient Nos.)**	**External Capacity (Patients Nos.)**	**Remaining Capacity Gap (+'ve shortfall / –'ve headroom) (Patients Nos.)**
Radiotherapy (With Enhanced IPC Measures)	4212	3692	520	520	0
Radiotherapy (No Enhanced IPC Measures)	4212	4004	208	520	-312

Service	Forecast Demand (Annual Patient Cycles)	Internal Capacity (Annual Patient Cycles)	Capacity Shortfall (Annual Patient Cycles)	External Capacity (Annual Patient Cycles)	Remaining Capacity Gap Gap (+'ve shortfall / –'ve headroom) (Annual Patient Cycles)
SACT Delivery	32240	30160	2080	2496	-416
Total	**40664**	**37856**	**2808**	**3536**	**-728**

It should be noted that this highlights that the annual forecast additional outsourced capacity may not fully be required, however this is dependent on demand and internal capacity assumptions being fulfilled.

2022-23 Annual Forecast Investment for Internal / External Capacity at Maximum Utilisation			
Service	**Internal Capacity (£'000)**	**External Capacity (£'000)**	**Total Capacity (£'000)**
Radiotherapy	1,592	2,900	4,492
SACT Prep & Delivery	1,207	1,250	2,222
Outpatients	698	0	698
Total	**3,497**	***4,150**	**7,647**

It should be noted that a proportion of Outpatient activity are SACT treatment appointments contributing to internal capacity.

**The £4,150 external capacity for outsourcing is not included with the summary of financial plan table on page 5 or within the MDS tables, however, is a requirement for the Trust which is based on the maximum cost exposure.*

The £3,487k internal additional Covid recovery capacity cost is included within the Covid Recovery & Response Funding requirement of £7,450k within the LHB and WHSSC figures

Contracting Model

The National Funding Flows discussion will determine the contracting arrangements for 2022-23, it is assumed that these temporary measures will be sufficient to meet the costs of delivery.

The Trust will continue to work with Commissioners to agree the process and timing of when the new model will go live. Consequences of the post COVID-19 "new normal" service delivery models and clinical pathways will require a review of the contract currencies and associated cost pools to ensure their appropriateness, monitoring of contract performance during 2022-23 will inform the prioritization of areas for review.

Financial Risks and Opportunities

There are a number of financial risks that could impact on the successful delivery of the plan. The Trust recognises this and is taking appropriate actions as set out below, in order to ensure risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and any identified risks are included within the Trust Assurance Framework and Trust wide Risk Register.

Key Financial Risks	Worst Case £'000	Best Case £'000	Risk Mitigation
Financial Plan Outturn	**0**	**0**	
Full Covid funding not flowing from Commissioners	TBC	0	Trust still in discussion with commissioners around strategic principles for funding Covid recovery capacity already in place in stead off national funds flow mechanism
Costs of service delivery for outsourced activity beyond internal planned volumes	(4,150)	0	Based on modelling of demand the additional covid recovery internal capacity established at Velindre and reinstated via HB outreach will be exhausted, outsourcing of activity to the Rutherford Cancer Centre will be required incurring a premium cost. This is the maximum cost exposure. There is a risk that Commissioners will not fund this cost.
Non-delivery of amber / red saving schemes	(850)	0	Service to urgently review savings schemes that are classified as red or amber with a view to turn green or find replacement schemes
Further rise in energy prices	(600)	0	Will form part of all Wales approach, reviewed and mitigated by EPRMG group.
Delayed implementation of Integrated Radiotherapy Solution (IRS)	(250)	0	Review Divisional budgets to absorb costs for up to 6 months prior to implementation.
Management of operational Pressures	(250)	0	Further Operational cost pressures to be mitigated at divisional level
Microsoft Agreement (Increase above figure included within Plan)	(126)		Inflated figures recently provided by DHCW with challenge from Trust on rationale for increase.
Total Risks	**(6,226)**	**0**	
Key Financial Opportunities	**Worst Case £'000**	**Best Case £'000**	**Opportunity application and action**
Covid Cost Reduction	TBC	TBC	Mitigation from plan by reducing Covid related expenditure
Further vacancy turnover savings above the vacancy factor held in divisions	200	400	Used to provide non-rec savings against savings schemes that are either amber or red.
Emergency Reserve	500	500	Reserve held for emergency expenditure but could be released to support position if no unforeseen costs materialise.
Total Opportunities	**700**	**0**	
Net Financial Risk	**(5,526)**	**900**	

Capital Plans for the Trust

The focus of the capital investment Programme it to maintain a high quality environment in which to collect, transport, process & supply blood, treat cancer patients and provide modern treatment equipment.

£69.7m of the capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All Wales Capital Fund. £24.981m has been submitted and agreed to date in relation to TCS (£23.902m), Fire Safety (£0.500m), and the Digital Cancer project (£0.579m). Further schemes to be considered for approval include additional TCS requirement of (£3.795m), Integrated Radiotherapy Solution (IRS) (£37.929m), WBS HQ infrastructure (£22.500m), Ventilation (£2.491m), VCC Outpatients (£1.2500m), WBS Hemoflows (£0.224m), WBS Fleet Replacement over the next four years totaling (£1.236m). Scalp Cooler Upgrade (£0.250n) and Plasma Fractionation with costs to be confirmed.

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

Summary of Capital Plans & Approved Funding	**2022-23 £m**	**2023-24 £m**	**2024-25 £m**	**2025-26 £m**	**2026-27 £m**	**Total All Wales Schemes £m**
Proposed All Wales Schemes	6.360	23.502	22.437	13.873	3.503	69.675
Proposed Discretionary Schemes	1.454	1.454	1.454	1.454	1.454	
Total Capital Schemes Proposed	**7.814**	**24.956**	**23.891**	**15.327**	**4.957**	
All Wales Schemes Funding Approved	**24.981**	**0.000**	**0.000**	**0.000**	**0.000**	
Total Capital Plans	**32.795**	**24.956**	**23.891**	**15.327**	**4.957**	

