Bundle Public Trust Board Meeting - Velindre University NHS Trust 4 June 2020

1.0.0 STANDARD BUSINESS
Led by Prof Donna Mead (Chair)

1.1.0 APOLOGIES
Led by Prof Donna Mead (Chair)

1.2.0 IN ATTENDANCE
Led by Prof Donna Mead (Chair)

1.3.0 DECLARATIONS OF INTEREST
Led by Prof Donna Mead (Chair)

1.4.0 MATTERS ARISING

1.4.1 Action Log
Led by Prof Donna Mead (Chair)
1.4.1 Action Log from Trust Board Part A Meeting - Final.docx

2.0.0 CONSENT ITEMS
Led by Prof Donna Mead (Chair)

2.1.0 FOR APPROVAL

2.1.1 Minutes from the Public Trust Board meeting held on the 30th April 2020
Led by Prof Donna Mead (Chair)
2.1.1 Draft Notes_Public_Trust_Board_Meeting_-_Velindre_University_NHS_Trust__30_April_2020 -LF (003).docx

2.1.2 Expected Urgent Expenditure
Led by Mark Osland, Director of Finance
2.1.2 TB Proc Submission Summary Jun 20 docx.pdf
2.1.2a WBS Haemophilia A Trust Board Paper V2 AP.pdf

2.1.3 Chairs Urgent Action Endorsements
Led by Lauren Fear, Interim Director of Corporate Governance
2.1.3 Report on Chairs Urgent Action.docx

2.1.4 Ammendment to Standing Orders Schedule 3 - TCS Programme Scrutiny Committee ToR
Led by Lauren Fear, Interim Director of Corporate Governance
2.1.4 Amendment to Standing Orders - TCS Programme Scrutiny Committee ToR Cover Paper.docx
2.1.4a Appendix 1_TCS Programme Scrutiny Committee Updated ToRs.docx

2.2.0 FOR NOTING

2.2.1 Trust Seal Report
Led by Lauren Fear, Interim Director of Corporate Governance
2.2.1 Trust Seal Report Dec 2019 - May 2020.docx

2.2.2 All Committee Recovery Actions Plan
2.2.2 All Committee Recover Actions Plan log cover..docx
2.2.2a All Committees Recovery Plan Actions Log submitted to public board 04 06 2020_.xlsx

4.0.0 KEY REPORTS

4.1.0 Chairs Update
Led by Prof Donna Mead (Chair)
4.1 Chair Update Report v2 - May 2020 - Final.docx

4.2.0 CEO Update
Led by Steve Ham, CEO
4.2 CEO Update Report - 4th June 2020 -Final.docx

4.3.0 COVID-19 Update
Led by Lauren Fear, Interim Director of Corporate Governance
4.3 COVID 19 Update Report - 4th June 2020 v4.docx

4.3 Annex 1 Welsh Blood Service. - New Ways of Working Summary Doc.umentdocx.pdf

4.3 Annex 2 Velindre Cancer Centre - New Ways of Working Summary Document.pdf

4.3.1 VCC Clinical Framework for Defining the Clinical Model and Treatment Decision Making During the Recovery Phase of COVID-19

Led by Dr Jacinta Abraham, Medical Director

4.3.1 VCC RECOVERY PHASE of COVID cover.docx.xlsx.docx

4.3.1 VCC RECOVERY PHASE of COVID.docx1.docx

4.3.1a VCC RECOVERY PHASE of COVID Appendix 1.docx1.pdf

5.0.0 QUALITY & SAFETY

5.1.0 Quality and Safety Highlight Report

Led by Jan Pickles, Independent Member

5.1 Quality Safety Committee Highlight Report.docx

5.2.0 Local Partnership Forum Highlight Report

Led by Sarah Morley, Executive Director of WF&OD

5.2 Committee Highlight Report - PARTNERSHIP MEETING.docx

5.3.0 VUNHST Risk Register

Led by Lauren Fear, Interim Director of Corporate Governance

5.3 Board Cover report Risk June vfinal.docx

5.3a TRR June 2020 vFinal.docx

6.0.0 PLANNING & PERFORMANCE

6.1.0 Delivering Excellence Performance Report Period

Led by Carl James, Director of Planning, Transformation, Estates & Digital

6.1a Delivering Excellence Performance Report - 4th June 2020.docx

6.1b Trust-wide Performance Report - New Template March 2020.docx

6.1c WBS March 2020 v3 PMF Report.pdf

6.1d VCC Performance Report - March 2020waynefinal.pdf

6.2.0 Welsh Blood Service Infrastructure PBC

Led by Carl James, Director of Planning, Transformation, Estates & Digital

6.2 WBS Infrastructure PBC final version 18 may 2020 RH.docx

6.2b TB Paper PBC for Talbot Green facility 29 may 2020 cj.docx

6.3.0 Q1 VUNSHT Operational Plan

Led by Carl James, Director of Planning, Transformation, Estates & Digital

6.3 VUNHST Op Plan Q1 2020.21 FINAL TRUST BOARD MASTER W.Govt v030 Trust Board.docx

6.4.0 Financial Report Period

Presentation / Oral Update - Mark Osland, Director of Finance

6.4 Finance Update - Board 4 June.pptx

6.5.0 TCS Scrutiny Committee Update

Led by Carl James, Director of Planning, Transformation, Estates & Digital

6.5 PUBLIC TCS Programme Scrutiny Committee Highlight Report April.May 2020 -LF.docx

7.0.0 INTEGRATED GOVERNANCE

Presenter: Name & Title

7.1.1 NWSSP Audit Committee Assurance Highlight Report

Led by Martin Veale, Independent Member

7.1.1 VUNHST Audit Committee Assurance Report.docx

7.1.2 NWSSP Review of Standing Orders

Led by Andy Butler, NWSSP

7.1.2 VUNHST Review of Standing Orders 04062020.docx

7.1.2a DRAFT Standing Orders for Operation of SSPC 21052020.doc

7.1.3 NWSSP VTB Proposed Payment Process for Existing Liability Scheme

Led by Andy Butler, NWSSP

7.1.3 VTB Proposed Payment Process for Existing Liability Scheme NWSSP .docx

7.1.3a Appendix A - Delegation letter for MDDUS.pdf

7.1.3b Appendix B - Financial Delegations NWSSP.pdf

8.0.0 ANY OTHER BUSINESS

Prior Approval By the Chairman Required

9.0.0 DATE AND TIME OF THE NEXT MEETING

25th June 2020

10.0.0 CLOSE

The Board is asked to adopt the following resolution:

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

VELINDRE NHS TRUST

UPDATE OF ACTION POINTS FROM PUBLIC TRUST BOARD MEETINGS 28.11.2019 / 19.12.2019/ 30.01.2020/26.03.2020/30.04.2020

MINUTE NUMBER	ACTION	STATUS	LEAD	RECOVERY PLAN
Public Trust Board 28.11.2019				
28-11-19 2.2.5	**Health Technology Wales – Annual Report** **Action:** Paper for Trust Board of Audit Committee outlining Steve Hams role in HTW and its governance	**UPDATE APRIL 2020** Work to be completed in Recovery Phase	**SC/SH** - **Now, LF/SH**	**Recovery Plan**
7.3	**Radiotherapy Performance** COB and MO will keep the Board appraised of the management of the financial risk. The detailed operational plan will be kept at operational level.	**UPDATE APRIL 2020** Confirmation of funding was received from Cardiff & Vale Health Board and Cwm Taf Morgannwg Health Board. The Trust is therefore proceeding on that basis. Agreement was not achieved with Aneurin Bevan Health Board and the Trust is continuing to manage the financial consequences of their non- contribution. The Trust managed this in the financial year 2019-20 within the operational budget. The Trust is currently engaging in active discussions for the financial year 2020-2021	**COB**	**Closed for 2019/20 position.** **Finalising Commissioning Model: Recovery Plan**

		as part of the ongoing commissioning dialogue.		
28-09-17 4.3	**Velindre NHS Trust Risk Appetite Statement** **Action:** Collect emerging themes and report back to the Board in 6 months. **Action:** Training event and practical plan to implement this process **The Board APPROVED on the basis that the above comments are noted and the actions taken forward.**	**UPDATE APRIL 2020** Board development session to be held during Recovery Phase, background preparation continuing	**LF**	**Recovery Plan**
19.12.2019 – Extraordinary Public Trust Board				
2.0	**Urgent Decisions Over £100k** 1. Mr Mark Osland and Mrs Lauren Fear will be addressing the process supporting the "Over 100k Commitments" with Procurement colleagues in January 2020, and this will include a review of the detail captured within the reports as well as improving consistency of content. An update will be received at the January Trust Board meeting.	**UPDATE APRIL 2020** Initial meeting was held with procurement agree the work that needs to be completed. A plan is being drawn up to include a full review of the whole process and to determine procedural responsibilities. Also now incorporated into the revised on-going process will be the learnings from the process working through the COVID response period.	**MO/LF**	**Recovery Plan**
30.01.2020 Public Trust Board				
30.01.2020 2.2.3	**SSPC Board Assurance Report**		**LF/SH/CJ**	**Recovery Plan**

	The Board raised a concern that the IP5 Strategic Outline Case was discussed at the 2 December SSPC but not discussed with the Velindre University NHS Trust Board. An action was captured to look at the process for overall review and sight by VUNHST as the host organisation.	**UPDATE AT APRIL BOARD**		
26.03.2020 Private Trust Board				
30.04.2020 Public Trust Board				
30.03.2020 3.0	**COVID-19 UPDATE** • **Board Briefing 14th May 2020 – two substantial items.** - Ways of Working - Mobilisation of essential services / phasing • Invite IMs to Q&S sessions in the future		**SM/LF CJ**	**Closed**
30.03.2020 5.0 5.1	**RISK** **VUNHST Risk Register** • Orpheus updated to be received at Board or circulated to the Board • Refresh of the risk register and in particular those new risks above and the ongoing risks discussed above		**COB** **LF**	**On the agenda** **To be received 4/6/2020**
30.03.2020 6.0 6.2	**PLANNING & PERFORMANCE** **Convalescent Plasma Collection by Welsh Blood Service** • Formal notice that WG is supporting this initiative is required for the Board		**COB**	**Open**
30.03.2020 6.0 6.4	**PLANNING & PERFORMANCE** **Charity Fundraising activity during Coronavirus in summary**			

	• To review the legal position with the Charity Commission should an event not go ahead – will need this information for closing the accounts		**MO/RG**	**Open**
30.03.2020 **6.0** **6.4.1**	**PLANNING & PERFORMANCE** **Charitable Funds Financial Briefing Paper** • Mr Mark Osland requested to confirm the naming of the organisation from the RD&I trial as detailed in the report – is it in the Public domain? • The Charity Funds committee to be re-established and consider the Trust's approach – noting the guidelines are still unclear on how fundraising will progress.		**MO** **MO**	**Closed** **Revised paper published** **Closed** **The Committee to be reconvened as part of the recovery plan**
30.03.2020 **7.0** **7.4.1**	**INTEGRATED GOVERNANCE** **nVCC and Enabling Works Timelines for Submission of Planning Applications** • Mr Stephen Allen requested further information of further engagement with the community and a status report		**CJ**	**Closed**
	• Mr Steve Ham confirmed that he has informed the NHS CEO in Welsh Government on the status and will follow this up in writing – confirmation that the letter has been sent.		**SH**	**Open**

MINUTES OF THE PUBLIC TRUST BOARD – PART A

VELINDRE UNIVERSITY NHS TRUST HQ / SKYPE
THURSDAY 30TH APRIL 2020 @ 11:00AM

PRESENT:

Professor Donna Mead	Chair (Chair)
Mr Stephen Harries	Interim Vice Chair
Ms Janet Pickles	Independent Member (until 12:55pm)
Mr Martin Veale	Independent Member
Mrs Hilary Jones	Independent Member
Mr Gareth Jones	Independent Member
Mr Steve Ham	Chief Executive
Mr Mark Osland	Executive Director of Finance and Informatics
Dr Jacinta Abraham	Executive Medical Director
Mrs Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Scientists
Mrs Sarah Morley	Executive Director of Workforce and OD

IN ATTENDANCE:

Mr Carl James	Director of Transformation, Planning, & Digital
Mrs Lauren Fear	Interim Director of Corporate Governance
Mr Stephen Allen	Community Health Council (CHC) Representative
Ms Cath O'Brien	Interim Chief Operating Officer

Agenda No.:	Agenda Item

A MINUTES SILENCE IN MEMORY OF NURSE DONNA CAMPBELL WAS HELD AT THE START OF THE TRUST BOARD MEETING

Led by Professor Donna Mead (Chair)

In memory of Donna Campbell the Board noted their affection and thoughts at this sad time with a minute's silence. The Board were informed that on the 16th April 2020, that the Clap for NHS Wales was held in memory of Donna and a very fitting tribute to a much loved colleague.

1.0.0	**STANDARD BUSINESS**
1.1.0	**APOLOGIES** Led by Professor Donna Mead (Chair) • Prof Donald Fraser, IM • Barbara Burbidge, PLG.
1.2.0	**IN ATTENDANCE** Led by Professor Donna Mead (Chair) • Rhian Gibson, Charity Director (item 6.3) • Kate Febry, Audit Wales
1.3.0	**DECLARATIONS OF INTEREST** Led by Professor Donna Mead (Chair) Nil
1.4.0	**MATTERS ARISING**
1.4.1	**Action Log** Led by Professor Donna Mead (Chair) Mrs Lauren Fear summarised the Action Log for the Board and updated briefly on the open actions as listed in the report. Mr Martin Veale requested an update on the Health Technology Wales (HTW) and Mr Steve Ham confirmed a briefing for the Board will be done shortly detailing the part they have played during COVID-19. The Board **NOTED** the update.
2.0.0	**CONSENT ITEMS** Led by Professor Donna Mead (Chair)
2.1.0	**FOR APPROVAL**
2.1.1	**Minutes from the Public Trust Board meeting held on the 26th March 2020** Led by Prof Donna Mead (Chair) The Minutes were **APPROVED.**
2.1.2	**Chairs Urgent Action Report** Led by Lauren Fear, Interim Director of Corporate Governance The Chairs Urgent Action Report for received and **APPROVED.**

2.1.3	**Corporate Governance Arrangements in response to Covid-19** Led by Lauren Fear, Interim Director of Corporate Governance The Corporate Governance Arrangements Report were received and **APPROVED.**
2.1.4	**Variation to Standing Orders - Board Committee Arrangements in response to Covid-19** Led by Lauren Fear, Interim Director of Corporate Governance The variations to the Standing Orders and Board Committee Arrangements were for received and **APPROVED.**
2.1.5	**Variation to Standing Orders and Standards of Behaviour Framework – The Declaration of Gifts During Response to Covid-19** Led by Lauren Fear, Interim Director of Corporate Governance The interim arrangements to the variation of the Standing Orders and the Standards of Behaviour Framework – the declaration of Gifts during COVID-19 was received both at Audit Committee 21st April 2020 and today at Board 30th April 2020 and **APPROVED.**
2.2.0	**FOR NOTING**
2.2.1	**Revised Annual Report Timetable 2019-2020 in response to Covid-19** Led by Lauren Fear, Interim Director of Corporate Governance The revised annual report was was received both at Audit Committee 21st April 2020 and today at Board 30th April 2020 and **APPROVED.**
2.2.2	**Board Decision Required for Commitments Exceeding £100k for the period 30th April - 25th June** Led by Mark Osland, Director of Finance **NOTED** a nil return on expected expenditure for the period 30th April - 25th June.
3.0.0	**COVID-19 UPDATE** Oral update Led by Steve Ham, Chief Executive Officer and Executive Colleagues Mr Steve Ham gave an oral update to capture the COVID-19 developments for the last month and summarised as below:- **<u>VCC</u>** • The bed model at VCC has seen a huge change to 47 ward bed & 8 assessment beds • The Oxygen supply increased in the hospital facility • Activity for patients has reduced (which is no different to other patterns in the HBS) • Acute bed is starting to increase again **<u>WBS</u>** • New collection model in place with fixed venues

	• Good donor collection attendance at clinics • Convaslent Plasma involvement – will be discussed in the agenda • NAT machine to be used to enable increased testing Mr Ham confirmed that the next phase is to re-start essential services and the start of a recovery phase. Obviously, clinical modelling and anticipating future surges is the challenge in planning and supporting staff going forward. The Board were briefed regarding a new communications approach with a Q&A session with staff of the Trust on Friday 24th April 2020. The Chair was keen to note the positive feedback from staff and that there will be a plan to do more sessions which will become a regular forum for communicating with Staff going forward. Mr Ham welcomed Ms Sarah Morley back to work and confirmed that Sarah will be undertaking a piece of work to review the way we work as an Organisation. The Chair informed the Board about a very informatative presentation from Dr Jacinata Abraham received in Gold Command today and it will form part of the Board Briefing agenda on the 14th May 2020. **Actions:** • **Board Briefing 14th May 2020 – two substantial items:-** **- Ways of Working – Sarah Morley/Lauren Fear** **- Mobilisation of essential services / phasing – Jacinata Abraham/ Carl James** • **Invite IMs to Q&S sessions in the future** The Board **NOTED** the update.
4.0.0	**KEY REPORTS**
4.1.0	**Chairs Update** Led by Professor Donna Mead (Chair) The Chair summarised her Chairs report for the Board. Mr Gareth Jones formally noted the Board's Congratulations to the Chair on the announcement of her Fellowship with the Learned Society of Wales. The mission of the Society is to promote excellence and scholarship, inspire learning and to benefit the nation. The Board **NOTED** the updated.
4.2.0	**CEO Update** Led by Steve Ham, Chief Executive Officer Mr Steve Ham summarised his CEO Report for the Board. In addition to this and the oral update on COVID-19, Mr Ham briefed the Board on a change to the Governance arrangements for NWIS - noting that the Interim Director of NWIS has been formally designated as an Accountable Officer.

	The Chair also informed the Board that there will be an investigation, by the ICO, on the letter breech. The Board will receive further updates in due course. Mr Martin Veale confirmed that NWIS moving to a Strategic Health Authority is currently on pause with further advice to follow. Mr Martin Veale, noted for the minutes, the stirling work, that has been led by NWIS as the NHS workforce moved to a more mobile and virtual way of working. The Board wanted to note their appreciation and thanks. Mr Martin Veale asked for clarification that the mis-reporting of deaths for COVID-19 was the responsiblity of individual Health Boards (HBs) and it was confirmed that was the process for NHS Wales. The Board were assured that the Velindre University NHS Trust was reporting in line with the requirements. The Board **NOTED** the updated.
5.0.0	**RISK**
5.1.0	**VUNHST Risk Register** Led by Lauren Fear, Interim Director of Corporate Governance Mrs Lauren Fear summarised the Trust Risk Register and confirmed that she is working the Army colleagues with regards to the risk work and progressing the risk control processes is still continuing in the background. The Risk Register was presented to Board and now includes the COVID0-19 risk and the approach to the phases and priority areas of work. There will additional risk assessments being undertaken and will progress through the usual path with the Executive Management Board (EMB) and will be received at the May 2020 Board. The following risks are currently under development and will be brought to EMB in May for consideration and will be reported to Board in May as appropriate: • Ventilation system in VCC • Financial risks resulting from COVID-19 • Legal risks resulting from COVID-19 The Board formally noted their thanks with regards the completed work on the Pharmacy Technical Services. Mr Gareth Jones queried the risk 10451 regarding Orpheus and his concern at the lack of confidence with the supplier contract as the risk was increasing. Mr Stephen Harries conveyed his concern also and requested a formal update to be received at Board to receive assurance at Board level. Mr Harries confirmed that this would normally be received at the IG&IM&T Committee but due to the stand down of the Committee that this had not been discussed.

	The Chair asked Dr Jacinta Abraham on the status of the Consultant recruitment and a request for a refresh of the risk to be undertaken through progression through the recovery plan. Mr Martin Veale updated the Board on discussions with Shared Services and whether it is a time to review the various levels and what catastrophic actually means. The Board noted that this will be discussed as part of the Risk work going forward. **Action:** • **Orpheus updated to be received at Board or circulated to the Board – Cath O'Brien** • **Refresh of the risk register and in particular those new risks above and the ongoing risks discussed above – Lauren Fear** The Board **APPROVED** the risk register
6.0.0	**PLANNING & PERFORMANCE**
6.1.0	**Performance Update Report - Oral Update** Oral Update Led by Carl James, Director of Transformation, Planning & Digital & Cath O'Brien, Interim Chief Operating Officer Mr Carl James gave a summary of discussions with Welsh Government (WG) and confirmed that he is working through the reporting metrics and the priority areas to manage the performance reporting requirements. This will be phased into the process in the next 6-12 months and the Trust will a have a framework in place to present to the Board by the end of May 2020. The Board **NOTED** the update.
6.2.0	**Convalescent Plasma Collection by Welsh Blood Service** Led by Cath O'Brien, Interim Chief Operating Officer Mrs Cath O'Brien informed the Board that the members of the Q&S Committee were briefed on the 29th April 2020 and confirmed Phase 1 is to collect Fresh Frozen Plasma (FFP) from the blood from donors that have positive antibodies for COVID-19. The process is fully regulated and detailed in the report. The Chair requested a formal notice that WG is supporting this initiative. Mrs Cath O'Brien updated the Board about producing the product and noted that there is a Clinical Reference Group who will decide where it can be trialled (UK trial). This will need to be contextualised for Welsh use and further updates in due course. **Action:** • **Formal notice that WG is supporting this initiative is required for the Board – Cath O'Brien** The Board **NOTED** the update and the recommendations outlined in the report.
6.3.0	**Financial Update - Year End Financial Outturn - Oral Update**

	Oral Update Led By: Mark Osland, Executive Director of Finance Mr Mark Osland confirmed the end of year out turn had been circulated to the Board but noted that there could be small changes and confident that the Statutory Accounts will be ready for the 27th May 2020 deadline and presented to the Board at the end of June 2020. Mr Osland confirmed that for the 2021 financial plan that is was aligned with the IMTP but will need to refreshed due to current COVID-19 costs. This will be worked through as we progress through the next couple of weeks. The Chair wanted to formally note her thanks to the Finance Team and Mr Osland confirmed that the majority of finance team are working from home and managing to deliver on the end of year commitments. Mr Osland confirmed that he has passed his thanks to the staff. The Board **NOTED** the update.
6.4.0	**Impact of Covid-19 on Velindre University NHS Trust Charity** Led by Ms Rhian Gibson, Charity Director Ms Rhian Gibson joined the Board at 12 noon to discuss the plan for the Charity as outlined in the paper. Ms Gibson confirmed that the Charity is very relient on events and only likely to re-arrange approximately 50% of the planned events due to social distancing guidelines. This is the reason for a cautious approach to income. In terms of the last 6 weeks, the fundraising office closed as it was a difficult time to fundraise. Within a couple of weeks, the Charity had engaged with our Ambassaors and Patrons to convey messages of support, particularly in supporting staff and patients with appeal fundraising i.e. Amazon Wishlist, Food suport and new companies to support staff and patients. The plan would be to bring them into the Trust to thank them, to continue that partnership and to work with them going forward. Ms Gibson is very keen to keep the profile of VCC very much in the focus. Tonight (Thursday 30th April 2020) the Charity is filming specialist nursing and their role in this pandemic. **Charity Fundraising activity during Coronavirus in summary:-** • Velindre Charity Frontline Just Giving Appeal • Velindre Charity Fundraising funds Clinical Nurse Specialists who are working on the frontline providing exceptional care to our patients • Appeal “There is now more need than ever for psychology and wellbeing support services, also funded by the charity, to support our staff and patients through these extremely challenging. If you can help support these crucial people and services please donate here.” • The Big Sleep Out in Aid of Velindre (Ambassador – Tracey Davies) - Raising money by encouraging families to go on a camping adventure in their own garden or home • The Pound-A-Press-Up Challenge (Ambassador – Simon Ford) • Family challenge in your own home stay safe and get into shape • Shane Williams 774 mile Challenge - Shane cycles 774 miles (the distance he would have covered if his events during the lockdown had not been cancelled • 2.6 Challenge (Mass participation led by President Jonathan Davies)

	• UK wide fundraising – be a stay at home hero initiative – set up by major events organisers • (including Run4Wales - Cardiff Bay10k partner) • Morgan Stoddart 1,000 mile Cycle - Morgan Stoddart and over 100 supporters completing a 1,000 mile cycle in May • Cory Band Virtual Performance In development to be confirmed: • Rhod Gilbert's Virtual Quiz • Mass on-line Raffle • Virtual Q and A with patrons • Grants and Donations during Coronavirus • The Charity, supported by Dr Tom Crosby were successful in applying for a grant with the Moondance Foundation for £50,000 • Hugh James Solicitor's Charity Partners donated £10,000 from their Charitable Funds **Action:** • **To reveiw the legal position with the Charity Commision should an event not go ahead – will need this information for closing the accounts - Mr Mark Osland/Ms Rhian Gibson**
6.4.1	**Charitable Funds Financial Briefing Paper** Led by Mark Osland, Director of Finance and Rhian Gibson, Charity Director Mrs Mark Osland summarised the full report as set out in the Velindre University NHS Charitiable Funds Briefing Report Month 12 – March 2020. Regarding investment; Appendix 1 – will show Market Update from Brewin Dolphin 17.04.2020 Mr Stephen Harries requested clarity on naming the income from the RD&I trial as detailed in the report and Mr Osland will confirm that he will look into this and report back to Board. Mr Mark Osland presented the proposed plan and the summary of commitments against the Charities of unrestricted funds for the Board. Mr Stephen Allen, CHC, asked if the Trust can access WG funds and Ms Rhian Gibson confirmed that the Trust is part of the NHS Charitable Funds association and will receive some income as part of the scheme. The Chair summarised the briefing and confirmed the discussion that the Charity can fund the current commitments but would be reluctant to take on any additional commitments at this point. The Board were informed that repeat requests, to extend projects, will need to be considered carefully. The Charity will also need to understand what the future planning assumptions will be and will need to be very cautious in the Charity's approach moving forward. To confirm that the Charity could consider using the pharma funding to meet some requests. **Action:-** • **The Charity Funds committee is to be re-established and consider the Trust's approach – noting the guidelines are still unclear on how fundraising will progress.** The Board thanked the Charity Director for attending Board and **NOTED** the update.

7.0.0	**INTEGRATED GOVERNANCE**
7.1.0	**Governance Recovery Phase Activity** Led by Lauren Fear, Interim Director of Corporate Governance Mrs Lauren Fear summarised the Governance Recovery phase and outlined two main aims:- 1. To be clear how actions are being managed 2. Confirmed way of cataloguing of the recovery log To confirm Mrs Fear has worked with Executive Leads and the IM Chairs and have gone through all the Committee action logs and confirmed a plan for the Committee moving forward. This has involed changes to the cycle of business and a review of the actions. The details are outlined in the presentation and will be convered as out of committee actions. The Audit Action Tracker and actions have been analysed and taken through Audit Committee. Mr Carl James confirmed that Item 7.1.b – the IMTP has been approved and noted that the plan still stands but it has been paused and is just for noting today at Board 30 April 2020. The Chair thanked Mrs Fear for her oversight of the work and **NOTED** the update.
7.2.0	**Quality & Safety Committee Highlight Report - Oral Update** Oral update led by Janet Pickles, Independent Member (Chair of the Quality & Safety Committee). The Quality & Safety Committee met on the 29th April 2020 and the Board will receive a written highlight report at the Trust Board in May 2020. The Chair picked up this item and noted the real achievements in the policy for death in service, the ambient hold progress and the amazing frozen stem cell work. Mrs Nicola Williams noted her thanks in relation to the staff and their response in doing the best for patients/donors. The Board **NOTED** the update.
7.3.0	**Audit Committee Highlight Report** Oral Update Led By Martin Veale, Independent Member (Chair of the Audit Committee) Mr Martin Veale summarised the Audit Highlight Report and confirmed that many items were discussed earlier in the meeting. In summary: • Agreeing the date for signing off the annual accounts at the end of June • Confirmed Internal audit had largely completed their work and had sufficient information to feed into WG. • Note the new name Welsh Audit Office – now Audit Wales but note no change to their statutory duty

	Mr Veale reported on the NWSSP Audit Committee and confirmed Andy Butler and Neil Frow did note their thanks and appreciation to the VUNHST Board for their support with signing off the procurement. The Chair wanted to thank her IM colleagues with the swift turnaround of comments approvals for the out of Board Chairs Urgent action. The Board **NOTED** the update.
7.4.0	**Transforming Cancer Services Programme Scrutiny Committee Highlight Report - Oral Update** Oral Update Led By Stephen Harries, Vice-Chair and Chair of the TCS Scrutiny Committee The TCS Programme Scrutiny Committee met on the 27th April 2020 and a written highlight report will be submitted to the Trust Board in May 2020. The main area for discussion was the nVCC and Enabling Works Timelines for Submission of Planning Applications and will be discussed in item 7.4.1. The Board **NOTED** the update.
7.4.1	**nVCC and Enabling Works Timelines for Submission of Planning Applications** Mr Carl James summarised the report and requested for the Board to noted the delay in submitting two planning applications for the new Velindre Cancer Centre (nVCC) and Enabling Works (EW). The Board is requested to endorse the pausing of the project and Mr Steve Ham confirmed that he has informed the NHS CEO in Welsh Government on the status and will follow this up in writing. Mr Stephen Allen requested further information on the engagement with the community and a status report. **Action:** • **Provide Mr Stephen Allen requested further information of further engagement with the community and a status report – Carl James** • **Mr Steve Ham confirmed that he has informed the NHS CEO in Welsh Government on the status and will follow this up in writing – Steve Ham** The Board **NOTED** the update.
8.0.0	**ANY OTHER BUSINESS** Prior Approval By the Chair Required
9.0.0	**DATE AND TIME OF THE NEXT MEETING** 28th May - Virtual meeting
10.0.0	**CLOSE** The Board is asked to adopt the following resolution:

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

Ymddiriedolaeth GIG Felindre Velindre NHS Trust

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENTS EXCEEDING £100k FOR THE PERIOD 4th June 2020 to 23rd July 2020

DATE OF MEETING	4th June 2020
PREPARED BY	Helen James
PRESENTED BY	Mark Osland
EXECUTIVE SPONSOR	Mark Osland

REPORT PURPOSE	For approval.

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING:		
NAME OF COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Numerous in accordance with the governance of the Division or Hosted Unit of the Trust.	Various.	Endorsed for submission to Trust Board.

ACRONYMS	Welsh Blood Service (WBS),

1. SITUATION/BACKGROUND

1.1. The Chief Executive's financial limit is £100k; purchases/ contracts requiring approval / extending over this amount requires Trust Board approval. For extensions, this only applies if the provision for extension was not included in the original approval granted by Trust Board.

1.2. The decisions expected during the period between Trust Board meetings are highlighted in this report, seeking approval for the Chief Executive and Chair to authorise approval outside of the Trust Board.

2. ASSESSMENT

2.1 Option Appraisal / Analysis:
Prior to the submission of this paper, each requirement will have undertaken an assessment by the Division or Hosted Unit, the outcome of which is variable and represented in the tender specification.

2.2 Impact Assessment:

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Due authority is being sought in advance of expenditure to ensure compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	This paper cuts across many of the Healthcare Standards, as it concerns the purchase of goods and services required to support operational needs.
EQUALITY IMPACT ASSESSMENT	Undertaken on a case-by-case basis, as part of the procurement process.
LEGAL IMPLICATIONS / IMPACT	If applicable, as identified in each case as part of the service design/ procurement process.
FINANCIAL IMPLICATIONS / IMPACT	Please see table below. Order placement subject to WG funding is indicated with a '*' against the value.

For each of the schemes seeking approval, a Board decision proforma is appended to this report. The following provides a summary of the decisions being sought from the Board

Appendix No	Division	Scheme/Contract/ Agreement Title	Period of Contract	Total Expected Maximum Value of Contract £ (ex VAT)
1	WBS	Procurement of Product for the Treatment of Haemophilia A by Welsh Blood Services	1st July 2020 – 30th June 2022 with an option to extend for a further two years to 30th June 2024.	£4,800,000

3. RECOMMENDATION

3.1 The Board is requested to **AUTHORISE** the Chair and Chief Executive to **APPROVE** the award of contracts summarised within this paper (and detailed within the attached Board Decision Pro-forma) and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. *TITLE OF SCHEME/CONTRACT: PROCUREMENT OF PRODUCT FOR THE TREATMENT OF HAEMOPHILIA A BY WELSH BLOOD SERVICES.*

2. *CONTRACT DETAILS*

2.1. ***Description of Goods / Services/ Works/Lease***

The Central Medicine Units (CMU) is procuring for a NHS national framework agreement for the supply of products for the treatment of Haemophilia A on behalf of the Department of Health and Social Care, Public Health England and the NHS in England, Scotland, Wales and Northern Ireland and may also be used by private sector contractors and agents working on behalf of the above.

The Welsh Blood Service (WBS) act as a wholesalers for all the Health Boards across Wales, this offers security of supply to the patient and minimises costs due to WBS bulk buying and reducing delivery costs if each Health Board individually ordered. In addition WBS holds stock to de-risk security of supply to the Health Boards to ensure patient care.

2.2. ***Nature of Contract***

(Please complete either 2.2.1 or 2.2.2).

2.2.1. ***New/First time contract***

Not applicable

- **Date of Board approval of business case**
  Not applicable

- **Issues to bring to Board's attention that differs from the detail within the approved business case.**
  Not applicable

- **Details of any matters that may be considered as Novel or contentious**
  Not applicable

2.2.2. **Contract Renewal/Extension**

This is a renewal of an existing service and contract.

2.3. ***Procurement Route***

Procurement route is through the NHS England Central Medicine Unit framework agreement CM/PHS/17/5564.

2.4. ***Timescales for implementation***

Not applicable.

2.5. ***Period of Contract***

1st July 2020 – 30th June 2022 with an option to extend for a further two years to 30th June 2024.

2.6. ***Maximum Expected Total Value of Contract – excluding and including VAT*** **(if contract renewal, please provide justification of difference in value from previous contract).**

Title	**Total £ (excl VAT)**	**Total £ (Inc. VAT)**
Procurement of product for the treatment of Haemophilia A	£4,800,000	£5,760,000

Please note that this total value is an estimate based on previous contract usage of £1,200,000 per annum and includes the optional years.

2.7. ***Source of Funds***

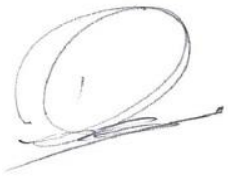
This contract shall be funded via revenue.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

3.1 The lead Director, has provided Procurement Services with email confirming approval to seek Board approval, is making a ***declaration that all procurement rules, Standing***

Orders and Standing Financial Instructions have been complied with. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name: Alan Prosser 20/05/2020



Service Area: Welsh Blood Services

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

chairs urgent action matter report

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	05/05/2020	Approved
Trust Board Members – Via Email	08/05/2020	Approved
Trust Board Members – Via Email	18/05/2020	Approved
Trust Board Members – Via Email	19/05/2020	Approved
Trust Board Members – Via Email	26/05/2020	Approved
Trust Board Members – Via Email	26/05/2020	Approved
Trust Board Members – Via Email	28/05/2020	Approved

ACRONYMS	
NWIS	NHS Wales Informatics Service
NWSSP	NHS Wales Shared Services Partnership
PPE	Personal Protective Equipment

1. SITUATION/BACKGROUND

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

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

1.3 This report details Chair's Urgent Action taken since the Trust Board meeting held in April 2020.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken since the April 2020 Trust Board Meeting as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. NWSSP – COVID 19 Personal Protective Equipment (PPE) Surgical Masks

The Trust Board were sent an email on the 4th May 2020, inviting the Board to **AUTHORISE** expenditure in relation to PPE in relation to COVID 19 activity.

Due to the urgency of this matter it could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Professor Donna Mead, Trust Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Martin Veale, Independent Member
Mrs. Hilary Jones, Independent Member
Mr. Gareth Jones, Independent Member
Professor Donald Fraser, Independent Member
Ms. Sarah Morley, Executive Director

No objections to approval received. A number of clarifications were provided by NWSSP in response to several queries raised in the consideration and review of this action, which were addressed in order for the action to be approved.

2. NWSSP – COVID 19 PPE Examination Gloves

The Trust Board were sent an email on 7th May 2020, inviting the Board to **AUTHORISE** expenditure in relation to PPE in relation to COVID 19 activity.

Due to the urgency of the above activity this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Professor Donna Mead, Trust Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Gareth Jones, Independent Member
Mr. Martin Veale, Independent Member

No objections to approval received.

3. NWIS - Contact Tracing System for Microsoft Dynamics

The Trust Board were sent an email on 15th May 2020, inviting the Board to **AUTHORISE** expenditure to procure a COVID 19 Case Management and Contact Tracing System.

Due to the urgency of the above activity, this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Professor Donna Mead, Trust Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Gareth Jones, Independent Member
Mrs. Janet Pickles, Independent Member
Mrs. Hilary Jones, Independent Member
Mr. Martin Veale, Independent Member
Professor Donald Fraser, Independent Member
Mrs. Sarah Morley, Executive Director

No objections to approval received; however, a number of queries were raised in the consideration and review of this action, which were addressed in order for the action to be approved.

4. NWSSP - Contract for the supply of COVID 19 Masks for NHS Wales

The Trust Board were sent an email on the 19th May 2020, inviting the Board to **AUTHORISE** expenditure in relation the purchase of COVID 19 Masks for NHS Wales.

Due to the urgency of the above activity this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Professor Donna Mead, Trust Chair
Mr. Steve Ham, Chief Executive Officer
Mrs. Hilary Jones, Independent Member
Mr. Gareth Jones, Independent Member
Mr. Martin Veale, Independent Member

No objections to approval were received.

5. NWSSP - Contract for the supply of COVID 19 Gloves for NHS Wales

The Trust Board were sent an email on the 26th May 2020, inviting the Board to **AUTHORISE** expenditure in relation the purchase of COVID-19 Gloves for NHS Wales.

Due to the urgency of the above activity this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Mr. Martin Veale, Acting Trust Chair
Mr. Carl James, Acting Chief Executive Officer
Mr. Gareth Jones, Independent Member
Professor Donald Fraser, Independent Member

No objections to approval were received, however a number of queries were raised in the consideration and review of this action which were addressed in order for the action to be approved.

6. NWIS – Purchase of COVID 19 TTP Telephony

The Trust Board were sent an email on the 26th May 2020, inviting the Board to **AUTHORISE** expenditure in relation the purchase of COVID 19 Case Management and Contact Tracing System.

Due to the urgency of the above activity this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Mr. Martin Veale, Acting Trust Chair
Mr. Carl James, Acting Chief Executive Officer
Mrs. Hilary Jones, Independent Member
Mr. Gareth Jones, Independent Member
Professor Donald Fraser, Independent Member

No objections to approval were received, however a number of queries were raised in the consideration and review of this action which were addressed in order for the action to be approved.

7. NWSSP - Contract for the supply of COVID 19 Masks for NHS Wales

The Trust Board were sent an email on the 28th May 2020, inviting the Board to **AUTHORISE** expenditure in relation the purchase of COVID 19 Masks for NHS Wales.

Due to the urgency of the above activity this matter could not wait until the June 2020 Trust Board meeting.

Recommendation Approved:

Mr. Martin Veale, Acting Trust Chair
Mr. Carl James, Acting Chief Executive Officer
Mr. Gareth Jones, Independent Member
Mrs. Janet Pickles, Independent Member

No objections to approval were received.

TRUST BOARD

AMENDMENT TO STANDING ORDERS – Schedule 3

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Transforming Cancer Services Programme Scrutiny Committee	27/04/2020	Endorsed for Approval

ACRONYMS	
	None identified.

1. SITUATION/BACKGROUND

1.1 The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Values and Standards of Behaviour framework, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales. All Trust Board members and officers must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Amendment to the **Transforming Cancer Services Programme Scrutiny Committee Terms of Reference.**

The terms of reference are included at Appendix 1 and changes have been identified in red for ease of reference.

3 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore ensuring good governance within the Trust can support quality care.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4 RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the amendments to the Trust Standing Orders, schedule 3 as outlined in section 2 of this report.

Transforming Cancer Services Programme
Scrutiny Committee

Terms of Reference

1. INTRODUCTION

1.1 Within 3.1.1 of the Trust's standing orders it provides that *"The Board may and, where directed by the Welsh Ministers must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".*

1.2 In line with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the Transforming Cancer Services (TCS) Programme Scrutiny Committee.

1.3 The Trust Board has approved the creation of the Transforming Cancer Services (TCS) Programme Scrutiny Committee to scrutinise the programme governance arrangements for the TCS Programme, which extends to its constituent projects. At a project level the committee will examine, Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Board.

1.4 The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny Committee is to:

- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme.
- Scrutinize the progress of the programme and provide the Trust Board with assurance that implementation is effective, efficient and within the budget available.
- Undertake any other scrutiny activity relating to the TCS Programme as directed by the Trust Board or Senior Responsible Owner (SRO).
- Seek advice and guidance from appropriate Technical Advisors as well as the MIM Transactor (if relating to the nVCC Project) to assist the Committee with their scrutiny of the TCS Programme.
- Provide assurance to the Trust Board on all aspects of the TCS Programme in relation to approvals sought on all decisions reserved for the full Board.
- Receive all audit, gateway and assurance reviews pertaining to the programme or its constituent projects and provide assurance (or otherwise) to the Trust that the

programme is being delivered in accordance with all professional, financial and Trust standards.

- Provide assurance to the Board and support to the Senior Responsible Officer in signalling the TCS closure activities once it has met its objectives.

2.2 Where appropriate, the Committee will advise the Trust Board and the Accountable Officer on where, and how, its system of assurance in relation to the TCS Programme may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

With regards to its role in providing advice to the Board, the committee will fulfil the following functions:

3.1 Strategy and Policy Development

- Scrutinise programme and project documentation to ensure the direction of the TCS Programme remains within the scope and parameters set by the Trust Board and its alignment with the external commissioner and political environment.

- Scrutinise and provide assurance that the Programme and its constituent projects are conducted in line with the Trust's requirements on policy and legislative compliance, best practice and within the Trust's governance framework.

3.2 Governance, Monitoring and Review

The Committee will, in respect of its assurance role:-

- Provide assurance that the Programme has a clear and consistent strategic direction of travel aligned with the Trust Boards requirements; strong and effective leadership; clear and transparent lines of accountability and responsibility; and effective reporting to key stakeholders and decision-makers.

- Provide assurance that Programme and Project governance arrangements are appropriately designed, proportionately applied and implemented and are operating appropriately to ensure the provision of a high quality programme and project management delivery.

- Undertake scrutiny and assurance of the Programme progress against the master programme plan, seeking explanations and remedies for any deviation from Programme timelines. It will report any concerns to the Trust Board as and when appropriate and necessary.

- Undertake scrutiny and assurance of Programme risks, issues and mitigating actions to satisfy itself that they can be placed back under the required levels of control.

- Scrutinise all sources of independent assurance in relation to the delivery of the Programme (e.g. Internal/External Audit, Independent Reviews, Gateway Reviews, CAP etc.) and scrutinise and monitor the organisation's response to independent reviews.

- Provide assurance that there are robust monitoring and management arrangements in place to identify important enablers and dependencies between the programmes projects, as failure to do so could impact on the programmes critical path.

- Scrutinise and assure that the Programme and Project expenditure against the budget allocated is appropriate and managed effectively.

3.4 **Authority**

- The Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committees remit and ensuring patient/service user, client and staff confidentiality, as appropriate. It may seek any relevant information from any:

    - Employee (and all employees and directed to cooperate with any reasonable request made by the Committee); and

    - Other Committee, sub Committee, or group set up by the Board (including the Project Board) to assist it in the delivery of its functions.

    - Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary, subject to the Board's budgetary and other requirements; and

    - By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Board at any meeting of the Committee.

- Provide assurance that any proposals /actual amendments to delegated limits as necessary in relation to the all TCS Projects are in accordance with the Trust Boards direction and it's Standing Orders and Statutory Financial Instructions.

- The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the Board's procurement, budgetary and other requirements.

3.5 **Access**

The Chair of the TCS Programme Scrutiny Committee shall have reasonable access to Executive Directors, Directors and other relevant staff.

3.6 **Sub Committees**

None currently identified.

The Committee may, subject to the approval of the Trust Board, establish sub Committees to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

4.1 **Members**

A minimum of ~~two (2)~~ three (3) members to include:

Chair	Independent member of the Board (Non-Executive Director) ~~or delegated Independent Board member~~
Vice Chair	Independent member of the Board (Non-Executive Director)
	One (1) other Independent member of the Board (Non-Executive Director)
	Other Trust Board members are extended an open invitation to attend all/any meeting

4.2 **Attendees**

Core Attendance;

- Chief Executive Officer/ Senior Responsible Owner ~~(Chair)~~
- TCS Programme Director
- Executive Medical Director
- Executive Director of Nursing, Therapies and Clinical Scientists
- Director of Corporate Governance
- Executive Director of Organisational Development and Workforce
- Executive Director of Finance
- Director of Commercial and Strategic Partnerships
- Director Velindre Cancer Centre
- Chief Operating Officer

4.3 **As Requested: Project Executives and other Programme / Project Staff**

- Project Executive Project 1
- Project Executive Project 2
- Project Executive Project 3
- Project Executive: Project 4
- Project Executive: Project 5
- Project Executive: Project 6

The Committee Chair may extend invitations to others from within or outside the organisation who the Committee consider should attend, taking account of the matters under consideration of each meeting.

4.4 **Secretariat**

As determined by the Director of Corporate Governance.

4.5 **Member Appointments**

The membership of the Committee shall be determined by the Board based on the recommendation of the Trust Chair – taking account of the balance of skills and expertise necessary to deliver the Committee's remit and subject to any specific requirements or directions made by the Welsh Government

Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

4.6 **Support to Committee Members**

The Director of Corporate Governance on behalf of the Committee Chair shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role: and

- Ensure the provision of a programme of Organisational development for Committee members as part of the Trust's overall OD programme developed by the Director of Workforce and Organisational Development.

5. COMMITTEE MEETINGS

5.1 **Quorum**

At least two (2) members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair or Vice Chair.

5.2 **Frequency of Meetings**

Meetings shall be held no less than four times a year and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

5.3 **Withdrawal of individuals in attendance**

The Committee Chair may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

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

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for the safety, security and use of information to support the quality and safety of healthcare for its citizens through the effective governance of the Organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees and Groups to provide advice and assurance to the Board through the:

- Joint planning and co-ordination of Board and Committee business: and
- Sharing of information

In doing so, contributing to the integration of good governance across the Organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board and the Accountable Officer on the Committee's activities. This includes verbal updates on activity, the submission of written highlight reports throughout the year and an annual Committee Report.

- bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees/Groups of any urgent/critical matters that may affect the operation and/or reputation of the Trust.

7.2 The Committee shall provide a written, annual report to the Board on its work. The report will also record the results of the Committee's self-assessment and evaluation.

7.3 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum – as per section 5.1 above.

Cross reference with the Trust Standing Orders.