Part 8

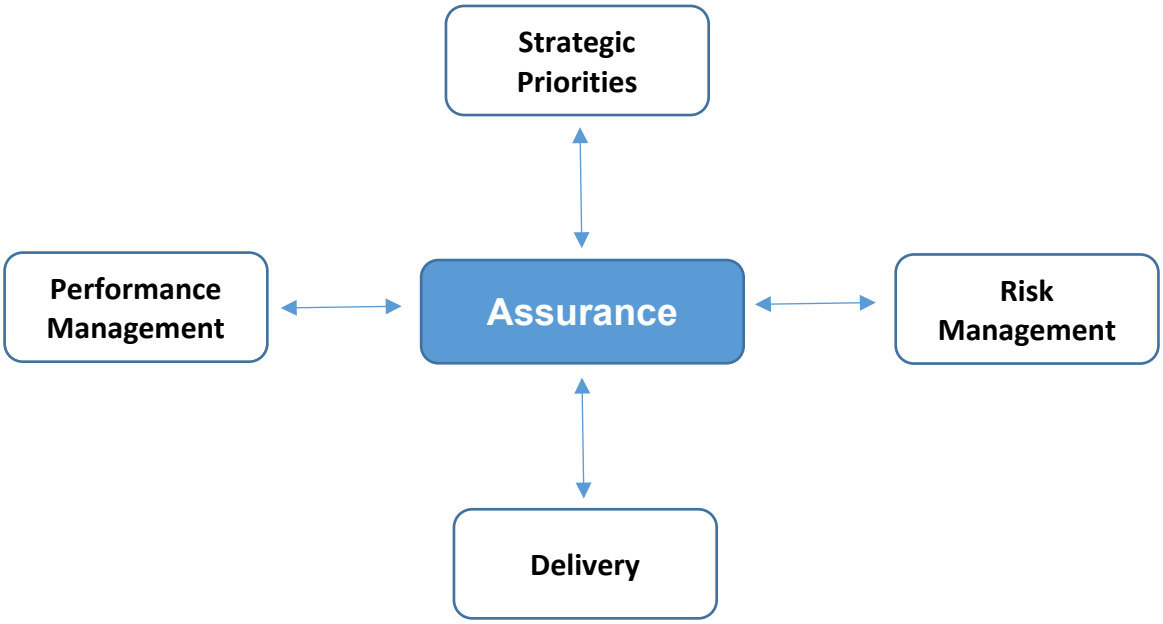
Our Performance Management Framework

We set out how we will manage the delivery of our plan and monitor progress in delivering the changes we wish to see.

Managing the Delivery of our Plan

We utilise an Integrated Framework to manage the delivery of service and strategic plans. This ensures that there is a '*golden thread*' that links all organisational plans and priorities, risk, delivery and measurement into an overall system of assurance.

Integrated Performance, Risk and Assurance Framework



Plans and priorities - Our strategic aims and priorities are set out within our strategies and translated into specific objectives and actions within this plan.

Delivery - The focus of delivery are the divisional service plans which set out the actions we will take to deliver the identified priorities and objectives.

Performance Measures - We use a range of quantitative and qualitative information to allow us to monitor our progress.

Risk Management - We assess the risk of achievement against each of our strategic aims, priorities and objectives as part of the planning process.

Performance Management Framework

We use a robust framework to support our staff in achieving the improvements required and in delivering our plan. The system is based upon four main elements:

- A clear set of aims, objectives, plans and supporting actions to improve quality
- A range of performance measures
- A regular process of monitoring and review
- A process of escalation/action if we are not on track to achieve our aims.

However, and despite the robust existing arrangements, a key priority for us during 2022 – 2023 will be further enhance our Performance Management Framework (PMF).

This is in line with the Welsh Governments introduction of quality statements in '*A Healthier Future for Wales' (2018 to 2030)'*, and has been described in the National Clinical Framework, as the next level of national planning for specific clinical services. It forms part of the enhanced focus on quality in healthcare delivery that was put forward in A Healthier Wales and the Quality and Safety Framework (QSF).

Governance Arrangements

The Board is accountable for governance and internal control of those services directly managed and for services delivered via hosting arrangements. The Board discharges its responsibilities through its Committees and scheme of delegation.

Delivering our Plan

Our plan sets out a clear set of milestones and trajectories that are owned by the Board who will receive a regular assessment of progress against the plan. Responsibility for delivering the plan is discharged to the divisional Senior Management teams who manage the detailed progress of service objectives and their associated performance and risks. Regular meetings between the divisions and the Executive Directors will take a more strategic overview of progress.

Whilst the plan objectives and related performance will be scrutinised by the most appropriate committee, the Planning and Performance Committee will assume overall responsibility for challenging plan progress and providing assurance to the Board.

Commissioning Arrangements

Health Boards are responsible for commissioning cancer and blood services from the Trust. However, there is a common view that the current arrangements are not sufficient to meet the future needs of the Trust in delivering services on behalf of our commissioners and the patients and donors who use them. We are therefore committed to working with our Health Board partners and the Welsh Government to develop a planning, commissioning and funding framework that provides us with the greatest opportunity to achieve our ambitions and achieve the levels of excellence that people can be proud of.

Implementation: How will we measure success?

We will track implementation of our plan through a small number of key metrics and strategic markers, which will be underpinned by more detailed reporting. The following metrics will be used to monitor and track implementation as they:

- **Provide a headline picture against our strategies and plans as a whole.** Identifying a small number of headline metrics allows for a simple mechanism to track progress and report to our patients, donors, staff and partners.

- **Includes a mixture of process, output and outcome measures.** This allows us to track specific actions in the short-term (process and output measures) and ensure they are translating into real change in the longer-term (outcomes and benefits).