8. REVIEW

8.1 These Terms of Reference shall be reviewed annually by the Committee with reference to the Board.

9. CHAIR'S ACTION ON URGENT MATTERS

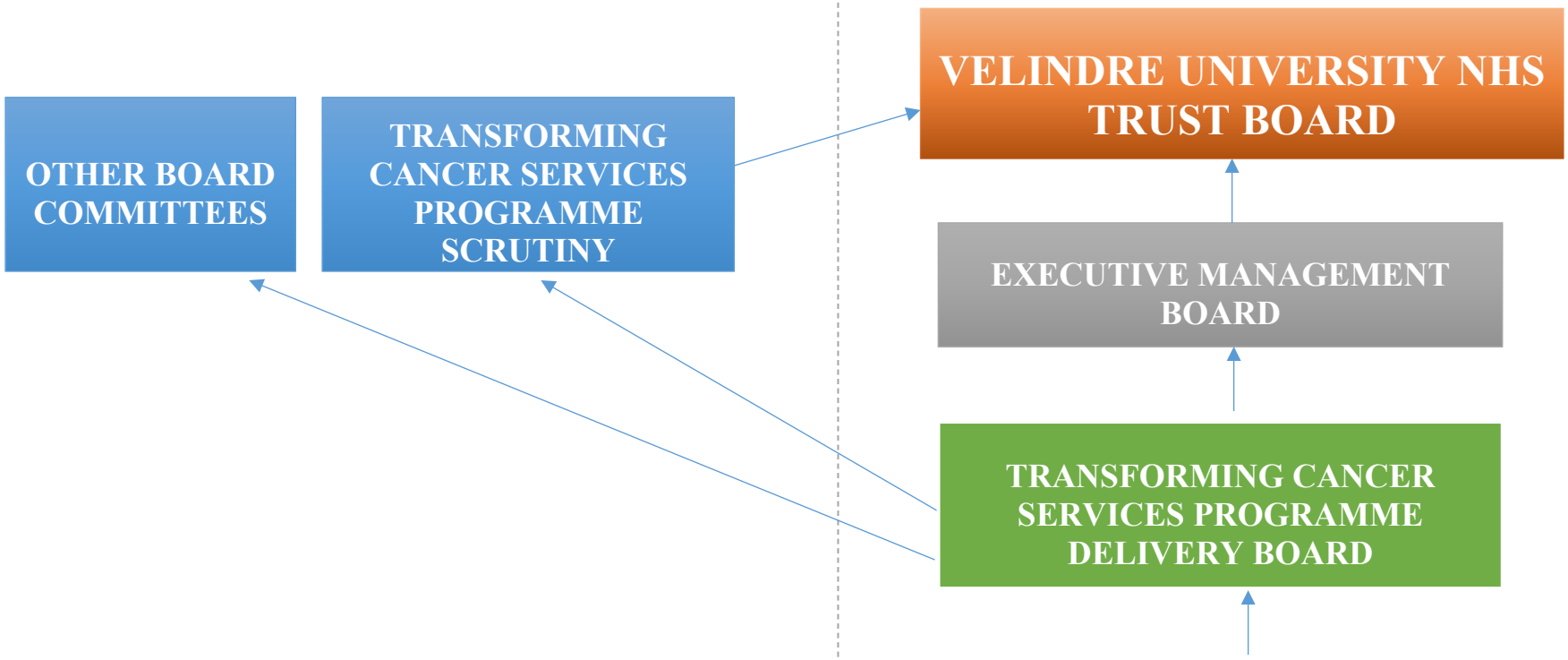
9.1 There may, occasionally, be circumstances where decisions which normally be made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

9.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Structure and governance arrangements

Scrutiny and Assurance

Management Accountability



TRUST BOARD

TRUST SEAL REPORT - DECEMBER 2019 – MAY 2020

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rebecca Goode, Executive Support Manager
PRESENTED BY	Lauren Fear, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Corporate Governance

REPORT PURPOSE	FOR APPROVAL

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

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (period December 2019 – May 2020).

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

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

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

Appendix 1 – Seal Register

Date	Document Details	Signed
23/02/2020	Deed of Grant and Covenant relating to land & Asda Cardiff Coryton Super centre, Longwood Drive, Cardiff CF14 7EW.	Prof Donna Mead, Chair Mr. Steve Ham, CEO
31//01/2020	NHS Building for Wales Framework agreement. Regional Supply Chain Partner – Partner Lot No.1.	Prof Donna Mead, Chair Mr. Steve Ham, CEO
31/01/2020	NHS Building for Wales Agreement – Regional Supply Chain Partner – Partner Lot No.2.	Prof Donna Mead, Chair Mr. Steve Ham, CEO
31/01/2020	NHS Building for Wales Agreement Regional Supply Chain Partner – Partner Lot No.3.	Prof Donna Mead, Chair Mr. Steve Ham, CEO
28/04/2020	Variation Agreement No.2 Service Agreement between VUNSHT and Mott MacDonald.	Prof Donna Mead, Chair Mr. Steve Ham, CEO

TRUST BOARD

ALL COMMITTEE RECOVERY PLAN ACTIONS LOG

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	REBECCA GOODE, EXECUTIVE SUPPORT MANAGER
PRESENTED BY	LAUREN FEAR, INTERIM DIRECTOR OF CORPORATE GOVERNANCE
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, INTERIM DIRECTOR OF CORPORATE GOVERNANCE

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Nil		

ACRONYMS	
Nil	

1. SITUATION/BACKGROUND

Attached is the updated Committee Recovery Plan Actions log for NOTING.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

This is an updated position of the actions and to inform Board Members that the recovery action log is reviewed regularly with the Executive Lead and Chair of the Committee.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Some actions may relate to the quality and safety as identified in the Health & Care Standards and the safe delivery of delivery of cancer treatments and blood donation.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board are asked to **NOTE** the updated Committee Recovery Plan Actions log up to May 2020 with regular updates to be received at Trust Board.

ID	ID	Action	Date Raised	Owner	Actionee	Estimated date for completion	Current status (open / closed)	Progress to date	Escalated to Gold Yes/No	Date of escalation	Means of escalation	date escalated	Date Closed	Recovery Plan	Propose to close	Propose transfer
Digital & Information Governance Committee	**Digital & Information Governance Committee 5.3**	**Fax Machines – Current Status** Following discussion from a query from Dr Jacinta Abraham, Mr Stuart Morris confirmed there is currently a fact finding exercise at present with a long term ambition to remove fax machines where we can. Next step is to assess volume of faxes currently in use and plan the next point of the process.	9/20/2019	AMS David Mason-Hawes	AMS David Mason-Hawes	Quarter 2 2020	Pending	Update: Investigations ongoing. List identified in service divisions/review underway to identify those machines that can be withdrawn. Risk assessments to be produced for those machines that will remain. Update: An exercise to understand what machines are within the Trust and to justify maintaining. An update to be provided at the February Committee meeting.						Fax Machine approach (NS) – will be actioned in Recovery Phase [Ref 5.3]		
Digital & Information Governance Committee	**Digital & Information Governance Committee 7.0**	**POLICIES AND PROCEDURES** Email Policy A section to be added to the policy to cover data management systems and a reminder that the email system, should not be used as a filing system. Lauren Fear, Stuart Morris and Neil Stevens to consider how the policy controls could be tested. Further work to be undertaken on aligning the Email Policy with GDPR Regulations. Policy to be represented to the IG&IM&T Committee	12/10/2019	Lauren Fear / Stuart Morris / Neil Stevens	Lauren Fear / Stuart Morris / Neil Stevens	31/01/2020 & 28/02/2020	Pending	Policy already covers this, O365 now provides message informing user of the retention policy for 7 years. NS to request change to policy. IG training to be amended to highlight management of email Development of a proposal for internal audit inspection, wrap with internal audit process for WBS as proof of concept for email policy. Amendment minutes to remove action Dependent on amendments						Email Policy, with respect to way in which emails are stored (NS and SM) - will be actioned in Recovery Phase [Ref 7.0.0]		
Planning & Performance Part A	**Planning & Performance 5.1.1**	**IMTP Tracker**	20/01/2020	Phil Hodson	Phil Hodson	End of Jan 2020	closed						04/05/20	WG direction received that plan is "approvable" although working/ measuring to it is on hold until recovery Phase work planning		
Planning & Performance Part A	**Planning & Performance 6.1**	**BLOOD SUPPLY CHAIN 2020 – Benefits Paper** Action: Map the benefits of the Blood Supply Chain against the Well-being of Future Generations (Wales) Act 2015 (PW)	14/11/19	Alan Prosser	Alan Prosser	No date set	Pending	UPDATE 14.11.9 Ongoing This action will be picked up by the Environmental Development Officer when in post with AP and Sarah Richards. A report will be received at the March 2020 Committee which will include areas of WBFGA and Decarbonisation across the Trust.						Mapping benefits of Blood Supply Chain 2020 against Well-being of Future Generations Act (AP) – this work had already started and will be actioned in Recovery Phase		
Planning & Performance Part A	**Planning & Performance Committee 5.1.2**	**Integrated Medium Term Plan 2019-2020 Tracker** Action: AP to provide an update report to the Committee in March in relation to the procurement of key equipment.	20/01/2020	Alan Prosser	Alan Prosser		Pending	This has been included on the Cycle of Business and will be received at the March 2020 Committee.						Update on procurement of Apheresis equipment in WBS (AP) – will be actioned when this procurement starts again		
Research Development & Innovation	**Research Development & Innovation Committee Part A 4.2.1**	ACTION: The need for a Repository for Publications, Abstracts and Posters was discussed. This will be explored with the Library Staff to look at the impact value of staff publications. JA stated that this work will be incorporated into the RD&I Strategy document.	06/11/2019	Mark Briggs	Mark Briggs	16/03/2020	Pending							Need for a Repository for Publications, Abstracts and Posters to be incorporated into RD&I Strategy Document (MB)		
Research Development & Innovation	**Research Development & Innovation Committee Part A 5.1**	**Moondance & Radiotherapy Programme Board Update** ACTION: Moondance Programme Board to be updated on the replacement for Independent Member - Jane Hopkinson. ACTION: Peter Sowerby requested an RD&I Representative should sit on the Moondance Programme Board.	06/11/2019	Peter Sowerby	Peter Sowerby		Pending	Update Eve Evans and Tom Crosby meeting with Prof Donald Fraser re IM Replacement						Representative to be confirmed for the Moondance Programme Board (PS) [Ref: 5.1]		
Workforce & Organisational Development	**Workforce & Organisational Development Committee 1.4.0**	**299. Risk Register Action from 07/10/19** Explanation action item 4.1.0 297: Workforce and OD Risk Register Nicola Williams would like to see the reliance on Charitable funds for core staff to be added to the risk register. Lisa Miller informed that this does sit on the divisional register, in a different guise. This needs to be revisited. Paul Wilkins to revisit risk and feedback. *ACTION: Darron Dupre to arrange to meet with Jo Williams to update on Welsh Language and support the work going forward **ACTION: Set up a meeting with Procurement regarding Ethical Employment in Supply Chains	15/01/2020	Paul Wilkins	Paul Wilkins	23/01/2020	Pending							Reliance on Charitable Funds for core staff to be added to risk register (PW) [Ref: 299]		
Workforce & Organisational Development	**Workforce & Organisational Development Committee 1.4.0**	**301. Medical Staff Revalidation Appraisal Report from 07/10/2019** **ACTION: 5.6.0 298: Medical Staff Revalidation Appraisal Annual Report There has been a delay on concluding this action due to staff sickness. Karen Wright will relook at the action and complete.	02/05/2019	Karen Wright	Karen Wright	23/01/2020	Pending							Medical Staff Revalidation Appraisal Annual Report (KW) [Ref: 301]		

Workforce & Organisational Development	**Workforce & Organisational Development Committee 3.1.0**	**Workforce & Organisational Development Risk Register** **303.Medical Staffing** Following discussion around medical staffing and medical education it was agreed that Susan Thomas would present to the committee about Medical Education at the next meeting.	02/05/2019	Susan Thomas	Susan Thomas	08/04/2020	Pending							Medical Staff Revalidation Appraisal Annual Report (KW) [Ref: 301]		
Workforce & Organisational Development	**Workforce & Organisational Development Committee 4.2.0**	**Workforce & Organisational Development Update Report** **304. Manual Handling Rates at VCC** Following discussion about the low manual handling compliance amongst clinical staff requiring specific training, which is provided by Cardiff and Vale. Dates are not made available for staff to attend the training. This matter needs to be further investigated	02/05/2019	Susan Thomas/ Lisa Love-Gould	Susan Thomas/ Lisa Love-Gould	08/04/2020	Pending							Manual handling training compliance – to be investigated further (ST, LLG) [Ref: 304]		

TRUST BOARD

chair's REPORT

DATE OF MEETING	4/6/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Interim Director of Corporate Governance
PRESENTED BY	Professor Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Corporate Governance

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
CEO	Chief Executive Officer

1. SITUATION/BACKGROUND

1.1 This reports provides information to the Board from the Chair.

1.2 Issues addressed in this report cover the following;

- Continuing to ensure public transparency of Board business during the next phase
- Covid-19 Incident Response Update
- Chair Urgent Action Process for COVID-19
- The Queen's Birthday Honours List and Covid-19 Honours Nominations

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Continuing to ensure public transparency of Board business during the next phase

2.1.1 In March we discussed as a Board that as the public could no longer appropriate given the public health concerns to attend our public meetings that instead we would share a summary of the meeting within a couple of days on our public website. For March and April meetings, we have been in a position to share the draft minutes each time.

2.1.2 Boards of Trusts and LHBs across Wales are now starting to consider how to best engage with the public on an on-going basis whilst essential travel only and social distancing principles remain in place.

2.1.3 There are two options being considered, either live streaming of the Board meeting or recording the meeting so that it can be uploaded in full or key sections of the agendas post the meeting onto the public website.

2.1.4 The Chair invites Board members to share their views on what could work best for the June Board onwards. This timing would also align with when the other majority of Trusts and LHBs are making these changes.

2.2 Covid-19 Incident Response Update

2.2.1 The Chair will like to thank all Trust Officers present and their teams across the Trust on behalf of the Board, for continuing to work so tirelessly to ensure we continue to deliver our services in light of such unprecedented times that Covid-19 presents.

2.2.2 The Chair reported that the Board has been received one informal briefly during May, given these have now been changed to a fortnightly meeting. The briefing was an opportunity for the Board to be updated on approach to the Q1 Operational Plan and an update to the Clinical Principles, which are being brought to the Board for approval today. The briefings are not for the purposes of decision making nor assurance, with these responsibilities continuing to sit with the Trust Board.

2.2.3 The Chair also reported the continued changes to her regular ways of working through the incident response period to date, including weekly all Wales Chairs CEO meetings and daily telephone calls with the CEO.

2.3 Chair Urgent Action Process for COVID-19

2.3.1 The Chair notes the significant amount of work undertaken by Independent Members over recent weeks in support of the approval process for purchase requests relating to COVID-19.

2.3.2 Much of this relates to the procurement by NWSSP of Personal Protection Equipment (PPE) and there have been a number of new suppliers to NHS Wales of PPE in this market, which has further increased the due diligence and oversight required from the Board.

2.3.3 Since beginning of April, the Board have approved [11 – as at 2pm on 26/5 – Donna, will update this if the two further are approved in next 24 hrs.] requests from NWSSP and one from NWIS. The Chair would like to thank the Board for their important work in this regard.

2.4 The Queen's Birthday Honours List and Covid-19 Honours Nominations

2.4.1 The Chair notes the Prime Minister's announcement on 20th May that that The Queen has agreed that the Birthday Honours List, scheduled for publication on 13 June, should be delayed until the autumn. The purpose of the postponement is to provide the opportunity to reflect that some of the exceptional contributions made by so many in response to coronavirus can be properly recognised.

2.4.2 In particular the Honours office is looking for people who have:

- Worked on the frontline of their organisation or in their sector to directly support the most vulnerable members of society and people who have caught C-19.
- Provide critical care to C-19 patients.
- Made significant innovations in order to support the vulnerable and those with C-19 OR their communities and sectors.
- Gone to extraordinary lengths to keep critical services going

- Volunteered in the community or for service organisations in support of those affected by C-19

2.4.3 The Chair is working with the CEO and Executive team to agree a short-list for nominations from the Trust and would welcome any thoughts from other Board members to be shared with the Chair by 8th June.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	4/6/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Interim Director of Corporate Governance
PRESENTED BY	Steve Ham, Chief Executive
EXECUTIVE SPONSOR APPROVED	Carl James, Acting Chief Executive

REPORT PURPOSE	FOR NOTING

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

1. SITUATION/BACKGROUND

1.1 This reports provides information to the Board from the Chief Executive Officer (CEO).

1.2 Issues addressed in this report cover the following;

- COVID-19 Update
- Change in NHS Wales Informatics Service (NWIS) hosting arrangement
- Developments in Trust Communications and Engagement

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Covid-19 Update

2.1.1 The CEO would like to extend the thank you of the Chair to also thanking all the staff in the Trust for their immensely hard work, resilience, agility, care of each other and care of our patients and donors, during the past couple of months.

2.1.2 The Operational Plan for Quarter 1 has been submitted to Welsh Government. The feedback specifically for the Trust has not been received at the time of publishing this report. It is due prior to the Board meeting and it will be shared with Board members as soon as received. Plans for developing the Quarter 2 plan are currently being drawn up, with a view to developing a plan for the remainder of 2020/21.

2.1.3 Current focus continues on increasing capacity in order to contribute effectively to the re-establishment of essential services at expected levels and the re-modelling of demand. Further priority is to strengthen the testing strategies for staff, patients and donors and these operations are in the context of the Welsh Government's 'Test, Trace and Protect' strategy. Although the population contact tracing which will be implemented from 1st June is being led by the Health Boards in the Welsh NHS, the role of VUNHST will be important in managing the impact on our staff patients and donors and also our role in supporting the contact tracing processes within our operations.

2.1.4 There have been a number of accelerated digital developments in our support of the COVID-19 response. A recent example has been the launch of Attend Anywhere video consultation service in Velindre Cancer Centre which provides clinicians and patients the choice and agility to offer appointments remotely.

2.2 Change in NHS Wales Informatics Service (NWIS) Hosting Arrangement

2.2.1 The CEO would like to update the Board on the change of the designation of Interim Director NWIS, to an accountable officer. The Interim Director NWIS has received this designation from the Director General Health and Social Services.

2.2.2 Full details of responsibilities of an Accountable Officer are set out in a Memorandum. For context for the Board, this memorandum is based on that currently in place for the NHS Wales Shared Service Accountable Officer.

2.2.3 A report "Hosting Arrangements for NWIS" was received by the Board in June 2019. This report is currently being reviewed in light of the designation change and if there are amendments required to this report, this will be brought back to the Board for noting.

2.2.4 It is also relevant to link to the open Board action to review the mapping of Health Technology Wales hosting arrangements against the Trust's governance framework. This action, currently on the recovery plan, will be actioned in line with the review of the Board Committee structure to be undertaken as the recovery phase progresses.

2.3 Developments in Trust Communications and Engagement

2.3.1 The CEO would like to note some further developments in our engagement with staff across the Trust, with the launch of using a "live event" platform to host Question and Answer sessions with Executives. There have been two Divisional events and one Trust wide session. Staff are able to raise any questions, concerns or comments in advance or live during the session. There has been good participation from staff and the feedback has been excellent to date and therefore these sessions are being planned as a regular feature.

2.3.2 To support this open and transparent model of engagement, a "request for information (RFI) tracker" has also been implemented as the on-going tool and record for staff to ask questions of the executive and senior teams.

IMPACT ASSESSMENT

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

3. RECOMMENDATION

3.1 The Board is asked to **NOTE** the content of this update report from the CEO.

TRUST BOARD

COVID 19 update report

DATE OF MEETING	4/6/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, Interim Director of Corporate Governance
PRESENTED BY	Steve Ham, Chief Executive
EXECUTIVE SPONSOR APPROVED	Carl James, Acting Chief Executive

REPORT PURPOSE	FOR NOTING

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

1. SITUATION/BACKGROUND

1.1 This reports provides a summary for the Board of a number of items in relation to the COVID-19 incident response.

1.2 It draws together a number of the latest developments, some of which have been briefed to the Board informally during the past month and also linking to items in the agenda.

1.3 Matters addressed in this report:

- Transition from incident response structures to the newly defined executive governance arrangements
- Changes to our operating models
- Development of the planning process from the Q1 plan to the next 12 months planning horizon

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Transition from incident response structures to the newly defined executive governance arrangements

2.1 As previously reported to the Board, the Trust has been operating the response to the COVID-19 incident through a Gold strategic command, a Silver tactical command and a Bronze operational command structure. For the next phase of the Trust's response, these arrangements have been stood down and are being incorporated into the standard leadership and management arrangements at Trust and service level. A number of improvements are being made to the standard arrangements including previously planned changes to the Executive Management Board arrangements and learning picked up during the initial COVID-19 phase.

2.2. Changes to our operating models

Peak COVID19 to the Q1 Operational Plan

2.2 The Q1 operational plan sets out the new ways of workings that have been made to date for Welsh Blood Service (WBS), the Velindre Cancer Centre (VCC) and for the support functions. COVID-19 has necessitated a number of changes to the sites, the operating models and pathways for patients and donors.

2.3 The plan identifies a number of key areas of work over the coming weeks which include:

- Putting arrangements in place which ensure that our services are as safe as possible for staff, patients and donors. These include staff, patient and donor testing; social distancing in the workplace and the track and trace to support community surveillance activities.
- Maintaining/maximising capacity of blood, transplant and cancer services so we can respond flexibly to requirements.
- Working with Health Boards to understand the future demand for blood, transplant and cancer services as a wider range of essential services are re-established across Wales.
- Starting to re-establish routine services internally, undertaking any work that has been delayed our paused where appropriate.
- Continued implementation of a testing plan for staff, patients and donors together with supporting the implementation of Test, Track, Trace and Protect strategy to managed COVID-19 in the community.

Welsh Blood Service

- Key changes for the Welsh Blood Service have included:
- Condensing collection model to run on consecutive days from a number of venues each week
- Increased digital collaboration tools to facilitate remote working across WBS
- Large scale transition of staff to work from home, through rapid implementation of technology
- Implementation of social distancing measures across WBS sites and at clinics

Velindre Cancer Centre

Since mid-March, we have been operating according to the decision making framework shared with the Board, led by the 'Clinical Principles' [*'Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19'*] and each decision is then subject to an impact assessment. The impact assessment is based on three key dimensions of quality and safety, workforce and public confidence and the resulting score determines where the decision can be made in the incident response structure. The changes that have required a Gold level decision have also been reported to Quality and Safety Committee.

Key changes for Velindre Cancer Centre, based upon these principles, include:

- Implementation of social distancing measures through facilitating and promoting home working, departmental spacing, change in shift patterns, introduction of new rotas, use of digital technology
- Implementation of site triage systems, including pre-treatment and on arrival
- Revised patient education and follow-up facilitating remote delivery of services
- Workforce re-alignment to support critical business service delivery, working from home support in place for shielding staff
- Introduction of video consultations through Attend Anywhere platform
- Changes to clinical pathways.

Please see Annex 2 for more detail

Following the initial COVID peak, and to support the recovery of national cancer services, the clinical principles and *Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19* have been reviewed and refreshed with to reflect the future challenge of providing clinical services safely as we initiate the recovery phase.

All changes made during the peak COVID phase are being reviewed in light of the changing context and aim to re-introduce services as quickly as is safely possible. This is being approached in priority of impact assessment score and the oversight will continue to be through the Quality and Safety Committee.

The current governance arrangements will be further strengthened with the creation of a Clinical Ethics Committee. Welsh Government has requested that each Health Board and Trust to establish such an advisory body focused on the ethical dimension of COVID-19 related decisions. The Board will be updated on this further in the meeting at end of June.

Returning to Business which is Better

The Executive team have been reflecting on some of the opportunities that the changes we have made have provided. This includes: capitalising on improvements to aspects of service delivery; capitalising on culture of innovation; embedding of the clear and transparent decision making; and embedding of the more efficient governance arrangements and reductions in bureaucracy.

The intention is not to return to 'Business as Usual' but 'Business which is better'. The Board will continue to be updated on the various work packages under this umbrella as they progress and deliver over the next 90 days.

3.0 Development of the planning process from the Q1 plan to the next 12 months planning horizon

The Trust is currently preparing to produce its next plan to cover the Q2 period, as required by the Welsh Government. It is also seeking to identify how far forward it can reasonably plan during 202/2021 given the fluid situation and levels of uncertainty in key areas e.g. forecasting demand from LHBs; re-activation of COVID; national policy on lock-down; impact of testing strategy etc.

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4.0 Recommendations

The Board is asked to **NOTE** the content of this update report from the Chief Executive.

Welsh Blood Service - New Ways of Working

Staff have created and embraced new ways of working rapidly to respond to the COVID19 challenge, in particular to comply with social distancing and essential travel guidance. A number of these new ways of working offer benefits in terms of safety and quality to both staff and donors. In addition, service models have adapted and developed in order to ensure that WBS as a demand-led service is able to continue to meet need and that of staff, patients and donors in terms of quality and safety.

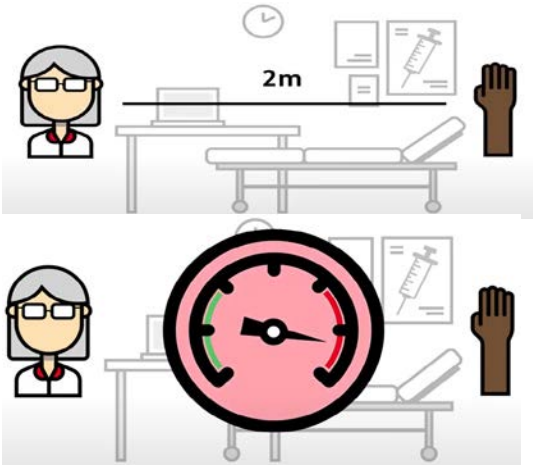
At the outset of the pandemic, the blood collections system in Wales came under considerable pressure:

- Venues started cancelling our bookings
- Staffing levels dropped through Covid-19 related absence
- Donor attendance levels started to fall.

April 2019: 117 Sessions held at around **104 venues**

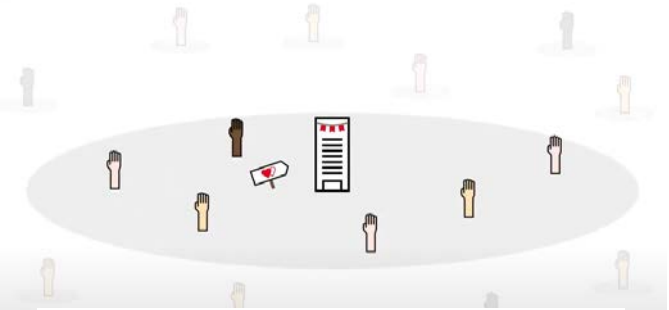
The Service responded by condensing its collections programme to run on consecutive days from a smaller number of venues each week.

April 2020: 95 Sessions held at around **31 venues**



Visiting fewer venues gave us greater control over the clinical environment, ensuring venues could be appropriately sanitised and social distancing could be maintained throughout. It would also enable us to consolidate the workforce into fewer teams to reduce pressure caused by Covid-19 related staff absence

Where under normal circumstances donors would be invited to their preferred donation centre, the new model would require donors to be invited to their nearest regional donation hub - unlikely to be their usual venue of preference



Invitations sent to donors within a 15 mile radius of each donation hub

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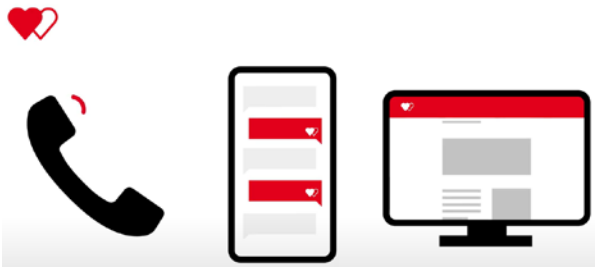


Communication with donors was maintained through telephone support, SMS messaging, the WBS website and on social media. Key messaging was cascaded as required, intended to reassure, to educate and to celebrate those who rolled up their sleeves to support the WBS.

Table 1 – New Ways of Working Introduced at WBS

Programme of work	Objective	Length of service change	Plan for evaluation
Implementation of partial Ambient Overnight Hold (AONH) brought forward	To increase the availability of blood products by enabling blood collected in North Wales to be kept at an ambient temperature whilst being transported to South Wales for processing.	Permanent	To be evaluated as part of wider AONH project.
Increased digital collaboration tools (via O365) e.g. MS Teams, rapid deployment of additional VC functionality (MS surface hubs)	To facilitate remote working across WBS necessary to support implementation social distancing requirements including wider home working and working across sites	Permanent	To be evaluated as part of wider O365 Programme
Large scale transition of staff to work from home, through rapid implementation of technology e.g. laptops	To facilitate social distancing and support individuals restricted to home working. Will support fast-track transition to more utilisation of mobile IT equipment, fewer desktops etc.	Permanent	Ongoing monitoring
Established Convalescent Plasma project and delivered initial phase (whole blood, males only)	To collect convalescent plasma from patients that have recovered from COVID-19 for use by Health Boards to treat patients that are suffering from COVID-19 infection in order to support the national clinical trials programme.	Temporary	To be evaluated as part of ongoing Convalescent Plasma Programme.
Revised Collection clinic model	• To enable WBS to continue to meet Health Board demand for blood and blood products.	Temporary	Monitored on a daily/weekly basis through WBS Resilience planning

Programme of work	Objective	Length of service change	Plan for evaluation
	• To mitigate removal of mobile donation clinics from the whole blood collection programme • To mitigate the reduction in the availability whole blood collection clinics provided by the independent sector. • To mitigate to impact of a reduced workforce due to 12 shielding. • To adhere to social distancing at collection clinics. • To adhere to PPE guidance The model includes fixed clinic model from fewer number of venues.		group to ensure supply is able to meet demand.
Introduction of donor triage	To ensure donors not have any symptoms relating to Covid prior to entering into the donation clinic environment	Temporary	Ongoing monitoring of impact via WBS Resilience planning group.
Workforce re-alignment	To support critical business service delivery, non-business critical programmes of work have been paused and the workforce have been re-aligned to support the critical elements	Temporary	Ongoing review via WBS Bronze meetings
Introduction of COVID-19 testing of Stem Cell Donors at medical assessment and actual donation	To ensure donor fit to donate and prevent transmission of COVID-19 to patient from stem cell product	Temporary	Continued review of NICE guidelines and international requirements

Programme of work	Objective	Length of service change	Plan for evaluation
Updated consent process for routine cryopreservation of stem cell products for national and international patients	As products have a limited shelf life of 72 hours this enables short term storage to ensure that donor does not develop COVID after donation which may infect the intended recipient	Temporary	Continued review of data on prevalence and transmission of COVID through stem cell transplantation
Update of HTA licence to enable import of cryopreserved stem cells I	As products have a limited shelf life of 72 hours this enables short term storage to ensure that donor does not develop COVID after donation which may infect the intended recipient	Permanent	Not applicable
Development of a third party agreement to enable cryopreservation of cells for export	Due to availability of flights and potential for delays at international borders as a result of COVID-19 some transplant centres are requesting cryopreservation of stem cells at collection centre	Permanent	Not applicable
Nucleic acid testing (NAT) for mandatory microbiology markers of blood donors outsourced to NHSBT	To enable WBS equipment to be used by Public Health England for COVID-19 testing	Temporary	Not applicable
Implementation of social distancing measures across WBS sites and at clinics	To maintain safety of the workforce at WBS through facilitating and promoting home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers on clinic transport maximum number of chairs within collection clinics etc.	Temporary	Ongoing review via WBS Bronze meetings and engagement with staff and Trade Unions through the WBS Partnership forum.

Velindre Cancer Centre - New Ways of Working

An overview of the service changes at VCC is provided below, supplemented by additional detail by service area in Table 1.

With the closure of LHB outpatient departments, through March VCC moved its outreach service provision to the VCC site for outpatient appointments and SACT delivery. Lung cancer SACT, traditionally delivered at Llandough was temporarily relocated to VCC, pending further service discussions.

Physical changes to the site have been made to respond to infection control measures. This has included the implementation of a site triage system for patients and a cessation in visitors to the hospital in line with government guidance. Covid 19 positive areas and pathways have been established to cohort and segregate known and suspected Covid 19 patients. These have been continually reviewed to ensure Infection control and capacity management.

To maintain safety of workforce at VCC we have implemented national guidance on PPE and staff testing, facilitated and promoted home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers in clinical/treatment areas. These actions, together with a range of wellbeing initiatives, have enabled us to sustain our workforce to deliver these service models.

For Radiotherapy we have continued to deliver radiotherapy services to Category 1 patients and those with emergencies. Delivery of RT to Covid-19 positive patients has been via a dedicated Linac. Changes to breast treatment protocols have reduced attendances through hypo fractionation.

In radiology and medical physics, reporting and planning from home via remote access have enabled services to be maintained.

For SACT, we have centralised delivery at VCC and retained delivery via the Tenovus mobile unit. Transfer to oral treatments had been made where this is clinically suitable and we have increased supportive care such as paracentesis. Additional capacity for Medicines at Home has been secured.

In reducing footfall to the site, telephone and video appointments have been introduced utilising AccuRX, Microsoft Teams, Attend Anywhere and increased capacity has been made available to the patient telephone helpline.

The GP hub will facilitate direct and timely access to clinicians at VCC for primary care colleagues with specific oncology related questions.

Consultants at VCC are also participating in consultant connect providing access for GPs regarding advice and support.

The Cancer Nurse Specialist (CNS) team have continued to provide advice and support to patients proactively through appointments and responsively as required.

We have expanded our capacity to meet unscheduled care needs of cancer patients through our Assessment unit.

Palliative care services have been reviewed to facilitate further support in the community and to LHBs. This has been overseen by the End of Life Care Programme Board.

An evaluation exercise will be completed for all ‘New Ways of Working’ implemented as a result of maintaining safe services during the COVID 19 pandemic, to determine ongoing adoption,

development or return to original provision. An evaluation template will be produced to provide service leads full knowledge of any issues experienced to date, feedback from users (patients and staff), a summary of what benefits are possible, lessons learnt, data analysis (if required), and recommendation for the next stage.

Table 1 - New Ways of working at VCC

Area	Key Changes and New Ways of Working at VCC
All	Activity for the majority of Site Specific Teams (SSTs) has declined in line with the reduced number of referrals as cancer diagnosis, screening and surgery activity has fallen.
	Implementation of social distancing measures across VCC To maintain safety of workforce at VCC through facilitating and promoting home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers in clinical/treatment areas. Other specific measures include: • Patients attending Radiotherapy encouraged to wait in their own vehicles • Oral SACT medications delivered to patients in their vehicles • Access of visitors to buildings restricted – any patient can attend with one other person if such support is deemed clinically necessary • *Amazon*-style locker system introduced which allows patients to collect enteral feeds and equipment out of hours to ensure flexibility and support social distancing
	Implementation of site triage system. Intensive pre-treatment triage measures include: • Telephone triage of patients on day prior to scheduled appointment • Additional triaging of patients on arrival at Radiotherapy and SACT day case treatments • Implementation of pathway for COVID suspected patients attending Outpatients department
	Revised patient education and follow-up facilitating remote delivery of services. Specific measures include: • Chemotherapy education information made available as videos posted on *YouTube* and VCC internet page • Pre-treatment education for Radiotherapy patients conducted remotely Workforce re-alignment to support critical business service delivery, working from home support in place for shielding staff, and workforce have been re-aligned to support the critical elements
Radiotherapy	Halted prostate brachytherapy services and developed contingency plans for gynaecological brachytherapy treatments should the Cardiff and Vale UHB anaesthetic and theatre staff be unable to support VCC services during the pandemic
	Managed deferral of treatment of prostate cancer patients

	Deferment of non-urgent Basal Cell Carcinoma (BCC), low-grade Glioma and benign Deferment of category 2 suspected/ positive COVID-19 patients
	Introduction of processes to enable remote consent to treatment and plan approval
	Designated linear accelerator (linac) for the treatment of suspected or COVID-19 positive patients
	Designated CT (simulator) time to reduce potential patient exposure
	Introduced an extended working day intended to smooth flow and reduce footfall
	Breast cancer treatment protocols have been amended to reflect hypofractionation. This will reduce the number of attendances per patient whilst maintaining treatment efficacy
	Working with WHSCC on increasing the capacity for Stereotactic Ablative Radiotherapy (SABR) for lung cancer, given the reduced thoracic surgery capacity
SACT	With exception of 2 SACT delivery sessions delivered via Tenovus mobile unit, repatriation of SACT Outreach activity to VCC (includes lung SACT service managed by Cardiff and Vale UHB). This was undertaken to enable health boards to respond to the initial projected peaks in demand for their acute services to support COVID
	Increased supportive care capacity implemented to address increased need for procedures such as paracentesis
	VCC is part of a national initiative for End of Life medicines including the medicines supply chain from Just in Case medicines to Just in Time via the new NHS Wales
	Pharmacists and technicians undertaking remote medicine reconciliation to reduce contact and footfall within inpatient areas
	Implementation of Virtual Assessment Patient Pathway (VAPP) project to assess patients and determine if clinically inappropriate for the patient to continue with SACT treatment
	Encouraged use of oral treatments, where this is deemed a suitable alternative
	VCC's Medicines at Home Service continues to provide home delivery for many and VCC has expanded capacity in this service for 50 new patients by engaging an additional third party supplier

Outpatients	Significantly reduced face-to-face consultations. Specific measures include: • Extensive utilisation of virtual and telephone clinics • Implementation of processes to enable consent to treatment to delivered remotely • MDT meetings conducted remotely
	Repatriation of Outreach activity delivered in outreach contexts to VCC
	Implementation of dedicated phlebotomy clinics at VCC in response to GP closures
	Treatment protocols have been amended and modified to reduce risks of contracting COVID infection
Inpatients	Created physical capacity to accommodate up to 47 inpatient and 8 Assessment Unit beds
	Managing COVID-19 patients in a dedicated area
	Refreshed admission criteria to reflect COVID-19 and VCC's support to the wider NHS and agreed appropriate escalation procedures with health boards for implementation during the pandemic
	All Therapy teams working over a 7-day timetable and trained in vital signs and interpretation of NEWS. This reduces the requirement for other staff members to enter areas where there is an elevated risk of infection
Radiology and Nuclear Medicine	Radionuclide Therapy (e.g. Radium 223 and Iodine 131) has been paused
	The number of days on which scans in Nuclear Medicine are undertaken at VCC reduced. The reduction of capacity at VCC supports the wider NHS system where staff shortages in radio-pharmacy are prevalent
	Home reporting workstations and a Radiology dedicated VPN enable reporting of complex studies remotely
	Radiology referrals have been reviewed and routine scans have been deferred where appropriate
	Radiographic justification of referrals to improve workflow which will reduce referral to scan times and reduce unnecessary interaction with consultant group
	Radiographic role extension for MR reporting and ultrasound training in place which will increase resilience and improve service provision

TRUST BOARD

Velindre Cancer Centre Clinical Framework for Defining the Clinical model and treatment decision making during the recovery phase of covid-19

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	CLINICAL ADVISORY GROUP (CAG)
PRESENTED BY	DR JACINTA ABRAHAM, MEDICAL DIRECTOR
EXECUTIVE SPONSOR APPROVED	DR JACINTA ABRAHAM, MEDICAL DIRECTOR

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	25/06/2020	ENDORSED FOR APPROVAL

ACRONYMS	
TCS WG	Transforming Cancer Services Welsh Government

1. SITUATION/BACKGROUND

This is a Velindre University NHS Trust document for use during the COVID19 Public Health emergency. As we move into the Recovery phase of COVID 19, it should be used as a replacement to the '***Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19'*** as discussed at the Private Trust Board meeting on the 28th March 2020.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The aim of the COVID-19 Recovery Phase – Clinical Framework is to provide a safe structure to support the delivery of cancer treatments within Velindre Cancer Centre (VCC). The Principles are aligned to Welsh Government (WG) Operating Framework and covers the following areas:-

- Definition of phases in delivery of services
- References to previous documents and guidance
- Background to give context to the document
  Recovery Phase Principles
- Ways of working

3. IMPACT ASSESSMENT

The risk to patients has been considered under item 4 of the document and is aligned with The Welsh Clinical Network framework that is being developed for the recovery of Cancer Services in Wales during COVID-19.

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The areas considered to have an impact on quality and safety are identified in the Health & Care Standards and the safe delivery of delivery of cancer treatments.

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability Timely Care Effective Care Safe Care Individual Care Dignified Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Requirements assessed on case by case basis
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Considered as part of the NWSSP COVID-19 Legal & Risk Guidance Impact Assessment and advice on the interim measures for each HB to consider during the Pandemic.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Board are asked to consider the proposed VCC Clinical Framework and **APPROVE** the Clinical Model and approach to Decision Making during the recovery of phase of COVID-19.

VELINDRE CANCER CENTRE CLINICAL FRAMEWORK FOR DEFINING THE CLINICAL MODEL AND TREATMENT DECISION MAKING DURING THE RECOVERY PHASE of COVID19

1. PURPOSE

This is a Velindre University NHS Trust document for use during the COVID19 Public Health emergency. As we move into the Recovery phase of COVID 19, it should be used as a replacement to the '***Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19'*** reference paper 1.

The aim of the COVID-19 Recovery Phase – Clinical Framework for defining clinical / patient pathway / treatment decision making document is to provide a safe framework to support delivery of cancer treatments and services within Velindre Cancer Centre within the recovery phase of the pandemic.

It is recognised that the trajectory of pandemic recovery is uncertain and agility will be required and refinement as the weeks / months pass. There is also a potential for further 'peaks' which will require further review of the clinical delivery framework.

It is essential that any proposed changes to clinical pathways/treatment have a documented impact assessment. This will be undertaken using an Impact Assessment tool (attached in ***Appendix 1***), to be signed off by the relevant site specific team (SST) Clinical Lead, and Clinical Director followed by 'Silver' or 'Gold' approval.

Patient outcomes will be actively monitored by Clinical Teams. Any adverse outcomes must be recorded on the DATIX system and a review of treatment / care pathway to be undertake. The risk register must be kept 'live'.

It is essential that the impact on the workforce / digital enablement /Regulatory Requirements /Communication strategy is considered for each action underlying each principle. Individual treatment decisions may need to be made on a case by case basis with input from patients and the respective multidisciplinary teams. Prioritisation will be overseen by the Nominated Trust Oncology Lead (Clinical Director).

2. DEFINITIONS

- ***Recovery Phase***: The phase which occurs after the planning and peak phase of COVID-19 and is likely to have several stages within it including a further 'peak' at some point. We should assume that this period will last for at least 12 months and possibly as long as 18 months.

- ***Essential Services***: "Services that are life-saving or life-impacting i.e. where harm would be significant and irreversible, without urgent or emergency intervention".

- ***Scheduled Care:*** This is planned and routine care which includes Inpatient planned admissions, Outpatient attendances , Radiology visits, Radiotherapy related visits and Systemic Anti-Cancer Therapies(SACT)

- ***Unscheduled care***: Unplanned health care such as emergency events which may be day case assessments, emergency radiology, in patient admission and Acute Oncology Services.

3. REFERENCES

This document has been developed in line with the following documents:

- Ref 1:Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID 19 [VUNHST 18th March 2020)
- Ref 2: Framework for Maintaining Essential Health Services during the COVID 19 Pandemic [WG]
- Ref 3:Draft NHS WALES COVID 19 Operating Framework-Quarter 1 [WG]
- Ref 4: Speciality guide for the management of non coronavirus patients requiring acute treatment for cancer [NHS NICE ref 001559]
- Ref 5:Ethical Framework NHS Covid19
- Ref 6:Operating framework for urgent and planned services in hospital settings during COVID-19 NHS

4. BACKGROUND

4.1 Risk to cancer patients of COVID 19

The cancer population considered at high risk of becoming seriously ill with coronavirus infection have already been defined (*Ref1*). Cancer patients continue to remain at high risk should they contract the disease, but the risk of community and hospital acquired transmission based on the R0 value is lower than previously. This is due to flattening of the peak incidence of Covid positivity in Wales as a direct consequence of the current national social isolation policy. It is anticipated that there will be an ongoing prevalence of COVID-19 for at least the next 12 -18 months. There is a great deal of uncertainty ahead and during this time it is anticipated that there will be fluctuations with further peaks and 'surge capacity' expected, although these are likely to be less intense. The impact of serology testing and the potential development of a vaccine, and the timescales for this, is yet to be determined.

4.2 Risk to cancer patients of not receiving optimal treatment

Cancer services in general have already been severely disrupted as a result of COVID-19.This is in part due to the impact on reduced screening and primary surgery but also the modification of therapy in order to minimise harm from treatments in the high risk cancer group. These pathway changes have resulted in a supressed demand for non-surgical oncology services which will become manifest in the coming weeks.

In Velindre Cancer Centre, essential cancer care has been continued in line with the high level principles defined at the outset of this pandemic (*Ref1*). However, there have been a number of examples where patients themselves have asked to have treatments modified or stopped because of concerns around their individual vulnerability and the risk of being infected in a hospital environment. In addition, staff capacity has been reduced because of staff COVID-19 infection and this may be an ongoing risk.

4.3 National framework for Recovery phase in cancer

There is agreement across the system in Wales and the UK that we need to urgently restore our ability to deliver essential health services for our cancer population. Where possible we are also asked to consider recommencing more routine care. However we need to do this in a safe way, and with caution, through short planning cycles that maintain the flexibility and agility without putting our patients and staff at any increased risk. The Welsh Clinical Network is developing a framework for the recovery of Cancer Services in Wales during COVID-19 and these Velindre principles are aligned with this document, which is currently in draft form.

5. RECOVERY PHASE PRINCIPLES

5.1 Overarching principle of the Recovery phase

Velindre University NHS Trust has a responsibility to continue to deliver non-surgical cancer services and palliative care, defined as essential, and now to gradually recommence routine cancer services in a safe and controlled way, for the population we serve, whilst working in collaboration with the with the wider NHS.

5.2 Principles of care

The following principles which we have already outlined (*Ref 1*) still remain:

- Patient care and safety is paramount.
- Care will be provided based upon clinical need.
- Care will be delivered to maximise clinical outcomes at a patient and population level.
- Care will be provided at home or as close to home as possible.
- Staff safety and well-being will be paramount.

To achieve these principles, the following 3 key elements will be considered in parallel:

i) The **background risk** of community and hospital transmission which is influenced by societal movement control and determines the phase of COVID-19

.ii) The ability to become a **COVID-Protected service** apart from designated COVID+ve zones (recognising it will not be possible to control all aspects of this or do this in all areas)

iii) The use of **clinical prioritisation** to manage capacity and demand whilst minimising impacting on patient outcomes. The NHS NICE definitions of patient priority level previously referenced will continue to be used (*See Appendix1*) in considering the clinical prioritisation of patients, the following factors also need to be considered:

- The individual patient risk including factors such as age, performance status, sites of disease, comorbidities
- The COVID-19 status of the patient which may be negative, positive, suspected or recovered.
- The treatment modifications already made and any outcome measures seen.
- The impact of future therapy on the basis of already modified treatment pathways.

5.3 Key Strategic principles that determine the clinical model during the Recovery phase

Given our vulnerable patient group, we need to take additional measures in delivering care in a safe environment, i.e. one that is protected, as far as possible, against the risks of COVID. In addition to the current arrangements during COVID19, we need to create distinct treatment areas now 'designated as COVID protected 'to resume non COVID activity. This will form the vast majority of space on site. This will now include Inpatients/Outpatients/Radiotherapy /SACT to allow services to resume.

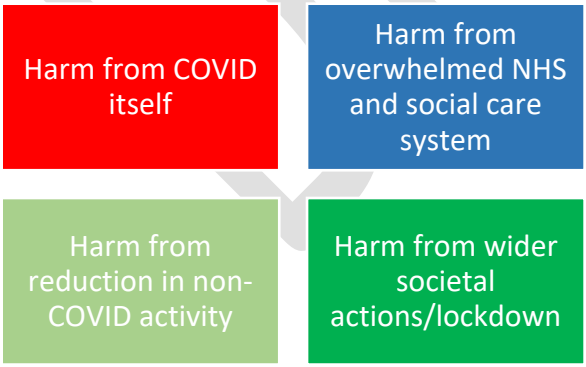
- Risk mitigation strategies for designation of a safe site would include a systematic programme of managing access /rapid triage/screening/ testing and case contact tracing, where necessary of both staff and patients.
- Example of patient risk mitigation may include Pre-treatment self-isolation for a 14 day period, swab testing (48hrs pre-treatment) and CT chest imaging for specified high risk groups. In addition frontline staff may need to be tested weekly.
- The principle of social distancing needs to be applied for patients and staff alike. In clinical areas where the 2metre social distancing rule cannot be maintained, this is mitigated by appropriate use of PPE. This has an implication for home working/use of remote consultation and consent.
- Enhanced cleaning regime and IPC protocols including use of appropriate PPE which is risk assessed according to the patient and procedure is mandatory.
- In addition to the current arrangements during COVID19, we need to create distinct treatment areas now 'designated as safe' for non COVID activity. (Covid-Protected

) This will form the vast majority of space on site. This will now include Inpatients / Outpatients/Radiotherapy / SACT to allow services to resume.