Part 9

Appendices

Trust Programmes and Trust Support Functions Key Deliverables and the Welsh Government Minimum Data Set

APPENDIX A

Trust Programmes – Key Deliverables 2022 to 2025

[Attached separately]

APPENDIX B

Trust-wide Support Functions – Key Deliverables 2022 to 2025

[Attached separately]

APPENDIX C

Velindre University NHS Trust Minimum Data Sets (MDS) Welsh Government Return

[Attached separately]

TRUST BOARD

QUARTERLY ACTION PLAN 2021/22 – QUARTER 3 PROGRESS UPDATE

DATE OF MEETING	31/03/2022

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Cath O'Brien, Chief Operating Officer / Carl James, Director of Strategic Transformation, Planning, Performance and Estates
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Chief Operating Officer / Carl James, Director of Strategic Transformation, Planning, Performance and Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board - Run	07/03/2022	NOTED
Quality, Safety & Performance Committee	24/03/2022	NOTED

ACRONYMS	
VUNHST	Velindre University NHS Trust

QSP	Quality Safety and Performance Committee
VCC SMT	Velindre Cancer Centre Senior Management Team
WBS SMT	Welsh Blood Service Senior Management Team
EMB	Executive Management Board
IQPD	Integrated Quality Planning and Delivery (Welsh Government review meeting)
RAG	Red Amber Green – quarterly action progress rating

1. SITUATION/BACKGROUND

1.1 The Quarterly Action Plan for this financial year was developed as part of the Annual (IMTP) Plan for 2021/22 which was approved by the Trust Board on 28th June 2021. The action plans *(see Annex 1 (VCC) / Annex 2 (WBS)*) monitor progress against the Trust's operational planning intentions by quarter for the current financial year.

1.2 Regular progress reports are presented to Executive Management Board (EMB) and Quality Safety and Performance (QSP) Committee. Updates are also provided to the bi-monthly Welsh Government Integrated Quality Planning and Delivery (IQPD) review meetings.

1.3 The purpose of this paper is to provide assurance to the Trust Board on progress being made against our quarterly actions for 2021/22 and will form the basis of information shared with IQPD.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Whilst good progress has been made against 2021/22 quarterly actions, due to recent Omicron COVID-19 operational pressures, a number of 2021/22 actions have been *'delayed'* in Q3.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	All plans are subject to the Trust quality assurance framework and the processes established during the Covid 19 outbreak.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
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)
	Financial impact of all service changes are being monitored and reviewed with finance colleagues for onward engagement with Welsh Government on Covid related costs.

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the content of this report.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

ANNEX 1 VELINDRE CANCER CENTRE

	VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTIONS BROUGHT FORWARD FROM 2021/22 ANNEX 1 - VELINDRE CANCER CENTRE								Progress Updates from Action Leads
ID	**Covid Harm**	**REF**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**February 2022**
VQ2	Covid	VQ 2.3	Continue to manage repatriated patient activity until safe plans are agreed with HBs	VCC	SACT Lead	Q1	Q4	**Green**	We are delivering SACT across VCC site, maximizing capacity and productivity, covering all HB area patients.
VQ2	Non Covid	VQ 2.4	Develop plans with all HB partners to deliver a safe return of SACT outreach services	VCC	SACT Lead	Q1	Q3	**Amber**	PCH has returned to 50% capacity. Increase in Tenovus mobile unit sited in ABUHB from 2 to 3 days. All other patients continue to be treated at VCC. There are plans for a new unit at Neville Hall, however no absolute deadline has been agreed. Discussions continue between ABUHB and VUNHST.
VQ2	Over Whelm	VQ 2.6	Implement capacity delivery options to meet demand changes	VCC	Senior Management Team.	Q1	Q4	**Green**	Targeted delivery plans in place supporting all areas to meet demand growth, supported by detailed demand forecasts.
VQ2	Societal	VQ 2.10	Workforce development and recruitment plan to be developed to support options	VCC	W & OD Lead	Q1	Q3	**Green**	Workforce plans in place for recruitment, retention.
VQ2	Covid	VQ 2.20	Gather patient feedback on the use of virtual appointments	VCC	Patient Experience/OPD Business Manager	Q1	Q4	**Green**	Survey tool developed and patient feedback process now in place.

	VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTIONS BROUGHT FORWARD FROM 2021/22 ANNEX 1 - VELINDRE CANCER CENTRE								Progress Updates from Action Leads
ID	**Covid Harm**	**REF**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**February 2022**
VQ3/4	Covid	VQ 3/4.8	Deliver and manage the private sector additional capacity provision in line with contractual requirements	VCC	Director of Cancer Services	Q1	Q3	**Green**	All private sector capacity secured through formal contracts and managed in accordance with those requirements.
VQ3/4	Covid	VQ 3/4 12	Relocate Phlebotomy service to support effective social distancing in outpatient department and to increase OP throughput	VCC	Director of Cancer Services	Q2	Q4	**Amber**	Phlebotomy service repositioned along with wider OP department patient flow changes. Permanent plan to move Phlebotomy is part of OP development plans which require major investment programme tba with WG.
VQ3/4	Covid	VQ 3/4 12	Continue to offer Phlebotomy services and monitor activity levels while initiating discussions on sustainable service model with Health Boards	VCC	Director of Cancer Services	Q2	Q4	**Amber**	Limitations on DGH and GP surgery access. Pressure on OP space as a result. Little progress on HB's repatriating phlebotomy to local provision. Being picked up by OP task and finish group commenced February 2022.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-4	Covid	V01	VCC Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations and Minimising the Risk of COVID-19 transmission – including enhanced infection control measures, vaccination and testing strategies during 2021/22	To maintain safety of patients and staff through ensuring appropriate range of measures relating to infection prevention, site access, social distancing, communication and engagement strategies (including the provision of advice and information), vaccination and testing.	Continued roll out of lateral flow testing and patient testing in accordance with WG guidance	VCC	General Manager	Q1	Q4	**Green**	The Trust continues to implement the use of Lateral flow testing in line with WG guidance for all staff in healthcare settings and all patients before they commence a course of treatment.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-4	Covid	V04	VCC Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations and Minimising the Risk of COVID-19 transmission – including enhanced infection control measures, vaccination and testing strategies during 2021/22	To maintain safety of patients and staff through ensuring appropriate range of measures relating to infection prevention, site access, social distancing, communication and engagement strategies (including the provision of advice and information), vaccination and testing.	Revise and implement new Home Working plan	VCC	General Manager	Q1	Q4	**Green**	Trust established Agile Working Board. Detailed analysis of home working activity, space availability and utilisation undertaken. Staff survey and focus groups on 'workspace' requirements undertaken. Recovery actions to follow WG advice on continued home working and workplace rules regarding 1 or 2 metre rule.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-3	Covid	V05	VCC Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations and Minimising the Risk of COVID-19 transmission – including enhanced infection control measures, vaccination and testing strategies during 2021/22	To maintain safety of patients and staff through ensuring appropriate range of measures relating to infection prevention, site access, social distancing, communication and engagement strategies (including the provision of advice and information), vaccination and testing.	Establish staff wellbeing unit	VCC	General Manager	Q1	Q4	**Amber**	Detailed accommodation requirements developed. Some digital equipment has been purchased and wider capital bid under development.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1 -4	Non Covid	V07	Priority 2: Delivery of appropriate capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment responding to further phases and government guidance including adaptation our clinical model as appropriate and reinstatement of local services with Health Boards.	To provide sufficient capacity to meet patient demand in 21/22 and to plan for future service requirements.	Develop the demand and capacity modelling infrastructure	VCC	Head of Planning	Q1	Q4	**Green**	Detailed demand model completed to ensure that we are able to predict demand at various points in patient pathways. This gives us early operational warnings of increases /decreases in volumes. We are also able to model overall demand projections impacting on OP, Radiotherapy and SACT services.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-2	Non Covid	V08	Priority 2: Delivery of appropriate Outpatient capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment.	To provide sufficient capacity to meet patient demand in 21/22 and to plan for future service requirements.	Return outreach provision to Local Health Board sites.	VCC	General Manager	Q1	Q4	**Amber**	We have maximised the use of virtual consultations to keep patients safe and accommodate the initial HB outreach activity at VCC. We have now returned over 80% of outpatient outreach back to HBs. Further work is required in partnership with HB's to address some of the gaps in clinic support when delivering services in outreach settings. This is impacting on our ability to fully return to our outreach clinical model.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-4	Non Covid	V10	VCC Priority 2: Delivery of appropriate Radiotherapy capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment.	To provide sufficient capacity to meet patient demand in 21/22 and to plan for future service requirements.	Fully explore and deliver capacity through third party suppliers as appropriate	VCC	Head of Radiotherapy	Q1	Q4	**Green**	Formal agreement with Rutherford Cancer Centre in place for radiotherapy provision. First patients using this pathway treated in July 2021. SACT agreement with Rutherford commenced in April 2022.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1-4	Non Covid	V11	VCC Priority 2: Delivery of appropriate capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment.	To provide sufficient capacity to meet patient demand in 21/22 and to plan for future service requirements.	Work with each SST to revise and optimise clinical pathways	VCC	Clinical Director	Q1	Q4	**Green**	Work continuing on Single Cancer Pathway (SCP) implementation which involves pathway review and improvement. Review sessions planned for each SST.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1 - 3	Covid	V15	VCC Priority 2: Delivery of appropriate SACT capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment.	To provide sufficient capacity to meet patient demand in 21/22 and to plan for future service requirements.	Establish supressed demand capacity for SACT	VCC	Head of SACT	Q1	Q4	**Green**	The primary driver for SACT demand is the internal increase in cycles of treatment for existing patients. This is as a result of improving patient's response to new/combination treatment regimes. Additional capacity has been in place throughout 21/22, however service pressure due to staff absence levels has increased in 2022. A task and finish group has commenced to scope further actions to support increased SACT capacity options.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ3	Non Covid	V17	VCC Priority 2: Delivery of appropriate capacity to meet patient demand and continue to operate in a COVID-19 pandemic environment.	To successfully deliver the Digital Health and Care Record replacement for CANISC and the next stages in the procurement of the Integrated Radiotherapy Solution. To further develop the Velindre Futures Initiative as the vehicle for service transformation.	Delivery of DHCR project including operational change in system use	VCC	Director of Cancer Services	Q1	Q4	**Amber**	DHCR plan slipped in year and has been delayed until 2022/23. IRS progressing to contract award stage. Velindre Futures programme embedded in each directorate.

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VQ 1 - 4	Non Covid	V19	VCC Priority 3: Deliver business critical initiatives through Velindre Futures as well as the outputs of the first phase and our service development plans.	To successfully deliver the Digital Health and Care Record replacement for CANISC and the next stages in the procurement of the Integrated Radiotherapy Solution. To further develop the Velindre Futures Initiative as the vehicle for service transformation.	Establish VF staff engagement programme	VCC	Director of Cancer Services	Q1	Q4	**Green**	Velindre Futures Programme structure in place with associated communication and engagement plan under constant review. Programme embedded in each directorate and delivering against agreed priorities.

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
ID	**COVID Harms**	**REF**	**Priority Areas**	**Key Objectives**	**Agreed Quarterly Actions**	**Work Area**	**Action Leads**	**Start Date**	**End Date**	**BRAG Rating**	**Last updated: February 2022**
VQ 1 - 3	Non Covid	V21	VCC Priority 4: Engagement with Health Boards and Regional Service Planning – including developing the regional approach in line with Nuffield recommendations	Regular meetings with each Health Board operational and cancer leads to address the challenges of service delivery and working with the CCLG to develop a regional service planning approach to cancer services in SE Wales.	Regular meetings with each Health Boards	VCC	Head of Planning	Q1	Q4	**Amber**	Regional Partnership Board meeting regularly with full Programme governance structure in place. Planning and operational meetings have commenced with HBs.
VQ 1-2	Covid	V22	VCC Priority 5: Patient Experience and Engagement – recognising and responding to the impact of COVID-19	To further develop our patient engagement approach and our patient experience gathering capability.	Establish project to develop a few Patient Engagement Framework for VCC Implement the new NHS Wales system for Patient Experience	VCC	General Manager	Q1	Q4	**Green**	Significant work undertaken to gain patient and staff views on development of the framework. CIVICA Once for Wales Patient Experience System went live on 29th July 2021. Ongoing phased plan for roll-

VELINDRE UNIVERSITY NHST OPERATIONAL PLAN QUARTERLY ACTION PLANS 2021/22 ANNEX 1 – VELINDRE CANCER CENTRE											Progress Updates from Action Leads
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											out and optimisation.
VQ2	Covid	V03	VCC Priority 1: Ensuring that Staff and Patients are Safe at our Treatment Locations and Minimising the Risk of COVID-19 transmission – including enhanced infection control measures, vaccination and testing strategies during 2021/22	To maintain safety of patients and staff through ensuring appropriate range of measures relating to infection prevention, site access, social distancing, communication and engagement strategies (including the provision of advice and information), vaccination and testing.	Delivery of vaccination programme	VCC	General Manager	Q1	Q3	**Green**	Trust Programme Board ensured delivery of COVID19 booster and flu vaccination as planned. Trust stepped down as part of wider NHS Wales vaccination programme.

objective	ID	Deliverables	op lead	SMT lead	Delivery date	Current position	Status at 28/02/2022
Strategic priority 1.		**Excellence in service delivery**					
To provide a modern, safe and sustainable blood and transplantation service	**1.01**	Review and develop revised WBS 5-year strategy, supported by an approved IMTP 2021/22	Rachel Hennessy	Rachel Hennessy	Q4	5-Year strategy approved by SMT 9/02/2022 to be considered by EMB 21/02/2022	**CLOSED**
	1.02	Ensure structure and project plan is in place to support the development of OBCs for Infrastructure PBC and implementation of phase 1 'ventilation' Ensure Models developed and OBC to support implementation of further phases including sanitation and renewable energy and lab modernisation	Jason Hoskins	Rachel Hennessy	Q4	OBC writer appointedFeb 2022. Lab modernisation to be excluded from the OBC for infrastructure Prgramme. OBC to be submitted April 2022	
	1.03	To consider and implement the findings of the clinical services review in line with clinical & service priority ensuring effective use of clinical and scientific resources	Zoe Gibson/Janet Birchall	Janet Birchall	Q4	Paper for Consultancy approved by SMT, actions to follwing post March 2022	

objective	ID	Deliverables	op lead	SMT lead	Delivery date	Current position	Status at 28/02/2022
	1.04	Develop a prioritised capital plan which reflects service requirements, secure funding and ensure clear plans are in place for delivery of approved programme.	Angela Robins	Rachel Hennessy	Q3	Capital plan supported by SMT, Trust Capital Group and by Trust EMB	**CLOSED**
	1.05	To develop a plan to ensure patient and donor testing platforms in the transfusion labs are updated including implementation of: - blood grouping/Immunohematology analysers - flow cytometers - bacteriology monitoring equipment - HbS Testing solution	Emma Cook/ Georgia Stephens/Deb Pritchard	Tracey Rees	Q4	Flow Cytometers are undergoing validation. BactAlert – procurement process underway. ABO Analysers- procurement process underway - now in implementation Phase HbS – paper received by SMT Feb 2022, implementation end of Q3 2022/23	

objective	ID	Deliverables	op lead	SMT lead	Delivery date	Current position	Status at 28/02/2022
						Bacteriology monitoring equipment due to be delivered in Q4 21/22, expected to be completed in Q1 22/23 Primary analysers expected to be completed by end of Q2 22/23	
	1.06	Scope and develop a Fleet Strategy and implementation plan in line with the revised strategic intent for the Collection model	Clive Francis/Simon Davies	Jayne Davey	Q4	TCV order now placed. Delivery forecast by March 2023 Electirc Vehicle - recieved	

To ensure the support functions that operate as part of the General Services Department are fit for purpose and integrated within service delivery across WBS.	**1.07**	To review the service model for estates and facilities in collaboration with wider Trust service model	Jason Hoskins	Rachel Hennessy	Q4	Service model in process of being developed for consideration by SMT	
	1.08	To review the service model for Business Intelligence in collaboration with wider Trust service model	Rachel Hennessy	Rachel Hennessy	Q4	Further discussions to take place across VUNHST	
	1.09	To review the service model for IHub and programme management in collaboration with wider Trust service model	Sarah Richards	Rachel Hennessy	Q2	Service model reviewed and considered by SMT April 2021.	**CLOSED**
To ensure compliance with regulatory and clinical governance standards across all service areas, where gaps are identified, plans are	**1.1**	Implementation of actions to support compliance with Fire safety requirements in line funding received as part of WG business case	Jonathan Fear/Jason Hoskins	Rachel Hennessy	Q4	Fire alarm upgrade complete Fire Doors have to be retendered due to lack of interest from the market and required updates to scope. This work will roll	

developed and implemented						over into the next finacial year.	
	1.11	Initiate donor individual review findings	Stuart Blackmore	Janet Birchall	Q2	FAIR Implementation due to go live on the 14.6.21 FAIR has gone live	**CLOSED**
	1.12	Scope wider QA role across NHS Wales including cell & gene and other pathology	Peter Richardson	Peter Richardson	Q2	Provide advise on regulator framework on ongoing basis. Cell and Gene therapy is not a deliverable for QA	**CLOSED**
Support UK Infected Blood Inquiry and delivery of its Terms of Reference	**1.13**	Continued engagement with UK Infected Blood Inquiry (IBI)	Cath O'Brien	Cath O'Brien	Q4	Blood inquiry continues. It has taken evidence from blood services in Q3 and Q4 and timeline has been extended to 2023	
To provide a National External Quality Assessment Scheme (NEQAS) service	**1.14**	Evaluate reporting and quality of samples distributed	Deb Pritchard	Tracey Rees	Q4	Complete	**CLOSED**
Ensure availability of plasma derived	**1.15**	Develop a project plan to support the future expansion of plasma	Peter Richardson	Peter Richardson	Q4	Formal request from WG to support All wales programme board	**CLOSED**

medicines across Wales in immediate to longer term		derived medicine across Wales				which will define the strategy and operation al planning required. Discussion are ongoing regarding the resources required, WBS to respond Backfill position has been advertised.	
	1.16	IVIG Strategy – scope & interrogate data to reduce variation across NHS Wales IVIG strategy – translate data insight to reduce variation	Chloe George	Peter Richardson	Q4	WBS providing IVIGs to BCUHB effectively creating a national service for Wales. Now complete	**CLOSED**
Meet service development needs to address changes in practice in line with evidence base	**1.17**	New Foetal D screening service model to be scoped and pilot implemented	Deb Pritchard	Tracey Rees	Q4	Agreed start of project May 2022 Awaiting update from Antenatal Screening Wales.	
	1.18	Clinic digitalisation, link up heamaflows to ePROGESA	Sally Gronow	Jayne Davey	Q4	Not able to pursue Capital funding due to delivery time exceeding March 2022. To be added	