- We would also need to have the ability to continue to treat an expected but smaller number of COVID+ve patients should the need arise. Designated COVID+ve areas need to be defined within the service to include Inpatients, Outpatients, Radiotherapy and SACT. Moving these patients to alternative locations where possible should also be considered.
- Where possible and aligned to the principles of TCS, care should be delivered as close to home as possible and the footfall of patients at VCC, reduced to a minimum. In line with this Ambulatory care and Admission avoidance should be encouraged.
- We should continue to embrace new ways of working and efficient treatment monitoring protocols, supported by the appropriate digital infrastructure which allow remote consultations and consent to occur in cases where this is deemed acceptable by patients and relevant to their needs.
- We need to monitor patient and carer outcomes and feedback throughout the recovery phase.
- We should ensure that communication during this time involves clear, and coordinated messaging to patients, carers, external partners and our staff.

5.4 Principles aligned to National WG Operating Framework

We need to balance the risks for our cancer patients, in these 4 defined areas of harm, and make a clinical judgement on the benefits of treatment. The ethical framework will guide decision making which will be based on the principles that everyone matters equally but this does not mean that everyone is treated the same.



6. WAYS OF WORKING

The broad principles set out in *Ref 1* still remain in relation to ways of working. Key areas where there are differences with the recovery phase will be included under the existing headings of criteria and ways of working.

6.1 Minimise risk of Transmission

We should take all actions to reduce the risk of any transmission of COVID-19 across any service provided by Velindre.

- Work with other Cancer Centres, HBs and organisations in Wales to align with recovery protocols for COVID-19.
- Maintain the 2 metre distancing rule throughout the cancer centre apart from necessary clinical requirements.
- Patient screening pre-treatment, dependent on risk factors to include COVID history / Antigen testing/CT imaging/Self isolation protocols 7-14 days and contact tracing.
- Only bringing patients into the cancer centre if there is no alternative i.e. optimise virtual / telephone clinics.
- Defined hospital area for access, triage assessment and patient flows within outpatients, day case delivery, inpatients and radiotherapy.
- IPC principles i.e. Handwashing / Hand hygiene / minimise physical contact / staff education & training and clearly defined use of PPE for all areas including a risk assessed approach.
- Limiting / preventing visitors / patient support (OPDs) in line with current national guidelines / requirements; all exceptions to be agreed with Nurse or person in charge.
- Enhanced touch point chlorine cleaning and extended site cleaning hours.
- Minimise attendances and duration of stay for outpatient / day case attendances.
- Consider designated Radiotherapy facilities and timing of treatment e.g. end of day followed by appropriate zone cleaning.
- Reduce numbers and attendance at MDT using video links where at all possible. (as per WCN guidance).
- Staff screening: Enhanced staff testing and contact tracing programme in line with maintaining COVID-19 free zones.
- Support staff working from home, working remotely e.g. maintain new protocols for remote treatment consent, authorisation, approval.
- Review staff rotas to minimise risk of transmission, maximise skill mix, expertise, adequate capacity and oversight while ensuring adequate compensatory rest.
- Robust risk assessment of vulnerable staff including BAME individuals to determine appropriate areas of work.

6.2 Scheduled care

We should aim, wherever possible to recommence scheduled care in a stepwise approach maintaining the criteria 1 above. Where possible, and where it does not compromise treatment options we should reduce non urgent, face to face patient contact within Velindre Cancer Centre / Outreach settings. It is recognised that this approach will not suit all patient groups and needs to be considered on an individualised basis. This will mean:

- Continuing limited ongoing face to face routine follow up.

- Maximising use of remote monitoring where acceptable to patients and staff.
- Reviewing intervals between visits / surveillance / monitoring.
- Reviewing mode & choice of treatments.
- Strengthening Homecare.
- Reducing fractions of RT where appropriate to do so permanently e.g. Fast Forward for breast cancer.
- Consider safe recommencement of trial recruitment and follow-up in line with individual trial protocols.
- Revised pathways for palliative patients / end of life care dependent on options for this e.g. third sector provision/Use of Dragon heart hospital.

6.3 Understanding the Patient risk

In addition to the approach we have taken to minimise risk of therapy outlined in *Ref1*, in this recovery phase we should consider the ability to now reduce the likelihood of a patient harbouring the disease by intensive pre-treatment triage which may include 7-14 day isolation/screening with swab testing and use of CT imaging where relevant.

We should then **consider the** management of our **patients** in terms of:

- Their risk of contracting COVID-19(now significantly reduced in recovery phase)
- Their risk of immunosuppression during and following cancer treatment
- Balance this risk against likely benefits of treatment/care
- Identifying the known high risk groups: >70,PS 2+, pre-existing lung conditions,
- lung cancer, comorbidity e.g. diabetes, heart disease and hypertension
- Identifying the most immunosuppressive regimens
- Develop risk stratification by treatment type for SACT/RT or Combination SACT-Radiotherapy
- Review evidence for benefit of therapy for that individual or group of patients
- Review evidence for prioritization criteria: SACT and RT neoadjuvant / adjuvant/non-curative.
- Consider choosing less immunosuppressive treatments or regimens where this is still felt to be relevant, particularly to reduce the risk of respiratory toxicities such as pneumonitis e.g. RT versus CRT, RT versus surgery
- Rationalisation of therapy in palliative settings: extending intervals/single agents/Less complex RT
- We need to consider treatment protocols for patients who are asymptomatic and have tested COVID positive who will require repeated testing.

6.4 Unscheduled care

Non COVID Unscheduled care

Where appropriate, Velindre Cancer Centre would aim not to admit or manage patients with acute respiratory symptoms and suspected or confirmed COVID -19 (admission pathways to relevant HB). In line with being a COVID free zone as far as possible we would aim to test every patient on admission irrespective of symptoms. The existing

Admission Criteria would otherwise apply and we aim to continue to support LHBs in managing non-respiratory acute toxicities.

- Telephone triage to keep patients in the community in line with PHW advice.
- Effective Admission policy: avoid direct admission of suspected cases in line with HB agreement.
- Effective Discharge policy to reduce length of stay.
- Expedite a pathway for blood testing in the LHB.
- Delivery of treatment to home with adequate supplies.
- Use outpatient treatment regimens.

Suspected and or confirmed COVID-19 positive Unscheduled Care:

Velindre Cancer Centre will continue to have designated isolation / cohorting arrangements and clear patient triaging / pathways for activation:

- Consistent robust history taking and risk assessment (including of household
- members).
- Identifying the at risk groups: >70,PS 2+, pre-existing lung conditions, lung.
- cancer, comorbidity e.g. diabetes, heart disease and hypertension.
- Identifying regimens that are most likely to immunosuppress individuals.
- Develop a pathway for isolation, assessment, testing and treatment that protects patients and staff.
- Develop pathways for escalation and resuscitation of COVID-positive cases.

6.5 Assessment Unit (AU)

Velindre should have a designated **assessment area** separated from any cohorting areas. The principles of reduced transmission (6.1) should be applied here. The assessment unit has been temporarily relocated and the feasibility of increasing from 4 to a maximum of 8 spaces is being explored. In addition, a two week pilot of 7 day working with 4 beds in use has been successfully undertaken. The recovery phase will consider the longer term implications and feasibility of this pilot. The AU will also include:

- Dedicated area with rapid turnaround AU for low risk patients (potential or unknown risk of COVID).
- Rapid on site testing for any suspected cases.
- Consider entry and exit routes for such an assessment unit.
- Clear signposting and communication for visitors.
- Primary care/community oncology services should be aligned to the function of the AU.

6.6 Flexible Inpatient capacity and Widening of admission criteria

In order to support our health board partners with the management of cancer patients during the 'peak or future surge capacity period' we have considered a flexible approach to widening our admission criteria. We have also developed a plan to increase our bed capacity to up to 47 beds. The operationalisation of this will depend on social distancing requirements and demand across a number of areas including our own capacity to deliver priority SACT / Radiotherapy and would be considered in collaboration with our Health Board colleagues. The areas we could increase activity would include:

- Palliative Care
- End of life care
- Management of CUP(Carcinoma of Unknown Primary earlier in the pathway)
- Symptom control
- Suspected Cord Compression
- Non-COVID related treatment toxicities

6.7 Mutual Aid during the recovery phase

Staff will continue to participate in mutual aid programmes as required by NHS Wales following agreement with the health boards, VCC line managers and as compliant within job plans as appropriate.

Prepared by: Trust Executive Medical Director & Executive Nursing Director and members of the VCC Clinical Team
Agreed by:EMB on 26/05/2020
Review Date:

1	Insignificant
2	Minor
3	Moderate
4	Major
5	Catastrophic

		Decision 1		
	What is the Decision?			
	Clinical or Operational?			
	If Clinical, does it meet the Principles for Clinical Activity?			
	If not, please provide a description, with clear references to the Principles documents			
	Please provide evidence base and/ or benchmarking data or insight			
		Is the impact Positive, negative or neutral?	**Brief description of impact**	**If negative, is impact 1-5?**
	Quality Impact			
1	Patient outcome - short term and long term			
2	Quality of care			
3	Patient / donor experience			
4	National best practice / guidance / current research evidence			
5	Dignity and respect			
6	Safeguarding			
	Workforce Impact			
7	Staff well-being			
8	Staff capacity and capability			
9	Consistency of approach			
	Reputation/ Public Confidence Impact			
10	Stakeholder Trust			
11	Patient/ Donor Trust			
12	Staff Trust			

TRUST BOARD

HIGHLIGHT FROM THE QUALITY & SAFETY COMMITTEE

DATE OF MEETING	4th June 2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Catherine Currier, Executive Support Assistant Nicola Williams, Executive Director Nursing, Allied Health Professionals, and Clinical Scientists
PRESENTED BY	Janet Pickles, Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Health Professionals, and Clinical Scientists

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Quality & Safety Committee at its meetings on the 30th March 2020, the 29th April 2020 and the 18th May 2020.

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

2. BACKGROUND

Since March 2020 the frequency of the Trust Quality and Safety meetings has increased from quarterly to monthly in order that the Trust can adequately discharge its responsibilities during the COVID-19 pandemic. It is planned that this will continue until at least September 2020. A formal review will be undertaken in August 2020 and a recommendation made to the Quality & Safety Committee and Board in September 2020 regarding the remainder of the year. This will be informed by the situation in relation to the pandemic and how effective the Committee has been executing its responsibilities as outlined in the Welsh Government Guidance: Discharging Board Responsibilities during COVID-19.

Verbal updates on the March and April Quality and Safety deliberations were provided to the subsequent Board meetings due to meeting timings. This report provides the formal highlights as well as highlights from the meeting held on the 18th May 2020.

3. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items to alert or escalate to the Board from either the 30th March 2020, 29th April 2020 & 18th May 2020 Quality & Safety Committee Meetings.
ADVISE	**30th March 2020 Quality & Safety Committee Meeting:** • ***Public Health Support*** - The Committee discussed the impact of not having a Public Health Wales (PHW) Director / senior representative as this is not a statutory requirement for the Trust. Discussions taking place at Chief Executive Level with Public Health Wales. • ***Divisional Quality & Safety*** – Committee requested a review of the Divisional Quality & Safety Group /s Terms of reference and to bring back to the Committee for approval in June 2020. **29th April 2020 Quality & Safety Committee:** No matters to raise **18th May 2020 Quality & Safety Committee:** • ***Welsh Blood Service (WBS) Quality Systems and Regulatory Accreditation Update***: A comprehensive report was received from

	WBS. There had been significantly reduced regulatory activity during Quarter 4 due to the COVID-19 pandemic. The MHRA Bi-Annual Inspection due on the 23rd March 2020 had been postponed and was rescheduled for the 15th June 2020, as a 'light touch' paper based review to be undertaken remotely. Both North and South Wales sites are legally required to have a review every 2 years.
ASSURE	**30th March 2020 Quality & Safety Committee Meeting:** • ***Infection Prevention & Control*** – the Committee were advised of actions being taken to strengthen the Infection Prevention and Control governance and Management Group functioning. This includes revised Terms of reference and being clear in relation to members roles and responsibilities. A reduction in microbiology Ward Rounds had been identified which will be discussed with Public Health Wales as part of the review of the Service Level Agreement. Urgent work has been undertaken to improve compliance levels with Hand hygiene audits as these were not across all levels of the Cancer Centre where they needed to be. Local Manager action had been agreed along with the development of local hand hygiene trainers and a revised training programme. • ***COVID-19 –*** Considerable work underway to prepare the services and staff to provide care and services during the COVID-19 Pandemic. All discussions, decisions and changes are being processed through a robust clinical, managerial and operational structure. A "Clinical Governance and Operating Framework for Clinical / Patient pathway/ Treatment Decision Making During Covid 19" had been produced and approved by the Trust's Board on the 18th March 2020. The framework outlines how clinical services at the VCC should respond during the COVID-19 Pandemic and a list of clinical prioritisation, adaptation and work in progress has been produced. • ***COVID-19 and WBS*** - Committee advised that COVID-19 bringing a number of operational challenges for the WBS, including the number of venues no longer available for providing blood donation clinics, and the need to secure alternative venues. Assurance is being provided to donors that safe processes are being put in place to continue with the blood collection programme, and clinics will be adapted to ensure compliance with social distancing.

29th April 2020 Quality & Safety Committee Meeting:

- ***COVID-19 and Safeguarding Implications****:* The Committee received report outlining the implications of COVID-19 on safeguarding arrangements and referrals. The Committee was advised there had been an overall decrease in the amount of contact and in staff asking for advice/support on safeguarding. This was felt to be due to the reduced number of patients and visitors to the Cancer Centre. Guidance had been published which included changes in the ways of working; around mental capacity and Deprivation of Liberty Standards. A comprehensive staff briefing had been produced, which provided the links to all of the guidance documents and a Covid-19 tab has been included on the Safeguarding internet site.

- ***Convalescent Plasma****:* The Committee received a verbal update outlining where the WBS Convalescent Plasma Project is in relation to its development. The service will produce fresh frozen plasma from people, who have recovered from Covid-19. The production method remained the same, with additional steps, for example ensuring the individual is no longer positive and has antibodies.

- The Trust is continuing to providing and maintain quality and safety standards continued despite COVID-19.

18th May 2020 Quality & Safety Committee Meeting:

- ***Gap Analysis against Welsh Government Guidance Note - Discharging Board Committee Responsibilities during COVID-19****:* The Committee received and approved the draft gap analysis that had been undertaken in relation to the above Welsh Government Guidance. The Committee work programme had been updated to reflect these requirements to ensure the Committee is adequately executing its responsibilities that was also approved.

- ***COVID-19 'Cell' Establishment:*** The Committee was informed of the establishment of seven COVID-19 cells, as commissioned by Gold Command to provide a layer of governance across the Trust. The Cells aimed to develop robust arrangements for system COVID-19 related processes, mechanisms and linkages with business as usual. A further cell has also been commissioned: Staff & Patient Testing. It was agreed that the following cells would provide a high level report into the committee each month as they key mechanism

	by which it will executive its responsibilities as detailed in the Welsh Government Guidance: Discharging Board Responsibilities During COVID-19: End of Life; PPE; Quality & Safety; Workforce; Testing; and Planning. • ***Risk Register***: The Committee reviewed the Risk Register and was updated that the register now includes a COVID-19 flag to allow for identification of any COVID-19 risks. A Risk Assurance Framework was being developed and new Risk Assessments were being undertaken against five key risks. • ***Health & Care Standards Self-Assessment 2019/20:*** The Committee was informed that the timescales for the completion of the Trust's self-assessment had been extended to all resources to be diverted to manage COVID-19. All improvement actions that have not been completed have been shared with the Executive Management Board for approval to be carried over to the 2020/21 plan. The process for managing the Health & Care Standards Self-Assessment for 2019/20 was being radically reviewed, moving to a process of quarterly assessment.
INFORM	**30th March 2020:** • ***Revised All Wales Safeguarding Procedures –*** have been published, the expectation is that the procedures would be adopted and fully implemented by every region by April 2020. Cardiff & Vale regional Safeguarding Board formally adopted the Wales Safeguarding Procedures in December 2019. Plan is in place within the Trust to ensure all future Safeguarding training and policy development will fully reflect the duties within the new procedures. The Committee endorsed the implementation of the Wales Safeguarding Procedures across Velindre University NHS Trust. • ***Shared Listening & Learning Sub Committee*** Terms of Reference & Operating Arrangements were approved by the Committee **29th April 2020 Quality & Safety Committee Meeting:** • **Implementation of an Ambient Overnight Hold Blood Processing:** The Committee was informed that the Welsh Blood Service had introduced an Ambient Overnight Hold for Blood Processing in response to COVID-19 that had been planned as part of the Supply Chain 2020 Project, but due to the pandemic had been

	brought forward. The Committee wanted to highlight the speed at which this had been introduced. • ***Reporting and Investigating Staff with Confirmed Covid-19 Diagnosis:*** The Committee was provide with an update on the work to develop an investigative process and toolkit. The Committee was informed by Peggy Edwards that the wider health community appreciated the work undertaken to develop the process and to Velindre for taking the lead. **18th May 2020 Quality & Safety Committee**: No items to raise
APPENDICES	Not applicable.

4. RECOMMENDATION

The Board is asked to **NOTE** the report.

TRUST BOARD

PARTNERSHIP MEETING HIGHLIGHT REPORT

DATE OF MEETING	04.06.2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Susan Thomas, Assistant Director Of OD
PRESENTED BY	Sarah Morley, Director Of OD And Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
PPE	Personal Protection Equipment
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by Trades Union Partnership meetings during the Covid-19 response. The meetings have been held on the following dates:

- 14.04.2020

- 17.04.2020
- 22.04.2020
- 06.05.2020
- 13.05.2020

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Nothing of note**
ADVISE	**Nothing of note**
ASSURE	• Personal Protection Equipment has been an ongoing discussion item at these meetings, specifically stock levels, procedure and effective communication with staff at Velindre Cancer Centre and the Welsh Blood Service. The establishment of the PPE Cell with Trades Union representation has provided assure on stock levels. Union colleagues have developed a staff survey on PPE usage and availability, supported by the Trust. The results have been discussed and actions taken via the PPE Cell. Monitoring of Fit Testing and Donning and Doffing PPE is done via the Cell and discussed at the meetings. • The implementation of the Social distancing guidance at all sites has been discussed. This continues to be a developing theme. Communication regarding social distancing was discussed and rolled out with posters in all sites. The risk assessments at all sites have been carried out and work is ongoing to plan the way forward, ensuring adherence to guidance. The work around social distancing will continue to be carried out in partnership. • Continuing the theme of staff safety – staff within High Risk categories have been identified via ESR and managers. Risk assessments are being completed, the ongoing compliance data is being reviewed at the Partnership Meetings

INFORM	• Cleaning arrangements at Velindre Cancer Centre has been discussed and a paper shared. The paper and subsequent discussions has provided assurance that guidance is being followed, adequate resource is available and plans are in place to facilitate upscaling if required. • Staff testing has been discussed, the availability of tests and the process around requisition. • The expansion of the bed capacity at VCC has been discussed and the plan shared with the Unions. Assurance has been provided that additional staff and oxygen facilities are in place should capacity need to be increased. • The meeting provides updates on wellbeing resources for staff and the available support mechanisms in place, including union offerings, to ensure wellbeing is maintained. • The Trust and Union colleagues have worked in partnership to create a shared document to supplement the annual leave policy during COVID. • The ongoing management of work related to workforce themes is now carried out via the Workforce Cell – with a focus on Staff Safety, Ways of Working and Wellbeing, union colleagues are a part of the membership of the Cell.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

trust risk register

DATE OF MEETING	4/6/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sian Lewis, Quality & Safety Coordinator
PRESENTED BY	Lauren Fear, Interim Director of Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Director of Corporate Governance

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	11th and 26th May	NOTED

ACRONYMS	
	EMB – Executive Management Board WBS – Welsh Blood Service VCC – Velindre Cancer Centre

1. SITUATION/BACKGROUND

The purpose of this report is to present to Board members the high level organisational risks included on the Trust Risk Register, and the management actions being taken to manage or mitigate these high level risks.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Trust Board, Board Committees also is received and reviewed at Executive Management Board (EMB).

The Trust Board and its Committees are asked to scrutinise risks and satisfy themselves with regard to the adequacy of management actions, and the control measures being implemented. Committees and Trust Board are requested to scrutinise decisions taken to de-escalate or close risks on the Trust Risk Register.

2.1 Overlay of the Trust's Incident Management Response for COVID 19 to Risk Framework

Datix is continuing to be used as the risk system of record in the Trust. A "Covid-19" flag has been added to the system and is being used by both Divisions.

Risks are being managed through the operational Bronze command structures and are being escalated to Silver and onto Gold as appropriate. This reporting is transitioning alongside the changes to the incident governance arrangements.

An additional piece of work has been completed this month to ensure that the risks highlighted in the Quarter 1 Operational Plan are also reflected clearly in the risk registers on Datix.

2.2 Development of the Risk and Assurance Framework

As reported to the January Board meeting, work had been planned and resourced to develop a number of aspects of the risk and control framework, including a refresh of the risk appetite, review of the risk register, development of the assurance framework and development of the risk management strategy.

The initial outputs from the first phase of this work will be progressed with the Executive Team during June and the workshops which are the key aspect of the

next phase are being planned for late June and early July. Newly committed to dates in the Annual Accountability Report for completing this work, including Board sign off is October 2020.

2.3 New risks assessments

Two new risk were approved at EMB on the 26th May 2020

- 16006 Risk Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre

- 16005 The total quantum for funding for addressing Covid-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2020-21

Risk 10451 has been revised and a SBAR has been completed advising of the current position which will be discussed in the Private Part B agenda.

The following risks are currently under development and proposed approval at June EMB:

- Legal risks resulting from COVID-19
- Social distancing risk
- Ventilation risk for Velindre Cancer Centre

2.4 De-escalated risk assessments

No risks have been de-escalated from the Trust risk register during the period.

2.5 Closed risks

No risks have been closed during this period although risks remain on the recovery plan as agreed in April Board meeting.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The high risk areas considered to have an impact on quality and safety are identified in the Trust Risk Register
RELATED HEALTHCARE	Safe Care

STANDARD	The related healthcare standard will vary for each risk identified on the Trust Risk Register.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The high risk areas considered to have an impact on equality are identified in the Trust Risk Register
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The high risk areas may have legal implications and will be identified on the Trust Risk Register
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial risk will vary for each individual risk reported on the Trust Risk Register In addition there have been resources allocated to support the risk framework development work over the coming months – scoping completed and tender will be progressed

4. RECOMMENDATION

The Board is asked to **APPROVE** the Trust Risk Register and the actions status of individual risks.

Risk Domain	Risk Ref	Summary of Risk	Risk Appetite	Initial Score	Current Score	Target Score	Last Review	Next Review	Scrutiny Committee – Updated to reflect interim Committee Structure during COVID-19 Response Period	Lead Director
Quality	15770	Implications of Coronavirus disease (COVID-19) outbreak to the patients, staff and operations of the Trust	**Low**	**25** Date risk identified April 2020	**16** Risk score reduced May 2020 ↓	**12**	26/05/20	July 2020	Board	CEO
	10451 **Revised Risk**	The continued failure to replace the existing WTAIL IT systems means there is a significant, ongoing risk that both current and future requests to deliver new WTAIL services will not be able to be supported and that, ultimately, WTAIL will be unable to delivery critical service modernisation that will meet service user expectations, presenting both a financial and reputational risk to the Trust if alternative service provision had to be provided	**Nil**	**12** Date risk identified May 2020	**20** Risk score remains the same ↔	**6**	22/05/20	June 2020	Board	Director of Welsh Blood Service
Reputation and Public Confidence	10415	Achieving the proposed timescales for the opening of the new Velindre Cancer Centre (nVCC).	**Nil**	**16** Date risk identified December 2016	**16** Risk score remains the same ↔	**8**	26/05/20	July 2020	TCS Scrutiny Committee	nVCC Project Director
	10416	Non delivery of the expected benefits from the Transforming Cancer Services Programme (TCS).	**Nil**	**16** Date risk identified Januay 2016	**16** Risk score remains the same ↔	**9**	26/05/20	July 2020	TCS Scrutiny Committee	Director of Transformation, Planning and Digital
	13819	The potential impact on staff wellbeing during the change process of the WBS Blood Supply Chain 2020 Programme.	**Nil**	**20** Date risk identified July 2017	**12** Risk score remains the same ↔	**6**	26/05/20	July 2020	Board	Interim Director WBS
Workforce & OD	14861	Achieving compliance against the new Welsh Language Standards (under the Welsh Language (Wales) Measure 2011) within the timescales set by the Welsh Language Commissioner.	**Nil**	**20** Date risk identified October 2018	**12** Risk score remains the same ↔	**4**	26/05/20	July 2020	Board	Executive Director WF&OD
Compliance	14860	Brexit – Disruption, delays or inability to provide full range of treatments and services if the government fails to achieve a withdrawal agreement when the UK leaves the EU.	**Nil**	**16** Date risk identified Octobe 2018	**8** Risk score remains the same ↔	**3**	26/05/20	July 2020	Board	Director of Transformation, Planning and Digital
	16006 **NEW RISK**	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	**Nil**	**15** Date risk identified May 2020		**9**	26/05/20	July 2020	Board	Director of Transformation, Planning and Digital

Performance & Service Sustainability	15143	Radiotherapy Planning CT scanners are nearing their end of useful life. This equipment will not have service/maintenance support after March 2020.	**High**	**25** **Date risk identified Jan 2019**	**16** **Risk score remains the same** ⟺	**1**	26/05/20	July 2020	Board	Chief Operating Officer
Finance	16005 **NEW RISK**	The total quantum for funding for addressing Covid-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2020-21	**NIL**	**12** **Date risk identified** June 2020		**4**	26/05/20	July 2020	Board	Director of Finance

Recovery Plan

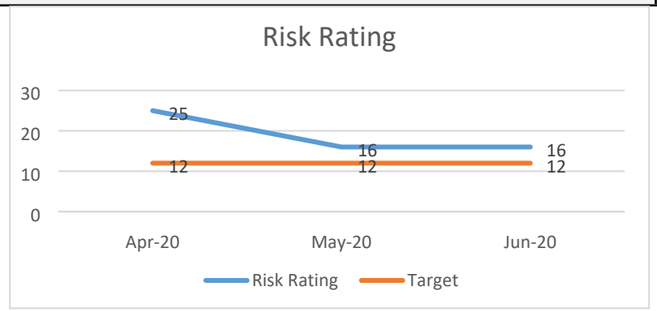
Quality	13614	The availability of sufficient consultant capacity to fulfil medical resource requirements for the service.	**Nil**	**16** **Date risk identified Nov 2017**	**12** **Date score reduced Feb 2019** ⟺	**4**	21/04/20	May 2020	W&OD Committee	Medical Director	Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.
Performance & Service Sustainability	5808	Insufficient radiotherapy capacity at VCC to meet demand.	**Nil**	**16** **Date risk identified July 2019**	**16** **Risk score remains the same** ⟺	**4**	21/04/20	May 2020	P&P Committee	Chief Operating Officer	Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.
	15713	Potential overcrowding of outpatient department	**Nil**	**16** **Date risk identified Feb 2020**	**16** **Date risk identified Feb 2020** ⟺	**6**	21/04/20	May 2020	P&P Committee	Chief Operating Officer	Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.

Risk Domain: Quality **Risk Ref:** **15770**	**Director Lead:** Chief Executive **Assuring Committee:** Board
Risk: Implications of Coronavirus disease (COVID-19) outbreak to the patients, staff and operations of the Trust	**Date Added to Register:** 21/04/2020 — **Date Last Reviewed:** 26/05/2020

Risk Rating
(impact x likelihood)

Initial	5x5	**25**
Current	4x4	**16**
Target	3x4	**12**

Risk Appetite:
Low



Rationale for current score	Rationale for target score	Groups discussed risk during period
In April's assessment the rationale for the score was that the Trust was in an initial period of a whole organisation and system response focused on tackling one of the most significant risks to world healthcare for generations. However, during May, there has been significant progress made on operationalising the control environment and actions required to both reduce the likelihood and impact of the risk at Trust level.	Modelling suggests the impact will be evident for at least 18 months, however, with the maturing of the control environment and continued focused management, aiming to continue to reduce the impact to moderate over the long-term	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

Controls articulated in original assessment in April	Progress made on operationalising control environment to date	Further key controls for next period
Incident Response Structure • Planning for the response in three key phases: 1. Preparation; 2. Acute; and 3. Recovery and reactivation • Mission and priorities set and communicated and engagement with all staff • Management structure implemented: Gold strategic command; Silver tactical command; and Bronze operational command	**Controls designed, implemented and operating effectively**	• Embedding of incident response governance into the developed governance framework for the Trust. • Cell structure for focused task and finish groups operating effectively.
Clinical model • Blood and transplant services: implemented a new collecting model based around a smaller number of larger sites on rotation to ensure we have sufficient blood, transplant and commercial products to support our partners • Cancer services: o Implemented a new clinical quality operating framework and clinical protocols to support clinicians/ healthcare professionals in decision-making o Engagement with local Health Boards and	**Controls designed, implemented and operating effectively**	• Continued review of blood collection model. • Alignment of clinical decisions and re-assessment of previously made decisions in line with the developed Clinical Principles for the recovery phase. • Oversight of clinical model changes through Quality and Safety Committee.

What actions should we take:
Focus over the next period:

Action	Lead	Date
Incident Response Structure: Establishment of Gold command "cell" structure to provide a co-ordinated and authoritative overview and management of the cross cutting and critical elements of the pandemic response: PPE; Q&S; Planning; Information & Performance; End of Life/ Death; Workforce; Digital	NW	15/5/2020 **Completed**
System Clinical model: Further engagement and decisions managed, as appropriate, on our continued broader role within cancer services with Local health Boards and Welsh Government	JA	Update end June 2020 **On-going engagement**
Planning & Information: Developing a one-year plan, which will identify demand and capacity requirements through the preparation, peak and recovery stages of the COVID-19 response. This will allow us to take actions to secure additional capacity to support us, e.g. additional staff, facilities	CJ	Update end June 2020 **On-going – update: - including capacity risks linked to social distancing, testing strategy and winter planning**
New action: Effective operation of Test, Track and Protect in the context of the Trust's accountability for staff, patients and donors.	JA	Update end June 2020

Welsh Government on our broader role for cancer services		
Providing kit, equipment and medicines • Developed guidance which provides staff with the clarity they need about what equipment/ PPE is required to remain safe • System approach established with NHS Wales and NHS Shared Services to secure the required PPE to deliver care. Tracking mechanisms established and governed • Worked with pharmaceutical/ industry to secure the supply chain for medicines and other products	**Controls designed, implemented and operating effectively**	• Continued effective operation of PPE cell. • Continued effective reporting and monitoring of key data. • Effective oversight of the cell and data through the divisional governance structure and into Executive Management Board.
Supporting staff with their health and well-being • Identified staff who are in the 'high-risk/ vulnerable category' and supporting them in shielding • Identified staff who can work from home and provided them with the technology to enable this • Established hubs for HR support and re-deployment • Enhanced the range of well-being/ support service available to staff e.g. psychological services	**Controls designed, implemented and operating effectively**	• On-going monitoring of high risk staff definitions and associated guidance for ways of working. • Model of well-being and support effective for the longer recovery plan period.
Governance • Focused Governance structures at Board and Executive level to ensure focused management, oversight and clear public scrutiny of the Trust's response • Decision making framework for both clinical and operational decisions, focused on quality, impact on staff and public confidence, and accountability levels aligned to impact and into the incident response management structures • Governance recovery phase planning completed and associated structure agreed to manage	**Controls designed, implemented and operating effectively**	• Continued development of effective governance arrangements at both Executive and Board levels.

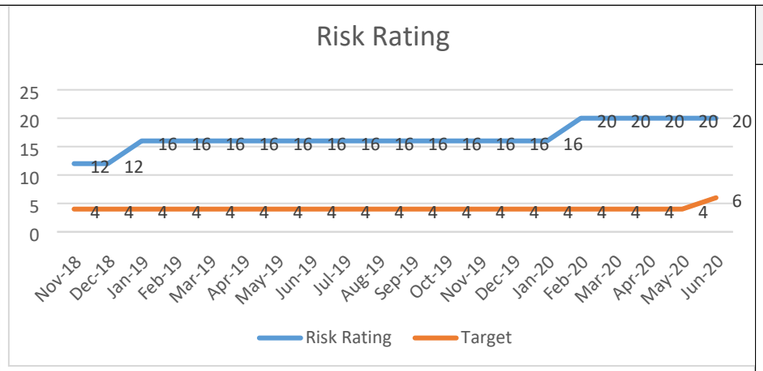
Additional Comments:
n/a

Risk Domain: Quality **Risk Ref:** 10451	**Executive Lead: Director of Welsh Blood Service** **Assuring Committee:** Digital & IG Committee	
Risk: As a result of the continued failure to replace the existing WTAIL IT systems, there is a significant ongoing risk that current and future requests to deliver new WTAIL services will not be able to be supported. Ultimately, WTAIL will be unable to delivery critical service modernisation that will meet service user expectations both a financial and reputational risk to the Trust if alternative service provision had to be provided. Failure to deliver an all Wales LIMS solution does not represent any significant risk to patient safety at present	**Date Added to Register:** 16/01/2018	**Date Last Reviewed:** 26/05/2020

Risk Rating
(impact x likelihood)

Initial	4 x 3	**12**
Current	**5 x 5**	**20**
Target	3 x 2	**6**

Risk Appetite:
None



Rationale for current score	Rationale for target score	Groups reviewed risk during period
The continued failure to replace the existing WTAIL IT systems means there is a significant, ongoing risk, that both current and future requests to deliver new WTAIL services will not be able to be supported. This could ultimately mean, WTAIL will be unable to deliver critical service modernisation that will meet service user expectations. This may necessitate users seeking alternative suppliers of these services presenting both a financial and reputational risk to the Trust Due to ongoing expectation that a replacement system will be delivered, the current system has been subject to limited development only (e.g. regulatory changes) for a number of years. The ability to deliver service improvements and introduce new technologies has been restricted due to the outdated nature of the current WTAIL IT platform. Furthermore, a series of manual workarounds have been introduced to ensure continued service delivery. Whilst this does not introduce clinical risk, the cumulative effect of an increasing number of manual workarounds greatly increases the risk of human / operational error. Lack of system configurability and adaptability constrains service ability to respond to external changes to service delivery requirements	Next steps to be formally agreed in writing with NWIS and Supplier post-COVID-19.	WBS SMT / EMB

What controls have we put in place for the risk:

- Initiate escalation to NWIS in respect of delayed project delivery.
- New ways of working agreed with supplier in Feb 2019. Specification for outstanding software development agreed.
- Updated Correction Plan agreed between NWIS and supplier.
- Twice-weekly 'scrums' have been established to monitor progress through ongoing software development, testing and validation phases.
- Development sprint 5-7 delivered July 2019. Gap developments 5 (of 7) deployed early through September 2019 to January 2020. Informal user testing ongoing.
- Regular on-site (WBS) and Skype-based supplier / SME workshops to discuss progress and review newly-delivered functionality. Supplier has consistently struggled to fully resource this requirement for additional on-site workshops.
- Monthly meetings of WTAIL Project Board to monitor progress.
- Bi-monthly updates supplied National Pathology Board.
- Recruitment of 2 WTAIL SMEs ring fenced for WTAIL project from April 2019 - completed.

What actions should we take:

Action	Lead	Date
Progress escalation with NWIS to agree 'next steps'.	Interim Director, WBS	*June 2020*
Supplier to ensure outstanding software development is delivered to enable UAT by 31/12/2019.	Interim Director, WBS	*Delayed to March 2020 – target missed.* *Revised date TBC due to COVID-19.*
WTAIL Subject Matter Experts to support ongoing software delivery through informal testing of system. (Dependant on completion of all software development activities)	Interim Director, WBS	*Delayed (see above)*

Additional Comments:

n/a

Risk Domain: Reputation and Public Confidence **Risk Ref:** **10415**	**Director Lead:** nVCC Project Director **Assuring Committee:** TSC Scrutiny Committee	
Risk: Achieving the proposed timescales for the opening of the new Velindre Cancer Centre (nVCC).	**Date Added to Register:** 30/12/16	**Date Last Reviewed:** 11/05/2020

Risk Rating
(impact x likelihood)

Initial	4x4	16
Current	**4x4**	**16**
Target		8

Risk Appetite:
Nil

Rationale for current score	Rationale for target score	Groups discussed risk during period
A preferred route of access to the nVCC site is yet to be finalised and approved, which presents a risk to the delivery of the nVCC Project within previously anticipated timescales. In addition the OBC is yet to be formally approved by the Welsh Government.	The risk appetite is nil due to the high level of public and commissioner and Welsh Government interest in the nVCC Project.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

Planning and reporting
- Programme Plan agreed with change control and tolerances set and reporting framework in place with associated escalation criteria linked to governance path
- Key dependencies mapped with the Integrated Radiotherapy Project, which is governed through project plan, agreed resources and financial tolerances with procurement
- Not to exceed target cost agreed for the hospital and reporting in place

Framework
- Legal and binding contract with commercial partner for access route and also optionality built into the next steps

Capability
- Skills and capability built into each business case, which were complied with technical advisors and benchmarking exercise

Engagement
- Effective engagement approach with Welsh Government and Commissioners

What actions should we take:

Action	Lead	Date
The actions below have been impacted by COVID 19. Our current planning assumption is both actions will be completed by June 2020, particularly final versions of the Procurement Strategy and commercial and design specifications. This is subject to change due to current uncertainties with COVID 19 and the availability of Welsh Government officers to finalise OBC scrutiny.		
Procurement strategy and commercial and design specifications to be agreed through internal governance	nVCC Project Director	July 2020
Secure WG approval for the OBC	nVCC Project Director	September 2020
Submission of planning applications for access and nVCC	nVCC Project Director	June 2020

Additional comments:

Risk Domain: Reputation and Public Confidence **Risk Ref:** **10416**	**Director Lead:** Director of Transformation, Planning and Digital **Assuring Committee:** TSC Scrutiny Committee	
Risk: Non-delivery of the expected benefits from the Transforming Cancer Services Programme (TCS).	**Date Added to Register:** 27/01/16	**Date Last Reviewed:** 11/05/2020

Risk Rating
(impact x likelihood)

Initial	4x4	**16**
Current	**4x4**	**16**
Target		**9**

Risk Appetite:
Nil

Rationale for current score	Rationale for target score	Groups discussed risk during period
The TCS is a complex program with many projects running individually and concurrently. This may lead to individual projects failing to achieve deadlines, over-running or costs increasing.	The risk appetite is nil due to the high level of public and commissioner interest in the programme and the potential benefits to all service users and other stakeholders.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

Planning and reporting

- Programme Delivery Board in place monitoring and managing programme within agreed controls and tolerances
- Master Programme in place with key deliverables, dependencies and milestone dates regularly updated
- Co-joining of approach between service change and improvement today with future service planning

Framework

- Quantification of benefits as part of the TCS Programme Business Case
- Optionality built into design to support to support an extent of flexibility depending on the outcomes of Project 6 in respect of target operating model

Engagement

- Joint approach with Economic Division of the Welsh Government to identify benefits
- Principal role in Collaborative Cancer Leadership Group to both define system benefits and ensure timely decision making to support benefit realisation
- Comprehensive staff engagement programme

What actions should we take:

Action	Lead	Date
Refresh of the Programme Business Case which will include review of benefits realisation scope, with appropriate updates for changing context of aspects such as: Well-being Future Generations Act; Socio-economic duty; and sustainability	Director of Transformation, Planning and Digital	Dates will be reviewed in line with the re-planning work across the the programme
Review process for tracking benefit realisation and associated reporting tolerances	Director of Transformation, Planning and Digital	
Formally align Programme to South East Wales Planning Forum	Director of Transformation, Planning and Digital	
Assessment of capability and capacity of programme resource requirements alongside BAU and service development and operational resource requirements, including dependency analysis and agreement of ways of working	Chief Operating Officer & Director of Transformation, Planning and Digital	
Review of scope, timing and approach to target operating model work in project 6 and it's alignment with immediate service development and service improvement	Chief Operating Officer. Director Service Transformation & Director of Transformation, Planning and Digital	

Additional Comments:

Risk Domain: Workforce & OD **Risk Ref:** **13819**	**Director Lead:** Interim Director WBS **Assuring Committee:** Board	
Risk: The potential impact on staff wellbeing during the change process of the WBS Blood Supply Chain 2020 Programme.	**Date Added to Register:** 18/07/17	**Date Last Reviewed:** 11/05/2020

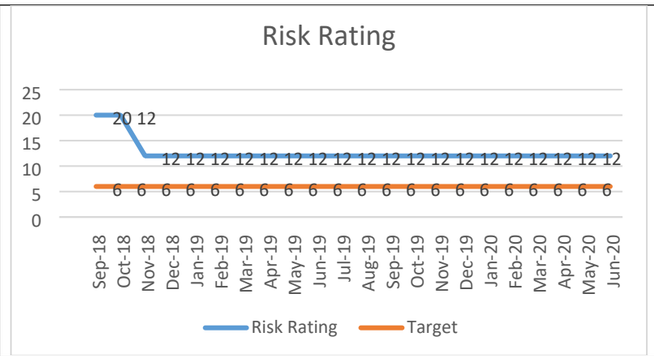
Risk Rating

(impact x likelihood)

Initial	4x5	**20**
Current	**3x4**	**12**
Target	2x3	**6**

Risk Appetite:

Nil



Rationale for current score	Rationale for target score	Groups reviewed risk during period
Risk reviewed at EMB and score reduced to 12. There is a risk that the organisation may see an increase in workforce related issues (sickness absence, staff grievances etc). As the WBS move through the Organisational Change Policy process across Laboratories & Collections.	Risk appetite is nil. This is a significant change programme for the service requiring early staff engagement and consultation to alleviate individual staff concerns. Robust change control should mitigate any adverse impact on staff and the service.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

- Early and ongoing engagement with staff.
- Full supporting Workforce and Organisational Development package in place.
- Occupational Health support available.
- Raise awareness of potential for future staff opportunities.
- Involvement of staff in decision-making.
- Monthly local WBS Local Partnership Forum with local officers and regional union representatives.
- Trade Unions included on Blood Supply Chain 2020 Strategic Board.
- Workshop held with WBS Local Partnership Forum to consider impact.

What actions should we take:

Action	Lead	Date
Development of a full staff support package, including regularly updated frequently asked questions (FAQs), OCP and contract variation process flows aimed at staff to clearly outline processes, regular keeping in touch (KIT) meetings, formal consultation launch events in partnership with WOD and trade union colleagues.	General Services Manager WBS	Sept 2020
Phased implementation plan within service for organisational change for both laboratory and collection staff to appropriately pace the changes.	General Services Manager WBS	Sept 2020

Additional Comments:

Formal consultation with laboratory staff closed on 30.09.19, implementation now underway. Formal consultation with collection team staff is ongoing. Formal and Informal engagement with staff is ongoing throughout the process in partnership with WOD colleagues and all trade unions.

Risk Domain: Compliance **Risk Ref: 14861**	**Director Lead:** Executive Director WF&OD **Assuring Committee:** Board	
Risk: Achieving compliance against the new Welsh Language Standards (under the Welsh Language (Wales) Measure 2011) within the timescales set by the Welsh Language Commissioner.	**Date Added to Register:** 17/10/18	**Date Last Reviewed:** 11/05/2020

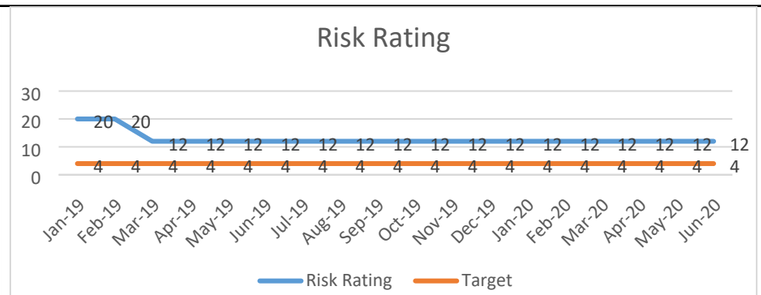
Risk Rating

(impact x likelihood)

Initial	4x5	**20**
Current	**3x4**	**12**
Target	2x2	**4**

Risk Appetite:

Nil



Rationale for current score	Rationale for target score	Groups reviewed risk during period
EMB agreed risk is escalated to Trust risk register but reduced score to 12 on 17th July 2019. The Welsh Language (Wales) measure 2011 introduced the need for Welsh Language standards to be placed on the NHS (round 2 of Standards). The Trust is not currently complaint with a number of the Standards.	The Trust will need to comply with the Standards to ensure a fully bilingual service for patients and users.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

- Impact assessment being completed against each of the WL Standards to enable prioritisation and risk management resulting in compliance;
- WL Commissioner monitors delivery against the Trust WL Scheme and provides feedback;
- WL Steering group in place to identify and monitor Trust WL priorities;
- Bilingual skills strategy in place;
- Managers guidance developed to ensure new posts assess WL requirements;
- WL Scheme in place;
- WL Steering group in place to identify and monitor Trust WL priorities
- Bilingual skills strategy in place;
- Local arrangements in place to capture language choice in some areas.

What actions should we take:

Action	Lead	Date
Ongoing education and communication with key personnel required to ensure compliance against key areas across the Trust and its divisions (most notably: websites, intranet sites, telephony systems and HR/workforce)	Asst Director of OD /WL officer	Extended to Sept 2020 due to Covid 19
Develop and Monitor compliance action plan with SMT's in VCC/WBS to produce compliance report to support the Corporate action plan focusing on patient/donor areas	Asst Dir of OD/WL officer	Extended to Sept 2020 due to Covid 19
Update on compliance and action to EMB	Asst Director of OD/WL officer	Extended to Sept 2020 due to Covid 19

Additional Comments:

The risk assessment relates to all services delivered by Velindre UNHST.
Hosted organisations have a duty to comply with the WL Standards, with the accountable Officer being the CEO Velindre UNHST.
Local assessments will be undertaken within the hosted organisations.
Corporate action developed, updated on progress to EMB in Dec

Risk Domain: Performance & Service Sustainability **Risk Ref:** **14860**	**Director Lead:** Director of Transformation, Planning and Digital **Assuring Committee:** Board
Risk: Brexit– Disruption, delays or inability to provide full range of treatments and services if the government fails to achieve a withdrawal agreement when the UK leaves the EU.	**Date Added to Register:** 17/10/18 / **Date Last Reviewed:** 11/05/2020

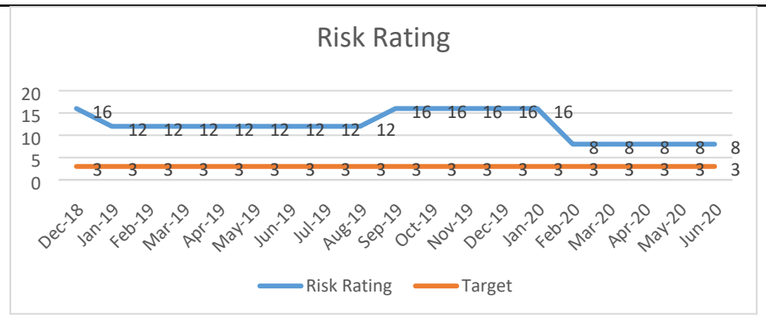
Risk Rating

(impact x likelihood)

Initial	4x4	16
Current	**4x2**	**8**
Target	3x1	**3**

Risk Appetite:

Nil



Rationale for current score	Rationale for target score	Groups reviewed risk during period
Risk originally scored 16, requested to reduce score to 12 at February 2019 Score reduced further to 8 in February 2020. On 23/01/2020, The UK's EU Withdrawal bill became law. The UK officially left the EU on 31/01/2020. An 11-month transition phase will run to 31/12/2020. This risk position and impact will be reviewed throughout the transition period, as and when the key milestones are reached. The current risk score remains at a risk rating of 8. Contingency arrangements to minimise the effects of disruption will be maintained for the immediate future & reviewed and revised following consultation with WG recommendations.	Risk appetite is Nil and the Trust objective would be to maintain services at the level pre Brexit.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

1. The UK Government is putting in place plans to ensure the supply of medical devices and clinical consumables.
2. Divisional risk assessments undertaken and regularly reviewed.
3. WBS – MOU's with UK & Ireland Blood establishments (extended to include consumables and blood components).
4. The current OJEU legislation of fairness, transparency and equal treatment will prevail. The engagement with EU entities will largely depend on the content of any trade agreements that are negotiated with the EU.
5. Fixed price agreements.
6. Workforce planning (Staff supported to apply for settled status).
7. Public Contract Regulations.
8. All Wales procurement services provided by NWSSP.
9. Management action plan being redrafted to reflect current understanding of risk profile.
10. Discussions and agreement at UK level on blood and transplantation mutual aid principle agreed for blood products and consumables.
11. Work ongoing on supply chain at VCC.
12. Contingency exercises planning events have taken in place for WBS, VCC, NWIS and NWSSP.
13. Review of critical supplier lists within both service divisions completed.
14. Undertake/review departmental Business Impact Analysis to identify key risk areas within both service divisions completed.
15. Services have identified range of contacts with EU suppliers and assessed delivery confidence.
16. Review contracts and discuss critical impact points with individual suppliers and contractors.