						to capital plan for 2022/23 - no further update	
	1.19	Review and update the platelet, plasma and Cryo component strategy and implement changes to include - the production of male only derived cryo - requirements of solvent/detergent plasma and transition to FFP - apheresis/pooled ratio	Georgia Stephens	Tracey Rees	Q4	1. Male only derived cryo production is implemented, the e-ePROGESA controls configuration being planned with IT, estimated work timescale for this work to be completed is Jan-Feb 2022 due to competing priorities on the IT Backlog. Will be followed up via the ongoing change process. 2.A SBAR for the requirements of solvent/detergent plasma and transition to FFP was submitted and accepted in RAGG meeting in August. Phased implementation planned to start in September, with	

						ongoing evaluation of impact on stocks as implementation is rolled out to each Health Board. Implementation delayed to October due to stock assessment and change control activities. This has now been implemented 3. The need to review the WBS platelet strategy was discussed in the Demand Planning Group meeting in August. The group agreed to take this topic forward for scoping with view to develop a new platelet strategy subject to SMT approval. This item is expected to be 'in progress' at end of Q3. It was agreed that a project/T&F Group will be established	

						to review the WBS strategy. No timelines available to date. Progress now expected in Q4. Plan to take forward via Demand Planning not agreed, awaiting SMT lead and prioritisation. Omicron variant pressures means that this objective is further delayed and will not be delivered by end of March 2022.	
To ensure staff have the skills, competencies and opportunities to develop themselves within WBS and beyond	**1.2**	Management and leadership development needs identified and implemented as appropriate	Angela Voyle-Smith	SMT	Q4	Management and leadership development needs identified and implemented as appropriate. Inspre programme has begun and currently on Cohort 3, with cohort 4 planned for April/May and cohort 5 in September	**CLOSED**

Ensure there is a planned and sustainable workforce model that supports and shapes WBS now and in the future	**1.21**	Developing the talent management /succession planning process that supports flexible career pathways	Sue Price (Donna Dibble)	SMT	Q4	Career Pathways have been developed for Nurses and Scientist and are ready to be uploaded to the new WBS website, when this is launched. New website luanch at end of March. Initial meeting staged with the porduction company and further detail of filiming needs now provided and being evalauated. Still working to 31/03/2022	**CLOSED**
	1.22	Develop a clear recruitment strategy and plan for implementation targeting specific areas of shortage and using a range of communication channels, focussing on Bi-lingual recruitment to grow our Welsh speaking workforce, flexibility	Sue Price (Donna Dibble)	Alan Prosser	Q4	Delivery plan to be agreed	
	1.23	Ensure each department has a workforce plan that reflect service needs,	Sue Price (Donna Dibble)	SMT	Q4	delivery plan to be developed	

		including skill mix, new roles and responsibilities, values and behaviours					
To ensure a healthy and engaged workforce, whereby work life balance is actively encouraged and supported	**1.24**	Welsh Language internal audit findings received and actions addressed, ensure Welsh Language and Welsh culture embedded in all programmes of work	Ceri Thomas	Rachel Hennessy	Q4	Compliance audit completed awaiting discssion with Trust W/l to confirm final gradin/scoring outcome, meeting to be arranged beofre 31/03/2022. Will be closed at 31/03/2022	
Implement Blood Stem Cell collection centre at VCC	**1.25**	Implement Blood Stem Cell collection centre at VCC	Emma Cook	Tracey Rees	Q2	PBSC phase now completed, remaining work on bone marrow collection to be completed. Bone marrow phase paused in response to Covid Pressures	
To ensure provision of blood and blood products to meet surge activity in health Boards	**1.26**	Ensure structures are in place to meet the demand from Health Boards for blood and blood products to support delivery of Health Board recovery plans	Simon Davies/Georgia Stephens	Jayne Davey/Tracey Rees	Q2	Risk assessment completed for next finanical year in light of reduced covid monies. Demand continues to be met & action will be extended into 22/23	**CLOSED**

Strategic Priority 2.		**Deliver a state of the art supply chain**					
	2.01	Review and evaluate Impact/benefits realisation of BSC2020 programme	Sarah Richards	Rachel Hennessy	Q4	Programme officially closed following final Programme Board meeting in August 2021. After Action Reviews and Benefits Realisation Reviews underway. Dec this year, PMs holding after actions reviews and expected to complete Dec 21.	
To work in partnership with donors, citizens & organisations to shape our services	**2.02**	Implementation of phased approach to improved donor interaction functionality within eDRM, including donor app	Andrew Harris/David Mason-Hawes	Jayne Davey	Q2	Donor engagement is ready, test (UAT) system available; unable to progress due to competing work priorities / COVID (see notes). Currently paused. Completion of project estimated for 2022 New software proposed to SMT (future), which will	

						aid the analysis, reviewing and speed of query responses. Due to competing work priorities & COVID, re-commencement of eDRM	
	2.03	Full implementation of recommendations from FAIR study.	Stuart Blackmore	Janet Birchall	Q1	FAIR went live 14th june 2021	**CLOSED**
Maintain healthy, prudent & sustainable donor panels to maximise the frequency people in Wales are able to donate blood	**2.04**	Scope and implement workstream(s) in line with strategic intent to improve donor health & increase donor personalisation	Edwin Massey/ Emyr Adlam	Janet Birchall	Q4	Project work to manage transgender donors in an improved way is ongoing. Completion of this task is reliant on a substantial upgrade to the ePROGESA system by MAK-Systems, which is not expected to be undertaken in the immendiate future - No further update Semester patch now expected post 2022, to be confirmed when prioritised by	

						orgainsation. Timelines to follow.	
To plan & coordinate blood collection activity across Wales, optimising clinic flow and ensuring provision of an effective & efficient cycle of clinics & processes for blood donation	**2.05**	Review the options for the potential introduction of electronic rostering system in line with NHS Wales implementation timeline and make recommendations to SMT to support a preferred way forward.	Simon Davies	Jayne Davey	Q4	Rota's from W/C 23/08/2021 went live in the E-rosta system, and the system now fully Live. Only task that remains for the initial phase is adding users from outside of the department. Awaiting Cyber Security Report from IT before this can happen.	**CLOSED**
	2.06	OCP undertaken to support the implementation of the new collection team model	Sally Gronow	Jayne Davey	Q3	In communications with Union reps to discuss next steps re: Implemtnation phase **- no further update**	
To optimise transport and logistics to effectively meet stakeholder requirements	**2.07**	Proposed model for make ready service reviewed as part of wider facilities/stores/estates model, recommendation made on service for West and North Wales and implementation if required	Michael Thomas/Carol Morgan	Rachel Hennessy	Q4	Recommendation being done as part of the facilities and estates review which is now underway. SMT decison March 2022 No update at present .	