What actions should we take:

Action	Lead	Date
Monitor and review position within Velindre UNHS Trust BC meetings	Director VCC & WBS	On-going
Continued engagement in UK groups.	Director VCC & WBS	On-going

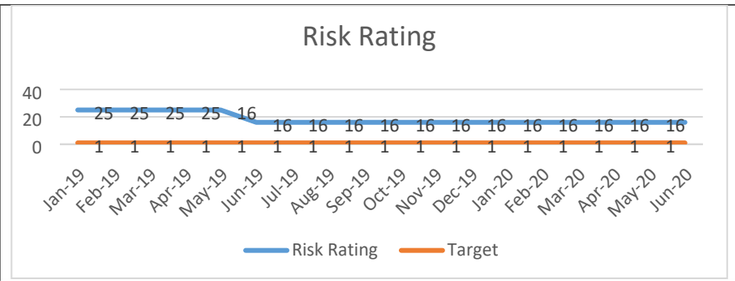
17. Website launched with internal / external information for patients/donors/partners and staff on issues related to Brexit. 18. Maximised critical inventory stock 19. Review of critical equipment maintenance programmes. 20. Joint Professional Advisory Committee will consider derogations to Regulations if critical supply chain issues arise. 21. HTA produced statutory instrument for import and export of tissues and cells.	
Additional Comments: 1. VCC and WBS have completed full risk assessments; under regular review as more information becomes available. 2. The hosted organisations have completed risk assessments. Under regular review as more information becomes available. 3. Regular meetings of the Trust Brexit Steering Group and engagement in national groups continues.	

Risk Domain: Performance & Service Sustainability **Risk Ref:** **15143**	**Executive Lead:** Chief Operating Officer **Assuring Committee:** Board	
Risk: Radiotherapy Planning CT scanners are nearing their end of useful life. This equipment will not have service / maintenance support after March 2019.	**Date Added to Register:** 22.01.2019	**Date Last Reviewed:** 11/05/2020

Risk Rating
(impact x likelihood)

Initial	5x5	**25**
Current	**4x4**	**16**
Target	1x1	**1**

Risk Appetite:
High



Rationale for current score	Rationale for target score	Groups that reviewed risk during period
Risk reviewed and score decreased June 2019. There is a risk that we will not have operational planning CT scanners in VCC if not replaced by January 2020.	Failure to deliver CT1 replacement in advance of 01/04/2020 would result in a temporary loss of service for paediatrics under anaesthetic and benign conditions until CT1 replacement was commissioned.	Executive Management Board sign off 26/05/2020

What controls have we put in place for the risk:

- Contingency plan to be developed outlining alternative plan and location where local patients can be scanned by CT scanner in the event of VCC being able to provide this service.
- Business case approved and procurement commenced for replacement equipment with adequate service level agreement attached. Project plan and timescales were delivered by required deadline(end of December 2019)

What actions should we take:

Action	Lead	Date
CT2 has been removed. CT3 has been installed but is only partially commissioned - Rt Physics to complete all the commissioning.	Director VCC	June 2020

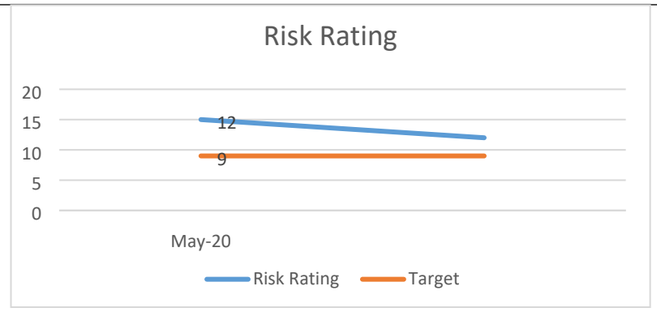
Additional Comments:

Risk Domain: Compliance **Risk Ref:** **16006**	**Director Lead:** Director of Transformation, Planning and Digital **Assuring Committee:**	
Risk: Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	**Date Added to Register:26.05.2020**	**Date Last Reviewed:** 26/5/2020

Risk Rating
(impact x likelihood)

Initial	5x3	**15**
Current	**4x3**	**12**
Target	3x3	**9**

Risk Appetite:
Nil



Rationale for current score	Rationale for target score	Groups discussed risk during period
a) The site adopts a holistic fire strategy[1] whereby a number of control measures are in place to mitigate against the risk of fire and compartmentation plays an integral role in both the protection of building users (life safety) and the protection of buildings, equipment and information/data (asset protection) by limiting the spread of flame, smoke and fumes. b) Under current fire legislation[2], the Trust have a number of legal duties including the ensuring that **all** building users are kept safe whilst in the building. c) Therefore, where compartmentation has been found to be in poor condition or non-existent, both life safety and property protection are jeopardised. Additionally, there is a potential impact on recovery of service and longer term resilience following a fire if the fire, smoke and fume spread beyond the room of origin. Additionally, during any investigation by the fire and rescue service, the condition of compartmentation may analysed and brought into question; especially should there be any injuries or fatalities.	a) On completion of the actions recommended, both the potential for a fire to escalate and the potential consequences of a fire will be reduced to more acceptable level. However, the completion of the works will have very little impact on the likelihood for a fire to occur as this is dictated by the proactive actions taken by the Trust. b) Completion of the actions also demonstrates the Trust's ongoing move towards compliance with its statutory, mandatory and moral obligations.	• Estates Management • Authorising Engineer (Fire) – NWSSP

What controls have we put in place for the risk:

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.

What actions should we take:

Action	Lead	Date
1. Capital scheme to address all "maintenance" items identified in 2020 Compartmentation report – works to be completed by 3rd party accredited contractor	Associate Director of Estates	31/03/2021
2. Develop prioritised action plan and budget costs for remedial works	Associate Director of Estates	31/05/2020
3. Develop work packages and tender works with 3rd party-accredited contractors	Associate Director of Estates	30/06/2020
4. Continue to consider fire risk assessment findings / remedial actions (including compartmentation defects) in Capital schemes.	Capital Planning Manager	CONTINUE TO MANAGE

	5. Develop cold works permit to control works involving potential disruption to compartmentation including requirement for any breaches/damage to be made good by contractors.	Estates Manager	30/06/2020
	6. Identify appropriate training course and train Estates staff in fire door inspections to ensure that they are competent to undertake inspections.	Estates Manager	30/11/2020

Additional Comments:

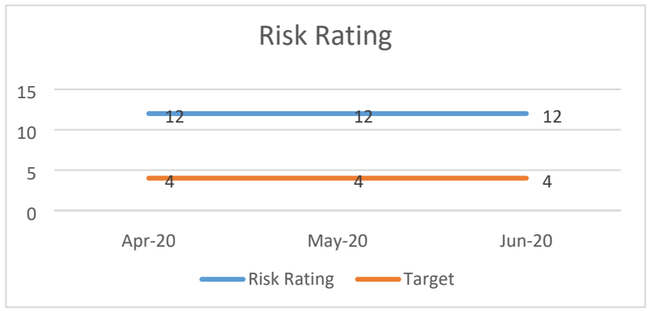
1. The fire strategy relies initially on the management of hazards and prevention of incident and *pro-active* actions; in the event of failure, the strategy falls back to *reactive* measures such as *detection & warning*, *containment (compartmentation)* which, in turn supports *evacuation* and also *extinguishment* (including safe access for the fire and rescue service).
2. The *Regulatory Reform (Fire Safety) Order 2005* which requires that the site protects all building users against the effects of flame, smoke and fume and demands that the building has means of escape able to protect anyone who uses them as well as any internal routes relied upon by the fire and rescue service during tactical fire-fighting.

Risk Domain: Finance **Risk Ref:** **16005**	**Director Lead:** Executive Director of Finance **Assuring Committee:** EMB and covid-19 Command Structure
Risk: (NEW RISK) The total quantum for funding for addressing Covid-19 across Wales remains fluid and uncertain. There is a risk that the organisation's operational cost of addressing the pandemic cannot be contained within available funding resulting in a potential breach of the planned outturn for 2020-21.	**Date Added to Register:**29.05.20 / **Date Last Reviewed:** 26/05/2020

Risk Rating
(impact x likelihood)

Initial	4x3	**12**
Current	**4x3**	**12**
Target	2x2	**4**

Risk Appetite:
Nil



Rationale for current score	Rationale for target score	Groups discussed risk during period
Impact - 4 The total costs estimated relating to the pandemic for Apr '20 – Jun '20 are:- £933k revenue £1,040k capital If the Trust were required to accommodate this level of financial commitments within its existing budget allocation this would have a serious impact on service delivery and its ability to financially breakeven. **Likelihood – 3** WG have stated that where an organisation has a need to incur specific additional costs, then WG will consider making additional revenue funding available. However, to date the Trust has not had confirmation (as at 08/05/20) that the costs it has incurred will be funded. In addition, more recently there has been suggestion from WG Finance Officers that WG may not fund all COVID-19 costs.	Based on the controls and mitigating actions and the submissions to WG seeking funding for COVID-19 costs the expectation is that the impact and likelihood of the financial risk can be reduced to 4.	Financial commitments made to respond to COVID-19 and associated risk have been discussed at Silver and Gold Commands and EMB.

What controls have we put in place for the risk:

- Grip and control
  - Modelling of costs relating to surge capacity have been driven by anticipated patient nos. and therefore additional bed nos., the resultant workforce, equipment and operational requirements. This has been managed through a project group and approved through the COVID-19 command structure;
  - Financial modelling of surge capacity costs and forecasting of all COVID-19 costs is updated on a regular basis;
  - Financial reporting to Welsh Government on local costs incurred as a result of Covid-19 to inform central and local scrutiny, feedback and decision-making;
  - Oversight arrangements in place at Executive Management level and through the command structure.

- Exploring funding sources

What actions should we take:

Action	Lead	Date
Ensure all costs identified as covid-19 are captured and robust review to ensure only additional costs are included and that they can be legitimately justified as covid-19 related	Director of Finance	Monthly for 2020-21 financial year
Submit all legitimate costs to WG as part of the monthly Financial monitoring return	Director of Finance	Monthly for 2020-21 financial year
Continued review by EMB / COVID-19 Command Structure of all proposed COVID-19 commitment of expenditure to ensure it is necessary and justified	Director of Finance	Monthly for 2020-21 financial year

• Trust reviewing what future costs are being / can be avoided through new ways of working and reduced activity to free up existing budgets to help fund covid-19 costs; • Trust reviewing what funding investments can be delayed to free up earmarked reserves funding for help fund covid-19 costs; • Assumption that there will be additional funding support from Welsh Government	
Additional Comments:	

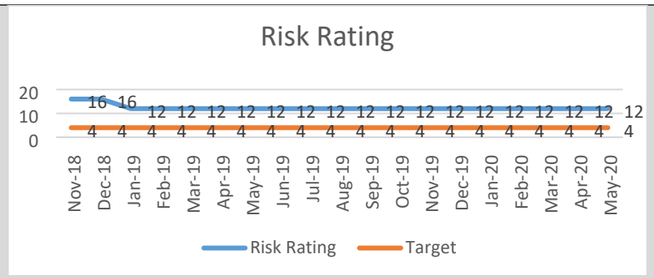
RISKS - RECOVERY PLAN

RISK ASSESSMENT CURRENTLY PAUSED - Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.		
Risk Domain: Quality **Risk Ref: 13614**	**Director Lead:** Medical Director **Assuring Committee:** Workforce & Organisational Development	
Risk: The availability of sufficient consultant capacity to fulfil medical resource requirements for the service.	**Date Added to Register:** 29/11/17	**Date Last Reviewed:** 21/04/2020

Risk Rating
(impact x likelihood)

Initial	4x4	**16**
Current	**4x3**	**12**
Target	2x2	**4**

Risk Appetite:
Nil



Rationale for current score	Rationale for target score	Groups discussed risk during period
Risk reviewed at EMB 13.02.19 and score reduced to 12. The Trust has several consultant vacancies. This situation could lead to an increase in waiting times and detrimental impact on patient experience and workforce stress.	The risk appetite is nil due to the impact on patient quality & safety.	EMB 09/03/20

What controls have we put in place for the risk:

- The Medical Business Manager meets weekly with the Clinical Director and Deputy Clinical Director to discuss medical workforce issues and agree appropriate actions to maintain service provision.
- Existing consultants have agreed to increase clinical sessions and to displace supporting professional activities (SPA) to outside of normal working hours to ensure the service is covered. This is not sustainable in the long term.
- Locum doctors have been recruited to provide short-term cover to mitigate the impact on service delivery.
- Recent consultant appointments have been made in Gynaecology, Urology, Colorectal, Melanoma, AOS/Assessment Unit, Lung, Anal Cancer, Phase I trials and Radiology to contribute to the relevant services.

What actions should we take:

Action	Lead	Date
Ongoing discussion with Performance & Planning Manager to identify the demand changes in certain tumour sites and how this should be taken forward with Commissioners with a view to increasing consultant funding	Clinical Director	Ongoing

Additional Comments:

:

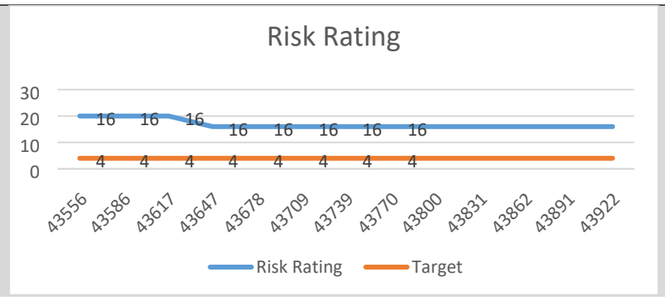
RISK ASSESSMENT CURRENTLY PAUSED - Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.

Risk Domain: Performance & Service Sustainability **Risk Ref:** **5808**	**Executive Lead:** Chief Operating Officer **Assuring Committee:** Planning and Performance Committee	
Risk: Insufficient radiotherapy capacity at VCC to meet demand.	**Date Added to Register:** 17.07.2019	**Date Last Reviewed: 21.04.20**

Risk Rating
(impact x likelihood)

Initial	4x4	**16**
Current	**4x4**	**16**
Target	1x4	**4**

Risk Appetite:
High



Rationale for current score	Rationale for target score	Groups that reviewed risk during period
Risk reviewed locally and EMB agreed to escalate risk to Trust risk register June 2019. Due to increase in demand for radiotherapy, there is insufficient radiotherapy (linac) capacity within financial resource to meet current and predicated demand, and deliver this demand with the RCR waiting time targets.		EMB 09/03/20

What controls have we put in place for the risk:

- Extended operating hours are in place on the treatment machines and in many other areas of the service to deliver increased capacity
- Agency radiographers in place to support additional hours
- Ongoing monitoring of capacity and demand and waiting times targets through weekly meetings
- Reports and business cases have been prepared and shared with Commissioners for their consideration of funding.
- Radiotherapy strategy developed and radiotherapy programme being implemented
- Discussion underway regarding future radiotherapy configuration through the TCS programme
- Ongoing work with Health Boards to review demand and investigate potential breaches
- Adherence to RCR categorisation for waiting times. Consultants are aware of patients who may breach and have the opportunity to escalate patients.

What actions should we take:

Action	Lead	Date
Regular review of the risks associated with capacity are required as the patient demand and machine availability fluctuate.	Radiotherapy Services Manager	ongoing
Have sufficient capacity at this moment in time due to covid. Taken 2 linacs out of routine use. One linac machine is being used for treating covid + patients, the other is removed as we have halted treating prostate patients. .	Radiotherapy Services Manager	ongoing

Additional Comments:

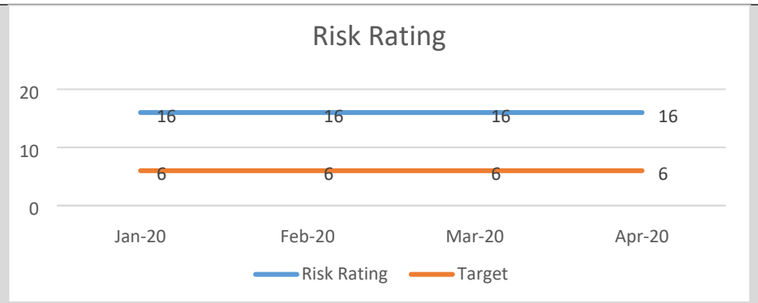
RISK ASSESSMENT CURRENTLY PAUSED - Risk assessment current paused, as currently being managed within the operation as part of the incident response. Capacity and demand planning will facilitate the continued assessment of this as we move into Recovery Phase.

Risk Domain: Performance & Service Sustainability **Risk Ref: 15713**	**Executive Lead: To be confirmed** **Assuring Committee: Planning & Performance Committee**	
Risk: Potential overcrowding of outpatient department	**Date Added to Register: 05.02.20**	**Date Last Reviewed: 21.04.20**

Risk Rating
(impact x likelihood)

Initial	4x4	16
Current	**4x4**	**16**
Target	3x2	6

Risk Appetite: 0



Rationale for current score	Rationale for target score	Groups that reviewed risk during period
Although a number of measures have been put in place, there are still days when the Outpatient department, seeing high numbers of patients numbers attending clinics. Tuesdays and Thursdays are particularly busy. Some clinics are also overbooked meaning that the OPD can get crowded with patients and families / carers.	Additional clinic rooms will be provided by the end of April 2020 rooms so clinics should be easier to manage. Ongoing monitoring of clinics and patients numbers by OPD Capacity & Planning Group.	EMB 09/03/20

What controls have we put in place for the risk:

- Decluttered OP clinic room area and waiting areas.
- Undertaken fire risk assessment with a subsequent risk assessment to be reported. Staff have been instructed to take fire training for full mandatory compliance.
- Capital plan, phase 1a and 1b has commenced 06.02.20; phase 2 capital plan will be produced by 31.3.20

What actions should we take:

Action	Lead	Date
21.4.20 Risk Reviewed but in light of unusual circumstances with reduced activity with ongoing COVID incident no assumptions have been made regarding this risk. An action has been raised to ensure the positive action of implementing telephone, virtual clinics etc is maintained.		
Try to reduce overbooking of clinics where possible thereby reducing overall numbers of patients and relatives in the OPD	Health Records Manager	30.3.20
Keep the department tidy and declutter at regular intervals	OPD Nurse Manager	30.3.20
Regularly review the Fire Risk Assessment	Fire Officer	30.3.20
Progress with Phase 2 of the OPD Capital Programme to improve the layout and size of the department	Director of Operations	30.3.20

Additional Comments:

Appendix 1

Risk Appetite Levels

Appetite Level	Described as:
None	**Avoid -** The avoidance of risk and uncertainty is a key organisational objective.
Low	**Minimal -** Preference for ultra-safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
Moderate	**Cautious -** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open -** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM).
Significant	**Seek -** Eager to be innovative and to choose options offering potentially higher business rewards despite greater inherent risk. **Mature -** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Matrix

	LIKELIHOOD				
IMPACT	Certain 5	Likely 4	Possible 3	Unlikely 2	Rare 1
5 Catastrophic	25	20	15	10	5
4 Major	20	16	12	8	4
3 Moderate	15	12	9	6	3
2 Minor	10	8	6	4	2
1 Insignificant	5	4	3	2	1

Risk Score	Risk Level	Action and Timescale
1-3	LOW	No action required providing adequate controls in place.
4-6	MODERATE	Action required to reduce/control risk within 12 month period
8-12	SIGNIFICANT	Action required to reduce/control risk within 6 month period
15-25	CRITICAL	Immediate action required by Senior Management

TRUST BOARD

DELIVERING EXCELLENCE PERFORMANCE REPORT

DATE OF MEETING	04/06/2020

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, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath Obrien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board*	26th May 2020	ENDORSED

*Note – only the Welsh Blood Service performance report was received by the Executive Management Board on 26th May 2020.

ACRONYMS	
IMTP	Integrated Medium Term Plan
PADR	Performance Appraisal and Development Review
N/A	Not Applicable
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports are intended to provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics.

1.2 The attached reports describe performance through to the end of March 2020 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The reports set-out performance at Velindre Cancer Centre (*appendix 1*), the Welsh Blood Service (*appendix 2*) and in relation to Trust-wide staff absence, PADR compliance and staff sickness (*appendix 3*). Each report is prefaced by an '*at a glance*' section which is intended to draw attention to particular performance issues.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The current performance reporting and monitoring system is predicated upon identifying performance issues and supporting effective decision making at service and operational levels to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability

	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Delivery against the performance metrics presented in the attached reports and the work associated with delivering improved performance supports sound financial governance across the Trust.

4. RECOMMENDATION

4.1 The Velindre University NHS Trust Board is asked to **DISCUSS** and **REVIEW** the contents of the attached performance reports.

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

March 2020

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR and Statutory and Mandatory training
- A 12 monthly trend report for Sickness, PADR and Statutory and Mandatory training with narrative to explain the data
- Snapshot of how we compare with NHS Wales and UK benchmarking data.

At a Glance for Velindre (Excluding Hosted)

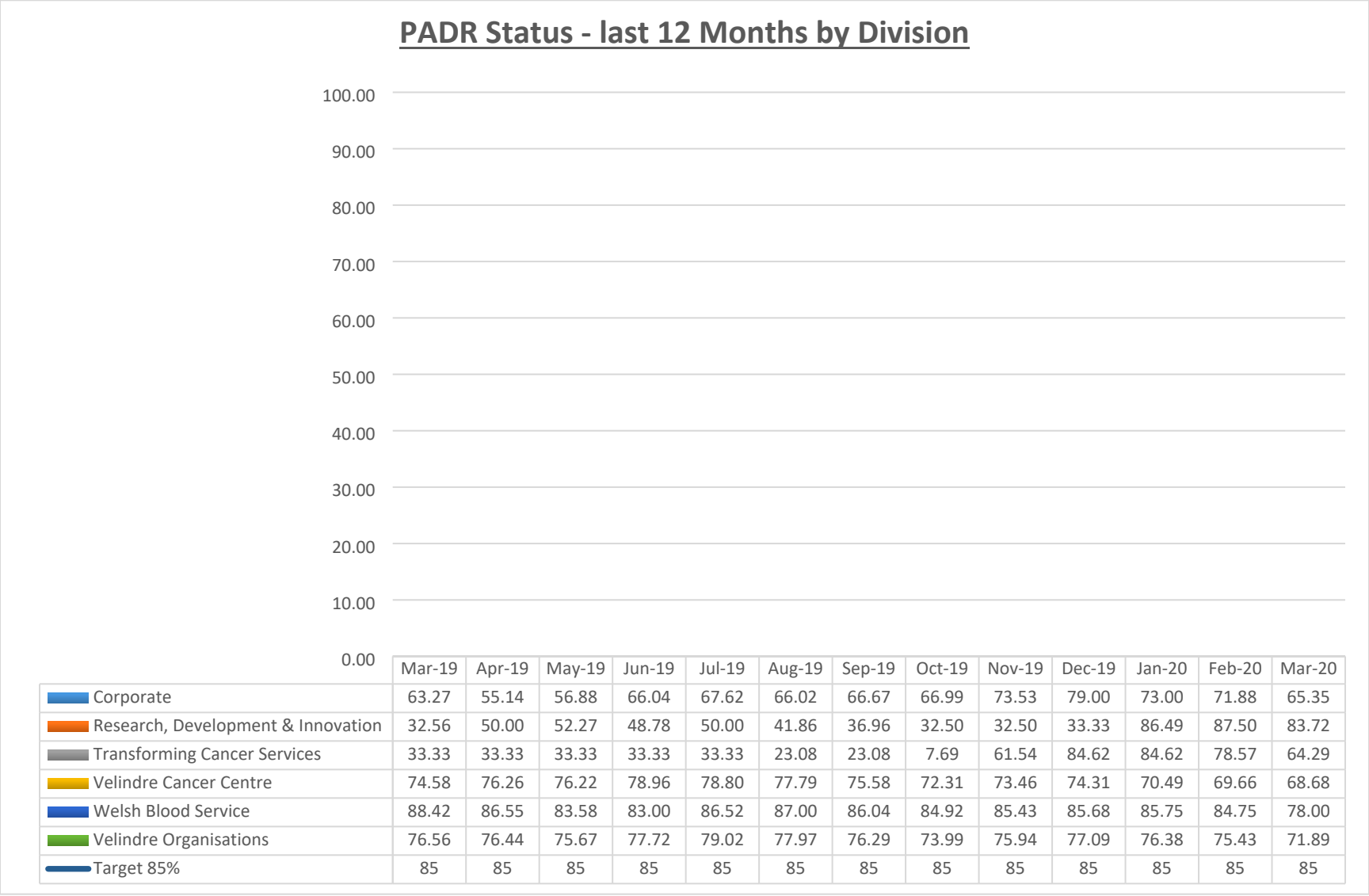
Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Mar-20	Feb-20	
PADR	71.89	75.43	85%
Sickness	4.69	4.47	3.54%
S&M Compliance	82.08	82.30	85%

Workforce Dashboard Highlights

Data below highlights rolling figures for workforce KPI's. This provides a running total of the values of the last 12 months of an indicator providing trend data for the indicators. Granular monthly data is generated for divisions as separate reports. Data Rag Rated for ease of reading.

PADR	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	63.27	55.14	56.88	66.04	67.62	66.02	66.67	66.99	73.53	79.00	73.00	71.88	65.35
Research, Development & Innovation	32.56	50.00	52.27	48.78	50.00	41.86	36.96	32.50	32.50	33.33	86.49	87.50	83.72
Transforming Cancer Services	33.33	33.33	33.33	33.33	33.33	23.08	23.08	7.69	61.54	84.62	84.62	78.57	64.29
Velindre Cancer Centre	74.58	76.26	76.22	78.96	78.80	77.79	75.58	72.31	73.46	74.31	70.49	69.66	68.68
Welsh Blood Service	88.42	86.55	83.58	83.00	86.52	87.00	86.04	84.92	85.43	85.68	85.75	84.75	78.00
Velindre Organisations	76.56	76.44	75.67	77.72	79.02	77.97	76.29	73.99	75.94	77.09	76.38	75.43	71.89
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85
Stat and Mand Compliance (10x CSTF)	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	78.06	77.24	79.32	81.47	80.17	80.17	76.81	76.42	76.89	77.11	77.04	76.47	74.21
Research, Development & Innovation	66.67	64.20	63.88	63.06	61.25	61.57	60.59	60.20	61.04	59.58	68.57	74.00	74.51
Transforming Cancer Services	78.33	78.33	74.17	72.50	71.67	70.77	72.31	70.00	69.23	80.00	82.31	77.50	77.65
Velindre Cancer Centre	72.30	72.09	74.07	74.89	76.54	75.93	75.47	75.55	76.62	77.05	78.10	79.11	78.16
Welsh Blood Service	91.88	92.34	93.13	93.90	93.49	92.37	90.90	91.22	90.96	91.88	90.85	90.68	92.26
Velindre Organisations	79.08	78.89	80.33	81.16	81.79	81.02	79.94	80.00	80.60	81.15	81.75	82.30	82.08
Sickness	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	3.64	3.72	3.93	4.25	4.44	4.48	4.65	4.79	4.91	4.90	4.82	4.68	4.69
Research, Development & Innovation	3.91	3.41	2.91	2.76	2.66	3.12	3.44	3.54	3.42	3.91	4.07	4.02	4.36
Transforming Cancer Services	10.26	10.02	10.39	10.92	11.52	11.28	10.02	8.58	7.18	5.79	4.92	4.18	4.17
Velindre Cancer Centre	4.85	4.83	4.65	4.42	4.20	4.09	4.01	4.02	4.05	4.14	4.25	4.29	4.58
Welsh Blood Service	5.22	5.14	5.07	5.02	4.91	4.78	4.79	4.79	4.77	4.78	4.73	4.79	4.93
Velindre Organisations	4.93	4.88	4.76	4.64	4.50	4.40	4.36	4.36	4.37	4.42	4.45	4.47	4.69
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

PADR – The Figures



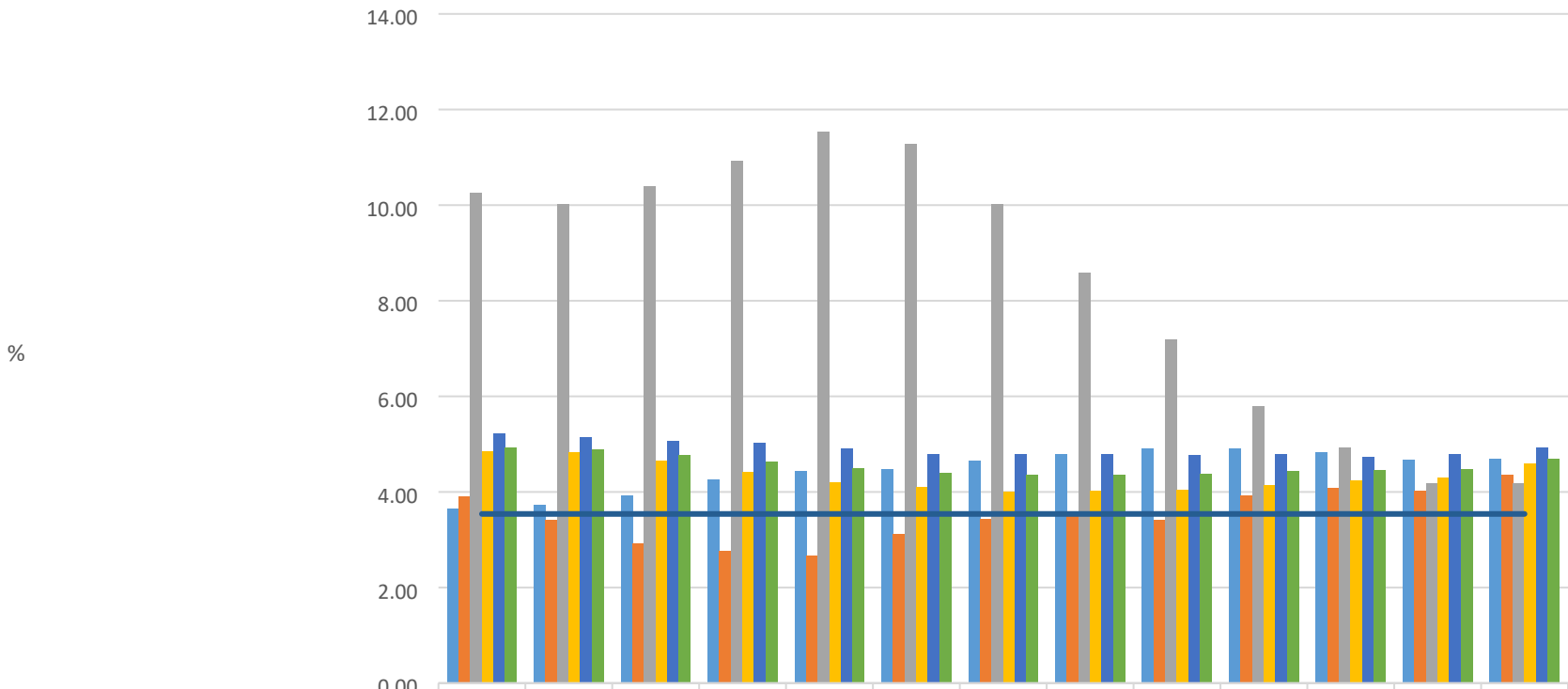
	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	63.27	55.14	56.88	66.04	67.62	66.02	66.67	66.99	73.53	79.00	73.00	71.88	65.35
Research, Development & Innovation	32.56	50.00	52.27	48.78	50.00	41.86	36.96	32.50	32.50	33.33	86.49	87.50	83.72
Transforming Cancer Services	33.33	33.33	33.33	33.33	33.33	23.08	23.08	7.69	61.54	84.62	84.62	78.57	64.29
Velindre Cancer Centre	74.58	76.26	76.22	78.96	78.80	77.79	75.58	72.31	73.46	74.31	70.49	69.66	68.68
Welsh Blood Service	88.42	86.55	83.58	83.00	86.52	87.00	86.04	84.92	85.43	85.68	85.75	84.75	78.00
Velindre Organisations	76.56	76.44	75.67	77.72	79.02	77.97	76.29	73.99	75.94	77.09	76.38	75.43	71.89
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Organisational Context PADR	Issue	Actions	Timelines
• Impact of COVID in March impacting on PADR completions	Compliance below 85% KPI rate	As we move to Recovery Phase local target plans to improve compliance and target hotspots ongoing. Local plans will include aligning PADR dates with pay progression	Local plan monitored via SMT monthly meetings, WOD committee and Senior WOD Team meetings
		Guidance on PADR completion rolled out via WOD Business Partners and Workforce information supporting to ensure PADRs on ESR	Guidance issued, ongoing support
		Sharing of good PADR practice compliance via the Education and Training Steering group	PADR standing agenda item on the Education and Training Steering Group
		Focus on managing development and succession planning to support PADR conversations and development	Re introduction of talent management pathways development work, completed for informatics, medical physics, management development
	Performance Management of PADRs	Triangulation of data in hotspot areas of poor PADR compliance is ongoing to ensure data provides effective information on the issues	Triangulated performance reports provided to SMT Ongoing development of report to benchmark in

		HR linked to hotspot areas and implementing an appraise and support approach to effective PADR management, ensuring best practice is shared	NHS Wales and UK wide

Sickness Data – The Figures



	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Corporate	3.64	3.72	3.93	4.25	4.44	4.48	4.65	4.79	4.91	4.90	4.82	4.68	4.69
Research, Development & Innovation	3.91	3.41	2.91	2.76	2.66	3.12	3.44	3.54	3.42	3.91	4.07	4.02	4.36
Transforming Cancer Services	10.26	10.02	10.39	10.92	11.52	11.28	10.02	8.58	7.18	5.79	4.92	4.18	4.17
Velindre Cancer Centre	4.85	4.83	4.65	4.42	4.20	4.09	4.01	4.02	4.05	4.14	4.25	4.29	4.58
Welsh Blood Service	5.22	5.14	5.07	5.02	4.91	4.78	4.79	4.79	4.77	4.78	4.73	4.79	4.93
Velindre Organisations	4.93	4.88	4.76	4.64	4.50	4.40	4.36	4.36	4.37	4.42	4.45	4.47	4.69
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

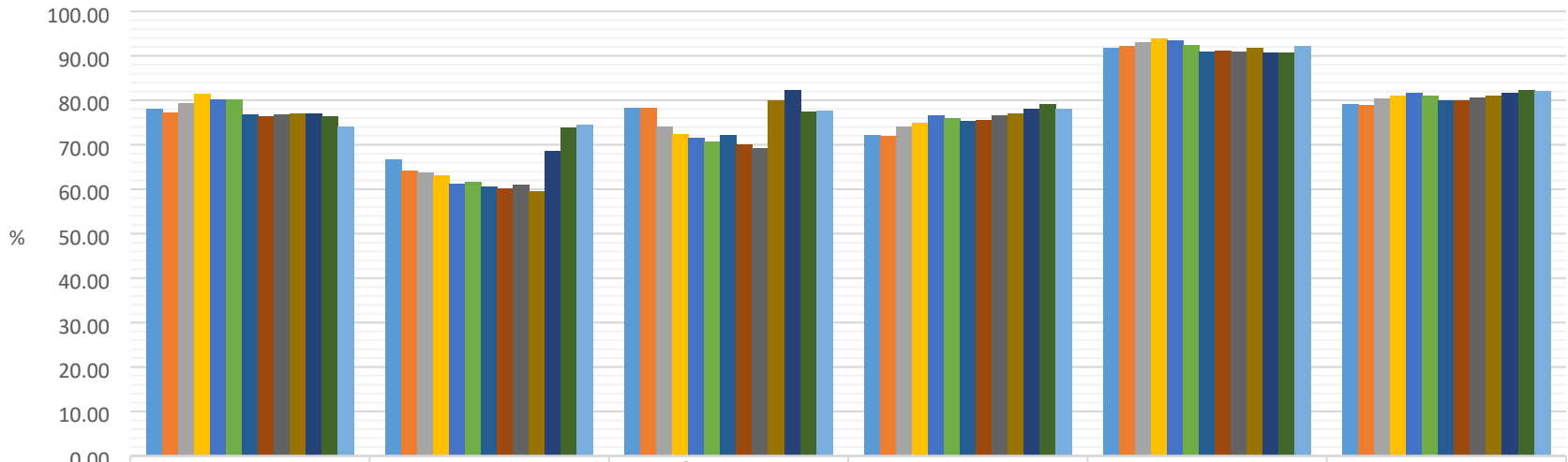
Sickness – The Narrative

Organisational Context Sickness	Issue	Actions	Timelines
• COVID Related absence sickness not always work related • Dedicated focus on staff's physical and psychological wellbeing	COVID related absence	- Daily wellbeing updates in Trust communications to signpost internal and external interventions and resources, this includes webinars; support lines; tools; resources for families etc - Creation of the Trust H&WB internet and intranet pages to support all staff during and after the pandemic, ranging from Self Care, EAP, Financial Wellbeing, Manager Support - Staff support via the Psychology Team – Maggie's Relax and Recharge Hub; 1-2-1 support; including support to colleagues not based at VCC; Virtual sessions for managers on supporting your team (delivered via MSTeams) - Also includes WOD support available via interventions such as coaching	Monitored via Workforce Cell

		- Offering staff places to recharge – Maggie's / Wellbeing Room at WBS - WOD & Psychology Team developing a session for managers on 'Identifying the Signs of Stress / Anxiety and Having those conversations with your team' - EAP reminder to staff included in Trust Communications and outlined clearly on H&WB pages (including Manager Assist)	
		Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas etc.	July 2020
		Linking in with national agenda (NHS Wales; NHS Improvement) to prepare and enhance interventions to support staff in recovery phase (e.g. monitoring; wellbeing champions; refocus as 'Time to Change Wales' employer – MH Awareness training etc;)	Ongoing reviewed in Workforce Cell
		Currently developing H&WB plan into recovery phase where	June 2020

		staff are more likely to require support (based upon CARE model – create, assist, rapid, engage)	

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Mar-19	78.06	66.67	78.33	72.30	91.88	79.08
Apr-19	77.24	64.20	78.33	72.09	92.34	78.89
May-19	79.32	63.88	74.17	74.07	93.13	80.33
Jun-19	81.47	63.06	72.50	74.89	93.90	81.16
Jul-19	80.17	61.25	71.67	76.54	93.49	81.79
Aug-19	80.17	61.57	70.77	75.93	92.37	81.02
Sep-19	76.81	60.59	72.31	75.47	90.90	79.94
Oct-19	76.42	60.20	70.00	75.55	91.22	80.00
Nov-19	76.89	61.04	69.23	76.62	90.96	80.60
Dec-19	77.11	59.58	80.00	77.05	91.88	81.15
Jan-20	77.04	68.57	82.31	78.10	90.85	81.75
Feb-20	76.47	74.00	77.50	79.11	90.68	82.30
Mar-20	74.21	74.51	77.65	78.16	92.26	82.08

Statutory and Mandatory Figures – The Narrative

Organisational Context	Issue	Actions	Timelines
• Baseline is compliant with the 10 Core Skills Training Framework Level 1 • Essential requirement for staff training is within individual compliance matrix, learning page in ESR	Compliance below 85% Welsh Government requirement	Mandatory and Statutory Focus Group set up to share best practice, membership includes Trust trainers and Subject Matter Experts	Held quarterly
		Guidance leaflets produced and circulated on how to access training	Guidance issued – on going support
• Accuracy of data within ESR on what mandatory and statutory requirements	Staff unclear what training they need to undertake for their role	Training needs analysis produced identifying levels of CSTF needed for each staff group and what is mandatory, this now includes COVID related training	CSTF data uploaded into ESR, COVID data being developed
	New staff requirements not aligning to current position numbers	Monthly reports from ESR on new starters given to the Education and Development team to check requirements and alignments	Beginning of each month commencing 2020.
	Not all staff are familiar in the usage of ESR	Dedicated computer training sessions, with laptops and support for all staff organised on different dates/times to	Regular sessions planned throughout the Trust for 2020

	and access to training	accommodate shifts patterns – drop in sessions	
• Culture of Education and Development	Training is not highly regarded with some areas of the Trust	Education Steering Group established to identify priority through IMTP, agree KPI's for work plans and hold to account, support divisions to provide detailed plans for educational support	Meetings held quarterly
		Provision of detailed reports to departments/Committees on staff compliance	Ongoing
		Department encouraged to develop action plans to increase compliance	M&S Focus Group action
		High level compliance encouraged to provide visibility and leadership	Executive /Senior Managers
	Release of staff to attend training	Virtual Reality project underway with Fire Clinical Training, current requirement to attend classroom, future will be staff can access this training at a time and place which is convenient making access to training more flexible	Pilot within Integrated Nursing March 2020 rollout delayed due to COVID

How do we compare?

	Velindre December 2019	NHS Wales* December 2019	UK Benchmarking**
Sickness	4.42	5.5	4.15
PADR	77.9	73.2	92.56
Statutory and Mandatory Compliance	81.5	79.9	92.02

*Information is shown as comparison for December 2019, source data Workforce Performance Measures supplied by HIEW.

** Data source references being collated – Clatterbridge Cancer Centre NHS Foundation Trust **(December 2019)**

Welsh Blood Service Monthly Report

March 2020

Gwasanaeth Gwaed Cymru
Welsh Blood Service

A number of key performance indicators were down on the previous months performance.

This may relate to the arrival of the COVID-19 pandemic towards the end of March, resulting in changes to donor behaviour, changes to demand from hospitals and changes to local/national/international service models.
As a result of COVID the following performance indicators were impacted:

- Stem cell cancellations were higher than expected
- Whole blood collection productivity was reduced
- Red cell time expiry and platelet expiry both failed to reach target due to strong stock positions against low hospital issues.

The following performance indicators were achieved:

- All clinical demand was met with overall stock position at 3364 red cells at the end of March.
- New Apheresis donors for the year exceeded the target of 56. 99 donors were registered.
- Turnaround times for concerns management continued to meet target in March.
- The Part Bags and Failed Venepuncture (FVP) rate successfully remained within the target threshold, demonstrating ongoing continued improvement in performance.
- Manufacturing productivity successfully achieved target position in March.
- Overall donor satisfaction continued to exceed target position at 96%.

8 Key Performance Indicators were above the previous month's performance.

5 Key Performance Indicators remained the same as the previous month's performance, however all achieved target.

9 Key Performance Indicators were down on the previous month's performance, however 3 achieved target.

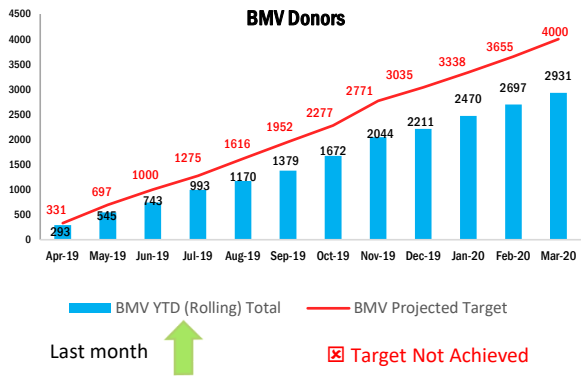
Reference Table

Measure	Target	Timeframe	National / Local
Number of new bone marrow donors aged 18-30 recruited to the Welsh Bone Marrow Donor Registry (WBMDR)	4,000	Annual	Local
Number of days when the Red Blood Cell (RBC) stockholding for O, A & B- fell below 3 days cover	0 days	Monthly	Local
Number of bags of RBCs manufactured as a % of the number of issues to hospitals **(% Red Cell Demand Met)**	100%	Monthly	Local
Number of bags of platelets manufactured as a % of the number of issues to hospitals **(% Platelet Demand Met)**	100%	Monthly	Local
Number of Confirmatory Tests (CTs) requested and bled as a % of the total CTs requested **(Confirmatory Tests Bled)**	65%	Monthly	Local
Number of Stem Cell Collections	80	Annual	Local
Number of antenatal patient results provided to customer hospitals within 3 working days from receipt of sample **(Antenatal Turnaround Times)**	90%	Monthly	Local
Number of samples referred for red cell reference serology work ups provided to customer hospitals within 2 working days. **(Reference Serology Turnaround Times)**	80%	Monthly	Local
% of Quality Incident Records (recorded in DATIX), closed within 30 days over a rolling 3 month period	90%	Rolling	Local
Number of critical non-conformances through external audits or inspections	0	Annual	Local
Number of Serious Adverse Blood Reactions & Events (SABRE) reported to the Medicines and Healthcare products Regulatory Agency (MHRA)	0	Annual	Local
Number of whole blood donations that are collected on session which are below the minimum viable volume, as a % of the total number of whole blood donations collected **(% Part Bags)**	3%	Monthly	Local
Number of donors where venepuncture is attempted to be performed on but no blood enters the bag, as a % of the number of donors who have reached the donation chair **(% Unsuccessful Venepuncture)**	2%	Monthly	Local
The number of blood components (weighted) collected per Standardised FTE (**Blood Collection Efficiency)**	1.25 WTE	Monthly	Local
Number of components manufactured per Standardised FTE. **(Manufacturing Efficiency)**	392	Monthly	Local
Number of platelets which have time expired as a % of the total number of platelets manufactured **(Time Expired Platelets)**	10%	Monthly	Local
Number of RBC units which become non-viable during the manufacturing process which could have been avoided, as a % of the number of complete whole blood donations **(Controllable Manufacturing Losses)**	0.5%	Monthly	Local
Number of bags of RBC, including Paediatric bags, which have time expired as a % of the total number of RBC bags manufactured **(Time Expired Red Cells)**	1%	Monthly	Local
Number of donors that scored 5 or 6 out of 6 (6 being totally satisfied and 1 being totally dissatisfied with their overall donation experience after they have been registered on clinic to donate **(Donor Satisfaction)**	71%	Monthly	Local
Number of 'formal' and 'informal' concerns received from blood donors	~	~	~
% of 'formal' concerns received and treated under 'Putting things Right Regulations within 30 working days	100%	Monthly	National
% of all concerns (formal and informal) acknowledged within 2 working days as required by the 'Putting things Right' Regulations	100%	Monthly	National
Number of new Whole Blood Donors recruited to the donor panel	2,750	Quarterly	Local
Number of new Apheresis Donors recruited to the donor panel	14	Quarterly	Local
Number of Deceased Donor Typing / Cross Matching reported within given period	80%	Quarterly	Local
Number of Anti D & -c Quantitation patient results provided to customer hospitals within 5 working days	90%	Quarterly	Local

Monthly Reporting

Equitable and Timely Access to Services

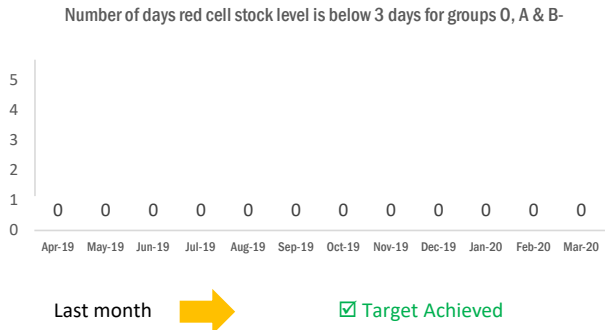
Mar-20



Annual Target: 4000	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Performance remains consistent. Previously identified recruitment based solely on bood donors alone is not sustainable. Alternative recruitment strategy is paused due to covid.	continuation of COVID may have an impact on the proposed strategy to recruit non-blood donors.	

Safe and Reliable Service

Mar-20

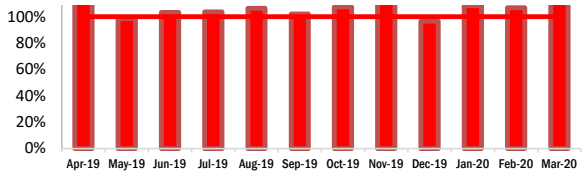


Monthly Target: 0	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All stock groups were maintained above 3 days. Stock levels are robust. Effective collaboration between the Collections and Laboratory teams within the Supply Chain supported the maintenance of robust stock levels.	Daily Resilience meetings are held in a collaboration of blood collection and manufacturing teams; this forum facilitates operational actions in response to challenges in maintaining adequate stock levels in order to minimise blood shortages. In addition, the Demand Planning Leadership Group meet on a weekly basis to monitor and review performance.	Business as Usual

Safe and Reliable service

Mar-20

Monthly Target: 100%	**SMT Lead: Jayne Davey/ Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**

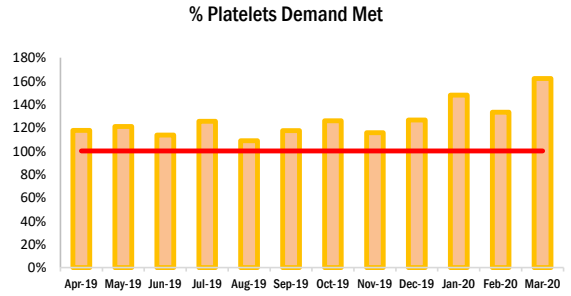


Last month ☑ Target Achieved

All demand for red cells was met. Stock levels remain robust across the blood groups. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs.	Daily Resilience meetings are held in a collaboration of blood collection and manufacturing teams; this forum facilitates operational actions in response to challenges in maintaining adequate stock levels in order to minimise blood shortages. In addition, the Demand Planning Leadership Group meet on a weekly basis to monitor and review performance.	Business as Ususal

Safe and Reliable service

Mar-20

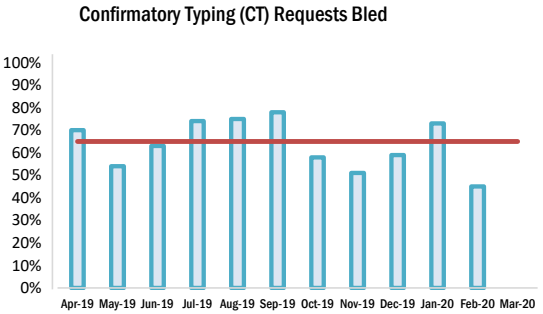


Last month ☑ Target Achieved

Monthly Target: 100%	**SMT Lead: Jayne Davey / Tracey Rees**	
What are the reasons for performance?	**Actions(s) being taken to improve performance**	**By When**
All clinical demand for platelets was met. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs.	A review of clinic planning for extended Bank Holiday periods has been initiated to review opportunities to apply learning following business continuity review. Work has also been initiated to review the WBS Platelet Production Strategy that will facilitate optimum supply chain management aligned with a wider programme of work in response to the recently revised SaBTO guidance on plasma production.	March 2020 Interim update March 2020, further updates throughought 2020

Safe and Reliable service

Mar-20



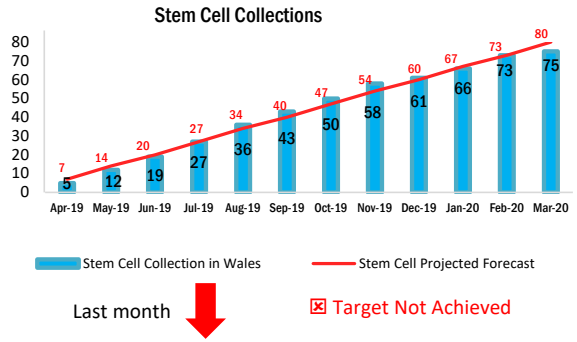
CT requests bled are reported a month in arrears

Last month ☒ Target Not Achieved

Monthly Target: 65%	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The number of CT requests forFebruary was 29: -13 donors were bled (45%) (no cancellations) - 69% of samples were bled within 7 days - 85% of requests were completed within 14 days. (Industry KPI's are 50% and 80% respectively) The requests for February were lower than expected. This in addition to the higher rate of donors who could not be traced (38%) attributed to the low bleed rate.	We have an ongoing system to keep donor details up to date and will continue to review all cancellations to apply learning to future practice wherever possible. We are engaging with stakeholders to improve understanding around turnaround times for donor requests and improve transplantation options for patients. Continuation of COVID-19 may impact on business as usual	Business as Usual

Safe and Reliable service

Mar-20



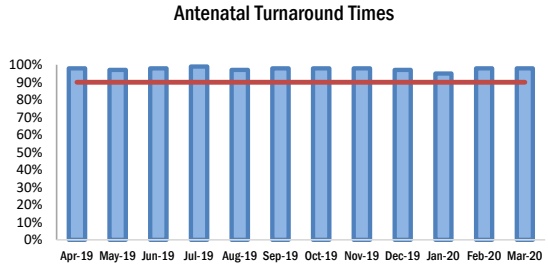
Last month

☒ Target Not Achieved

Annual Target: 80	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were 2 Stem Cell Collections in March due to higher than expected cancellations by the patient transplant centre.	Define and agree future strategy for Stem Cell collection as part of wider review of future strategy for the WBMDR, outlined earlier on page 3 of this report. Continuation of COVID-19 may impact on business as usual	May 2020

Safe and Reliable service

Mar-20



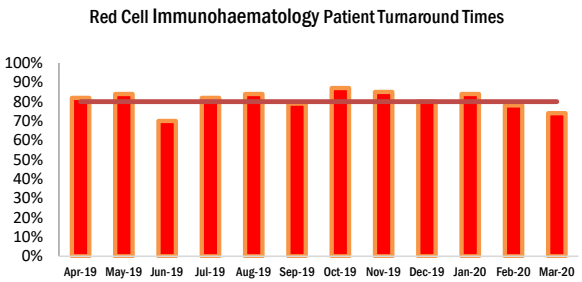
Last month

☑ Target Achieved

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turnaround times for routine Antenatal tests in March remained above target at 98%. Continued monitoring and active management is in place.	Continuation of existing processes which are maintaining high performance against current target.	Business as Usual

Safe and Reliable service

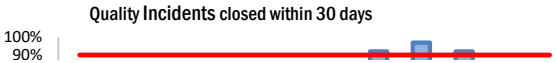
Mar-20



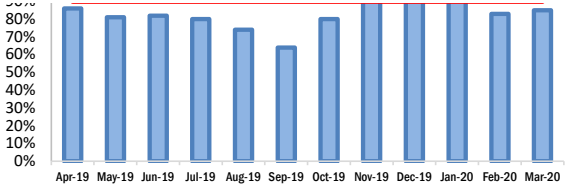
Last month

☒ Target Not Achieved

Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turnaround times for specialist referrals remain just below target at 74%. (Impact of COVID-19 staff redeployment to other labs & increased contingency meetings & planning by senior staff). Compatibility testing (>50% of workload) continued to be completed by required date. Workload was temporarily below average for 1 week but was at normal level for majority of March.	A review of complex patient referrals will be undertaken as part of a laboratory modernisation project which is currently being scoped. This will be supported by a benchmarking exercise to review current turnaround time KPIs with UK counterparts.	June 2020



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**

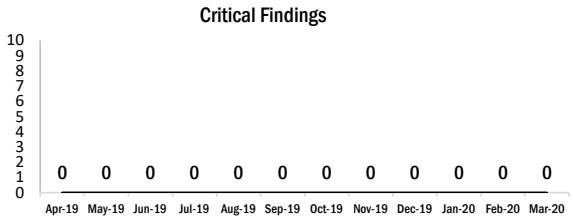


Last month ⬆ ☒ Target Not Achieved

Performance in March is below target position with 85% of quality incidents closed within the required 30 days. This indicates a 2% improvement in performance. The number of incidents reported in the three month rolling period has remained steady (80 reports); 12 reports were not closed within this period.	The agreed SMT action plan will remain in place to ensure that the improved performance is sustained.	Continue with close monitoring and feedback issues to SMT huddle weekly.

Safe and Reliable service

Mar-20



Last month ➡ ☑ Target Achieved

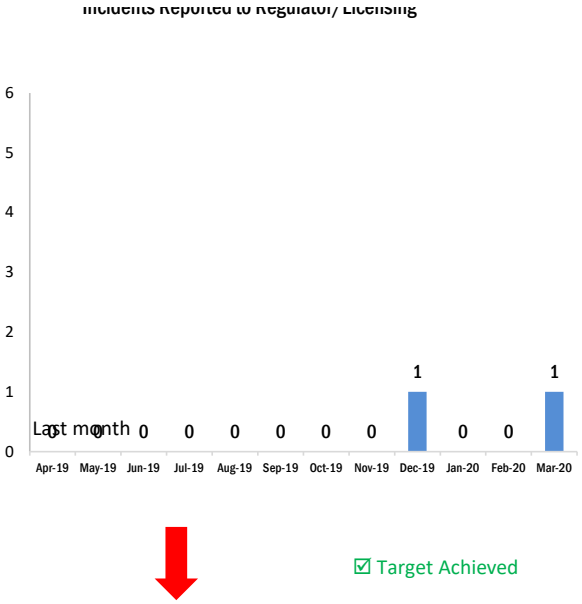
Target: 0	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
No external audits or inspections were undertaken during March 2020; the MHRA were due to undertake an inspection of South Wales facilitiy and activities from 23rd -27th March. However, this inspection has been postponed due to the Covid-19 pandemic.	No new actions required.	Business as usual. MHRA inspection of South Wales facility and activites to be rearranged (MHRA will advise WBS

Safe and Reliable service

Mar-20

Incidents Reported to Regulator/Licensing

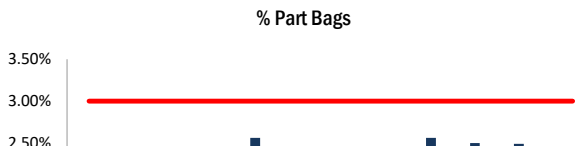
Annual Target: 0	**SMT Lead: Peter Richardson**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**



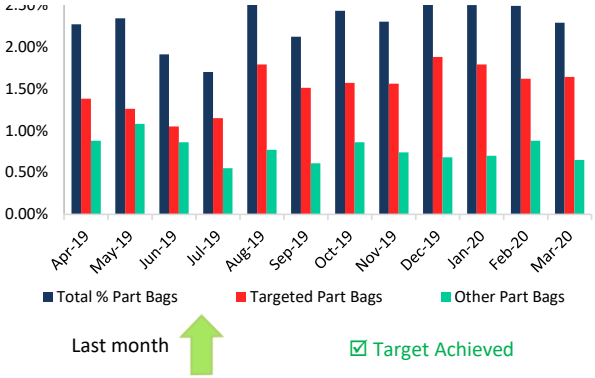
No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in March. However, details of a 'near miss' were reported to SHOT (Serious Hazards of Transfusion), for review and to aid cross-organisational learning: The requirement for irradiated red cells had not been indicated on a crossmatch request received by WBS. The form requires a YES/NO answer, but this part of the form was incomplete and the person dealing with the request assumed this meant irradiated red cells were not required. WBS met the requirements as indicated by the request form. However, an opportunity to highlight the hospital error was missed, as this patient had previously been cross-matched by WBS and irradiated red cells were issued at that time.	No action required	Business as usual

Spending Every Pound Well

Mar-20

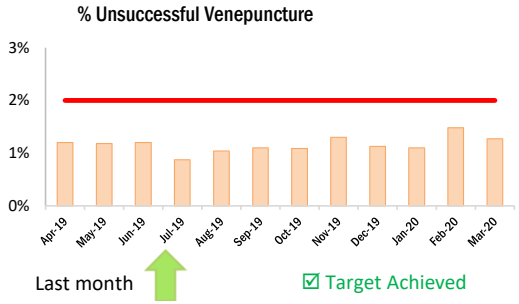


Monthly Target: Maximum 3%	**SMT Lead: Janet Birchall**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The overall Part Bag rate for March 2020 remains within the 3.0% tolerance at 2.29% of donors who donated.	Level of part bags overall is much improved and this has been sustained for many months now. There has been some influence from the	



The breakdown of reasons for part bags in March 2020 is provided below: Targeted: Needle Placement = 23.8% ,Needle Displaced = 3.4%, Clot in Needle = 29.2%, Vasovagal = 15%, Other: Bruise / Discomfort = 13.6%, Poor Access = 12.2%, Equipment Issues = 1.4% At Donor Request = 1.4%, Late Donor Information = 0.% %Total 'Targeted' Factors = 71.4% % Total 'Other' Factors = 28.6%	There has been some influence from the inftroduction of PPE at clinic - but this did not come into place until the beginning of April 2020 - so do not affect these figures. However, the collection teams had started working differently at this point, social distancing, reduced 'flexing' between donors in the pod area and possibly heightened awareness of covid risk at clinic which may influence PB and FVP figures to a degree. In the light of the additonal work that COVID 19 has brought our way, in particular administrative staff taking part in the ever increasing demand for screening of convelesant plasma donors, a workload review of these staff members has taken place. Some work has been re-allocated. However, it has been agreed by Department Head that the collation of the information recieved from Collection Teams with regard to reasons for part bags for May 2020 will not be collated at this time. April's	Review at end of May 2020

Spending Every Pound Well **Mar-20**

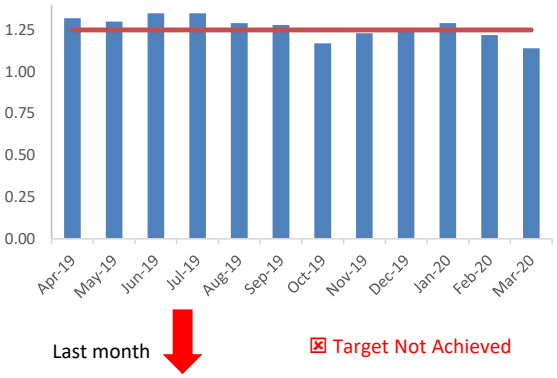


Monthly Target: Maximum 2%	**SMT Lead: Janet Birchall**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
The overall Failed Venepuncture (FVP) rate in March 2020 successfully remained inside the tolerance threshold at 1.27%.	Monitoring of FVP rates by team continues.	Business as Usual

Spending Every Pound Well **Mar-20**

Whole Blood Collection Productivity

Monthly Target: 1.25	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**



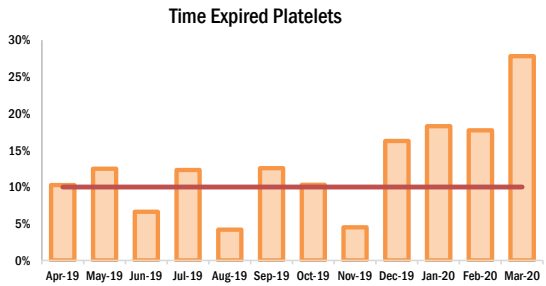
Collection efficiency has reduced to 1.14 and not met the target. This is in part due to the beginning of the coronvirus outbreak, we were subjected to a high number of venue cancellations which resulted in less clinics being deployed and more staff per clinic being available therefore reducing the efficiency score.	Currently in process of staff realignment as part of the Blood Supply Chain 2020 programme. This will identify the required variation in roles, skill mix and workforce numbers based on evidence, service need and modelling (Simul8) data. A final proposal has been shared with staff on the 12/02/2020 following the conclusion of the Organisational Change Process. A meeting has been arranged for March to discuss and agree next steps. Further staff changes overtime may impact on collection team productivity. Continuation of COVID-19 may impact on collection team productivity consideration	March 2020

Spending Every Pound Well

Monthy Target 392	**SMT Lead: Tracey Rees**	
What are the reasons for performance?	**Actions(s) bring taken to improve performance**	**By When**
Performance in March continued to achieve the target position. Recruitment of new staff to meet the Ambient Model has reduced the workload within the department to more normal levels. The department has also had addiotional staff allocated to improve resileince against the risk of Covid 19. The optimum efficiency level is still being explored as we are working through the necessary operational changes as part of the Blood Supply Chain 2020 initiative.	Target to be reviewed in line with processing / staff changes as part of the Blood Supply Chain 2020 initiative. Recruitment of staff to replace leavers and bring staffing in line with the ambient overnight hold model is underway. Changes to staff working patterns introduced to reduce risk of Covid 19 to staff within the department at expense of some efficiency	Ongoing as recruitment and movement to ambient model continues

Spending Every Pound Well

Mar-20

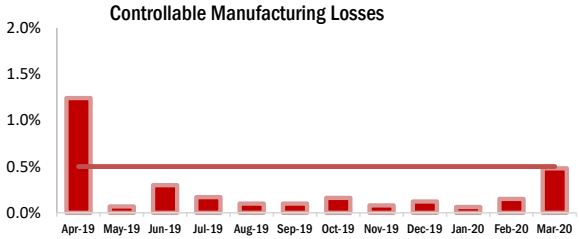


Last month ↓ ☒ Target Not Achieved

Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Time expiry of platelets was above the target tolerance threshold in March. Platelet Issues decreased to an average of 146 per week. Platelet production remained constant due to uncertainty of situation. Operational focus directed towards provision of platelets not reduction of waste.	Keep platelet issues under review and consider reduction in production. Preferential issue of apheresis platelets. Pooled platelets are made or the buffy coats discarded (waste either way).	Interim update end of March 2020

Spending Every Pound Well

Mar-20

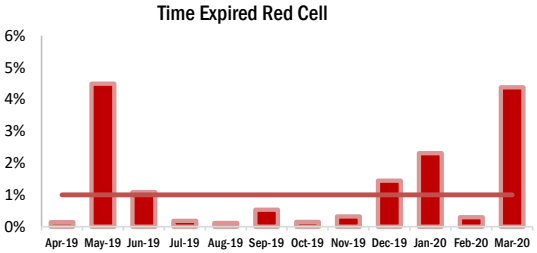


Last month ↓ ☑ Target Achieved

Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Controllable manufacturing losses successfully remained inside the tolerance threshold in March. The three top controllable losses were : 1- Incorrect storage (5%) 2: Operator error - blood press (2.3%) 3: Heat Seal Failure (operator) (1%)	Local reporting and manangement of incidents where they occur for monitoring of losses and lessons learnt.	Business as Usual

Spending Every Pound Well

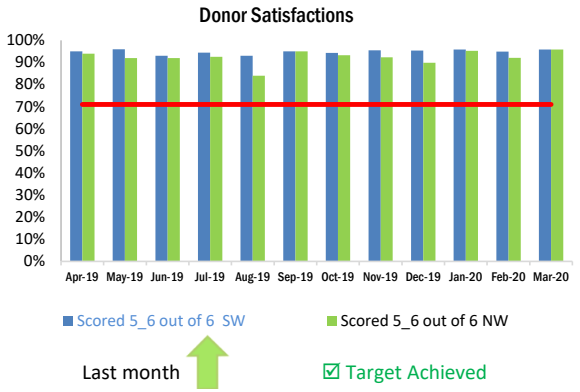
Mar-20



Last month ↓ ☒ Target Not Achieved

Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Red cell time expiry was above the 1% target in March. Red cells issues dropped through the month (weekly issues - 1433, 1365, 1195, 1027, average for year 1569 per week prior to this) against a strong stock position. The resulted in being unable to issue sufficient numbers to prevent time expiry	Issuing pattern changed after discussion with customer hospitals. First in first out approach taken which shifted older blood in to hospital blood banks.	Expiry kept under continual review.

First Class Donor Experience

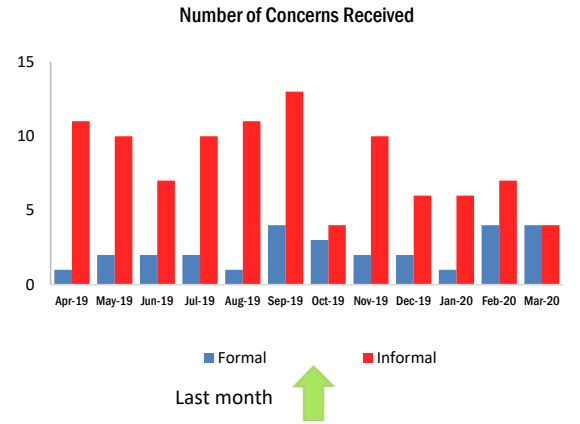


Mar-20

Monthly Target: Minimum 71%	**SMT Lead: Jayne Davey**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Overall donor satisfaction continued to exceed target at 95.9%. In total there were 754 respondents who shared their donation experience, 167 were from North Wales and 587 were from South Wales (where location was able to be defined).	A review of the revised donor satisfaction survey tool that has been trialled over the past few months is to be presented to the February SMT for evaluation.	June 2020.

First Class Donor Experience

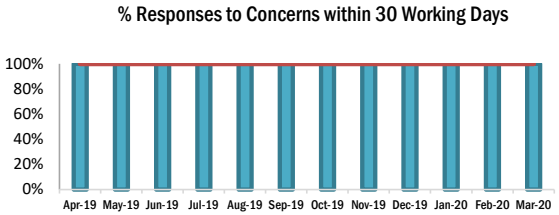
Mar-20



Target: N/A	**SMT Lead: Alan Prosser**	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
In March 2020 a total of 7,479 donors were registered at clinic and 6,638 total donations collected. A total of 7 concerns were reported within this period with 50% (4 concerns) being managed as early resolution (ER) within 2 working days. 4 concerns were formal concerns. Reasons for concerns during this period were: - Donor concern for PPE worn by staff on clinic and social distancing. (2 Formal, 2 ER) - Damage sustained to Clinic venue after a donaiton session.(1 Formal) - Clniic availability not exactly on 16 week interval.(1 ER) - Donor sustained injury to face several hours post donation which they believe to be attributable to fumes on mobile donation vehicle. (1 Formal). - Donor complained at staff shoulting at	Concerns education pack developed to be delivered to managerial staff with responsibility for concerns management to ensure clear understanding of Putting Things Right requirements, individual roles and responsibilities and WBS concerns process to ensure consistent concerns response across the service. User guide developed to aide transfer to upgraded version. Continue to monitor and learn to identify opportunities for continuous improvement.	June 2020

First Class Donor Experience

Mar-20

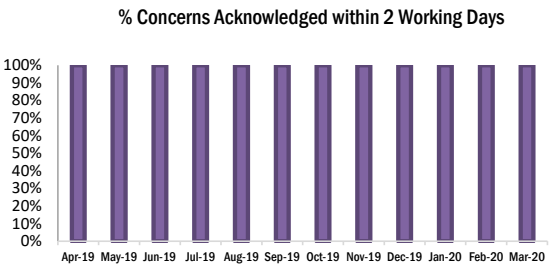


Last month ➡ ☑ Target Achieved

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All formal written responses were completed within the required 30 working day timescale.	Continue to monitor 30 day timescale requirement and have included management timescales within training package.	Business as Usual

First Class Donor Experience

Mar-20



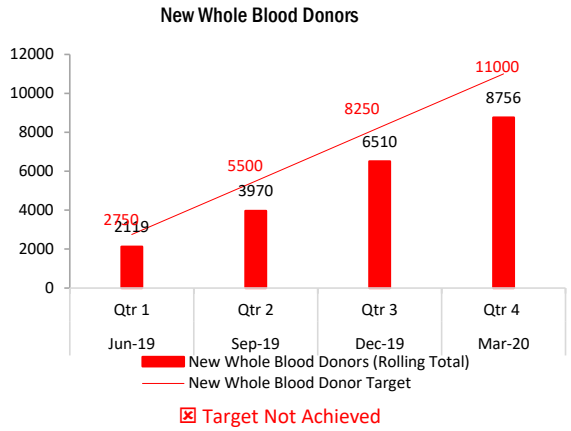
Last month ➡ ☑ Target Achieved

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
All concerns were acknowledged within 2 working days of receipt.	Continue to closely monitor concern management timescales reinforced within training package	Business as Usual

Quarterly Reporting

Equitable and Timely Access to Services

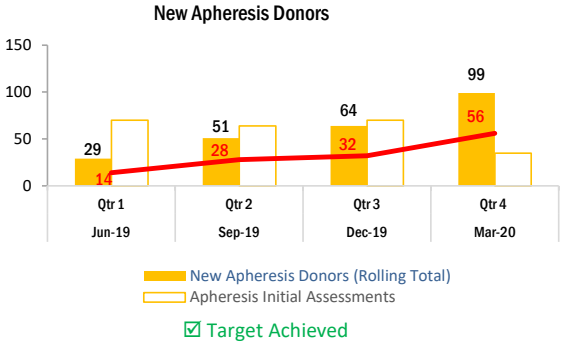
Mar-20



☒ Target Not Achieved

Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
715 new donors gave a donation in March.	New donor recruitment is likely to be high in the coming months as trhe Service visits a number of university sessions. The impact of COVID at the end of March will need to be monitored as there is the potential to affect the model for blood donation.	

Mar-20

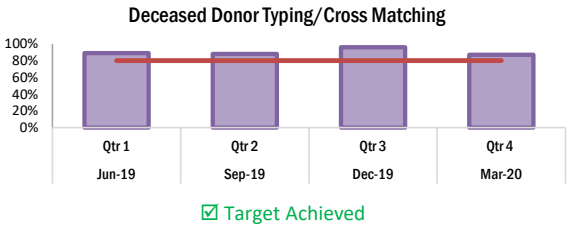


☑ Target Achieved

Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
There were 35 new apheresis donors in the quarter, 25 more than the quarterly target of 14	Continue to recruit new apheresis donors.	Ongoing

Safe and Reliable service

Mar-20

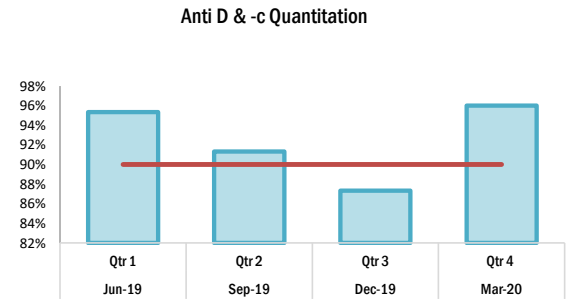


☑ Target Achieved

Quarterly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turnaround times for this critical service remain above target at 87%.	Continued monitoring and active management is in place.	May 2020

Safe and Reliable service

Mar-20



☑ Target Achieved

Quarterly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	**Action(s) being taken to improve performance**	**By When**
Turnaround times remain above target for March 2020 at 93%. The average for Jan - March 2020 was 96%	Continued monitoring and active management is in place.	Business as Usual

Velindre Cancer Centre Monthly Report

At a Glance Highlights - March 2020

The majority of VCC targets were met against a backdrop of unprecedented demand, complexity and operational pressures. The organisational emergency response to the COVID-19 pandemic came into effect in late March. There was disruption to patient treatment pathways and activity at Velindre Cancer Centre during that time. A number of actions identified for delivery at the time have been delayed due to the COVID pandemic. Normal performance management arrangements with the Welsh Government have also been suspended for the forseeable future which impact on the priorities and actions arising from this report. A return to internal scrutiny will be part of the planning through the recovery phases of COVID -19.

High level Summary of Achievement

- % of patients receiving radical radiotherapy within 28-days.
- % of patients receiving palliative radiotherapy within 14-days.
- % of patients receiving emergency radiotherapy within 2-days.
- % of patients receiving non-emergency SACT treatment within 21-days.
- % of patients receiving emergency SACT treatment within 5-days.
- % of therapies inpatients seen within 2 working days.
- % of urgent therapies oupatient referrals seen within 2 weeks.
- % of routine therapies oupatient referrals seen within 6 weeks.
- % of outpatients seen within 20 minutes.
- % outpatient DNA rates.
- Number of potentially aviodable hospital acquired thrombosis (HAT).
- Number of delayed transfers of care (DToC's).
- Number of VCC acquired potentially avoidable pressure ulcers.
- Number of pressure ulcers reported to Welsh Governments as serious incidents.
- Number of VCC inpatient falls.
- Number of VCC aquired healthcare associated infections.
- % of patients who receive a diagnosis of sepsis and receive all 6 treatment elements within 1 hour.
- % of patients who rated experience at Velindre as 9 out of 10 or above.
- % clinical coding within 1 month.

RAG rating above indicates that the individual target was achieved, not achieved or close to being achieved

The detailed performance Informatiion is reflected in the pages that follow with the arrows below describing changes to target attainment for individual targets relative to the previous month

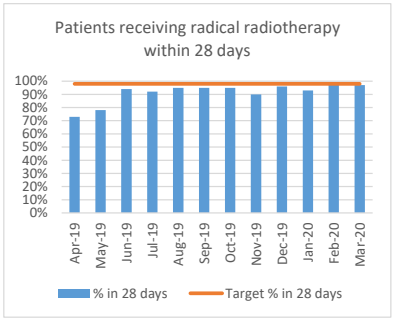
2 KPIs improved relative to the previous month's performance.

9 KPIs fell below the previous month's performance.

17 KPIs remained unchanged relative to the previous month's performance of these all 17 KPIs met or were above target.

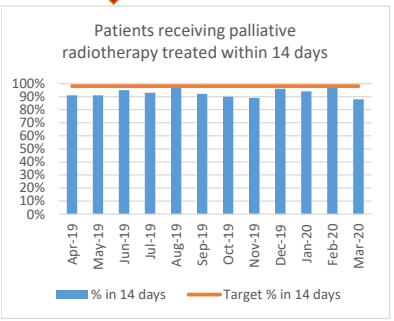
Equitable and Timely Access to Services - Radiotherapy

Mar-20



Last month

Target Not Achieved



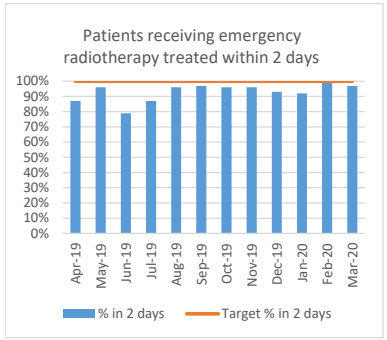
Last month

Target Not Achieved

Target: 98%	**SMT lead: Radiotherapy Services Manager**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion dat**
Demand for radiotherapy services remains high with 414 new patient referrals received. Performance against the 28-day time to treatment target was at 97% in March. 194 radical referrals were received and 6 radical breaches recorded. 4 commenced radiotherapy within 35 days. The breaches were due to the following: 1- treatment was delayed due to rescan requested 1 - treatment delayed due to plan complexity 1 - target not deliniated 1 - delay in submitting eIRMER 1 commenced radiotherapy within 40 days. The breach was due to the following: 1- rescan required Performance was 88% with 110 referrals and 13 palliative breaches. Of these breaches: 4 commenced radiotherapy within 28 days The breaches were due to the following: 2 - change of intent from radical to palliative 1 - treatment delayed in agreement with consultant in order to treat 2 areas 1- unable to undertake planning scan on day 1 due to machine breakdown- delay requested by consultant until returned from leave due to complexity of plan	A1: Increased capacity has been realised in the immediate term by means of the recruitment of agency staff. A2: A work plan has been developed to increase capacity. A3: Work is progressing in collaboration with health board colleagues to fully understand recent increases in demand. This work will also inform demand and capacity and forward planning. A4: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.	E1: To be reviewed June 2020. E2: To be reviewed June 2020. E3: To be reviewed June 2020. E4: Commencing June 2020

Equitable and Timely Access to Services - Radiotherapy (Cont.)

Mar-20

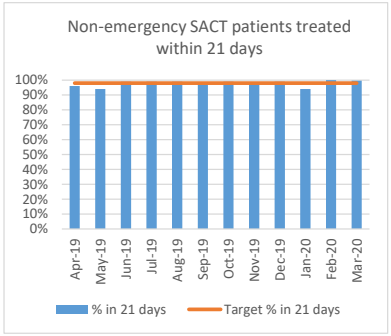


Last month ↓ ☒ Target Not Achieved

Target: 98%	**SMT lead: Radiotherapy Services Manager**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance was 97%. This represents 1 breach out of 33 emergency referrals. The breach was due to the following: COVID related	A1: A review of the current measures and the means of reporting is underway which is intended to provide clarity with respect to the reporting of breaches. A4: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.	E1: To be reviewed in June 2020. E4: Commencing June 2020

Equitable and Timely Access to Services - Non-Emergency Systemic Anti-Cancer Therapy (SACT)

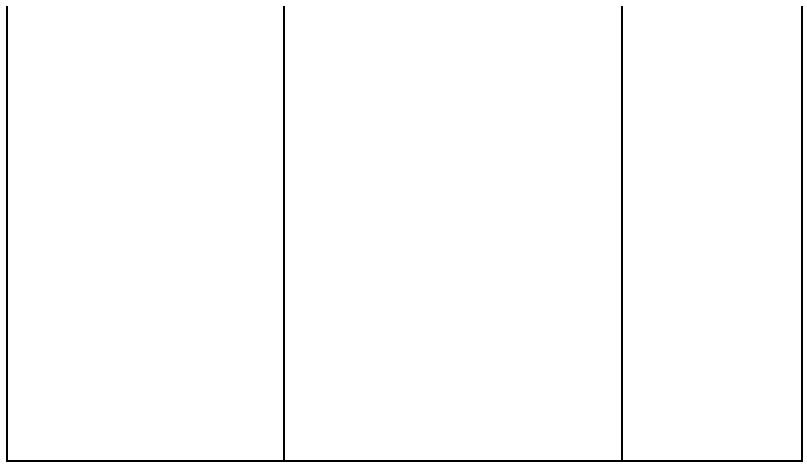
Mar-20



Last month ↑

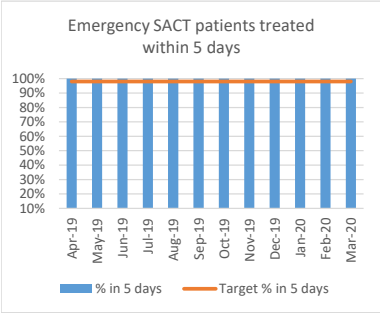
☑ Target Achieved

Target: 98%	**SMT lead: Chief Pharmacist**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
100% (99.7%) was achieved for March 2020. 332 new patients were treated (of which 3 were emergencies). 1 breach was recorded.	A1: A project is underway to outline a plan to deliver a sustainable increase to SACT (Systemic Anti-Cancer Therapy) capacity. This includes consideration of the increased capacity made available by new pharmacy aseptic production alongside the re-purposing of Chemotherapy Inpatient Unit (CIU) to include a daycase facility.	E1: The first phase of the CIU repurpose is complete. CIU patients have been accomodated in the first floor ward from late December 2019. SACT Service capacity is planned to increase from April subject to successful commissioning of the Pharmacy Technical Services and training of new staffing.
	A2: A new cohort of SACT nursing staff will begin 8 week training programme.	E2: Action complete - The new cohort of nurses commenced at VCC as planned. However, due to Covid-19, sign off of the SACT Passport Competency wil lbe delayed. Despite this, the new staff are only missing the formal study days, otherwise, training has been making good progress.



Equitable and Timely Access to Services - Emergency Systemic Anti-Cancer Therapy (SACT)

Mar-20



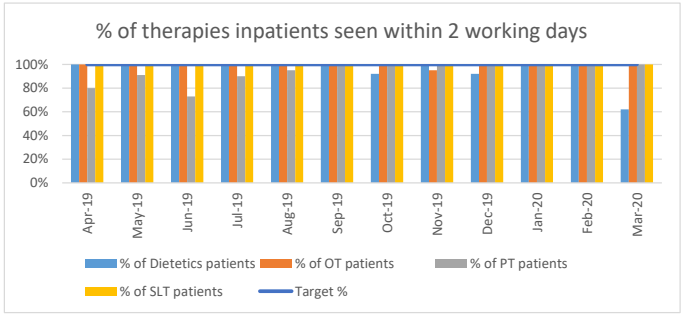
Last month

Target Achieved

Target: 98%	**SMT lead: Chief Pharmacist**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track		

Equitable and Timely Access to Services - Therapies (Inpatients)

Mar-20



Dietetics - last month ↓

OT - last month →

PT - last month →

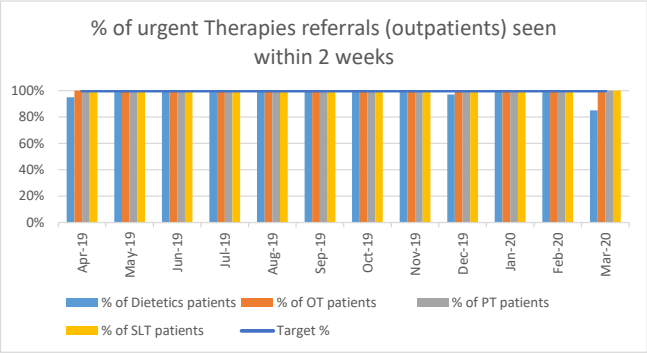
SLT - last month →

SMT lead: Therapies Manager

Target: 100%	**Actions being taken to improve performance:**	**Expected completion d**
Reason for performance:	A1: Following workforce review, need for extra whole time equivalent dietician identified to deliver extra capacity and ensure service resilience. Business case to be developed and presented to VCC Scrutiny Panel. A2: Weekend working to be piloted by utilising capacity freed following suspension of routine outpatient activity. Pilot began in April and to run for an initial 6-weeks. Pilot will be evaluated and a report submitted to the VCC Senior Management Team. A3: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.	E1: Meeting of March panel cancelled. Business case to be presented to VCC SMT May 2020. E2: June 2020 E3: Commencing June 2020
100% of inpatients were seen by Physiotherapy, Speech and Language Therapy and Occupational Therapy. Workforce constraints resulted in some delays in the provision of dietetics service and 6 patients were not seen within the target time. Two of these patients were seen 2 days past target, one each after 3 days, 5 days, 9 days and 11 days following referral. Routine,face to face, outpatient appointments were suspended with effect from the 16th March as part of the Trust's response to the COVID-19 pandemic.		

Equitable and Timely Access to Services - Therapies (Outpatients) Urgent Referrals Seen Within 2 Weeks

Mar-20

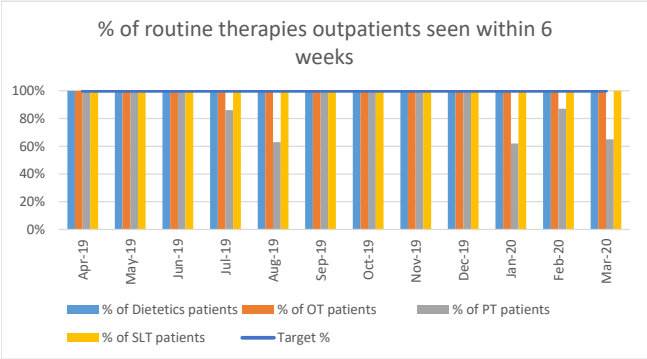


Dietetics - last month ↓
OT - last month →
PT - last month →
SLT - last month →

Target: 100%		
Reason for performance:	**SMT lead: Therapies Manager**	
	Actions being taken to improve performance:	**Expected completion d**
100% of inpatients were seen by Physiotherapy, Speech and Language Therapy and Occupational Therapy. Workforce constraints resulted in some delays in the provision of dietetics service and 6 patients were not seen within the target time. Two of these patients were seen 2 days past target, one each after 3 days, 5 days, 9 days and 11 days following referral. Routine,face to face, outpatient appointments were suspended with effect from the 16th March as part of the Trust's response to the COVID-19 pandemic.	A1: Following workforce review, need for extra whole time equivalent dietician identified to deliver extra capacity and ensure service resilience. Business case to be developed and presented to VCC Scrutiny Panel. A2: Weekend working to be piloted by utilising capacity freed following suspension of routine outpatient activity. Pilot began in April and to run for an initial 6-weeks. Pilot will be evaluated and a report submitted to the VCC Senior Management Team. A3: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.	E1: Meeting of March panel cancelled. Business case to be presented to VCC SMT May 2020. E2: June 2020 E3: Commencing June 2020

Equitable and Timely Access to Services - Therapies (Outpatients) Routine Referrals Seen Within 6 Weeks

Mar-20



Dietetics - last month →
OT - last month →
PT - last month ↓
SLT - last month →

Target: 100%
Reason for performance:
Workforce constraints resulted in some delays in the provision of physiotherapy service and six patients were not seen within the target time. Of the six patients, two were seen 1 day past target, one after 2 days, 2 after 4 days, and one after 6 days. Routine, face-to-face, outpatient appointments were suspended with effect from the 16th March as part of the Trust's response to the COVID-19 pandemic.

SMT lead: Therapies Manager	
Actions being taken to improve performance:	**Expected completion date:**
A1: Following workforce review, need for extra whole time equivalent dietician identified to deliver extra capacity and ensure service resilience. Business case to be developed and presented to VCC Scrutiny Panel.	E1: Meeting of March panel cancelled. Business case to be presented to VCC SMT May 2020.
A2: Weekend working to be piloted by utilising capacity freed following suspension of routine outpatient activity. Pilot began in April and to run for an initial 6-weeks. Pilot will be evaluated and a report submitted to the VCC Senior Management Team.	E2: June 2020
A3: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.	E3: Commencing June 2020

Equitable and Timely Access to Services - Outpatient Waiting Times

Mar-20

☒ Target Not Achieved

Target: <20 minutes	**SMT lead: Head of Nursing**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion date:**
48% of patients were seen within 20 minutes of their scheduled appointment. 62% were seen within 30 minutes. N.B. This data is obtained from a manual data collection exercise snapshot over the first week of each month. Outpatient clinics during the first three weeks in March were busy and this is reflected in the waiting times figures. The last week of March saw the introduction of COVID-19 social distancing measures and a significant reduction in the number of face to face Outpatient attendances in the department.	A1. The Welsh Patient Administration System (WPAS) Operational Readiness Work will review length of appointments and the number of slots allocated to the clinics. A2. Meetings with consultants are taking place to review their clinics to ensure that they are set up correctly ahead of data migration. This should result in a balance of planned demand and available capacity. A3. Weekly Outpatient demand and capacity meetings continue to be held to monitor and manage capacity issues. This will address overbooking and short notice additions to clinics resulting in lengthy waits for patients and also review adherence to the clinic planning deadlines. A4. A new process for recording outpatient waiting times directly into CaNISC (Cancer Network Information System Cymru) is being explored. The pilot took place in September 2019 and the data has been evaluated by the Business Intelligence Team and they have confirmed that the data can be extracted and reported on. Outpatient Programme to agree method for collecting accurate, real time data. Limitation at present due to inability of staff te to input data. A5: Improve internal communication and data sharing by developing SST (Site Specific Team) and Consultant level data. Plans to review performance by individual consultant to enable focussed priority for actions. A6: Establishment of Outpatient Development Programme to bring together all aspects of current and planned improvement workstreams.	E1: The WPAS Operational Readiness Work stream is currently also on hold because of the COVID-19 pandemic and other work being prioritised. E2: Due for review in March 2020. Meetings on hold in light of pandemic response. E3: Originally March 2020 (dependent upon Business Intelligence support being available). On hold due to requirements of pandemic repsonse. Being revisited for next phase capacity planning during June 2020. E4: Originally due for completion in March 2020. On hold due to requirements of pandemic response. E5: Originally March 2020 (subject to review of business intelligence capacity). On hold due to requirements of pandemic response. E6: Work of Outpatient Programme Group, overseeing implementation, on hold due to the requirements of the pandemic response.

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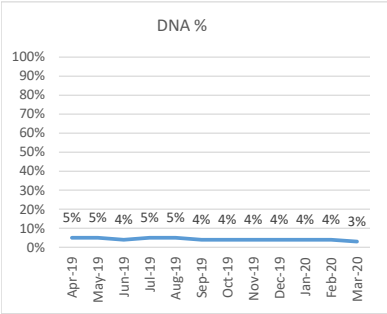


Last month

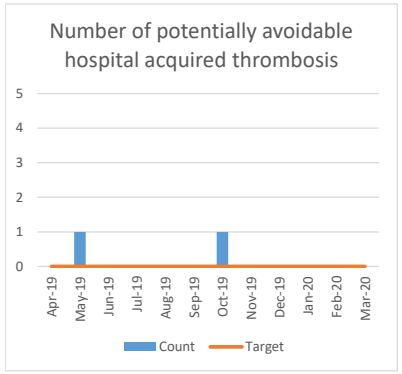
Target Achieved

Outpatients - Did Not Attend (DNA) Rates

Mar-20

Target: <5%	SMT lead: Head of Nursing	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.		

Safe and Reliable Services - Potentially Avoidable Hospital Acquired Thrombosis (HAT) Mar-20



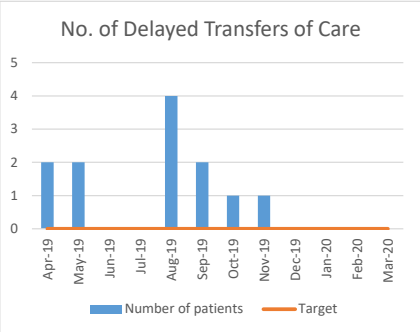
Last month

Target Achieved

Target: zero	SMT lead: Clinical Director	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.		

Safe and Reliable Services - Delayed Transfers of Care (DToC's)

Mar-20



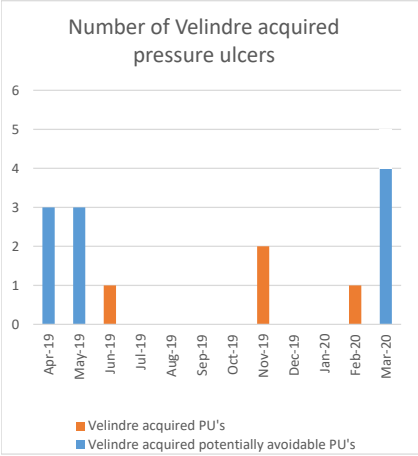
Last month

Target Achieved

Target: zero	**SMT lead: Head of Nursing**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.	A1: Head of Nursing to continue to review all Delayed Transfers of Cares to determine underlying trends, etc.	E1: Business as usual with effect form March 2020.

Safe and Reliable Services - Velindre Acquired Potentially Avoidable Pressure Ulcers

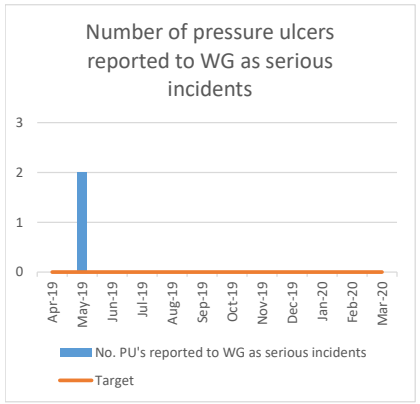
Mar-20



Last month ↓ ☒ Target Not Achieved

Target: zero pressure ulcers	**SMT lead: Head of Nursing**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion date:**
There were four reported Velindre acquired pressure ulcers in March. Reviews were conducted in all cases. All 4 cases were reviewed at the Pressure Ulcer scrutiny panel. The outcome was that 3 case were confirmed as unavoidable, however 1 case was deemed avoidable.	A1: All-Wales Directors of Nursing due to approve an all-Wales Purpose T care plan. A2: The Pressure Ulcer Scrutiny Panel is responsible for monitoring the implementation of any agreed actions or recommendations.	E1: Pilot began in February 2020. Currently, on hold due to requirements of pandemic respnse.