						Make ready service on hold until further notice	
	2.08	Review, evaluate and refine Ambient Overnight Hold facilities and workflow model for maximum efficiency	Sarah Richards/Georgia Stephens	Rachel Hennessy	Q4	Ambient and overnight hold has now been transitioned to BAU and can now be closed as part of the programme closure.	**CLOSED**
To work collaboratively with our hospital partners to provide an assured distribution service for blood components and products	**2.09**	Work with Digital services to Review, develop and implement Hospital Web Based Ordering system	Georgia Stephens/David Mason-Hawes	Tracey Rees/Stuart Morris	Q4	Unable to progress - delayed due to COVID-19, work will not be undertaken in 2021/22 - deferred.	
	2.1	BHNOG KPI report to be developed, ensuring data is provided, warehoused and verified to BI recommended standards and dashboards produced	Lee Wong	Janet Birchall	Q1	KPI dashboard approved by BHNOG meeting 30/06/2021	**CLOSED**
Strategic Priority 3.		**Provision of progressive Histocompatibility and**					

		Immunogenetics services in support of transplantation, transfusion and advanced therapies					
Develop services that are evidenced based and in line with best practice	**3.01**	Review an update antibody testing strategy for solid organ transplantation and commence work required to inform future strategy	Deb Pritchard	Tracey Rees	Q4	Ccomplete	**CLOSED**
	3.02	Implement changes required for compliance with NHSBT-ODT donor characterisation project	Deb Pritchard	Tracey Rees	Q4	Complete	**CLOSED**
	3.03	Undertake a review of the virtual crossmatching policy to identify opportunities to extend further in order to benefit more patients, making recommendations for implementation	Deb Pritchard	Tracey Rees	Q4	Data collection complete. Analysis of data to take place in Q1 2022-23	
	3.04	Full implementation of NGS technology in transplant services	Deb Pritchard	Tracey Rees	Q2	Complete	**CLOSED**
	3.05	Development of platelet immunology and granulocyte antibody testing in support of transfusion services	Deb Pritchard	Tracey Rees	Q4	Delays to project due to IT resource avaliability and competing priorities.	

						Estimated completion May 2022.	
To ensure the Welsh Bone Marrow Donation Registry (WBMDR) contributes at a national and international level	**3.07**	WBMDR strategy to be delivered in full, Evaluate WBMDR donor panel to assess required growth / service developments	Emma Cook	Tracey Rees	Q4	Pending the workshop being held which has been delayed until April 2022.	
	3.08	Undertake a workforce review of the WBMDR and develop an action plan which support optimise of the service and succession planning	Emma Cook	Tracey Rees	Q4	Pending the workshop being held which has been delayed until April 2022.	
Strategic Priority 4.		**Digitally enabled to deliver in the modern world**					
Optimisation of the core Blood Establishment Computer System (BECS) & Appointments System	**4.01**	Routine enhancement of BECS via 'delta' release programme	Emyr Adlam	David Mason-Hawes	Q3	Delayed due to competing priorities. Implementation of the maintenance patch on 03/10/2021 - updated IT work plan to be considered via Business Planning Group and SMT -	

						to include consideration for timing of next 'delta' release. - No further update	
	4.02	Commence re-procurement / extend current BECS contract	David Mason-Hawes	David Mason-Hawes	Q4	Agreement in principle with Procurement to pursue a 2+1 extension to current contract. T&F Group established; however, currently unable to meet due to COVID pressures. Aim to seek SMT, EMB and Trust Board approval by end of March 2022, with contract renewed by end of May 2022.	
Optimisation of the core Blood Establishment Computer System (BECS) & Appointments System	**4.03**	Initiate integration of clinic equipment & full roll out of live connectivity	Dan Rainbird	David Mason-Hawes	Q4	Launch of the project has been delayed due to COVID-19 pandemic. Meetings have recently been re-established to revisit the Project Brief with the goal	

						of launching a proof of concept later this year. The results of this will determine the scope of the wider deployment to all Collection Teams.	
	4.04	Deploy transition state labelling functionality - UK wide go-live	Emyr Adlam	David Mason-Hawes	Q4	Position now known, meeting took place w/c 23/08/2021 agreement on specification now awaiting approval from JPAC. - No further update	
	4.05	Refresh existing WBS external & BH Team websites	David Mason-Hawes/Andrew Harris	David Mason-Hawes	Q4	Work progressing. Full go-live for both BH Team and WBS websites by end of March 2022.	
Establishment of industry standard Business Intelligence (BI) services	**4.06**	Ongoing delivery of advanced 'self-service' BI dashboard and reporting capabilities Automation of core data set refresh; dimensional modelling of core datasets; migration to new infrastructure; migration of published datasets from Excel to PowerBI	Zoe Wilder	Rachel Hennessy	n/a	Core data set refresh completed for Q1, Dimensional modelling of core datasets is ongoing but expecting it to be completed in parallel with migration of published datasets from Excel to PowerBI aiming to	**CLOSED**

						complete end of Q3. Migration to infrastructure still at has specification stage, completion date for this element unknown at present, but not expecting this to be completed before Q4	
Delivery of modern, resilient, secure IT infrastructure services supporting organisational objectives incorporating innovative developments	**4.07**	Upgrade telephony infrastructure to include replacement of existing call centre software - Trust programme	Dan Rainbird	David Mason-Hawes	Q4	Digital Services team reviewing current telephony provision across VUNHST. Telephony Strategy document being developed, for future review by Divisional SMTs / Trust Board.	
	4.08	Progress deployment of Office 365 and define use	Dan Rainbird	David Mason-Hawes	Q4	Complete in terms of initial migration. Office 365 fully adopted across all staff groups using core features like Outlook, Teams and OneDrive. On track and expected to be delivered as	**CLOSED**

						planned - work underway to migrate VCC users onto OneDrive. Deployment of Microsoft InTune Mobile Device Management (MDM) started, ongoing.	
	4.09	Explore opportunities to utilise AI / machine learning to support business processes	David Mason-Hawes	David Mason-Hawes	Q4	If required, further features will be enabled as part of a Trust O356 project – current recruitment ongoing to build adoption of wider range of O365 services. Plans to deliver AI / Machine Learning to be reviewed against available resources and prioritised work plan, following publication of pan-Trust Digital Strategy (March 2022).	PAUSED