Safe and Reliable Services - Number of Pressure Ulcers Reported to Welsh Government (WG) as Serious Incidents (SI) Mar-20

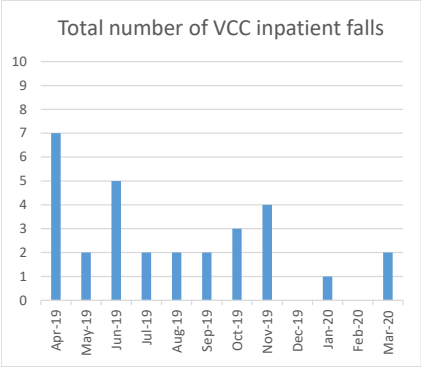


Last month ⇨ ☑ Target Achieved

Target: zero	SMT lead: Head of Nursing	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.		

Safe and Reliable Services - Falls

Mar-20



Last month

Target Not Achieved

Reason for performance:	SMT lead: Head of Nursing Actions being taken to improve performance:	Expected completion d
There were two falls reported in March. No injuries were reported and a post fall assessment was conducted in both cases as required by policy. Both cases were reviewed and considered unavoidable as patients did not require constant supervision.	A1: The post falls pathway was completed in the case of all patients. A2: Develop a final version of a falls prevention policy for approval and adoption by the Trust. A3: To participate in the all-Wales Welsh Nursing Care Record (WNCR) pilot and to evaluate the 'Falls and Bone Health Multifactorial Assessment' and contribute to future development. A4: Contribute to development of all-Wales standardised falls prevention care plan.	E1: Complete E2: March 2020. Activity on hold due to requirements of pandemic response. E3: March 2020. Activity on hold due to requirements of emergency response. E4: March 2020. Activity on hold due to requirements of emergency response.

Safe and Reliable Services - Healthcare Associated Infections (HCAIs) (Velindre-acquired only) Mar-20

Number of Velindre-acquired infections:

C.diff infections = 0

MRSA infections = 0

MSSA infections = 0

E.coli infections = 0

Klebsiella infections = 0

Pseudomonas Aeruginosa infections = 0

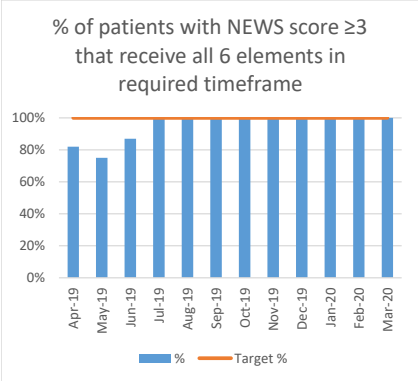
Target: 0 infections	SMT lead: Head of Nursing	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.	A1: Identified hand hygiene champions in departments to receive cascade hand hygiene training (this is not being implemented as a response to a particular issue or incident, but will support business as usual). Training scheduled February 20th & 3rd March 2020	E1: Complete.

Last month ☑ Target Achieved

Annual figures for Velindre-acquired infections:

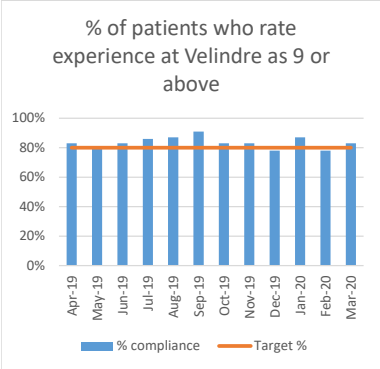
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
C.Diff	1	0	0	0	0	0	0	0	0	0	0	0
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	1	0	0	0
E.Coli	0	0	0	0	0	0	1	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
P. Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Safe and Reliable Services - % of patients who receive a diagnosis of sepsis and receive all 6 elements of treatment within 1 hour (newly presenting patients only) **Mar-20**



Last month ⇨ ☑ Target Achieved

Target: 100%	**SMT lead: Clinical Director**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
In March, 11 patients met criteria for sepsis. All received sepsis bundle within one hour. Of these 11 patients - 6 patients went on to receive diagnosis of sepsis.		



Last month

Target Achieved

Target: 80%	SMT lead: Director of Operations	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
87% of patients who provided feedback via the survey and online methods rated their experience at Velindre as 9 or above.	A1: Full analysis of scores obtained during the month and ares for improvement highlighted to relevant managers, service groups etc. A2: All patients who were contactable (ie not anonymous) contacted to discuss concerns further. A3: Outpatient Development Programme established and will contain a dedicated workstream on patient experience and engagement. This will include a plan to increase the level of patients completing the core experience questions. A4: Proposal to increase patient and visitor car parking space on VCC site.	E1: Complete E2: Business as usual E3: March 2020. Activity on hold due to requirements of emergency response. E4: April 2020

First Class Patient Experience - VCC Concerns

Mar-20

Concerns:

4 Formal concerns were received and managed under Putting Things Right and closed within 30 working days.

Themes included:

1. Lack of communication in relation to treatment plan and prognosis.
2. Cancellation of treatment (on day) and lack of communication with patient.
3. Access to Services – Lack of communication with patient.
4. Clinical treatment / assessment – unhappy with treatment plan and lack of communication with patient around prognosis.

2 Early Resolutions were received and were closed within 2 working days.

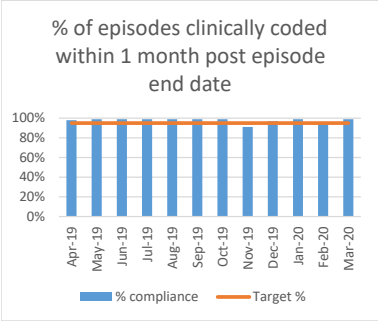
Themes included:

1. Cancellation of appointment
2. Concerns regarding inpatient care and treatment in line with Covid symptomatic patient

Type of concern	No.
Early resolution	2
PTR (formal concern)	4
Claims	0

Information - Clinical Coding

Mar-20



Last month

Target Achieved

Target: 98%	**SMT lead: Head of IM&T**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
Performance on track.		

VCC Measures Glossary

Measure	Target	Monthly/Annual/Rolling	National/Local
Patients Receiving Radical Radiotherapy Within 28 Days	98% or greater	Monthly	Local (Based on RCR Guidance)
Patients Receiving Palliative Radiotherapy Within 14 Days	98% or greater	Monthly	Local (Based on RCR Guidance)
Patients Receiving Emergency Radiotherapy Within 2 Days	98% or greater	Monthly	Local (Based on RCR Guidance)
Non-Emergency SACT Patients Treated Within 21 Days	98% or greater	Monthly	Local (Based on JCCO Guidance)
Emergency SACT Patients Treated Within 5 Days	98% or greater	Monthly	Local (Based on JCCO Guidance)
Percentage of Therapies Inpatients Seen Within 2 Days	100%	Monthly	Local
Percentage of Urgent Therapies Outpatients seen within 2 weeks	100%	Monthly	Local
Percentage of routine Therapies Outpatients Seen Within 6 Weeks	100%	Monthly	Local
Monthly Percentage of NPs, Ops and Chemo Assessment Appointments where patients were seen within 20 minutes of the scheduled appointment times	100%	Monthly	Local
Number of Potentially Avoidable Hospital Acquired Thrombosis	0	Monthly	Local (Adapted from NHS Wales Delivery Framework and Reporting Guidance which Requires Reporting on a Quarterly Basis)
Number of Delayed Transfers of Care	0	Monthly	National
Number of Velindre Acquired Pressure Ulcers	0	Monthly	Local
Number of Pressure Ulcers Reported to the Welsh Government as Serious Incidents	0	Monthly	Local (Adapted from NHS Wales Delivery Framework and Reporting Guidance)

VCC Measures Glossary - Cont.

Measure	Target	Monthly/Annual/Rolling	National/Local
Number of Velindre Acquired Healthcare Associated Infections	0	Monthly	National
Percentage of patients who receive a diagnosis of sepsis and receive all 6 elements of treatment within 1 hour (newly presenting patients only)	100%	Monthly	Local (Adapted from NHS Wales Delivery Framework and Reporting Guidance)
Death within 30 days of SACT	2.2%	Monthly	Local (based on NEPOD Audit Benchmark)
Percentage of patients who rate experience at Velindre as 9 or above	80%	Monthly	Local
Percentage of episodes clinically coded within 1 month post episode end date	98%	Monthly	Local (Adapted from NHS Wales Delivery Framework and Reporting Guidance)

Welsh Blood Service

Sustainable Infrastructure Programme Business Case

Contents

Appendices

Welsh Blood Service
Infrastructure Programme Business Case

SRO:	**To be confirmed**
Project Manager:	**To be confirmed**
Organisation:	**Velindre University NHS Trust**

	Name	Date
Prepared by:	Rachel Hennessy, General Service manager WBS	20/04/20
Reviewed by:	Phil Hodson, Assistant Director Planning & Performance	28/04/20
Approved by:	Stephen Lloyd, Assistant Director Estates VUNHST	30/04/20

1. EXECUTIVE SUMMARY

1.1. Strategic overview

The Programme Business Case (PBC) sets out a programme of strategic developments in relation to improvements in the infrastructure at Welsh Blood Service (WBS). These improvements will support the provision of high quality, safe, sustainable, efficient services and help to meet Good Practice (GP).

The programme sets out the investment, help and support required to provide the technical infrastructure, systems and expertise to deliver a sustainable and future-proofed service and to enable our strategic objectives to be delivered, which are:

- Maintaining excellence in core service delivery and planning our future
- Developing an increasing prudent and sustainable supply chain
- Meet the needs of an evolving transplant service
- Digitally enabled to deliver in the modern world
- Implementing effective clinical systems to support improved outcomes
- Be known for our strength in research, development and innovation
- Clinical engagement and demand planning
- Be active in the establishment of Advanced Therapeutic Medicines (AMTPs) in the NHS

The WBS facility at Talbot Green plays a vital contribution in supporting the collection, supply and manufacturing of blood products across Wales. Furthermore, the Trust Board has confirmed that this facility will continue to be the primary strategic location over the medium to long term.

Therefore, the continued provision of blood and other services from WBS site in Llantrisant requires investment in the electrical and mechanical infrastructure and the modernisation of the laboratories in order to meet the strategic objectives.

In addition, the WBS is moving towards a carbon neutral footprint.

The capital expenditure for the preferred option to address the business needs set out in this business case is as follows:

Financial year	£'000,000
2020/21	**3**
2021/22	**8**
2022/23	**5**
2023/24	**5**
Total	**21**

1.2. Challenges facing blood supplies and transplant services

The provision of blood supplies to the NHS in Wales is fundamental to patient care.

In addition to the general challenges facing the NHS, such as an ageing population which is living longer with increasing co-morbidities, the specific challenges facing the Welsh Blood service (WBS) are:

- Meeting demand and delivering a prudent supply chain.
- Keeping pace with medical, scientific and technological advances in clinical, blood and transplant services.
- Addressing the capacity and capability gaps within the organisation to ensure it is 'Fit-for-the-Future'.
- The WBS should provide blood and transplant services from a building that contributes to a low carbon society, through ensuring it has an electrical and mechanical infrastructure that is fit for purpose and provides the resilience commensurate with the Strategic Importance of the building.

1.3. Infrastructure constraints in providing services

The main building of the WBS in Llantristant is over 20 years old and there are problems and issues with the electrical and mechanical infrastructure.

The existing mechanical and electrical infrastructure does not comply with Welsh Health Technical Memorandum (WHTM) and Welsh Health Building Notes (WHBN) design guidance, which raises concerns around the security of the infrastructure and the ability to withstand utility outages. This is primarily due to single points of failure in the current system.

The lack of duplex systems means that the maintenance and replacement of plant and equipment results in a disruption in power supplies and, in turn, disruption to the delivery of services.

The issues are summarised below:

- The building which has exceeded its nominated electrical supply capacity and is close to the 500KVa output of the transformer – this limits the future development of the site.
- Existing electrical switchboards have been added to on an ad hoc basis – there is no further room for expansion and some of the internal wiring is in a poor condition.
- The existing electrical infrastructure does not allow for maintenance without shutting down services.

- The heating and cooling systems have been expanded with a plethora of split units installed to provide local heating and cooling. This has resulted in poor control with heating and cooling systems working against each other.

- The central ventilation plant which is the original unit installed when the building was new. It is no longer fit for purpose and life expired.

- The Building Management System is obsolete and needs to be replaced. This system is key to future infrastructure projects.

The challenges can be categorised as follows:

- **Mechanical and electrical infrastructure**
    - Asset life expired and in poor condition
    - Resilience inadequate with many points of single failure
    - Inability to maintain plant without disruption to service
    - Existing infrastructure is inefficient

- **Renewables** - the need to meet the requirements for renewable energy, including the Welsh Government's target to be carbon neutral by 2030, by installing:
    - Ground source heat pumps
    - Air source heat pumps
    - Solar photo voltaic cells

Note: attachment 3 includes full list of renewable technologies considered.

1.4. Laboratory modernisation

The aim of the Laboratory modernisation programme is to re-design the pathways and supporting infrastructure of WBS blood and transfusion laboratories to ensure that their functions are future-proofed and sufficiently flexible to accommodate new developments including additional processes, tests, equipment and to ensure staff are able to comply with GP.

Work to scope the laboratory modernisation programme is in its infancy but will draw on best practice examples from other blood and transport services e.g. the Scottish National Blood Transfusion Service (SNBTS) where they have developed a new service model and supporting infrastructure which:

- Enhances the contribution of the health sector to sustainable development in respect of travel, procurement, facilities management, workforce, community engagement and buildings.

- Addresses safety, capacity and regulatory compliance.

- Has improved business effectiveness, efficiency and service quality.

- Enables the retention and recruitment of staff.

- Complies with GP.
- Provides a high quality building with a focus on lifetime costs, quality and design.

The programme will be aligned to the major developments in science, infrastructure, technology and informatics required to improve the interconnectivity and automation of our laboratory processes, which in turn will create a more prudent and sustainable supply chain.

1.5. Strategic aims

The strategic aims of this Programme Business Case are to:

- Ensure there is an integrated sustainable blood and transfusion service provided from premises that are fit for purpose, sustainable and support a more automated and efficient service, contributing to the overall reduction in carbon emission.
- Reduce the overall level of carbon emissions produced by Velindre University NHS Trust
- Maximise the opportunities to utilise and embed innovative technologies in the delivery of public services
- Improve the well-being of staff and the population of Wales and the world through contributing to the global reduction in carbon emission

1.6. The case for investment

In order to achieve the strategic aims we need to

- Address infrastructure issues at the Welsh Blood Service (WBS). The building is over 20 years old and the infrastructure is life expired and not fit for purpose. In particular, the electrical infrastructure is limiting development of the service. New equipment cannot be installed due to the limitations of the current system.
- Improve the resilience of the infrastructure allowing continuity of service from outside disruption or routine maintenance – providing a building that can maintain services during any emergency.
- Make proposals to reduce the building's carbon footprint by introducing renewable technologies into the supply stream. These include photovoltaics, ground source heat pumps and air sources heat pumps. Initial modelling suggests a reduction of up to 75% is achievable.
- Improve the pathway for the management and processing of blood and transfusions services within WBS through the development of a single integrated laboratory service on the ground floor. This operational service model would facilitate strengthened processes, pathways and systems. It would

bring operational efficiencies to the service, reducing waste and move towards models of excellence comparable with other leading Blood Services.

- Review the current layout of the laboratory areas with a view to co locating on the ground floor. This would bring operational efficiencies to the service, reducing waste and move towards models of excellence comparable with other leading Blood Services.

1.7. Desired outcomes and benefits

The proposed programme will deliver:

- A building that is compliant with WHTM and WHBN and meet standards for legislation and regulation including MHRA, UKAS, ISO.
- A building that ensures it has mechanical and electrical infrastructure that is fit for purpose and provides resilience commensurate with the Strategic Importance of the building and is able to support continued provision of blood and blood products to hospitals across Wales both now and in the future
- Contributes to zero carbon emissions through maximising efficiencies of innovative technologies such as solar photovoltaics, water turbine, bio mass boilers, ground source heat pump etc.
- A modern blood and transplant laboratory with increased automation that supports opportunities to develop a service that is integrated, efficient, maximises the use of innovative technology and minimises duplication and waste.
- Provision of a facility that supports and contributes to the well-being of laboratory staff by creating an environment that meets best practice, provides state of the art equipment

1.8. Next steps

The next step is to continue to develop this programme business case as it progresses through the trust's approval process with the aim of being approved at the Trust Board in June 2020.

After that, the business case will be submitted to Welsh Government for approval.

When approved, then it is envisaged that a minimum of 3 linked business justification cases will be developed:

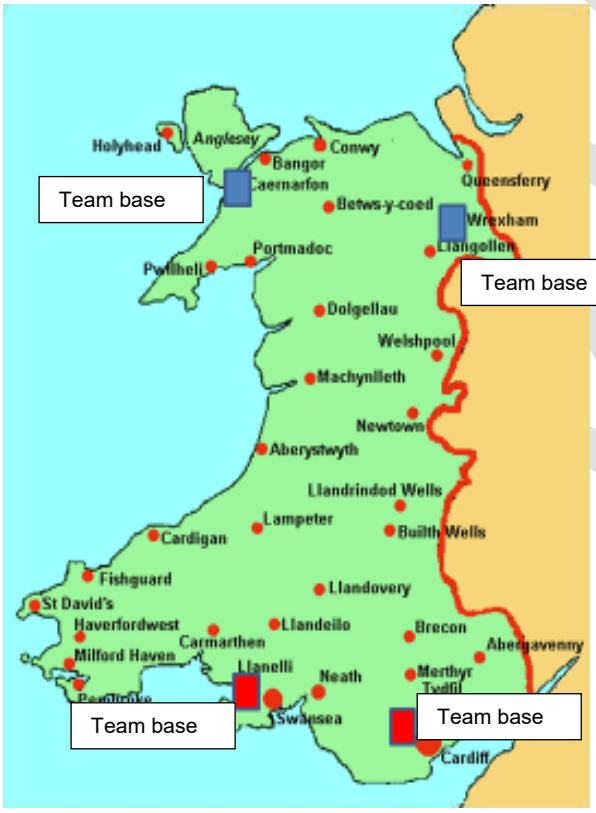
- Mechanical infrastructure, including renewables and carbon footprint reduction
- Electrical infrastructure, including renewables and carbon footprint reduction
- Laboratory modernisation

1.9. Organisational overview: Welsh Blood Service and Velindre University NHS Trust

The Welsh Blood Service (WBS) is a division of Velindre University NHS Trust (VUNHS Trust) and plays a vital role in modern prudent healthcare striving to save and transform lives through the generosity of donors.

WBS has responsibility for coordinating and supplying blood and blood components to hospitals across NHS Wales. It provides a range of essential multifaceted, highly specialised services for NHS Wales, ensuring that it has access to blood and blood components to treat patients and support the transplant programmes through the Welsh Transplantation and Immunogenetics Laboratory.

The image below shows the estate across Wales and table puts the service provided by WBS into context:



100,000	Donations taken per year
1,400	Donation sessions per year
425	Staff
370+	Donor venues
350	Units issues daily
19	Customer hospitals
4	Team bases – Cardiff, Dafen, Bangor Wrexham (Stockholding unit),

1.10. The Commissioner's perspective

WHSSC receives funding from the Health Boards to pay for specialised healthcare for everyone who lives in Wales and is entitled to NHS care. Welsh Health Specialised Services Committee (WHSSC) plans, secures and monitors the quality of a range of specialised services.

WBS is commissioned by the WHSSC on behalf of health boards in Wales as part of VUNHST.

WHSSC is the commissioning body who plan, secure and monitor the quality of a range of highly specialised (tertiary services) for the population of Wales. WHSSC receives funding from the Health Boards to pay for these services for everyone who lives in Wales and is entitled to NHS care.

For WBS this consists of blood donations, antenatal screening, inherited bleeding disorders, renal, stem cell, blood and marrow transplant services.

The WBS estate and infrastructure is supported by the funding allocated to VUNHS Trust via the discretionary capital programme, alternatively through direct funding submissions to Welsh Government.

WHSCC is not allocated a discretionary capital programme as provided direct to health boards/trusts. Revenue funding cost pressures are intended to be managed by VUNHS Trust. However, service developments beyond the current scope of commissioned services are submitted to WHSCC for its consideration. If approved, these are resourced by funding flows from health boards.

1.11. WBS Strategy Priorities

WBS has eight strategic priorities which underpin the delivery of blood and transfusion services both now and in the future, ensuring strategic and operational plans remain focused and allow the service to deliver its strategic intent. This forms the WBS Integrated Medium Term Plan (IMTP) and includes the following:

strategic priority 1.	• **Maintain excellance in core service delivery & planning our future** • continually raise the quality, safety, effectiveness and clinical outcomes of blood and transplant services
strategic priority 2.	• **Develop an increasingly prudent & sustinable supply chain** • realigned supply chain to maximise donor experience and employment of resources
strategic priority 3.	• **Meet the needs of an evolving transplant service** • meet demand for transplantaiton services & keeping abreast of technologucal developments
strategic priority 4.	• **Digitally enabled to deliver in the modern world** • 21st centuary digital service for our donors and customers to future proof the service
strategic priority 5.	• **Implementing effective clinical systems to support improved outcomes** • fully integrated systems, data led decison making, improved clincial outcomes
strategic priority 6.	• **Be known for our strength in Research, development and Innovations** • ensure the WBS remains at the cutting edge of science, innovation and development
strategic priority 7.	• **Clinical engagement and Demand Planning** • using evidence & data to drive service planning & improvement to reduce inappropriate variation and promote blood health for the people of Wales
strategic priority 8.	• **Be active in the establishment of Advanced Terapeutic Medicine (ATMPs)** • improved, timely and equitable patient access to new and emerging cell and gene based advanced therapies

1.12. The Blood Supply Chain 2020 Programme

A key strategic driver for WBS is the Blood supply chain 2020 programme, which was established in 2017. It set out a three year integrated transformational programme of change for WBS focusing on the complete blood supply chain function, from recruitment and selection of donors to delivery of components to customer hospitals, to ensure it is fit for purpose and to address the service development and improvement opportunities that have been identified.

WBS is about to enter the final phase of delivery which will see the introduction of significant organisational change for collection and laboratory services; these will help streamline and strengthen the operation in terms of process flows and efficiencies.

1.13. Challenges facing WBS

There are a number of challenges facing the WBS, which are outlined below:

- Meeting demand and delivering a prudent supply chain.
    - People are living longer than ever before with more chronic and complex conditions – blood components are currently used as part of the care for a range of conditions with over 50% used in people aged over 70
- Maintaining an engaged healthy donor panel in the context of increasing regulatory requirements
    - An ageing population additionally impacts upon donations of blood, as those who become too old or unfit to donate are not necessarily replaced by younger donors.
    - Different lifestyles, increased foreign travel, emerging diseases and changing social responsibility impact upon blood supply with increasing numbers of donors having to be turned down and fewer regular donors from the younger age group
- Keeping pace with medical, scientific and technological advances in clinical, blood and transplant services.
- Addressing the capacity and capability gaps within the organisation to ensure it is ‘Fit-for-the-Future’
- The ability to attract, recruit and retain a workforce with the skills and capabilities for the future.
- Improving the standard of facilities ensuring donors and users receive the same quality and experience wherever the location.
- Limitations on service expansion as a result of current infrastructure limitations.

- Risk to business continuity as a result of multiple single points of failure which in the event of a catastrophic failure is likely significantly impact on service delivery and loss of product.

1.14. Strategic investment objectives

The spending objectives for this programme have been developed within the context of the Well-Being of Future Generations Act 2015 (the Act) and seek to implement the Principles of the Act within WBS and VUNHST through enhancing the contribution of the health sector to sustainable development in respect of procurement, facilities management, workforce and buildings. This Programme of work focuses on delivering long-term well-being goals in a sustainable manner and has strong alignment with the goals of delivering a prosperous Wales, a resilient Wales

Programme Spending objectives:

Programme Spending Objective	Description	KPIs
Programme Spending Objective 1	To provide a facility that delivers safe, quality services, that meet standards for legislation, regulation and of accreditation bodies	Delivery against required standards including WHTM, WHBN, external regulation and accredited bodies including Medical and Health Products Regulatory Agency (MHRA), United Kingdom Accreditation standards (UKAS) and against standards as determined by audit outcomes
Programme Spending Objective 2	To provide a blood and transplant service from a building that ensures it has mechanical and electrical infrastructure that is fit for purpose and provides resilience commensurate with the Strategic Importance of the building and is able to support continued provision of blood and blood products to hospitals across Wales both now and in the future.	Supply of blood and blood products Waste Measure of down time
Programme Spending Objective 3	To provide capacity and facilities that supports the delivery of high quality education, strengthens research, technological developments and innovation and ensures future service demand is realised.	Contribution/number of research. Development and innovation projects
Programme Spending Objective 4	To provide a facility that supports the delivery of Welsh Government target of carbon neutral for all public sector buildings by 2030 through maximising efficiency and utilising innovative technologies such as solar photovoltaics, water turbine, bio mass boilers, ground source heat pump, has mechanical infrastructure that provides heat, cooling and hot water services in an efficient manner.	Reduction in emissions

Programme Spending Objective 5	To provide modern blood and transplant laboratories that support and contributes to the well-being of laboratory staff by creating an environment that is integrated, maximises the use of technology through increased innovation, meets best practice, and minimises duplication and waste uses	Increase in productivity Output from staff survey. Recruitment and retention

2. STRATEGIC CASE: BUSINESS NEED

2.1. Summary: Business needs and service requirements

Because of the challenges and issues discussed above, Consilium SG consulting engineers were appointed to undertake a resilience analysis and make recommendations for the upgrade and planned replacement for the following systems at the WBS Headquarters in Llantrisant:

- Mechanical: Infrastructure including main heating, cooling and ventilation plant
- Electrical infrastructure including mains electrical distribution systems

The main problems and issues for each element are summarised in the following sections and, in addition, will involve:

- Developing a new Energy Centre to centralise main plant
- Ensuring the infrastructure is resilient for equipment failures
- Seizing the opportunity to move towards a carbon neutral service (renewables)
- Modernisation of laboratories, in line with best practice, that will support improved efficiency and innovation.

2.2. Mechanical infrastructure

Ventilation

The existing ventilation plant serving the majority of the WBS, has reached the end of its serviceable life and does not meet the recommended standard set out in HTM 03-01 Specialised Ventilation for Healthcare Premises.

Furthermore, the existing ventilation systems have no form of temperature control with respect to summertime temperatures, therefore warm, uncontrolled air is delivered to spaces which require temperature control for compliance purposes.

It is recommended that the AHU's are replaced with new HTM 03-01 compliant units, with the ability to control summertime air temperatures. By the very nature of complying with HTM 03-01, the units would also meet the guidelines of WHBN 00-07, by providing robustness and redundancy in the form of twin fan arrangements, heat recovery for energy efficiency and improved maintainability with the correct access arrangements and instrumentation.

The ventilation philosophy will remain the same, which is that the ventilation plant is used to provide the necessary air change rate or fresh air rate for occupant comfort

only, the temperature control of the individual spaces is to be provided by alternative, more efficient methods. This will be the most efficient way of providing environmental control.

Heating & Cooling
Cooling and Air Conditioning to the WBS is delivered by a vast range of split type refrigeration systems, which appear to have been added on an individual basis and not part of any Heat Recovery system. Within the majority of the rooms which have split refrigeration units, there are also radiators or radiant panels. This presents a scenario where both systems can, if activated, fight against each other for temperature control, which we understand is a common occurrence.

To ensure accurate and efficient control of the summertime air temperatures in the ventilation systems, it is recommended that a central chilled water plant is provided to deliver chilled water, which will ensure the air temperature leaving the AHU's during the summertime is constant throughout the building.

It is proposed that the ground source heat pump is used in its reverse cycle, to act as the lead cooling plant, supported by two air cooled chillers, rated at 200kW each, during the peak summer months. By providing a central cooling system for the ventilation, separate to the VRF systems, it provides redundancy in the control of indoor temperatures.

Air source heat pumps will be installed to provide localised control of heating and cooling in laboratories and controlled spaces. This will provide localised control of required temperatures.

To ensure the cooling and heating systems are controlled effectively and efficiently, it is recommended that an upgrade of the central Building Management system is included. This will include new MCCP panels within the major plant rooms and an upgrade of the head-end software.

To support the temperature control within controlled spaces, additional space temperature sensors will be provided. This will provide improved monitoring of critical spaces.

Additional energy metering (for mechanical and electrical systems) will be provided to inform usage and assist with and overall energy monitoring and targeting programs.

2.3. Electrical infrastructure

The existing electrical infrastructure within the WBS Headquarters building in general (generator and bulk tank excluded) appears to be at the end of its serviceable life including the Main LV Switchboards, the Street LV Switchboards and most distribution boards.

Based on the anticipated future growth of the site (WTAIL) plus a 3% year on year growth, the available maximum demand will be exceeded and the WPD transformer will not be enough to support these loads.

In order to provide an approximate 15 year typical growth profile a 1MVA (double the existing) will be required.

The existing electrical infrastructure does not provide the required resilience for the business risk as defined by HTM 06-01 Electrical Services Supply & Distribution. Furthermore, there are no spare ways available on the Main LV Switchboard and Street LV Switchboards, and the protective devices are no longer supported by the manufacturer. Any extensions or major works at the WBS Building will not be feasible until the electrical distribution is completely overhauled.

The conclusion is that a wholesale replacement of the WBS Headquarters substation to provide dual primary and secondary supplies with dual distribution (A +B) is required. This consists of 2 transformers, 2 generators, new bulk tank, 2 Main LV Switchboards, A+B Street LV Switchboards and strategically positioned dual distribution boards situated throughout the building.

New switch rooms will be required within the energy centre and in the building for electrical plant

2.4. Laboratory modernisation

The laboratory modernisation programme will be aligned to the major developments in science, infrastructure, technology and informatics required to improve the interconnectivity and automation of our laboratory processes, which in turn will create a more prudent and sustainable supply chain.

Through the programme we aim to re-design the pathways and supporting infrastructure of WBS laboratories, enabling their functions to be future-proofed, as well as sufficiently flexible to accommodate new developments including additional processes, tests, equipment and ensure staff are able to comply with GP standards.

Work to scope the laboratory modernisation programme is in its infancy but will draw on best practice examples from other blood and transport services, such as the Scottish National Blood Transfusion Service (SNBTS).

The programme will look at the different functions of the laboratory and how the infrastructure can be reconfigured to best support service delivery, taking into consideration safety, capacity, regulatory compliance, efficiency, effectiveness and sustainability. The programme will include but is not limited to:

- Blood processing
- Processing of tissues and cells
- Cell therapy manufacture
- Testing of blood tissues and cells
- Research, development and innovation

- Quality assurance and regulatory compliance (including maintenance and validation services)
- Office accommodation

The infrastructure re-design will also look to integrate the existing laboratories into a single function. The facility will need to be designed to maximise efficiency and minimise waste. It will also need to support GP to allow the retention of MHRA and HTA regulatory licences. The laboratory infrastructure will need to comply with all current and predicted regulatory and GP requirements and all relevant accreditations and guidance.

2.5. Energy Centre

The architectural options to support the electrical and mechanical upgrade works include the following options for a new energy centre:

1. Extend existing energy centre

2. Create a new energy centre in the existing site garage.

The following factors have been considered when deciding the location of a new energy centre

1. Maintaining operation of the existing service

2. Health & Safety

3. Phasing

4. Programme

5. Cost

6. Re-configurability

7. Potential for extension

The conclusion is that on ease of the maintaining the site operation, programme and cost benefits and the creation of an opportunity to extend the WBS building in the future that a new energy centre be created in the existing site garage.

2.6. Decarbonisation

Melin Consultants were engaged to investigate the potential for improvements to the existing building's fabric and services and integrating low and renewable technologies.

Generally, the conclusion was that improvements to the fabric of the building would have relatively small energy and CO2 savings and taking in to account the significant cost and disruption of carrying out the works would likely be prohibitive, the paybacks would be long and these have therefore been discounted.

Upgrades to the ventilation, cooling and lighting systems have been identified as providing large savings in energy and CO2 and are viable options to consider. The ventilation and cooling systems improvements have been included in the mechanical works summary and the cost plan.

The report concludes that several LZC technologies show significant improvements in the buildings carbon footprint and are considered suitable for inclusion in the development. The most appropriate technologies at this stage for consideration are (attachment 3 provides detail of available technologies and suitability):

- Solar Photovoltaics
- Air Source Heat Pumps
- Ground Source Heat Pumps.

Biomass, CHP and Solar Thermal were identified as potential technologies for further investigation. At this stage, due to the relatively low base heat demand, maintaining local air quality and relatively low hot water consumption these technologies were not recommended.

Hydro and Wind are not considered suitable at this stage due to difficulties in obtaining water extraction licenses/impact on local biodiversity/distance. Wind studies show a low return on installation of a wind turbine on this site.

The options that yield the highest return in CO2 reduction be considered be included in these works. The proposed resilience infrastructure upgrade would be the most practice time to include strategic changes to heating and cooling systems. The proposal includes:

- Ventilation system efficiencies and heat recovery improvements
- Lighting installation efficiency improvements
- Photovoltaic cell installations
- Air source heat pumps
- Ground Source Heat Pumps

2.7. Desired investment outcomes

The desired outcomes and benefits are as follows:

- A building that is compliant with WHTM and WHBN and meet standards for legislation and regulation including MHRA, UKAS, ISO.
- A building that ensures it has mechanical and electrical infrastructure that is fit for purpose and provides resilience commensurate with the Strategic Importance of the building and is able to support continued provision of blood and blood products to hospitals across Wales both now and in the future
- Contributes to zero carbon emissions through maximising efficiencies of innovative technologies such as solar photovoltaics, water turbine, bio mass boilers, ground source heat pump etc (attachment 4).
- A modern blood and transplant laboratory with increased automation that supports opportunities to develop a service that is integrated, efficient, maximises the use of innovative technology and minimises duplication and waste.
- Provision of a facility that supports and contributes to the well-being of laboratory staff by creating an environment that meets best practice, provides state of the art equipment

The table bellows provides more detail relating to the specific components of the Programme.

Mechanical	• A building where heating and cooling can be achieved in an efficient manner. • A building that has a mechanical infrastructure that is fit for purpose and meets current HTM and HBN standards. • Improved ventilation systems that meet the requirement of HTM 03, with improved operational arrangements.
Electrical	• A building that has an Electrical system fit for purpose and meets current HTM and HBN standards. • An electrical system that provides the necessary resilience commensurate with the Strategic Importance of the building. • A system that is controlled and managed in line with the associated risks moving forward.
Opportunities	• Solar photovoltaics • Water turbine

to move towards carbon neutral solution (renewables)	• Bio mass boilers • Ground source heat pump (linked to improved car parking provision)
Laboratories	An environment that: • Reflects best practice in management of blood services across home counties and further afield • Addresses safety, capacity and regulatory compliance • Supports improved business effectiveness, efficiency and service quality. • Supports and contributes to the well-being of laboratory staff • Supports the retention and recruitment of staff • Supports increased research, development and innovation

3. ECONOMIC CASE

The Economic case looks to ensure that the project will provide value for money against a number of key project spending objectives (PSOs).

This section of the Programme Business Case provides details on the range of options that have been considered in response to the potential scope identified within the strategic case and identifies a long-list of options and a short-list of options, together with a preferred option.

3.1. Anticipated objectives

The anticipated benefits of this programme are:

- Replacement of life-expired assets (plant and equipment - current plant is around 25 years).
- A reduction in the carbon foot print up to 75%% (scope 1 and scope 2) (attachment 4)
- A reduction in energy consumption
- Load balancing of thermal and electrical supplies.
- Supports continued delivery of services by reducing potential single points of failure.
- Modern laboratory services in line with best practice.

3.2. Constraints and Dependencies

The main constraints and dependencies of this programme are:

- Approval by Welsh Government.
- Funding from Welsh Government
- Availability of Trust technical and project management resource.
- Trust Board approval
- Senior responsible officer (SRO).
- Financial and other resource changes that may take place during the project
- The skill of managerial staff to implement the project
- Progress through the approval and review process
- Subject Matter Expertise in relation to estates, laboratories and renewable.

3.3. Long list of Options

A long-list of fourteen options has been developed (attachment 1). This has been reviewed against the Project Spending Objectives and a short-list created.

3.4. Short list of options

The short list of options includes 'Business as Usual' (option1) and 'Like for like' replacement (option 2).

Option	Reason for acceptance or rejection
Option 1. Do Nothing: Business as usual; continue with existing infrastructure	This option does not address the immediate risk associated with lack of resilience for the WBS Is not WHTM compliant. Does not contribute to zero carbon Does not support Lab modernisation.
Option 2. Do Minimum: Essential building and maintenance work undertaken only, replacing 'like with like'	This capital solution looks to address the existing infrastructure requirements to ensure business continuity with some resilience in the system Is not WHTM compliant. Does not contribute to zero carbon Does not support Lab modernisation.
Option11. Limited WHTM compliance, maximising opportunities to fully utilise low carbon alternatives and reduce wastage across the whole WBS site including reconfiguration and modernisation of laboratories.	Does not provide a fully WHTM solution Does not provide assurance for resilience in the system. It demonstrates a full commitment to zero carbon Supports lab modernisation programme
Option 13. Full WHTM compliance, maximising opportunities to selectively utilise low carbon alternatives and modernisation of laboratories.	This capital solution looks to utilise selective carbon alternatives, that are the most effective Does provide a full WHTM solution Does provide assurance for resilience in the system. Supports lab modernisation programme
Option 14. Full WHTM compliance, maximising opportunities to fully utilise low carbon alternatives and reduce wastage across the whole WBS site including reconfiguration and modernisation of laboratories.	This capital solution looks to fully utilise carbon alternatives, Does provide a full WHTM solution Does provide assurance for resilience in the system. Supports lab modernisation programme

4.5 Preferred option

The short- list of options has been assessed against a number of Critical Success Factors (CSFs) and the Project Spending Objectives (PSOs) (attachment 2)
The preferred option is:

Option 13:
Full WHTM compliance, maximising opportunities to selectively utilise low carbon alternatives and modernisation of laboratories

4. COMMERCIAL CASE

4.1. Introduction

The Commercial Case sets out the planned approach the Trust will be taking to ensure there is a competitive market for the supply of services.

4.2. Services and outputs to be procured

It is intended that VUNHST will go to tender for Consultants to undertake business case developed, design work, mechanical and electrical infrastructure and building reconfiguration.

Attachment 5 outlines indicative timescales.

4.3. Procurement strategy

Advice will be sought from NHSWSSP in relation to the appropriate procurement process for this programme of work.

4.4. Risk allocation and management

A formal risk management strategy and associated project risk register will be developed. The risk register will be monitored/updated for the life of the project with the focus being on mitigating actions and the controls to be adopted to manage/treat risks.

5. FINANCIAL CASE

5.1. Introduction

The purpose of the Financial Case is to ascertain the affordability and funding requirements of the preferred option and to demonstrate that the recommended programme and its supporting projects are affordable.

Initially the financial framework used for the development of the Financial Case is set out. Then the approach to the establishment of the revenue and capital costs is explained.

This Financial Case highlights the cost impact over the following areas of expenditure within the Project:

- Construction and Equipment Capital costs;
- Project 'Delivery' Capital costs;
- Transitional (Non-recurring) Revenue costs;
- Balance Sheet; and
- Recurring Revenue costs.

Costs within the Financial Case are based on the same underlying models as the Economic Case but with non-recoverable VAT and inflation included, in line with HM Treasury guidance. Fundamentally, the Financial Case outlines the full financial costs of the Programme and the sources of funding.

5.2. Capital Requirements

Total upfront capital investment to implement the preferred way forward is estimated at £21m in today's prices.

The capital costs were calculated based upon a report prepared by Consilium SG, which was presented to the WBS in November 2019. The estimate of the total costs of the work to be undertaken was as follows:

Phase 1: Mechanical and Electrical Infrastructure with sustainability works

Cost Category	Total
Mechanical	£1.0m
Electrical	£3.1m
Renewables	£1.3m
Other	
Building works	£1.1m
Fees	£1.1m
Contingency	£0.8m
VAT	**£1.4m**

TOTAL	**£9.8m**

Phase 2: Laboratory Modernisation

It is anticipated that approximately £10m + VAT will be required for laboratory modernisation works based on m2 footage and capital equipment.

The costs provided are commensurate with a level of certainty based on a RIBA stage 0/1 Strategic and Initial Brief. In order to provide a more accurate level of cost certainty further design development to RIBA stage 2/3 would be required.

The building work is shown as a separate element and includes works to support the mechanical, electrical and renewables elements. In order to allocate building works costs we anticipate a spread of 40% mechanical, 40% electrical and 20% for sustainability be applied to each element.

Note: if the work was undertaken as separate projects, the full absorption cost will be higher.

Financial year	£'000,000
2020/21	**3**
2021/22	**8**
2022/23	**5**
2023/24	**5**
Total	**21**

Project Delivery Capital Costs

There will be additional NHS resources required to deliver the projects to ensure robust progression to OBC. Following approval of this Programme Business Case the additional resources will be scoped and will need to include, (but may not be limited to), Project Manager, administrative support, support for backfill of departmental leads and facilities management.

Transitional Costs

Costs incurred as a result of transition are assumed to be capitalised, costs may include the temporary hire of external facilities or insourcing of blood and transplant products, resultant from the need to decant from operational service areas.

5.3. Impact on balance sheet

The current value of the Welsh Blood Service estate at Talbot Green is approximately £12m.

5.4. Impact on Income and Expenditure account

Recurring Revenue Costs

As a result of the enhanced infrastructure case, it is anticipated that there may be a reduction in the estate running costs however this is likely to be offset by increase in maintenance costs.

Workforce Planning

For the purpose of the financial analysis at this stage it has been assumed that there will be no workforce changes as a direct result of the proposed changes to infrastructure. Any future changes will be subject to internal approval through delivery of a financially balanced WBS. Workforce has therefore been excluded from the financial analysis at this stage.

5.5. Overall affordability and funding

Affordability has been assessed by using the efficiencies in revenue costs planned as deliverable as a result of enhancing the WBS infrastructure. These savings will be developed further at the Outline Business Case stage as specific implications become more tangible.

5.6. Confirmation of commissioner support

The Welsh Blood Service is under the responsibility of Velindre University NHS Trust, though commissioned via Welsh Health Specialised Services Committee (WHSSC). The Welsh Blood Service estate and infrastructure is supported by funding allocated to Velindre University NHS Trust via the discretionary capital programme, alternatively through direct funding submissions to Welsh Government.

The Sustainable Infrastructure Programme Business Case is a direct submission from Velindre University NHS Trust to Welsh Government. WHSCC has been engaged in the development of this Programme Business Case, whilst there are no funding flow consequences, support has been provided for the strategic intent.

6. MANAGEMENT CASE

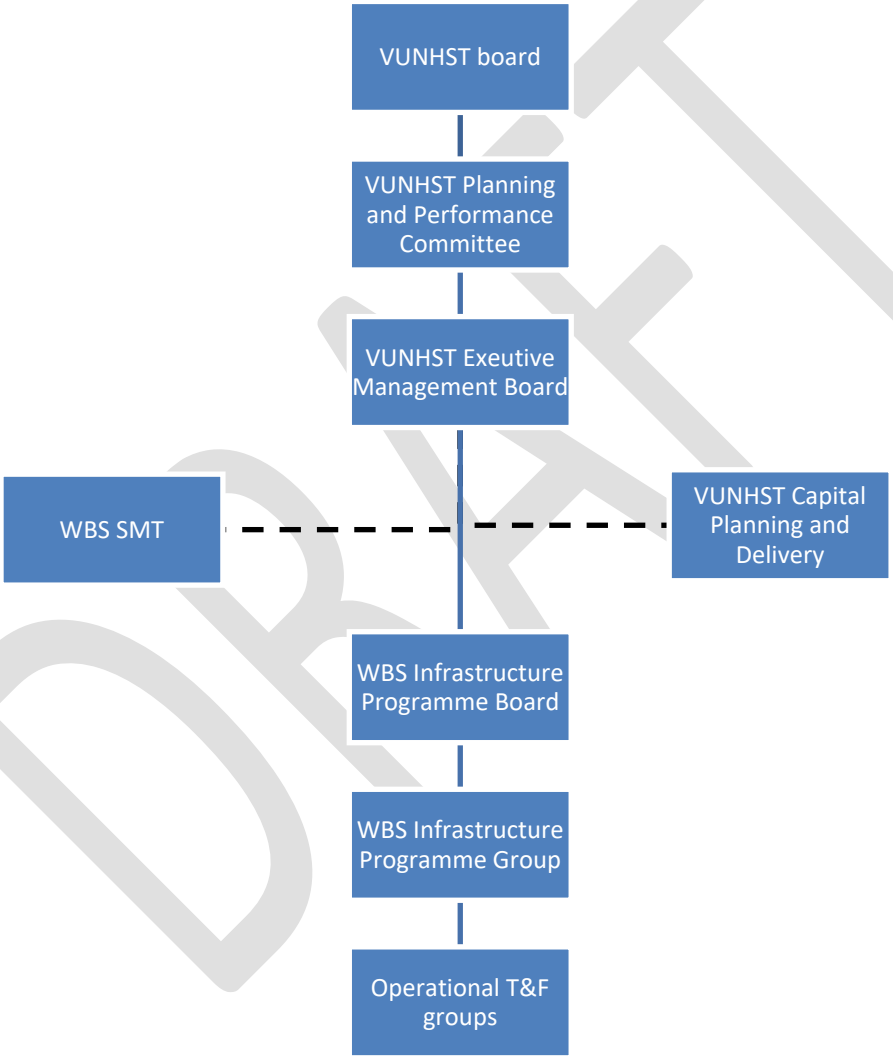
6.1. Governance arrangements

The programme will follow standard MSP programme guidance a Programme Board being established and offices appointed to the following roles.

Role	Responsibility
Senior Responsible Owner (SRO)	The SRO is accountable for the success of the Programme and is responsible for enabling the organisation to exploit the new environment resulting from the Programme, meeting the new business needs and delivering new levels of performance, benefit, service delivery and value. The SRO owns the vision for the Programme and provides clear leadership and direction and secures the investment required to set up and run the Programme.
Programme Director	Responsible for providing the interface between Programme ownership and delivery, and is accountable for defining the Programme objectives and ensuring they are met within the agreed time, cost and quality constraints. The Programme Director will act as the link point for stakeholders at a strategic level.
Programme Manager	Responsible for leading and managing the setting up of the programme through to the delivery of new capabilities, realisation of benefits and programme closure.
WBS Senior Management Lead	Responsible for providing the interface between WBS Senior management Team and the Programme Board. Is accountable for ensuring effective service engagement, ensuring views of WBS are identified and considered and securing consensus within WBS for the improvements identified within the programme.
Scientific Lead	Responsible for providing Scientific leadership and expertise to the programme.
Estates Lead	Responsible for the delivery of the infrastructure sub-programme and related projects relating to the re-provisioning of VCC, Satellites and Outreach facilities.
Sustainability hero	Responsible for providing advice and challenge to ensure the infrastructure supports the delivery of the Trusts aim to achieve carbon neutral.
Finance Lead	Responsible for all financial aspects of the TCS Programme. This includes the strategic financial planning for the Programme, financial reporting, and financial risk management.
Workforce Lead	Responsible for ensuring consideration is given to all issues relating to and impacting on the workforce and appropriate processes are considered.