Strategic Priority 5.		**Building our business on a foundation of research, development and innovation**					
Implement the research, development & innovation strategy	**5.01**	Review WBS RD&I strategy in line with Trust RD&I strategy	Sian James	Peter Richardson	Q4	14 Jul No action to date Overarching Velindre UNHST strategy still to be produced Further clarification required from COO on preferred direction of travel	**CLOSED**
	5.02	Plan to operationalise outputs of exiting KESS studentships	Sian James	Peter Richardson	Q3	A programme of knowledge transfer has taken place, Next end of studentship Winter 2021 - Completed 30/09/2021	**CLOSED**
	5.03	Review opportunities for ongoing engagement of KESS students	Sian James	Peter Richardson	Q3	Replacement programme for young donor motivation September 2021 and a studentship in Component Development - which will utilise the IMTP allocation	**CLOSED**

						for FY 2021-22 is in hand	
Actively seek partners for collaborative projects	**5.04**	Scope the opportunity enabled by our University status in improving our capability in RD&I and the opportunities enabled as a result of collaborations with academia	Sian James	Peter Richardson	Q4	Remains on Target	**CLOSED**
	5.05	Deliver goals outlined in new component development plan	Chloe George	Peter Richardson	Q4	Component development laboratory now performing several pieces of research work. Component Development Board established to prioritise work plans in line with organisational objectives. Component development awaiting estates expansion in line with original agreed business case.	**CLOSED**
Strategic Priority 6.		**Implementing effective clinical systems to support improved outcomes**					

To support to the clinically safe, effective and appropriate use of blood and blood products, working in conjunction with partner agencies	**6.01**	Review and update the Blood Health Plan in line with national guidelines	Lee Wong	Janet Birchall	Q3	Blood Health plan issued on 30/09/2021 from WG	**CLOSED**
	6.02	Develop and deliver Blood Health Education Strategy, facilitated by BHT with delivery by end users	Lee Wong	Janet Birchall	Q3	Draft BHNOG Education Strategy was submitted to BHNOG meeting for approval/ratification in September 30th.Currently out to consultation for sign off BHNOG meeting in December 2021. **Approved 21/12/2021**	**CLOSED**
	6.03	Review current arrangements for NABT Programme, clarifying service requirements and agreeing contracting arrangements	Lee Wong	Janet Birchall	Q4	WBS **Action is now Null and Void** as HEIW will now own NABT Course. A steering group being established including WBS which includeds all key stake holders	**CLOSED**

						to review current arrangement for NABT programme.	
	6.04	Working with All Wales LINC project to develop a core dataset for transfusion e.g. demographics, unit distribution etc.	Lee Wong	Janet Birchall/David Mason Hawes	Q4	LINC Contract now awarded Working with programme team to review benefits realised. Delivery will be via the national programme anticipated deadlines 23/24	
	6.05	Oversee the implement SHOT recommendations with HBs and identified opportunities to meet recommendations	Lee Wong	Janet Birchall	Q4	Gap analysis of SHOT recommendations completed by HBs . Agreed action planby Transfusion Lab Managers & Transfusion Practitioner meetings in December. Actions compelted fpr 2020 SHOT recommendations completed. New cycle to start in July 2022. to be inlcuded in 2022/23 IMTP	**CLOSED**
	6.06	Work with Health Board partners to develop a pre-op	Lee Wong	Janet Birchall	Q4	Anaemia Pathway approved Health	

		amenia strategy, whereby reducing the need for blood transfusions resulting in reduced hospital lengths of stay and fewer post surgery complications				Board Anaemia leads and ratified at BHNOG meeting in December 2021. Presentation to agree testing strategy at NPOMG meeting,on 10th February 2022. No funding available from WHSSC, alternative funding pathwaySBAR completed and awaiting approval from WBS SMT using interoperative cell salvage funding. Working with DHCW to develop audit collection tool Expected to completed against original timeline	
Work in partnership with DHCW to facilitate the delivery of WLIMS modules across WBS	**6.07**	Deliver WLIMS modules for Blood Transfusion (BT) which facilitate appropriate use and real time audit - national decision awaited on progressing	David Mason-Hawes	Tracey Rees/David Mason-Hawes	Q4	Internal project remains on hold; however, confirmation now received that ABHB, Cwm Taf and SBU health boards are all planning to go live	**PAUSED**

						with BT LIMS in early-2022. WBS supporting this activity, as required. These implementations require no change to existing operational management arrangements in WBS. Advice from DHCW is that no other HBs are currently planning to go live with BT LIMS.	
	6.08	Deliver WLIMS modules for H&I & DCS to include: procurement and deployment of transplant centre IT system and phase 2 WTAIL IT solution	David Mason-Hawes	Tracey Rees/David Mason-Hawes	Q4	Prometheus go-live delayed to January 2022 (from December 2021) - re-testing and validation underway. Refreshed URS for H&I system being drafted, Labs Digitisation Programme Board ToR agreed, first meeting August 2021. WTAIL H&I Systems Project	

						Group due to meet 15/12/2021.	
Inform and support the national procurement for LINC (WLIMS2)	**6.09**	Complete development & testing of LINC - as part of national programme	David Mason-Hawes	Tracey Rees/David Mason-Hawes	Q4	Procurement completed - Citadel Health selected supplier. Testing to commence Q2/Q3 2021/22. Local Deployment Project will be handled under Labs Digitisation Programme Board. Development & Testing phase due to extend into 2022/23, as per national programme plan	
WTAIL IT System development	**6.1**	Implement systems to support Donor Characterisation requirements	Deb Pritchard	Tracey Rees/David Mason-Hawes	Q4	Update from ODT that electronic HLA result transfer element of donor characterisation has been pushed back from April 22 to April 23 go live date.	
	6.11	Develop bespoke application to support recruitment of non-blood Bone Marrow volunteers	Chris Harvey/ David Mason-Hawes	Tracey Rees/David Mason-Hawes	Q1	Application delivered for operational use by WTAIL staff.	**CLOSED**