Design Champion	Responsible for developing a design vision for infrastructure elements of the programme in accordance with Welsh Government guidance.
WHSSC	To provide challenge to the programme costs and commissioner affordability issues related to one-off/recurrent revenue funding requirements for the infrastructure and/or other changes e.g. staffing

A formal Programme structure will be established.



6.2. Timelines

It is anticipated that the PBC will be consider by VUNHST Board in May before formally being submitted to Welsh Government for consideration at there Investment Board in July.

It is anticipated that the Business Justification Case (BJC) for mechanical and electrical infrastructure will be completed Autumn 2020 and formally submitted to Welsh Government for consideration in Winter 2020.

Attachment 5. provides indicative timelines for the overall WBS Infrastructure Programme.

6.3. Use of specialist advisers

Specialist advisers will be appointed to advise on specific components of work as appropriate to the overall business case.

It is also recognised that specialist knowledge of the blood and transfusion services will be required. This is will include operational and scientific managers from within the service. Expertise may be sought from other blood and transfusion services outside of Wales.

6.4. Change and contract management arrangements

This will be managed through the programme management structure and in line with VUNHST existing contract management arrangements.

6.5. Risk management arrangements

A standard programme management approach will be taken to the management of risk.

Risk management arrangements will also comply with VUNHST policy.

A risk register and associated documents will be developed and updated for the life of the programme with the focus being on mitigating actions and the controls to be adopted to manage/treat risks.

Attachment 1a. Long List of Options

		Non WHTM	Limited WHTM	Full WHTM	No carbon	Selected Carbon	Full Carbon	
Option 1	Business as usual	X			X			
Option2	Electric and mechanic 'Like for like' replacements	X			X			
Option 3	Limited WHTM compliance		X		X			
Option 4	Limited WHTM compliance selected carbon		X			X		
Option 5	Limted WHTM compliance full carbon		X				X	
Option 6	Full WHTM compliance			X	X			
Option 7	full WHTM compliance selected carbon			X		X		
Option 8	Full WHTM compliance full carbon			X			X	
Option 9	Limited WHTM compliance, no carbon, lab modernisation		X		X			X
Option 10	Limited WHTM compliance selected carbon, lab modernisation		X			X		X
Option 11	Limted WHTM compliance full carbon, lab modernisation		X				X	X
Option 12	full WHTM compliance no carbon, lab modernisation			X	X			X
Option 13	full WHTM compliance selected carbon, lab modernisation			X		X		X
Option 14	Full WHTM compliance full carbon, lab modernisation			X			X	X

Attachment 1b.

0	does not meet
1	meets in part
2	fully meets

		INVESTMENT OBJECTIVES					
		PSO 1	**PSO 2**	**PSO 3**	**PSO 4**	**PSO 5**	**Total**
Option 1	Business as usual	0	0	0	0	0	**0**
Option2	Electric and mechanic 'Like for like' replacements	0	0	0	0	0	**0**
Option 3	Limited WHTM compliance	1	1	0	0	0	**2**
Option 4	Limited WHTM compliance selected carbon	1	1	0	1	0	**3**
Option 5	Limted WHTM compliance full carbon	1	1	0	2	0	**4**
Option 6	Full WHTM compliance	2	2	0	0	0	**4**
Option 7	full WHTM compliance selected carbon	2	2	0	1	0	**5**
Option 8	Full WHTM compliance full carbon	2	2	0	2	0	**6**
Option 9	Limited WHTM compliance, no carbon, lab modernisation	1	1	2	0	2	**6**
Option 10	Limited WHTM compliance selected carbon, lab modernisation	1	1	2	1	2	**7**
Option 11	Limted WHTM compliance full carbon, lab modernisation	1	1	2	2	2	**8**
Option 12	full WHTM compliance no carbon, lab modernisation	2	2	2	0	2	**8**
Option 13	full WHTM compliance selected carbon, lab modernisation	2	2	2	1	2	**9**
Option 14	Full WHTM compliance full carbon, lab modernisation	2	2	2	2	2	**10**

Attachment 2.Assessment of Short List of Options against Critical Success Factors (CSFs) and Project Spending Objectives (PSOs)

	Option 1	Option 2	Option 11	Option 12	Option 13	Option 14.
CSF1: Strategic fit	0	0	1	1	2	2
CSF2: Service sustainability	0	1	1	2	2	2
CSF3: Value for money	0	1	1	2	2	1
CSF5: Achievability	2	2	2	2	2	2
CSF6 Acceptability	**0**	**1**	**1**	**1**	**2**	**1**
POS 1: Regulation compliance	0	0	1	2	2	2
POS 2: Resilience	0	0	1	2	2	2
PSO 3: R&D	0	0	2	2	2	2
POS 4: Low Carbon	0	0	2	0	1	2
PSO 5: Lab Modernisation	0	0	2	2	2	2
Total	**2**	**5**	**14**	**16**	**19**	**18**

KEY	
0	does not meet
1	meets in part
2	fully meets

Attachment 3.

Summary of the available renewables and an assessment of their suitability

Technology	Suitable	Requires further investigation	Unsuitable	Summary
Solar thermal				Solar Thermal panels are a suitable technology for the site; however, the low hot water demand would mean that payback time could be considerable. Therefore, further consideration needs to be given to the DHW loads of the building.
Photovoltaic				Solar PV panels are considered suitable for the site providing there is suitable roof space for the panels.
Hydro				This technology has deemed to be not suitable based on the location of the site.
Wind				This technology has deemed to be not suitable based on the location of the site.
Biomass				A Biomass boiler may be suitable for the site, but, further consideration would need to be given to the storage of the fuel.
Combined Heat & Power				CHP systems are potentially suitable for the site; however, further consideration would be required into the heating and electric loads of the building.
Air Source Heat Pump				An Air source Heat Pump would be suitable for the site and could provide costs savings for heating and cooling.
Ground & Water Source Heat Pump				A Ground source Heat Pump would be suitable for the site and could provide costs savings for heating and cooling.
Upgrade Walls				Poor payback times and long payback times mean this would likely be unviable
Upgrade Roof				Poor payback times and long payback times mean this would likely be unviable
Upgrade Windows				Poor payback times and long payback times mean this would likely be unviable

Technology	Suitable	Requires further investigation	Unsuitable	Summary
Air tightness improvement				Carrying out an air test would be relatively cheap, although achieving an air tightness low enough to have any energy or CO_2 savings would be difficult in a building of this age.
Cooling				Large savings in energy usage and CO_2 make this a viable option. Further consideration would need to be given to costs.
Ventilation				Large savings in energy usage and CO_2 make this a viable option. Further consideration would need to be given to costs.
Lighting				Large savings in energy usage and CO_2 make this a viable option. Further consideration would need to be given to costs.

Attachment 4.

Summary of the likely energy and carbon savings

Option	Energy Reduction (kWh)	Energy Reduction (%)	CO2 reduction (Kg)	CO2 reduction (%)	Cost Savings (per year) *
Upgrade Walls	13,084.47	1.19	1,869.21	0.17	£497.00
Upgrade Roof	13,582.93	1.24	5,607.63	1.32	£516.00
Upgrade Windows	30,094.29	2.75	6,853.77	1.61	£1,143.00
Air tightness improvement	57,633.98	5.26	7,476.84	1.76	£2,190.00
Cooling	69,347.70	6.33	35,514.99	8.36	£4,800.00
Ventilation	195,581.67	17.86	41,122.62	9.67	£5,460.00
Lighting	285,615.29	26.08	176,328.81	41.50	£39,986.10
PV – Based on 400m²	35,000.00	3.20	14,350.00	3.37	£36,44.20
Air Source Heat Pump	338,393.47	30.90	36,781.9	8.66	£9,475.00
Ground Source Heat Pump	375,175.37	34.26	51,862.47	12.20	£21,892.58**

Attachment 5. Indicative Timelines

	2020/21				2021/22				2022/23				2023/24			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
PBC VUNHST internal approval pproces																
Consultants appointed to develop BJC																
PBC Welsh Government Submissions																
PBC Welsh Government Investment Board																
BJC phase 1 and phase 2 complete																
BJC Internal Approval Process																
BJC Welsh Government Approval Process																
Design team appointed																
contractors appointed																
work commences phase 1																
work commences phase 2																
Phase 3 BJC developed																
Phase 3 BJC submitted for internal approval																
Phase 3 BJC Welsh Government approval process																
Design team appointed																
contractors appointed																
work commences phase 1																

TRUST BOARD

programme business case for welsh blood service infrastructure

DATE OF MEETING	04/06/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
WBS SMT Capital Planning Group	0/05/2020 18/05/2020	ENDORSED FOR APPROVAL
Executive Management Board	11/05/220	APROVED

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 The Programme Business Case (PBC) sets out a programme of strategic developments in relation to improvements in the infrastructure at Welsh Blood Service (WBS). These improvements will support the provision of high quality, safe, sustainable, efficient services and help to meet Good Practice (GP).

1.2 The programme sets out the investment, help and support required to provide the technical infrastructure, systems and expertise to deliver a sustainable and future-proofed service and to enable our strategic objectives to be delivered, which are:

- Maintaining excellence in core service delivery and planning our future
- Developing an increasing prudent and sustainable supply chain
- Meet the needs of an evolving transplant service
- Digitally enabled to deliver in the modern world
- Implementing effective clinical systems to support improved outcomes
- Be known for our strength in research, development and innovation
- Clinical engagement and demand planning
- Be active in the establishment of Advanced Therapeutic Medicines (AMTPs) in the NHS

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The WBS facility at Talbot Green plays a vital contribution in supporting the collection, supply and manufacturing of blood products across Wales. Furthermore, the Trust Board has confirmed that this facility will continue to be the primary strategic location over the medium to long term.

2.2 Therefore, the continued provision of blood and other services from WBS site in Llantrisant requires investment in the electrical and mechanical infrastructure and the modernisation of the laboratories in order to meet the strategic objectives.

2.3 The main building of the WBS in Llantristant is over 20 years old and there are problems and issues with the electrical and mechanical infrastructure.

2.4 The existing mechanical and electrical infrastructure does not comply with Welsh Health Technical Memorandum (WHTM) and Welsh Health Building Notes (WHBN) design guidance, which raises concerns around the security of the

infrastructure and the ability to withstand utility outages. This is primarily due to single points of failure in the current system.

2.5 The lack of duplex systems means that the maintenance and replacement of plant and equipment results in a disruption in power supplies and, in turn, disruption to the delivery of services.

2.6 The issues are summarised below:

- The building which has exceeded its nominated electrical supply capacity and is close to the 500KVa output of the transformer – this limits the future development of the site.
- Existing electrical switchboards have been added to on an ad hoc basis – there is no further room for expansion and some of the internal wiring is in a poor condition.
- The existing electrical infrastructure does not allow for maintenance without shutting down services.
- The heating and cooling systems have been expanded with a plethora of split units installed to provide local heating and cooling. This has resulted in poor control with heating and cooling systems working against each other.
- The central ventilation plant which is the original unit installed when the building was new. It is no longer fit for purpose and life expired.
- The Building Management System is obsolete and needs to be replaced. This system is key to future infrastructure projects.

2.6 Undertaking the programme of work in respect of electrical and mechanical issues is therefore considered business critical.

2.7 In addition, the Trust is seeking to take every opportunity to move towards sustainable services and comply with the Well-Being and Future Generations Act (2015). This programme offers the opportunity to provide a high level of sustainable development for a modest additional investment which would provide a 70% carbon neutral facility.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The programme of work is essential in achieving and maintain a safe environment.
RELATED HEALTHCARE STANDARD	Safe Care
	The provision of WBS services is critical to the safe and effective care across Wales and aligns with a significant number of the healthcare standards.
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	Not yet – this will be undertaken if approval is secured to commence initial design works on the scheme
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The WBS is required to comply with a range of legal and statutory duties and the MHRA regulatory framework to continue operations. The delivery of the programme would support compliance.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust is seeking to accelerate the process by commencing BJCs in parallel with the scrutiny of the PBC by the Welsh Government – if approved the costs would be reimbursed to the Trust.

4. RECOMMENDATION

4.1 The Executive Management Board is asked to approve:

i. the Programme Business Case.

ii. the submission of the Programme Business Case to the Welsh Government.

TRUST BOARD

QUARTER ONE OPERATIONAL PLAN FOR VUNHST

DATE OF MEETING	04.06.2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Corporate Planning
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning and Digital
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	19.05.2020	Approved

ACRONYMS	
Q	Quarter
TCS	Transforming Cancer Services
nVCC	New Velindre Cancer Centre
R	Reproduction Rate
WBS	Welsh Blood Service
VUNHST	Velindre university NHS Trust
WTAIL	Welsh Transplantation and Immunogenetics laboratory
WBMDR	Welsh Bone Marrow Donor Registry
WHC	Welsh Health Council
NEQAS	National External Quality Assessment Service

WASPs	Welsh Assessment of Serological Proficiency scheme
IMTP	Integrated Medium Term Plan
RCI	Red Cell Immunohematology
SOP	Standard Operating Procedures
PPE	Personal Protective Equipment
LHB	Local Health Boards
UHW	University Hospital of Wales
EMRTS	Emergency Retrieval Services
SLA	Service Level Agreement
NAT	Nucleic Acid Testing
C&VUHB	Cardiff and Vale University Health Board
PHW	Public Health Wales
VCC	Velindre Cancer Centre
RT	Radiotherapy
Linac	Linear Accelerator
DoF	Director of Finance
SpRs	Specialist Registrars
HSST	Higher Specialist Scientist Training
KESS	Knowledge Exchange Skills Scholarship
WHSCC	Welsh Health Specialised Services Committee

1. SITUATION/BACKGROUND

This paper is written at a time when the whole country is living through a very worrying period, as we all deal with the COVID-19 challenges of lockdown, social distancing, missing close friends and family and tragically for too many, the sadness of bereavement. Our staff have responded magnificently, demonstrating huge commitment and professionalism to ensure essential services are maintained for our patients during this health emergency. This paper describes the context in which our Operational Plan is delivering cancer treatment and blood services in Q1 and the underpinning assumptions we have made, followed by detailed Q1 plans for the Welsh Blood Service, Tertiary Cancer Services and Corporate Departments.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Operational Plan for Q1 2020/21 sets out the Trust's plans for the period to 30th June, in the context of the COVID-19 pandemic, including how we propose to manage our capacity in response to surges in demand, a progressive return to routine service provision and how we have embraced new ways of working with the support of our staff and patients and donors. The Q1 Operational Plan sets out how we will maintain supplies of blood and blood products to the whole of NHS Wales; deliver essential tertiary cancer services to the South East Wales population and the enabling activities that will be undertaken by Corporate Departments. This plan will provide the baseline upon which we will build plans for Q2, Q3 and Q4. Feedback is awaited from Welsh Government and will be appended to the Board papers when received.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board are asked to approve the VUNHST Q1 operating plan.

Velindre University NHS Trust

Operational Plan for Quarter 1 2020/21

(1st April to 30th June 2020)

Table of Contents

Document control sheet:

Date	Versions	Author	Description of Changes	Document Status
07.05.2020	1-10	Daniel Phillips	First Draft	Draft
08.05.2020	11-20	Daniel Phillips	Addition of content for WBS and VCC	Draft
08.05.2020	21	Peter Gorin	Addition of content for Corporate services	Draft
11.05.2020	22	Peter Gorin	Addition of graphics and tables, addition of detail for WBS plans	Draft
11.05.2020	23	Peter Gorin	Addition of Appendices, addition of actions to contents of paper	Draft
11.05.2020	24	Peter Gorin	Contents and Headings, additional information from finance	Draft
12.05.2020	25	Peter Gorin	Numbering and formatting	Draft
14.05.2020	26	Daniel Phillips	Amendments to paper, addition of information, formatting	Draft
18.05.2020	27	Peter Gorin	Submitted to EMB & approved on 19th May	Final
18.05.2020	28	Peter Gorin	Final Version submitted to WG	Final
20.05.2020	29	Katie Foward	Formatting prior to Trust Board	Final
22.05.2020	30	Katie Foward	Formatting prior to Trust Board and removal of logos	Final
26.05.2020	31	Peter Gorin	Final editing	Final

1. Purpose

The purpose of this Operational Plan for Q1 2020/21 is to set out the Trust's plans for the period to 30th June, in the context of the COVID-19 pandemic, including how we propose to manage our capacity in response to surges in demand, a progressive return to routine service provision and how we have embraced new ways of working with the support of our staff and patients and donors.

The Q1 Operational Plan sets out how we will maintain supplies of blood and blood products to the whole NHS Wales; deliver essential tertiary cancer services to South East Wales and the enabling activities that will be undertaken by Corporate Departments. This plan will provide the baseline upon which we will build plans for Q2, Q3 and Q4.

2. Summary

We are writing this paper at a time when the whole country is living through a very worrying period, as we all deal with the COVID-19 challenges of lockdown, social distancing, missing close friends and family and tragically for too many, the sadness of bereavement. Our staff have responded magnificently, demonstrating huge commitment and professionalism to ensure essential services are maintained for our patients during this health emergency.

This paper describes the context in which our Operational Plan is delivering cancer treatment and blood services in Q1 and the underpinning assumptions we have made, followed by detailed Q1 plans for the Welsh Blood Service, Tertiary Cancer Services and Corporate Departments.

The Q1 Operational Plan sets out how we propose to manage the following key COVID-19 challenges:

- Employing news ways of working
- Managing patients with COVID-19 and supporting Health Boards
- Maintaining 'Essential' services and working with partners
- Progressive reintroduction of 'Routine' services
- Supporting our staff and communicating with our patients and donors
- Financial impacts and risks

The Trust Board was updated on key aspects on the plan and the progress made at a special briefing meeting on 15th May prior to submission to Welsh Government. It will be submitted to the Trust Board meeting on Thursday 4th June 2020 for approval. In developing our Operational Plan, the following key principles have been applied:

Purpose

- Maintaining capacity for essential cancer and blood services and increasing routine services
- Understanding the demand for cancer and blood services as more patients present for essential services and Health Boards and Trusts increase their routine diagnostics and surgical services
- Ensure that both cancer services and blood donor services minimise the transmission of COVID-19 within the services

Planning and organisation of clinical activity

Principles

- Services will maximise opportunities for creating physical and / or visible separation between clinical and non-clinical areas used by patients on a Planned attendances and those Urgent or unplanned attendances.
- Staff allocation will be revised to consistently reduce movement of staff and the cross-over of care pathways where feasible between Planned and unplanned attendances.
- Ensure planned activity aligns with other dependencies, including testing capacity, medicines supply, consumables and PPE.
- **Clinically extremely vulnerable (shielded) patients** will be identified from their care record and receive enhanced planning and protection
- **Urgent and unplanned patients** attendance will be immediately identified as either i) asymptomatic; ii) symptomatic for COVID-19; iii) COVID-19 positive and apply appropriate Infection Prevention and Control procedures.
- **Patients subsequently tests positive or shows symptoms** will be immediately isolated or managed in a COVID-19 positive cohorted area.

Infection Prevention and Control

- Follow the NHS Wales IPC to ensure that recommended IPC measures are being reliably implemented within & across the organisation.
- Use the appropriate level of Personal Protective Equipment (PPE), in line with the latest guidance from Public Health Wales.
- Minimise potential COVID-19 Health Care Worker (HCW) transmission (including HCW to HCW) through supporting staff with:
    - Good hand and respiratory hygiene
    - Declaring all COVID-19-like symptoms
    - Wherever possible, reducing movement between different areas.
    - Social distancing (2 metres) inside & outside of clinical areas.
    - Understanding and reducing the risk of surface contact transmission

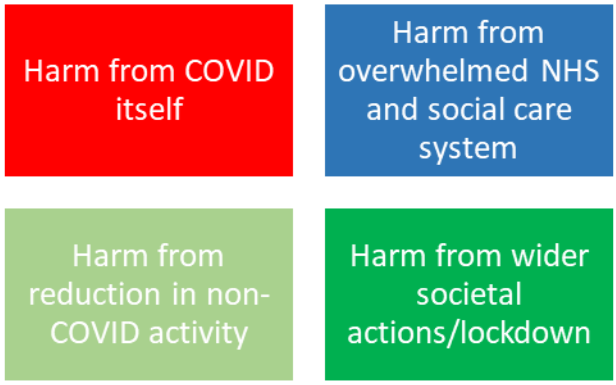
Testing staff and patients

- **Patients**:
    - Unplanned admissions: All patients will be tested on admission.
    - Planned admissions: Patients will be required to isolate before admission and then tested before admission, allowing patients who test negative to be treated appropriately
    - Staff
- **Staff**:
    - Symptomatic: staff or members of their household who are symptomatic will be tested
    - Asymptomatic: a testing stagey for asymptomatic staff will be developed which will be implemented as increased testing capacity becomes available
- **Serology**
    - As access to antibody testing is made available, serology testing will be made available to staff and patients in line with NHS wales guidance

3. Context

NHS Wales has responded well to the first peak of the COVID-19 pandemic. Velindre University NHS Trust has developed this plan in a scenario following the initial peak, we are expecting a longer period where there remains significant numbers of COVID-19 patients and we need to provide essential services to patients requiring cancer treatment and Health Boards will continue to require secure supplies of blood and blood products and support for transplant services. Therefore, our operational planning needs to recognise that we will be responding to COVID-19 demands for some months to come, particularly as we monitor the impact of moving out of lockdown arrangements and 'routine' services recommence.

Welsh Government guidance on the new operating framework stressed the need to develop a balanced approach to managing four key types of harm which are of particular relevance to cancer services:



In response, Velindre University NHS Trust Gold Command has commissioned 7 key 'cells' that cut across all parts and levels of the organisation in response to the COVID-19 pandemic. The Purpose of the cell is to ensure that there is a single, timely, proportionate, co-ordinated and authoritative overview and management of cross cutting and critical elements of the pandemic response to assure service delivery, patient and staff safety.

Each cell reports to Trust Gold Command that approves the remit, outputs, proposed time period, and membership and reporting arrangements for each cell. Each cell formally reports into Gold at least weekly, and the outputs are scrutinised to ensure delivery is being achieved and direction is still congruent with the developing situation.

Each cell is led by an Executive Director and an operational lead, with designated administrative support and have designated members from across all relevant areas of the organisation and seek specialist advice and support from external agencies as required.

- Personal & Protective Equipment Supplies
- Quality & Safety for Staff and Patients
- New Capacity and Demand Modelling
- Information & Performance Dashboards
- End of Life, Visiting & Bereavement Support
- Workforce Capacity and Wellbeing Support
- Digital Staff and Patient Connectivity

However, we recognise how important it is to retain the ability to respond effectively and with maximum agility to a potential increase in COVID-19 patients and to ensure that any future peaks do not overwhelm our tertiary cancer or blood service.

We also need to assure ourselves going forward that patients continue to access our 'essential' services appropriately during any future peaks whilst also working towards the ultimate aim of restoring routine activities over time.

Clearly, the current COVID-19 health emergency is having a significant impact on the ability of the Trust to progress many of the Q1 objectives identified in our Integrated Medium Term Plan 2020/21 to 2022/23. However, this position will be reviewed and plans developed for Q2, Q3 and Q4 to ensure our Transforming Cancer Services (TCS) agenda and new Velindre Cancer Centre (nVCC) build continue to move forward.

4. Assumptions

The Operational Plan delivery for Quarter 1 (Q1) and progress against 2020/21 IMTP objectives has been prepared using the following Trust-wide assumptions:

Corona incidence and R value

- The R value will remain below 1 and COVID-19 infections will remain broadly at current levels
- Until revised COVID-19 modelling is available, we will continue to assume that the Reasonable Worse Case scenario is that described n V2.4 of modelling and that the most likely is that described in v2.5 Poor Compliance
- We will continue to refine our COVID-19 related contingency planning in line with advice from Public Health Wales, Welsh Government and the Technical Advisory Cell

Demand for NHS services – will continue at broadly current levels for over Q1 with some small increase in last weeks but not to normal levels

Health Board's services – will maintain their focus on essential services and the reintroduction of routine services will be very limited

Capacity – priority will be given to "Essential Services" but physical and workforce capacity will continue to be reduced by wider COVID-19 guidance e.g. cleaning and patient/donor separation.

- Plans will be developed to address current capacity constraints in "essential services" with the aim of ensuring capacity is available at historic levels. There will be no change to venue availability for donor blood collection clinics during Q1

Social distancing policies – staff and patients/donors will comply with recently issued social distancing guidance, with workforce capacity continuing to be affected

PPE equipment Stocks to meet latest guidance will continue to be available

Testing

- **Patient testing**: Further guidance will be made available on patient self-isolation and testing protocols for planned patient attendances

- **Staff Testing**:
    - a testing strategy for asymptomatic staff will be developed which will be implemented as increased testing capacity becomes available
    - As access to antibody testing is made available, serology testing will be made available to staff and patients in line with NHS wales guidance

Workforce – the following will continue to apply:

- Staff shielding due to being defined as extremely vulnerable will continue through Q1
- Staff sickness will not rise above current levels
- Staff self-isolation will not rise above current levels
- Social distancing guidance will be applied to working areas
- Staff working for home will decrease, but many will need to continue to work from home
- Schools & Pre-schools will remain closed for Q1 and staff will continue to be impacted
- Staff will continue/be encouraged to take annual leave wherever it can be accommodated

Updated guidance will be issued for the Operational Plan for Q2 – a draft operational plan for Q2 is likely to be needed before the end of June 2020

Individual Operational Plan areas may have applied further assumptions relevant to their own service and are described in the following **Section 5.**

5. Operational Plan by Service Areas

5.1 Welsh Blood Service

The Welsh Blood service (WBS) is a division of Velindre University NHS Trust (VUNHST). WBS covers the whole of Wales and collects voluntary, non-remunerated blood donations from the general public.

These donations are processed and tested before distribution to hospitals where they support patient care. WBS also holds blood-derived products (both NHS and Commercial for purchase by our customer hospitals).

WBS provides an antenatal screening service to several hospitals and offer all customer hospitals specialist laboratory services to assist in the investigation of complex serological problems.

The Welsh Transplantation and Immunogenetics laboratory (WTAIL), within WBS provides direct support to local providers of renal and stem cell transplant services. It also operates a national panel of unrelated potential blood stem cell donors – the Welsh Bone Marrow Donor Registry (WBMDR)

Medical consultant support is provided to Hospital Blood Transfusion Committees which includes support in achieving the objectives of WHC (2002)137 Better Blood Transfusion. Clinical advice is provided to customer hospitals as required.

WBS also contribute to the maintenance of quality standards in the transfusion and transplantation community by hosting the UK NEQAS external quality assessment scheme for histocompatibility and immunogenetics and the Welsh Assessment of Serological Proficiency scheme (WASPs).

5.1.1 Summary of Current Situation as at week commencing 11 May 2020

WBS is designated a critical service and therefore has continued to function during COVID-19 pandemic, albeit with a reduction in service in a number of areas. Section 1.4.2 provides an overview of the new ways of working which have been introduced during this period. Section 1.4.5 provides an overview of the current status of these services. Whilst services such as solid organ transplant, NEQAS, RCI activity, wholesale licensing have continued with limited changes to the service model, this has not been the case for all areas. WBMDR has continued but with the introduction of cryopreservation of stem cells to address the disruption to international flights and border control. Blood collection has continued but with a new clinic model comprising a moved to a significantly reduced number of clinics at fixed venues. Although it should be noted that due to the reduction in demand from hospitals it has still been possible to meet their requirements.

Impact on IMTP

WBS has eight strategic priorities within its IMTP. As it remains unclear how long the restrictions from the pandemic will remain in place, it is difficult to provide any level of assurance in relation to delivery of the 20/21 Component of WBS IMTP.

However, attachment 1 outlines the expectations of delivery of each component of the eight strategic priorities within the current year. This is taken at Q1.

5.1.2 New ways of working

Staff have created and embraced new ways of working rapidly to respond to the COVID-19 challenge, in particular to comply with social distancing and essential travel guidance. A number of these new ways of working offer benefits in terms of safety and quality to both staff and donors. In addition, service models have adapted and developed in order to ensure that WBS as a demand-led service is able to continue to meet need and that of staff, patients and donors in terms of quality and safety.

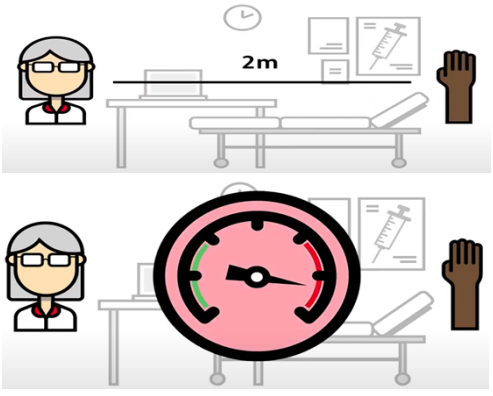
At the outset of the pandemic, the blood collections system in Wales came under considerable pressure:

- Venues started cancelling our bookings
- Staffing levels dropped through COVID-19 related absence
- Donor attendance levels started to fall.

April 2019: 117 Sessions held at around **104 venues**

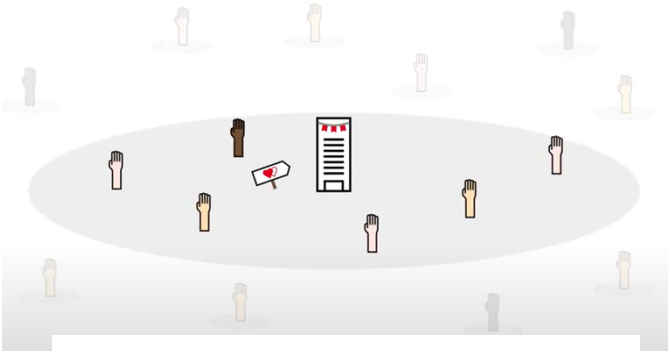
The Service responded by condensing its collections programme to run on consecutive days from a smaller number of venues each week.

April 2020: 95 Sessions held at around **31 venues**



Visiting fewer venues gave us greater control over the clinical environment, ensuring venues could be appropriately sanitised and social distancing could be maintained throughout. It would also enable us to consolidate the workforce into fewer teams to reduce pressure caused by COVID-19 related staff absence

Where under normal circumstances donors would be invited to their preferred donation centre, the new model would require donors to be invited to their nearest regional donation hub - unlikely to be their usual venue of preference



Invitations sent to donors within a 15 mile radius of each donation hub

Communication with donors was maintained through telephone support, SMS messaging, the WBS website and on social media. Key messaging was cascaded as required, intended to reassure, to educate and to celebrate those who rolled up their sleeves to support the WBS.

Table 1. New Ways of working introduced in WBS			
Programme of work	Objective	Length of service change	Plan for evaluation
Implementation of partial Ambient Overnight Hold (AONH) brought forward	To increase the availability of blood products by enabling blood collected in North Wales to be kept at an ambient temperature whilst being transported to South Wales for processing.	Permanent	To be evaluated as part of wider AONH project.
Increased digital collaboration tools (via O365) e.g. MS Teams, rapid deployment of additional VC functionality (MS surface hubs)	To facilitate remote working across WBS necessary to support implementation social distancing requirements including wider home working and working across sites	Permanent	To be evaluated as part of wider O365 Programme
Large scale transition of staff to work from home, through rapid implementation of technology e.g. laptops	To facilitate social distancing and support individuals restricted to home working. Will support fast-track transition to more utilisation of mobile IT equipment, fewer desktops etc.	Permanent	Ongoing monitoring
Established Convalescent Plasma project and delivered initial phase (whole blood, males only)	To collect convalescent plasma from patients that have recovered from COVID-19 for use by Health Boards to treat patients that are suffering from COVID-19 infection in order to support the national clinical trials programme.	Temporary	To be evaluated as part of ongoing Convalescent Plasma Programme.
Revised Collection clinic model	• To enable WBS to continue to meet Health Board demand for blood and blood products. • To mitigate removal of mobile donation clinics from the whole blood collection programme • To mitigate the reduction in the availability whole blood collection clinics	Temporary	Monitored on a daily/weekly basis through WBS Resilience planning group to ensure supply is able to meet demand.

	provided by the independent sector. • To mitigate to impact of a reduced workforce due to 12 shielding. • To adhere to social distancing at collection clinics. • To adhere to PPE guidance The model includes fixed clinic model from fewer number of venues.		
Introduction of donor triage	To ensure donors not have any symptoms relating to COVID-19 prior to entering into the donation clinic environment	Temporary	Ongoing monitoring of impact via WBS Resilience planning group.
Workforce re-alignment	To support critical business service delivery, non-business critical programmes of work have been paused and the workforce have been re-aligned to support the critical elements	Temporary	Ongoing review via WBS Bronze meetings
Introduction of COVID-19 testing of Stem Cell Donors at medical assessment and actual donation	To ensure donor fit to donate and prevent transmission of COVID-19 to patient from stem cell product	Temporary	Continued review of NICE guidelines and international requirements
Updated consent process for routine cryopreservation of stem cell products for national and international patients	As products have a limited shelf life of 72 hours this enables short term storage to ensure that donor does not develop COVID-19 after donation which may infect the intended recipient	Temporary	Continued review of data on prevalence and transmission of COVID-19 through stem cell transplantation
Update of HTA licence to enable import of cryopreserved stem cells I	As products have a limited shelf life of 72 hours this enables short term storage to ensure that donor does not develop COVID-19 after donation which may infect the intended recipient	Permanent	Not applicable

Development of a third party agreement to enable cryopreservation of cells for export	Due to availability of flights and potential for delays at international borders as a result of COVID-19 some transplant centres are requesting cryopreservation of stem cells at collection centre	Permanent	Not applicable
Nucleic acid testing (NAT) for mandatory microbiology markers of blood donors outsourced to NHSBT	To enable WBS equipment to be used by Public Health England for COVID-19 testing	Temporary	Not applicable
Implementation of social distancing measures across WBS sites and at clinics	To maintain safety of the workforce at WBS through facilitating and promoting home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers on clinic transport maximum number of chairs within collection clinics etc.	Temporary	Ongoing review via WBS Bronze meetings and engagement with staff and Trade Unions through the WBS Partnership forum.

5.1.3 Managing COVID-19

5.1.3.1. Managing patients with COVID-19

WBS does not directly manage patients, but provides blood and blood products to hospitals to support the management of patients. WBS does however, provide a serological service for Health Boards across Wales, where COVID-19 patients present at hospital. These samples are treated as high risk and are managed in accordance with existing Standard Operating procedures (SOPs) for high risk testing.

Whilst the laboratories are already working in line with Good Practice Guidance, the risk assessment recommends that where it is difficult to adhere to social distancing guidance due to the nature of the work, consideration should be given to the use of PPE and implementation of Perspex screens where appropriate.

	Action	Lead	Timeframe
Q1.	Recommendations from the Risk assessment will be implemented, including where appropriate Perspex screens and PPE	Head of Labs	June 2020

5.1.3.2 Supporting Health Boards to manage COVID-19

WBS does not have a direct role to play in supporting Health Boards to manage COVID-19.

However, Blood Health Team have worked in collaboration with hospitals in relation to the management of bloodstocks, (aided by real time data) during this period. Laboratory staff with expertise in testing have been redeployed to PHW to support COVID-19 testing activity.

In addition, as a response to the current COVID-19 pandemic it has been identified that plasma taken from patients that have recovered from COVID-19 may help to treat patients that are still suffering from COVID-19 infection. During quarter 1, WBS has commenced a collaboration with PHW, WG and UHW for the provision of convalescent plasma for use in clinical trials.

WBS is manufacturing convalescent plasma from whole blood donations from individuals previously diagnosed with COVID-19, for use by Health Boards to treat patients suffering from COVID-19 infections as part of a trial.

WBS is exploring the scope of the convalescent plasma programme to enable a wider demographic of individuals to donate to the programme.

	Action	Lead	Timeframe
Q1	Establish internal Programme Board to progress implementation of Convalescent Plasma	Head of QA	May 2020
Q1.	Continue to support Health Boards to manage COVID-19 patients through collecting convalescent plasma for their use. NB: none has been transfused to date	BSC lead, Collections	Ongoing
Q1	Scope and develop the programme of work to support roll out of the convalescent plasma programme	Head of QA	May 2020
Q1	Submission of Business Case to Welsh Government to support expansion of convalescent plasma Programme	Head of QA	May 2020

5.1.4. Surge capacity availability and activation plans

5.1.4.1. Surge capacity

Health boards have created a significant amount of additional surge capacity in preparation for the anticipated peak in COVID-19 demand. Fortunately the measures that have been put in place to minimise the peak have meant that we have not needed to utilise the surge capacity to date. It is recognised that some parts of surge capacity within hospital (and independent hospitals) may be utilised to deliver essential and routine services. Health Boards need to ensure WBS is engaged in any plans to utilise surge capacity for surgical activity which may have been paused during the initial COVID-19 peak, in order to ensure enough time is available to collect additional blood and blood products required to support this activity.

For blood and blood components, WBS experienced a circa 20% reduction in demand as LHB service delivery has diminished in a range of clinical areas. A surge in demand for treatment of COVID-19 patients is not anticipated and WBS continue to engage with LHBs via blood bank managers.

5.1.4.2. Field Hospitals

The majority of NHS Wales “field hospital” capacity in non-NHS settings has been based on a provisional timescale of the first quarter. We will need to determine future plans by the end of Q1 including consideration of more regional solutions.

The introduction of ‘field hospitals’ has had no impact on WBS. WBS continues to provide health boards with blood required to meet demand for its services. It is noted that only the ‘Dragon’s Heart’ Hospital, run by Cardiff & Vale UHB has a blood bank fridge.

There has been no support required for blood beyond normal levels provided to the host Health Board at this stage.

	Action	Lead	Timeframe
Q1.	WBS will continue to work with Health Boards to ensure clear understanding of plans regarding utilisation of 'field hospitals and impact on blood and blood products'	Head of Labs	May 2020

5.1.4.3. WBS Activation Plans

The tables below outlines the activity at collection clinics pre-COVID-19 and following the implementation of COVID-19 model.

Pre-COVID-19 summary of activity (April 2019)

- The Service currently operates eight teams across Wales and provides resilience by regularly cross-covering for sickness and annual leave.
- Collections take place at multiple venues across wales including supermarkets, workplaces and leisure facilitates

Monthly activity pre-COVID-19

No. venues	105
No. of sessions held	117
No. donors attending	8742
No. viable donations	7711

COVID-19 (April 2020)

WBS has seen a reduction in the demand for red cells (average 20%) and platelets (average 15%) due to changes in business as usual service delivery at its customer hospitals. Therefore it should be noted that based on current activity in Health Boards, WBS is currently able to meet demand for blood and blood products as at Q1.

Key phases to change in service model

- Mid-March 2020 WBS experience an increase in number of clinic venues cancelling.
- End March 2020 the Government imposed 'lock down' which meant existing venues were no longer available as organisations were forced to shut, limited attendance, removal of trailers and social distancing was introduced.
- New clinic plan developed based on reduction in number of clinics and introduction of temporary fixed venues in high population areas.
- Support was given from Welsh Government, numerous Councils, private companies and academic centres, to allow the use of large public buildings throughout Wales. These buildings ranged from schools, leisure centres, schools and theatres etc.
- This model of planning clinics at large venues supported the social distancing and lockdown elements impacting on blood collections and enabled whole blood collection programme plans to been confirmed for April, May, June and July 2020.

- Alternative whole blood collection plans for July have been established and are ready for activation in the event of a loss of the independently owned fixed clinic locations no longer being available to WBS.

Monthly activity April 2020

No. venues	26
No. of sessions held	95
No. donors attending	6582
No. viable donations	5879

Recovery phase

In order for WBS to plan red cell collection that continue to meet demand it is essential for the demand to be understood. The organisation has issued a letter to all Health Boards in Wales asking for intelligence and forecasting on clinical activity over the next 3 months. This information will inform demand modelling to understand variation between clinical demand during lockdown, social distancing and containment.

Consideration also needs to be given to information from the European Blood Alliance indicating that some European countries having seen an increase in demand to 100% of pre-COVID-19 activity. For the WBS this equates to a collection target of 1,750 blood donations per week and issuing estimate of 1,600 red cells per week (the difference is due to processing). However, this is continuing to be closely monitored.

It is anticipated that many donors will return to work and resume normal life in the coming months. This change to donor behaviour, combined with schools returning to the academic year, will cause operational issues for the collections department. The organisation is likely to see the following:

- Changes in appointment uptake
- Higher deferral rates
- Cancellation of fixed site venues/limited suitable venue availability
- Higher DNA rates
- Changes in donor availability
- Potentially higher staff sickness/self-isolation resulting in a need to recruit additional staff

In light of lack of clarity around health board plans to increase surgical and supporting activity and with unknown timescales for the relaxation of isolation measures, the collection clinic planning team have drafted three flexible blood collection plans to support the recovery phase over the next 4 months:

Table 2 Activation Options

ID	Option	Description	Capacity (per week)	Time to implementation
Option 1.	Continuation of 'lock down	Current model of fixed site venues continues	1100 units red cells	No change
Option 2.	Some relaxation of lock down. Social distancing continues to apply	Community venues/WBS excludes trailer, workplace and educational clinics.	1100 unit increasing to 1750	12 weeks
Option 3.	Containment	'Business as usual'	1750 units	20 weeks

Timelines

It should be noted that there is currently a time lag of 20 weeks to return from current status to business as usual, with the above assumptions. This reflects the current time taken to recruit and train workforce. However, work is taking place to explore opportunities to reduce this timeline.

Table 3 Risks

Risk	Cause	Effect	Mitigation
Unable to meet demand for blood and blood products	Lack of workforce available to support increased clinics (reduction in number of collection teams from 8 to 5) Currently 10 members of staff 'shielding' which could be extended past 12 week date Average of one referral for COVID-19 testing per week amongst this staff group and/or household members that results in either a 7 or 14 day self-isolation exclusion or sickness absence	Unable to support health boards in their recovery phase	Increase establishment Temporary increase in contracted hours for staff
Unable to meet demand for blood and blood products	Health Boards implement waiting list initiatives to meet activity backlog	Unable to support health boards to undertake additional activity.	There is a blood shortage plan and alert process in place
Unable to meet demand for blood and blood products	Independent venue capacity, which supports social distancing is unavailable as	Insufficient number of clinics are able to run	Increase in fixed site capacity through: procuring further permanent sites

	organisations start recovery phase		reducing reliability on external organisations extend its collection footprint at Talbot Green HQ by considering demountable units Identify further temporary fixed sites for densely populated areas which would ensure resilience within the delivery plan
Unable to meet demand for blood and blood product due to Health Boards not communicating their planned intentions with WBS	Health Boards have not engaged or shared proposals with WBS	Unable to collect sufficient blood with current clinic capacity to meet demands	The Organisation has written to health boards asking for plans to be shared WBS liaise with teams in health boards

	Action	Lead	Timeframe
Q1.	Develop an agreed workforce plan to support each clinic option	BSC Lead, Collections	June 2020
Q1	Work with health boards to understand plans for recovery	Blood Health Team	May 2020
Q1.	Work with Health Boards to actively progress prudent use of blood and the use of alternatives to prevent demand outstripping supply when routine services are re-introduced.	Blood Health Team/Medical Director	June 2020
Q1	Work with independent sector to understand plans for recovery, impact on availability of fixed capacity and additional clinic capacity	BSC Lead, Collections	Ongoing
Q1	Explore options to reduce minimum time required to recruit and train new workforce for collection clinics.	BSC Lead Collections	June 2020
Q1	Blood Health National Oversight Group has written to Health Boards requesting they implement blood conservation methods to prevent blood shortage when non-essential work reintroduced.	Blood Health Team/Medical Director	May 2020

5.1.5. Maintaining "Essential" services

Essential services should be maintained at all times throughout the pandemic. Organisations must identify any risks to local delivery of essential services and collaborate on regional solutions to deliver the best outcomes for patients and the safest environments for staff.

In line with WHO guidance on high priority categories, and the Essential Services technical document developed by Welsh Government, categories supported by WBS include the following:

- Transplant
  - Welsh Bone Marrow Donor Registry (WBMDR)
  - Renal transplant/ Solid organ transplant
  - NEQAS
- Antenatal
- Blood and blood products
  - Collections
  - Wholesale

5.1.5.1 Essential Services and their Risks

Table 4 Period Q1. April – June 2020		
Area	**Service status**	**Risks**
Transplant		
WBMDR	No change to service provision during COVID-19 Workload for stem cell collection has continued as normal even though transplant operations have been suspended as samples are now being cryopreserved No issues anticipated in terms of collection and support to importation and exportation of stem cells.	Capacity available within Independent sector (in line with SLA) to support stem cell donations may be reduced resulting in the need to WBS staff to support. Disruption to international flights and border control requires constant surveillance and revision for transport and logistics for import and export of haematopoietic stem cells. To some degree this is offset with mitigation measures arranged to use cryopreservation of stem cells at country of origin. Cryopreservation reduces stem cell dose, which has caused inadequate doses for transplant, which has affected the work of WBMDR.
Solid organ transplant	On hold Working with C&VUHB to understand proposals for solid organ transplant restarting	Staff redeployment/sickness may limit ability to provide compatibility services for testing and matching services for haematopoietic stem cells (current) and solid organ transplant services when they restart
NEQAS (National External Quality Assessment Service)	On hold Delayed the start of the new EQA distribution year (due to start in April 2020), to allow a full appraisal of the impacts of COVID-19. Services are now being prepared to recommence in June 2020, with the full EQA schedule planned to be delivered in a reduced timescale (10 months instead of the usual 12).	Staffing levels, participating laboratories, and key suppliers (e.g. couriers, blood units are not available to support the EQA schedule.

Antenatal		
RCI activity	No change to service provision during COVID-19 In the event activity within Hospitals is 'stepped-up', it is not anticipated that there will be any issues. A planned new service for Foetal DNA screening is being reviewed to assess ability to delivery in line with IMTP.	Foetal DNA service impacted by lack of availability of new equipment and staff
Blood and blood products		
Collections	Currently supply is meeting demand.	Hospitals increase activity without the introduction of blood conservation measures/close collaboration with WBS resulting in the inability to meet Hospital demand Staff redeployment/ sickness or limited PPE may reduce blood collection and precipitate inability to meet demand Capacity to undertake collections from donors may be impacted as large venues will be required to maintain social distancing. As buildings re-open, there may be issues with securing appropriate venues required for clinics.
Wholesale license	No change to service provision	Potential for disruption of blood derived medicines (commercial products) across international supply chain. This has been mitigated in part by the service holding increased stock against a range of products.
Reference testing (complex serological testing)	No change to service provision	Any surge/backlog in health board services (surgery and medical) may impact on the ability to support the health boards.

Manufacturing and testing of blood products	Currently managing service requirements Outsourcing NAT testing	Any surge/backlog in health board services may impact on the ability to support the health boards

5.1.5.2. Regional, National and International Collaboration and Solutions

Whilst WBS provides a service for the whole of Wales, it works closely with the blood services at a UK level including the Scottish Transfusion Service (SNBTS), NHSBT in England and Northern Ireland (NIBTS).

Table 5 *Regional Collaboration*

WBS has been working with UHW in relation to solid organ transplant restarting.

WBS via the Blood Health Team are holding weekly liaison meetings with Transfusion Laboratory Managers and Transfusion Practitioners to manage blood supply within Health Boards resulting in a number of prudent blood health practices being implemented including:

Use of short dated stock within hospitals to conserve stock

Implementation of Major haemorrhage changes to conserve O D Negs in three HBs

Implementation of Major Haemorrhage changes to conserve O D Negs with EMRTS

National collaboration

WBS laboratories work in collaboration with other UK blood services for business continuity arrangements In such circumstances the following are in place:

- Under the Memorandum of Understanding (MoU) with NHSBT, it was agreed that should the WBS Stock Holding Unit in North Wales experience a significant staff shortage, WBS will request NHSBT to provide out of hours service including weekend cover for North Wales Hospital requests.
- WBS is working with NHSBT to develop an SLA for the provision of the RCI lab specialised tests for Foetal Maternal Haemorrhage and Quantification in the event of staff capacity drops significantly and we need to prioritise testing.
- WBS are working in collaboration with NHSBT in relation to COVID-19. In order to increase testing capacity in England, the WBS NAT analyser has been relocated from WBS to Porton Down. As a result of this all donor NAT testing is being referred to NHSBT. WBS IT systems were enhanced to allow for the electronic transfer of results from NHSBT (rather than manual data entry), in order to ensure the recording of results was manageable.
- WBS has continued to contribute and implement required Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidance.
- Weekly meeting of aligned registry (which includes WBS).

WBS is working with Welsh Government, C&VUHB, PHW and NHSBT to roll out convalescent plasma, and is working with Welsh Government, NHS Wales and linking closely with UK blood services to scope phase 2 of the Programme of work (Plasmapheresis).

International collaboration

The Welsh Bone Marrow Donor registry is managed through WBS and works with international partners to identify potential donors for stem cells matches and solid organ transplants.

In order for this service to continue during COVID-19 pandemic WBS has been working with C&VUHB to have stem cells cryopreserved before dispatching to international centres. There has also been significant work involved in obtaining Human Tissue Authority (HTA) licenses required to support the transport of stem cells across international boundaries.

WBS continues to contribute to and draw upon guidance and advice from the European Blood Alliance (EBA).

	Action	Lead	Timeframe
Q1.	Work with C&VUHB to understand plans/timelines for UHW to restart solid organ transplant	Head of Labs	Ongoing
Q1	Work with Welsh Government, C&V UHB, PHW and NHSBT to roll out convalescent plasma phase 1	Head of QA	Q2 2020
Q1	Work with Welsh Government, NHS Wales and linking closely with UK blood services to scope phase 2 of the Programme of work (Plasmapheresis).	Head of QA	June 2020
Q1	Continue to participate in weekly briefings with national Organ Donation Teams (ODT) as part of recovery planning.	WTAIL	Ongoing
Q1	Meet with Transfusion Lab Managers/Transfusion appropriate use of blood in HBs	Blood Health Team	Ongoing

5.1.7. Roles and activity plans for independent sector facilities

WBS works closely with the independent sector as part of its clinic model to collect blood from donors. 97% of the venues used by the collection team to take blood from donors are provided by independent sector and include community venues such leisure centres, universities, council buildings etc.

During the COVID-19 pandemic, a number of these venues have been unavailable. The collection model has reduced the number of clinics it is providing and moved to fixed clinic model, with venues primarily in the independent sector. It is assumed this model and these venues will remain in place in quarter 1.

With the exception of and SLA with Spire Hospital in Cardiff, WBS does not provide blood or blood products directly to the independent hospital sector. Demand is met through requests

from the host Health Board, who may have commissioned capacity from the independent sector.

Table 6 WBS Relationship with independent sector.

Service area	Role and activity plans
Independent Clinic venues	It is assumed that for Quarter 1 independent venues secured to provide clinics during COVID-19 will remain available to WBS. Activation plans to support increase in demand for blood and blood products have consider the need to increase the number of clinical venues as we move toward 'business as usual'.
Independent Hospitals	WBS has an SLA in place with Spire Hospital in Cardiff and has seen no change to its current arrangement during COVID-19 pandemic.
	WBS has an SLA with St Joseph's Hospital in Newport to provide capacity to undertake stem cell collection. It is understood that Aneurin Bevan UHB are using St Joseph's Hospital as part of their management plan for COVID-19. As such, the nurses in St Joseph's unable to provide nurses to support stem cell collection and the role is being covered by WBS. To date there has been no impact on stem cell collection in St Josephs for WBS donors. However, clarity is needed as to the intended use of the Hospital by ABUHB as part of its ongoing management of COVID-19 and recovery plan and any potential impact on stem cell collection.
	WBS is working with Nuffield hospital to ensure medicals are undertaken for donors participating in stem cell collection.

	Action	Lead	Timeframe
Q1.	WBS to work with Health Board to understand how independent hospitals fit into recovery plans and if there will be an impact on demand for blood and blood products to Health Boards.	Blood health Team	May 2020
Q2	Ensure recovery plans for collection clinics take into consideration loss of current independent venue capacity as the venues move towards 'business as usual' and workforce due to shielding	BSC Lead Collections	May 2020

5.1.8. Progressive reintroducing of Routine services

It is understood that capacity exists in some parts of the NHS to support the re-introduction of routine services and there is an expectation on all health organisations to adopt a progressive approach towards the aim of restoring normal and routine activities, although it is noted that this is a local operational decision for Health Boards and Trusts in conjunction with relevant partners. There is a recognition that Health Boards need to take into consideration the availability of key supplies including 'medicines and blood products' when considering re-introduction of routine services and any plans to address some of the accumulated surgical backlog.

Section 1.4.5 outlines the plans for WBS to move through recovery stage to 'business as usual'.

	Action	Lead	Timeframe
Q1.	WBS need to understand plans from health boards for re-introducing surgery and addressing any surgical backlog	Blood Health Team	May 2020
Q1	Blood Health National Oversight Group has written to HB's requesting them to implement blood conservation methods to prevent blood shortage when non-essential work reintroduced.	Blood Health Team/Medial director	May 2020

5.1.9. Workforce Well-being

Our workforce are our most important asset and therefore we need to ensure that we provide them with appropriate support, training, equipment. It is important that we listen to our staff and ensure that they feel able to raise any concerns they have. Clear communication remains essential.

In addition to working to implement VUNHST trust-wide initiatives to support the well-being of the workforce, WBS has undertaken the following:

- **PPE training:** In response to COVID-19, PPE has been introduced across collection teams. Training has been led by the Infection Control team. The Unison staff survey has noted the positive response by staff to the training and understanding of how and when to use PPE in WBS – 92% of individuals questioned at WBS said they were clear on what to wear and when.

- **Staff Wellbeing:** A well-being room has been set up to provide a 'safe space' for staff to take 'time-out'. It sits within the clinical services space, which provides additional support from the nursing and medical team.

- **Partnership forum:** WBS have an established partnership forum comprising regional and local trade union representatives. This continues to be the main forum for two-way discussion between WBS and staff and provides an opportunity for detailed discussion regarding areas of concern to staff. Particular discussions have

focused around social distancing and action has been taken in response to the issues raised.

- **Flexible Working:** Home working and flexible working arrangements have been implemented, to minimise staff numbers on all sites, to support isolation and, in particular to support staff who may have issues regarding childcare.

Accessed staff testing arrangements via LHBs in line with PHW Guidance.

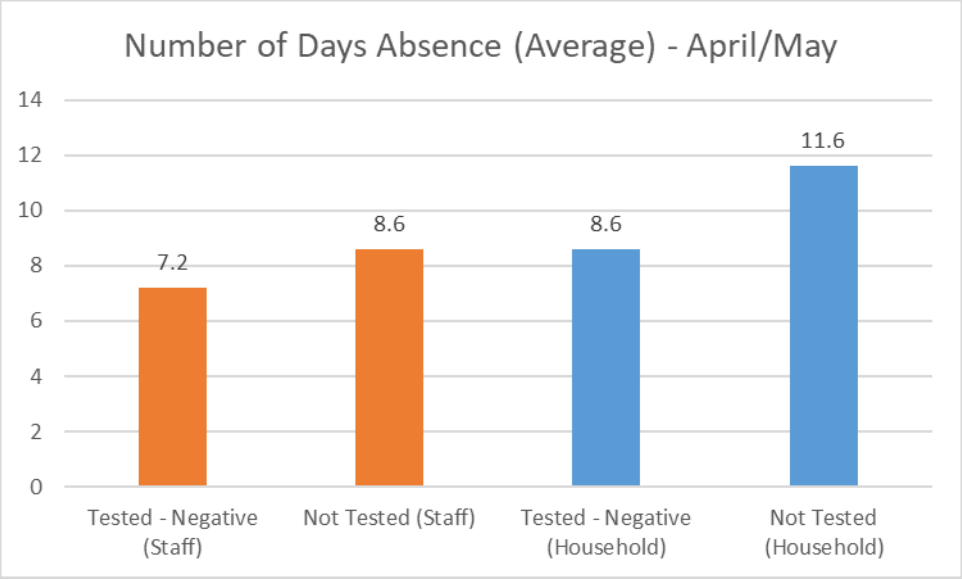
- Analysis of data suggests that where testing has taken place staff have returned to work earlier.
    - **Symptomatic Staff -** Return to work on average 1.4 days earlier when tested (and have a negative result) compared to those not tested
    - **Symptomatic Household Members** – Return to work on average 3 days earlier when tested (and have a negative result) compared to those not tested

Table 7 Analysis of Number of Days Absence WBS – Negative Test Result Vs Not Tested (April/May)

Outcome	Number
Negative Test Result	22
Positive Test Result	2
Awaiting Result	4
Not Tested*	8

*Not tested includes those rejected at Bronze/Gold and those declined by the test centre

Complete data were available for 26/30 of the requests



Implementation of PHW/VUNHST policy on risk assessment of vulnerable groups, pregnant women, BAME groups has been completed across WBS. Workforce wellbeing/safety is seen as a priority. Wherever possible action has been taken to implement and maintain social

distancing, actively encourage annual leave, publicised well-being support available both internally and externally across NHS Wales.

5.1.10. Social Care Interface & Resilience

WBS does not have an interface with social care.

5.1.11. Communication

5.1.11.1. Communication with donors

The WBS is in regular contact with donors through its direct channels; phone, SMS and social media. These channels are routinely used to invite donors to donation sessions, to support donors with eligibility queries and to inform donors of any change in Service.

As the COVID-19 pandemic has evolved, the need for timely and accurate communications with donors has been essential to inform of clinic cancellations, reductions in clinic capacity due to social distancing measures and to invite donors to newly created sessions.

Upon the announcement of lockdown, the donor contact centre was inundated with donor queries, most commonly:

- *Will my donation session take place?*
- *I'm over 70, can I donate?*
- *Am I allowed to travel to donate?*
- *How do I know if I'm eligible?*
- *Is it safe to attend blood donation sessions?*

A new automated telephone greeting was recorded to dampen the volume of calls arriving within the DCC by responding to some of the most common queries at the outset of the call.

Social media was also used to communicate key messages around essential travel, donor eligibility and key updates on donation venues.

Social media has provided an invaluable tool for sharing our donors' positive donation experiences. The social media strategy throughout the pandemic has been to reassure, to educate and to celebrate those who are rolling up their sleeves to support the WBS.

Social media was also used as the primary delivery channel to support communication with donors around the transition to a regional hub collections model. A short video was created and shared on Twitter, Instagram and Facebook to explain how COVID-19 had put pressure on the Service and to outline the new collections schedule. The video was very positively received and widely shared across social media.

To further extend the reach of its messaging, the donor engagement team enlisted the support of key influencers in local communities across Wales to share key messages on social media. Our network of key influencers responded, with notable social media posts from Welsh Government, local health boards, Swansea City FC, Football Association of

Wales, Cardiff Rugby Club, Pontypridd RFC, Wrexham Football Club, Newport FC, and many councils, MPs, AMs, and local councillors.

Table 8 Key phases of communications with donors during onset of COVID-19 pandemic

Inbound/outbound Contact with donors	To inform of clinic cancellations as COVID-19 emerges
Inbound/outbound contact	To inform that travel to donate considered 'essential' as part of lockdown announcement
Outbound contact	To inform donors of shift to new regional hub model – booking appointments where possible.

In addition, donor information leaflets have been developed in relation to stem cell collection and donor consent prior to cryopreservation.

As the COVID-19 pandemic progresses through its next stages, the Service will rely on its direct channels (phone, SMS, letter, social media) and the media to ensure donors are informed of key developments.

5.1.11.2 Communication with Media

The WBS has maintained close contact with the media throughout the pandemic, ensuring key information is distributed in line with the needs of the Service. Given the Service has direct channels for communicating with donors (phone, SMS, social media, letters), media engagement has primarily been used to provide population-wide assurance of the blood supply in Wales.

Language and messaging have been carefully crafted to communicate that donors should attend donation sessions as planned but to protect against an unwelcomed surge in donor attendance. Language has remained calm and assuring, leaving room for an escalation in tone should blood stocks dip below required levels.

The key period for media engagement during the pandemic came prior to the 6th April as the Service transitioned to a new collections model. A press release and a copy of the COVID-19 explainer video were distributed to key outlets across Wales and widespread media coverage was achieved. This coverage effectively conveyed that blood stocks were healthy,

that the Service had introduced its new regional donation hubs and that travel to donate was considered essential travel under government guidance.

	Action	Lead	Timeframe
Q1.	Continue to address issues raised by donors, utilising direct and indirect channels of communication	Donor engagement	Ongoing
Q1	Continue to work with the media to cascade core messages to donors.	Donor engagement	Ongoing

5.1.11.3 Communication with staff

In conjunction with VUNHST daily briefing, WBS has continued to communicate with its workforce through its established weekly electronic communication briefing.

In addition to the above, the WBS widened the scope of its SMS text messaging service (usually limited to communication with donors), to ensure urgent communications could be issued with all Trust staff simultaneously.

Some departments have also developed Q&A leaflets specific to the issues within their service areas.

5.1.11.4 Communication with Customer Hospitals

WBS hosts a Blood Health Team Resources Intranet page on its intranet site. This is populated with information around guidance and policies for hospitals to access.

With the advent of COVID-19 a specific Hospital Information page has been developed with key messages about the pandemic that may impact on hospitals and appropriate use messages for blood conservation. This is maintained by the BHT.

5.1.12. Workforce Plans including use of Temporary Workforce

COVID-19 has seen the need for additional workforce to be recruited and existing workforce on short term/temporary contracts to be extended in order to ensure the workforce is available to meet the demand on the service. This is in addition to internal staff recruitment.

5.1.12.1 Current situation

In order to support the management of services during COVID-19 pandemic additional hours have been recruited through a variety of means, including agency, temporary appointments and by increasing the hours of existing staff on a short term basis. The table below provides and overview of appointments to support service delivery during COVID-19. Recruitment is currently ongoing for the speciality doctor.

Table 9 Temporary appointments

Service Area	Posts appointed/extended to support COVID-19	Band	WTE	Agency/ Secondment/ Permanent	Length of post
QA Laboratories	Associate Practitioner	4	1.6	Fixed Term	3 months
Clinical Services	Lead RN Quality and Governance	7	0.2	Fixed term	6 months
Clinical Services	Governance Support Officer	3	0.2	Fixed Term	6 Months
Digital Services	365 Implementation Advisor	7	0.5	Fixed Term	6 Months
Clinical Services	Speciality Doctor in Transfusion	MC46	0.8	Fixed Term	6 Months

5.1.12.2 Workforce to support Convalescent Plasma

This project consists of three stages. Firstly the collection of whole blood from convalescent patients to produce plasma product. This has been accommodated within existing WBS staff. The next stage is the establishment of a plasmapheresis service in two phases. A business case has been submitted to Welsh Government outlining the support required to progress phase 21 of convalescent plasmapheresis programme and delivery. The progress of phase 2 is dependent on approval by Welsh Government of this business case. The workforce

required for phase 1 is agreed. Phase 2 is for an expansion in capacity of the plasmapheresis service and the BC for this is in progress.

5.1.12.3 Impact of COVID-19 Pandemic on Educational Collaborative

The COVID-19 pandemic has had an impact on educational collaboration with partners as follows:

- There have been no placements from Cardiff Met in the laboratories.
- Training has been paused for SpRs and HSSTs
- KESS partnership with universities has been paused – this partnership supports funding of MSc and PHD students to work on projects that informs ours work e.g. clinic planning model.
- Medical and nursing student face to face training has stopped. ELearning packages have been promoted to support transfusion learning

5.1.13 Financial Implications

The urgency needed for the initial service response meant that changes have been requires to the normal financial governance to facilitate response to business and time critical commitments has not been able to be in place as decisions have, by necessity, had to be driven by the assessment of demand and the immediate service plans in response. Many decisions have been taken to commit significant resources without the normal certainty of funding. **Figures for Quarter 1 April – June 2020**

The table below outlines the actual costs incurred for month 1 and forecast costs for month 2 and 3.

Table 10 Financial position

Q1	**Actual**	**Forecast**	**Forecast**
	April	**May**	**June**
Revenue expenditure	£39,824	£71,100	£122,732
Loss of income	£27,042	£53,042	£53,042
Total costs incurred	£66,866	£124,142	£175,774

*Month 1 actual costs £66,866
*Forecast costs for Q1 £366,782

Forecasts will be updated on a monthly basis and submitted with the monthly monitoring returns to Welsh Government. Note: the revenue increase forecast in June is aligned to anticipated staffing costs (admin, nursing, support workers) associated with Convalescent Plasma.

5.2 Velindre Cancer Services

5.2.1 Responding to the Pandemic

The service delivery model in VCC has been revised to ensure all appropriate services, patient pathways and treatment plans can be maintained or adapted to ensure the best possible outcomes for patients and staff within the challenges provided by the COVID-19 pandemic.

In response to the COVID-19 pandemic VUNHST established a *'Clinical Governance and operating framework for Clinical patient pathway / treatment decision making during COVID-19'.* This framework, approved by VUNHST's Trust Board, underpinned the approach to service review and adaptation and enabled the required adaptations.

The following principles are included:

- Patient care and safety is paramount.
- Care will be provided based upon clinical need.
- Care will be delivered to maximise clinical outcomes at a patient and population level.
- Care will be provided at home or as close to home as possible.
- Staff safety and well-being will be paramount

National UK and devolved Welsh guidance, including that from NICE and professional bodies was used to shape changes and decision making on pathway changes, treatment modification and harm minimization for our high risk patient group.

These changes have been developed through the establishment of a Clinical Development Group, drawing expertise from all service areas including imaging, SACT, radiotherapy, therapies, inpatients and the assessment unit and outpatients as well as across each site specific clinical team.

The CDG, has undertaken many activities and pieces of work to deliver services in line with these principles and its outputs have been scrutinised by a Clinical Advisory Group (CAG) which has overseen and provided assurance on these activities.

Through this structured approach since the COVID-19 outbreak, VCC had responded extensively and comprehensively across a wide range of service delivery areas and patient treatment pathways, designed to firstly respond to the needs of our cancer patients, as well as the presenting COVID-19 disease and its impact upon patients and staff. Additionally, we were also committed to providing forward resilience dependent upon social response to the changing disease presentation and the multiple scenarios that may produce. These decisions were made against a backdrop of high level principles, but patient specific where needed.

We have continued to actively engage with Local Health Boards through MDTs and through senior clinical staff to facilitate patient care and have worked on a regional basis to sustain service delivery. Details of these changes are outlined later in this document. Ongoing engagement with the Wales Cancer Network, its Cancer Implementation Group and Cancer Managers Group as well as the Imaging Essential Services Group have been key in shaping service delivery.

VUNHST medical staff have been redeployed to LHBs to support service delivery and have undertaken sessions at the Dragons Heart Field Hospital.

Acknowledging the difficulty the disease presented across the globe, we determined that the application of all treatment guideline changes should be individual patient specific with shared decision making, enabling a comprehensive clinical response to treating cancer patients.

All clinical arrangements were assessed and selected in order to minimise undue exposure of patients to environments in which COVID-19 pathogens may be present; it is imperative that COVID-19 associated risk to patients is minimised through careful planning of clinical flow.

Activity was contained within VCC itself and with existing service areas. There was no requirement during this time to utilise any private or independent sector facilities or service. This is being planned as part of the options for addressing surge capacity to deal with backlogs and manage increased demand from Health Boards.

5.2.2 VCC Operational Model

The Chief Executive of the NHS in Wales has written to all Health Board and Trust Chief Executives stating that 'essential services' including urgent cancer diagnosis, treatment and care must continue as well as possible during this period to avoid preventable mortality and morbidity. The priorities were:

- Urgent and emergency tests and treatment must continue
- The resultant harm caused by disruption to essential, non-COVID-19 services should be minimised
- Adequate safety netting should be in place for deferred care and
- Robust plans should be drawn up for the recovery phase in cancer services

The following services were expected to continue:

- Radiotherapy (definitive treatment of rapidly growing cancers)
- Chemotherapy (curative treatment of acute leukaemia and other haematological malignancies, testicular cancer)

Other cancer treatments should be delivered according to the risk of treatment and the availability of care to manage associated toxicities.

NHS Wales outlined the expected impacts for the VCC services below:

- SACT (Chemotherapy, biological therapies)
    - Greatly increased morbidity and mortality with concurrent COVID-19 infection
    - Only those cases where absolutely vital or very clear risk/benefit ratio
    - Changing to regimes which are less likely to be hazardous or require hospital admission (COVID-19 and non-COVID-19 cases)
    - Lack of access to usual providers for some home-administered treatments
- Radiotherapy
    - Will be particularly affected by loss of highly-specialised staff
    - Less effective without concurrent chemotherapy in many cases

  - Loss of key ancillary support e.g. oesophageal stents, gastrostomy tubes will make some morbid radical radiotherapy treatments unsafe
  - Rationalisation to reduce complexity, duration, morbidity

- Palliative Medicine
  - Immense demands caused by shift to community-based care for many sick and dying patients, both cancer and non-cancer.

The realignment of services and pathways in VCC led to a range of changes in ways of working, revised pathways and treatment options that have accommodated both non COVID-19 patients as well as those who tested positive.

'Through the implementation of all of the changes, we have actively engaged with patients in shared decision making and provided information, guidance and advice. Throughout the pandemic communication with and support for patients has been key to our approach through one to one discussions and support to more general advice and information and wellbeing messages.'

This has used a range of channels including social media and apps, webpages, signposting to third party resources and telephone support via the patient helpline.

5.2.3 Service changes

An overview of the changes is provided below, supplemented by more details by service area in Appendix 1.

With the closure of LHB outpatient departments, through March VCC moved its outreach service provision to the VCC site for outpatient appointments and SACT delivery. Lung cancer SACT, traditionally delivered at Llandough was temporarily relocated to VCC, pending further service discussions.

Physical changes to the site have been made to respond to infection control measures. This has included the implementation of a site triage system for patients and a cessation in visitors to the hospital in line with government guidance. COVID-19 positive areas and pathways have been established to cohort and segregate known and suspected COVID-19 patients. These have been continually reviewed to ensure Infection control and capacity management.

To maintain safety of workforce at VCC we have implemented national guidance on PPE and staff testing, facilitated and promoted home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers in clinical/treatment areas. These actions, together with a range of wellbeing initiatives, have enabled us to sustain our workforce to deliver these service models.

For Radiotherapy we have continued to deliver radiotherapy services to Category 1 patients and those with emergencies. Delivery of RT to COVID-19 positive patients has been via a dedicated Linac. Changes to breast treatment protocols have reduced attendances through hypo fractionisation.

In radiology and medical physics, reporting and planning from home via remote access have enabled services to be maintained.

For SACT, we have centralised delivery at VCC and retained delivery via the Tenovus mobile unit. Transfer to oral treatments had been made where this is clinically suitable and we have increased supportive care such as paracentesis. Additional capacity for Medicines at Home has been secured.

In reducing footfall to the site, telephone and video appointments have been introduced utilising AccuRX, Microsoft Teams, Attend Anywhere and increased capacity has been made available to the patient telephone helpline.

The GP hub will facilitate direct and timely access to clinicians at VCC for primary care colleagues with specific oncology related questions.

Consultants at VCC are also participating in consultant connect providing access for GPs regarding advice and support.

The Cancer Nurse Specialist (CNS) team have continued to provide advice and support to patients proactively through appointments and responsively as required.

We have expanded our capacity to meet unscheduled care needs of cancer patients through our Assessment unit.

Palliative care services have been reviewed to facilitate further support in the community and to LHBs.

An evaluation exercise will be completed for all ‘New Ways of Working’ implemented as a result of maintaining safe services during the COVID-19 pandemic, to determine ongoing adoption, development or return to original provision. An evaluation template will be produced to provide service leads full knowledge of any issues experienced to date, feedback from users (patients and staff), a summary of what benefits are possible, lessons learnt, data analysis (if required), and recommendation for the next stage.

5.2.4 Surge Capacity Preparation

Recognising the need to sustain the provision of cancer services during the pandemic, an initiative was undertaken to expand the inpatient and assessment unit capacity at VCC. This was based on assessment that Velindre Cancer Centre would continue to provide inpatient services to Acute Oncology Service users with or without confirmed or suspected COVID-19. An options appraisal enabled the regular capacity of VCC of 30 inpatient beds and 4 assessment unit beds to be expanded to 47 and 8. The operational arrangement for this configuration has been established but if fully utilised could potentially provide a staffing challenge. These arrangements were commenced during the early weeks of the outbreak and the demand that presented did not meet these levels. This is further discussed in later sections of this document and are currently subject to review as we plan for the next phase. We need to factor in the impact of social distancing in all plans to maximise capacity during the next phase.

The work undertaken creates a range of service delivery options that will enable VCC to flex to meet the various scenarios that could be encountered based on the path of the pandemic and its impact on the health system. These changes have been subject to ongoing review and are now being evaluated to determine which will be sustained and what further developments are required as we move to the next phase. Whilst we continue to be mindful of the potential for further peaks in COVID-19 infection rates, we also need to prepare for the

new demand that will reach VCC in the forthcoming weeks from LHBs deferred demand and the delayed patient to GP and GP to secondary care referrals that will recommence.

This demand will need to be delivered alongside the reintroduction of services to meet the deferred demand for existing patients within VCC.

5.2.5 Planning for the next phase (recovery) and increased demand from deferred patients

Our work to plan for the next phase has commenced and incorporates the need to understand future need, develop a COVID-19 Protected Clinical Operating Model and putting that model into operational delivery

The next 6 weeks will see us continuing to determine the immediate and future demand with LHBs and plan on a regional basis. This will include:

5.2.5.1 Forecasting demand:

- internal demand e.g. patients treatments which have been paused due to the risk presented by COVID-19)
- System demand e.g. LHB referrals/increases as elective and diagnostics are re-introduced; reintroduction of screening programmes and patients who have not presented in primary care.

This will be undertaken alongside the further developing and implementing of our new operating model. This will be supported by ongoing evaluation of the changes we have introduced and ensuring our data and information resources underpin our service planning and delivery.

5.2.5.2 Maximising Capacity

Work is ongoing to identify the maximum service capacity that can be delivered for cancer services within the cancer service to effectively manage the provision of services in a COVID-19-secure environment. The capacity will need to be in place to deal with:

- Any backlog within VCC
- Backlog in LHBs
- Suppressed/unmet demand

The initial work has identified what capacity can be delivered at VCC. This is being supplemented with work to identify additional potential capacity from other partners/providers:

- **SACT**: discussions are progressing with Tenovous regarding physical space; workforce and manufacturing/provision of medicines.
- **Radiotherapy**: discussions progressing with the Rutherford Centre regarding radiotherapy and SACT capacity; workforce and manufacturing/provision of medicines.

These discussions are being taken forward in partnership with Swansea Bay University LHB and WHSSC to provide a regional solution.

5.2.5.3 Strengthening our clinical operating model in a COVID-19 environment

The VUNHST Clinical Governance and Operating framework for Clinical patient pathway and decision making during COVID-19 has provided the basis for the establishment of the COVID-19 clinical operating model.

A review of the operating model has been undertaken to identify how we consolidate it to deal with the medium term delivery of service with COVID-19 in communities. The clinical operating model is being evolved to deal with the following issues:

- **Risk to cancer patients of COVID-19**: The cancer population considered at high risk of becoming seriously ill with coronavirus infection have already been defined. These individuals continue to remain at high risk should they contract the disease, but the risk of community and hospital acquired transmission is lower than previously. The impact of serology testing and the potential development of a vaccine is yet to be determined.

- **Risk to cancer patients of not receiving optimal treatment**: Cancer services in general have already been severely disrupted as a result of COVID-19.This is in part due to the impact on reduced screening and primary surgery but also the modification of therapy in order to minimise harm from treatments in the high risk cancer group. These pathway changes have resulted in a supressed demand for non-surgical oncology services which will become manifest in the coming weeks. In Velindre Cancer Centre, essential cancer care has been primarily continued in line with the high level principles defined, unless patient preference has been to do otherwise.

- **National framework for Recovery phase in cancer**: There is agreement across the system in Wales and the UK that we need to urgently restore our ability to deliver essential health services for our cancer population. Where possible we are also asked to consider recommencing more routine care. However we need to do this in a safe way, and with caution, through short planning cycles that maintain the flexibility and agility without putting our patients and staff at any increased risk.

  We are currently developing the operating model to provide solutions to a number of complex issues:

  - The **background risk** of community and hospital transmission which determines the phase of COVID-19
  - The ability to become a **COVID-19-Protected service** apart from designated COVID-19 positive zones(recognising it will not be possible to control all aspects of this or do this in all areas)
  - The use of **clinical prioritisation** to minimise impact on patient outcomes whilst managing capacity and demand. NICE definitions of patient priority level previously referenced will continue to apply
  - **Minimising the risk of transmission:** we are implementing a range of actions to reduce the risk of any transmission of COVID-19 across any service provided by Velindre Cancer Centre.
  - **Understanding the Patient risk:** we are taking actions which consider the ability to now reduce the likelihood of a patient harbouring the disease by intensive pre-treatment triage. This will support us in managing patients in:

- their risk of contracting COVID-19 (now significantly reduced in recovery phase);
- their risk of immunosuppression during and following cancer treatment and;
- Balance this risk against likely benefits of treatment/care.

Given our vulnerable patient group, we need to take the additional measures outlined below, in '*Delivering safe care in a protected environment*', i.e. One that is mitigated of the risks of COVID-19. In addition to the current arrangements during COVID-19, we need to create distinct treatment areas now 'designated as COVID-19 protected to resume non COVID-19 activity. This will form the vast majority of space on site. This will now include Inpatients/Outpatients/Radiotherapy/SACT to allow services to resume.

We are progressing work in the following areas to support the development of a medium term clinical and operational model around the following areas:

- **TRIAGE**: Isolate/screening/**TESTING** and contact tracing where necessary of both staff and patients.

- **ENVIRONMENT:** IP&C principles in all areas: Access to site/Flows of staff/PPE access and appropriate use which is risk assessed according to the patient and procedure is mandatory/Enhanced Cleaning and decontamination programme.

- **DISTANCE**: the principle of social distancing needs to be applied for patients and staff alike. In clinical areas where the 2metre social distancing rule cannot be maintained, this is mitigated by appropriate use of PPE. This has an implication for home working/use of remote consultation and consent.

- **DESIGNATED COVID-19 SITES:** suspected or confirmed positive. Designated COVID-19 positive sites (Hot) need to be defined within the service to include Inpatients/Outpatients/radiotherapy and SACT. Moving these patients to alternative locations where possible will also be considered.

- **MINIMISE FOOTFALL on site:** Where possible and aligned to the principles of TCS, care should be delivered as close to home as possible and the footfall of patients seen at VCC as well as in HB's, reduced to a minimum. In line with this Ambulatory care and Admission avoidance should be encouraged.

- **REALIGNING and SUPPORTING THE WORKFORCE:** Cohorting of teams across professions and in multidisciplinary teams. We are determined to focus attention on staff physical and mental wellbeing and well as working safely in the workplace. Positive feedback has been received on the implementation of a staff facing psychological wellbeing pilot.

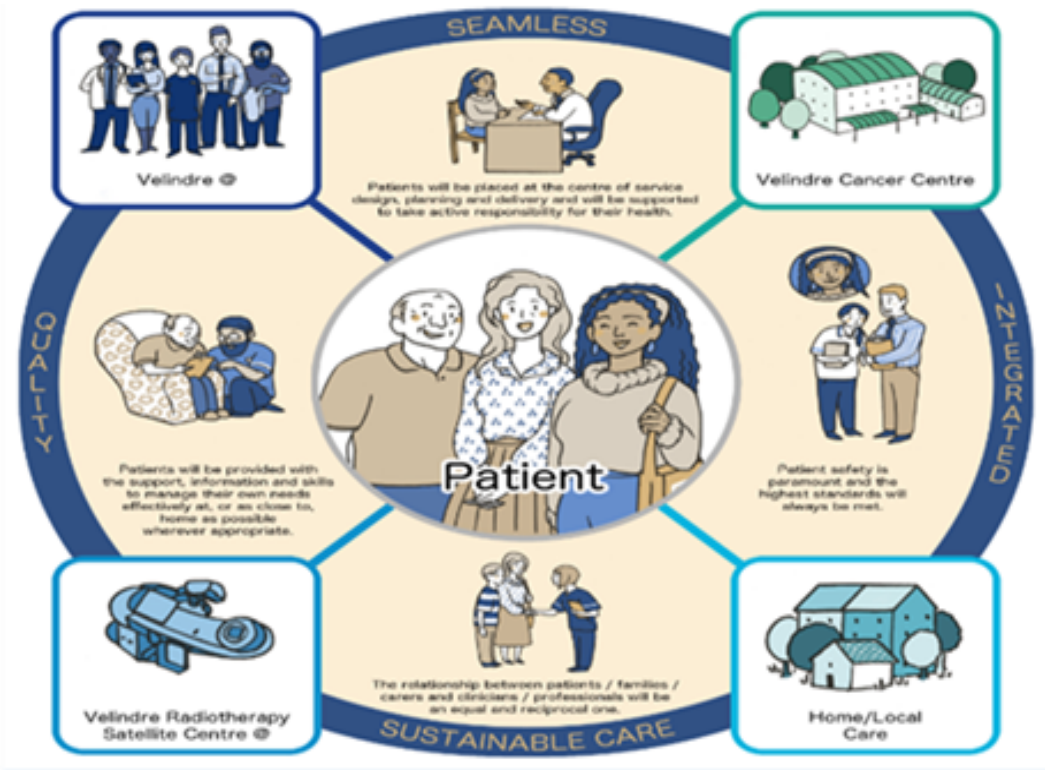
- **DIGITAL SYSTEMS:** Maximise use of digital processes to support new ways of working and maximise capacity.

- **MONITOR OUTCOMES:** We need to monitor patient and carer outcomes and feedback throughout the recovery phase.

- **COMMUNICATION:** Clear simple coordinated messaging to patients, public and staff.

Developing our operating model for the medium term in a COVID-19 environment: May 2020 and onwards

The clinical model outlined in the TCS programme is the model we are working towards. This becomes even more important in a COVID-19 environment as seeks to deliver care at home; close to home and only travel for specialist care when absolutely necessary.



Scheduled Care: Where possible, and where it does not compromise treatment options we will aim to:

- Reduce non-urgent, face to face patient contact within Velindre Cancer Centre / Outreach settings.
- Continue to accelerate and deploy technology to avoid the need for patients to attend site where possible.
- Seek to identify capacity solutions which provide treatment away from a hospital site e.g. Tenovus buses which avoid increasing risks to patients in attending VCC or outreach sites in hospitals.
- It is recognised that this approach will not suit all patient groups and needs to be considered on an individualised basis.

Unscheduled care: Where appropriate, we will aim to:

- Not admit or manage patients with acute respiratory symptoms and suspected or confirmed COVID-19 (admission pathways to relevant HB).
- Continue to accelerate and deploy technology to avoid the need for patients to attend site where possible
- Test every patient on admission irrespective of symptoms (the existing admission criteria would otherwise apply and we aim to continue to support LHBs in managing non-respiratory acute toxicities).

Assessment Unit: Where appropriate, we will aim to:
- have a designated assessment unit area separated from any cohorting areas
- continue with the increased capacity in the assessment unit from 4 to 8 beds
- Pilot of 7 day working to deal with to deal with reduced throughput/social distancing requirements (feasibility of this pilot being undertaken).

Flexible approach to capacity: the operational model will be create capacity which is flexible and agile to manage increased activity during the recovery phase to deal with
- existing backlog
- increasing referrals
- reactivation of COVID-19 throughout

This will be achieved by having an operational model and plan which clearly sets out stages of escalation and what capacity is required at what state e.g. move easily from an ambulatory phase (fewer inpatient beds) to a potential surge where more inpatient beds are required to support the healthcare system. The procurement of external independent/third sector capacity will add to the Trusts' agility and flexibility.

Mutual Aid during the next phase: Staff will continue to participate in mutual aid programmes as required by NHS Wales following agreement with the health boards, VCC line managers and as compliant within job plans as appropriate.

5.2.6 Financial Implications

The urgency needed for the initial service response meant that normal financial governance has not been able to be in place as decisions have, by necessity, had to be driven by the assessment of demand and the immediate service plans in response. Many decisions have been taken to commit significant resources without the normal certainty of funding.

Figures for Quarter 1 April – June 2020

The table below outlines the actual costs incurred for month 1 and forecast costs for month 2 and 3.

Table 11 Financial position

Q1	Actual	Forecast	Forecast
	April	May	June
Revenue expenditure	£58,681	£136,986	£58,783
Loss of income	£12,500	£12,500	£12,500
Undelivered Savings	£45,834	£45,834	£45,834
Total costs incurred	£117,015	£195,320	£117,117

*Month 1 actual costs £117,015.
*Forecast costs for Q1 £429,452

Forecasts will be updated on a monthly basis and submitted with the monthly monitoring returns to Welsh Government. The increased expenditure in period 2 relates to the provision of equipment and PPE.

There are risks identified in the plan that should they crystallise could lead to additional cost / or further loss of income above that reflected in the Q1 COVID-19 forecast or Trust annual forecast.

The additional costs associated with the new service models described in Appendix 1 are not included in the current COVID-19 cost forecasts. Once the service model scenarios have been developed they will be costed and included in the COVID-19 financial returns based on the most likely service models.

5.2.7 Action Plan

Table 12 Action plan			
Qtr.	**Action**	**Lead**	**Timeframe**
Demand Management			
Q1	Complete our internal and external demand planning methodology to create a flexible model to respond to pandemic phases and understand the work we have to do internally to clear backlog.	Senior Management Team	June 2020
Q1	*Internal* – continue departmental analysis of deferred demand.	Departmental Leads	June 2020
Q1	*External* - continue to engage with DU, WCN and LHBs to determine demand profile from deferrals and screening and align with pandemic modelling.	Planning Leads	June 2020

Capacity Planning			
Q1	Develop a capacity plan to meet the proposed COVID-19 protected clinical operating model (C19 PCOM) for each service area in the context of patient and staff factors and IPC measures.	Director of Operations & Departmental Operational and Clinical Leads	June 2020
Q1	Determine requirement for additional external capacity	Director of Operations	May 2020
Q1	Explore additional capacity with external providers (Tenovus, Rutherford etc.)	Director of Strategic Transformation, Planning and Digital	May 2020
Q1	Continue to engage with LHBs on outreach provision	SACT Lead	May 2020
Q1	Revisit estate utilisation (including the surge capacity provision of 47 beds and 8 AU beds) to meet the new C19 PCOM and establish an estate management plan for COVID-19 protected "green" and COVID-19 "red" zones in light of the demand profiles.	Head of Nursing Assistant Director of Estates	May 2020
Q1	Develop pan-regional partnership with Swansea Bay and Hywel Dda LHBs to purchase additional capacity and deploy it	Director of Strategic Transformation, Planning and Digital	June 2020
Developing a COVID-19 protected operating model			
Q1	Compete review of the VUNHST Clinical Governance and Operating framework for Clinical patient pathway and decision making during COVID-19	Medical Director	May 2020
Q1	Complete Phase 2 of the patient triage model	Clinical Director	June 2020
Q1	Engage with PHW and LHBs to enable the additional patient testing to deliver the triage model	Executive Director of Nursing, Therapies and Healthcare Scientists	May 2020
Q1	Evaluate service changes and treatment protocols to develop model and understand the		

	impact on capacity and demand (by service area for SACT, RT, medical physics, radiology, palliative care, therapies, patient support, nuclear medicine, CNS, outpatients, inpatients, ambulatory care) (by SST)	Clinical Director	June 2020
Q1	Review service changes against the service improvement and service development plans in IMTP to ensure next steps are in line with these plans and maximise efficiency and productivity.	Director of Operations	May 2020
Q1	Evaluation of patient outcomes resultant of agreed treatment plans (curative and palliative care)	Clinical Director	June 2020
Q1	Establish new staff testing regime to maintain COVID-19 protected status	Executive Director of OD and Workforce	June 2020
Q1	Engage CHC in service change proposals	Director of Cancer Services	May 2020
Operationalising the new model			
Q1	Engage with LHBs via operational teams to determine their new ways of working and ensure effective two way engagement including agreement on care pathways	Departmental and SST Leads	May/June 2020
Q1	Continue to establish a revised Clinical Development Group work programme and programme board for the next phase plan	Director of Cancer Services	June 2020
Q1	Complete VCC workforce review to assess roles, responsibilities and priorities including redeployment and temporary staff and student workforce.	Workforce & OD Business Manager	June 2020
Q1	Data flow and management – refine our data management and reporting to incorporate LHB data and establish planning model including pandemic indicators to signal service flex.	Information and Planning Leads	May/June 2020
Q1	Data flow and management – revise operational planning tools for SSTs and operational departments to utilise additional data.	Information and Planning Leads	June 2020
Q1	Further develop RT capacity planning model based on Attain consultancy work	Information and Planning Leads	Ongoing

Q1	Review the recent SACT planning proposal and agree next steps	Director of Cancer Services & Clinical Director	May/June 2020
Q1	Continue to review patients on their care pathway to agree next steps in care plan including patient treatment alterations and ability to move to alternative treatment pathways.	Consultant workforce	May 2020
Q1	Specific review of prostate care pathway and recommencement of services as a priority	SST Lead and Clinical Director	May/June 2020
Q1	Patient communication – establish next stages in communication plan for patients based on WG framework	Director of Operations	May/June 2020
Q1	Review the operating model for psychology service	Director of Cancer Services	June 2020
New Ways of Working			
Q1	Establish new ways of home working supported by appropriate policy consideration	Workforce & OD Business Manager	June 2020
Q1	Scope staff mental and physical wellbeing support interventions	Workforce & OD Business Manager	June 2020
Q1	Establishment of monitoring processes for workforce safety and risk assessment	Workforce & OD Business Manager	June 2020
Q1	Establish and introduce estate capacity plan to meet social distancing needs (working safely)	Director of Strategic Transformation, Planning and Digital /Assistant Director of Estates, Environment and Capital Development.	June 2020
Q1	Work in collaboration with estates and facilities to determine social distancing plans to ensure all staff are working safely	Workforce & OD Business Manager	June 2020

Q1	Evaluate impact and success of virtual clinic processes and technology	Head of Nursing & Clinical Director	May/June 2020
Q1	Explore opportunities to improve audio/visual technological capability	Associate Director of Informatics	June 2020

5.3 Transforming Cancer Services (TCS)

The TCS Programme is fundamental to the development of sustainable cancer services in South East Wales. The Trust paused the programme and a number of its projects in the programme following the COVID-19 pandemic (Project 5: outreach; Project 6: clinical transformation) but continued with a small number (Project 1: enabling works; Project 2: nVCC; Project 3: procurement of the integrate radiotherapy solution) given their critical nature with regards to immediate/medium term capacity and capability.

The ongoing work has enabled the programme to take a number of important aspects forward, with some key milestones expected to be achieved by June 2020.

	Action	Lead	Timeframe
Q1.	Planning permission submitted to Cardiff City Council for the enabling works and nVCC	nVCC Project Director	May/June 2020
Q1	Receipt of initial solutions from bidders for integrated radiotherapy solution	Director of Transformation, Planning and Digital	May 2020
Q1	Completion of procurement documents and commercial strategy for nVCC	nVCC Project Director	June 2020
Q1	Completion of OBC nVCC	nVCC Project Director	June 2020

5.4 Research, Development & Innovation (RD&I)

5.4.1 Current Position

In light of the significant additional pressures on clinical services as a result of the COVID-19 pandemic, and in the interests of our staff and research participants, the Trust:

- Stopped screening and recruitment activities for all clinical trials/research studies hosted by the Trust (being reviewed monthly).
- Will not open any new academic or commercial studies, with the exception of:
- Studies identified as specifically relating to Coronavirus (COVID-19) and
    - prioritised by the Chief Medical Officer (CMO) and Health and Care
    - Research Wales; or
- Studies identified, by Principal Investigators from within their study portfolio,
    - that are beneficial to patients and that reduce the burden on clinical services

- Resources will be focussed on managing patients who are already recruited/enrolled into clinical trials and ensuring they are appropriately followed-up.

5.4.2 Research Activity During COVID-19 Period (Peak and into Recovery)

A number of research activities have been progressed during the COVID-19 peak phase. Trials planned during March – June 2020;

- Convalescent Plasma: Currently, there are no proven and approved antiviral agents for the 2019 novel coronavirus disease (COVID-19) and specifically for the SARS-CoV-2 virus. Preliminary clinical evidence from China and Italy indicate that transfusion of CP can aid in the treatment, improvement and potentially successful recovery of other disease sufferers (1-3). The Welsh Blood Service is a key partner in the convalescent plasma trial, collecting convalescent plasma (CP; blood plasma containing antibodies to SARS-CoV-2 virus from recovered COVID-19 patients in the form or 'fresh frozen plasma (FFP)) and particularly with respect to Phase 1 and quality and safety aspects pertinent to WBS, vide infra.

- TERAVOLT (Thoracic cancEs international coVid 19 cOLlaboraTion): a longitudinal multi-centre study on thoracic cancer patients (any age, sex, histology, stage, in active treatment as well as in clinical follow-up) which, experienced COVID-19. Information on clinical features, clinical course, management and outcomes will be collected for both, thoracic cancers and COVID-19 infection.

- RECOVERY trial: a randomised trial among adults hospitalised for confirmed COVID-19. Eligible patients are randomly allocated between several treatment arms, each to be given in addition to the usual standard of care in the participating hospital: No additional treatment vs Lopinavir-Ritonavir vs Interferon β vs low-dose corticosteroids. For patients for whom not all the trial arms are appropriate or at locations where not all are available, randomisation will be between fewer arms.

- National UK Cancer Monitoring Project: a UK corona virus cancer monitoring project tracking patients who have tested positive for COVID-19.

5.4.3 Planning an effective recovery from COVID-19 disruption

The COVID-19 pandemic continues to evolve and the Trust has deployed business continuity plans for prevention and response, to protect the patients/donors and staff. The RD&I division is now considering how it will reactivate study activity in a phased, risk-adapted and managed approach with the aim of returning to full capacity.

At the time of writing, there is no UK Governmental or regulatory guidance on how RD&I services in healthcare return to full capacity. However, the Trust continues to collaborate with its industry partners and stakeholder organisations to ensure synergy in preparation to resume normal business services.

In order to prepare the Trust to resume "normal" research business, the RD&I division is considering the following:

- Reviewing the current situation

  - Review and understand the UK Governmental and Regulatory position on the COVID-19 recovery for healthcare research.
  - Review and understand the research sponsor organisation's position on the COVID-19 recovery for their research studies.
  - Consider, anticipate and document any potential risks identified in reviewing the differing positions on the COVID-19 recovery phase.
  - Develop a risk mitigation plan that includes any additional study and patient support in the COVID-19 recovery phase.
- Restarting best practices
  - Develop the Trust RD&I "restart" strategy and process.
  - Prioritise research studies based on the following key principles:
    - Patient/donor benefit, risk, safety and rights;
    - Current study success in recruiting on time and to target;
    - Remaining time until planned end date;
    - External resource requirements/services from external stakeholders due to the potential disruption in availability from those organisations;
    - Internal resource requirement/services from internal stakeholders taking into consideration departmental recovery strategies;
    - Individual research study income; and
    - Safety of employees from possible exposure to COVID-19.

The Trust RD&I Research Study Prioritisation Tool, reviewed at the RD&I Operational Management Group in readiness for testing, will be utilised in an adapted form to inform the prioritisation for reactivation of research studies.

- Prepare the Trust for a staged reactivation of research studies. Regular monitoring of this reactivation process is required to inform decisions on moving to the next stage. Additionally, the decision must consider any further surge in COVID-19.
- Continue the use of a Trust RD&I site visit/travel checklist, updated as necessary, to identify any potential need for COVID-19 testing prior to and/or delay in visits to Trust sites by patients or external study monitoring staff.

Building capacity and develop evidence

- That continues to ensure the prioritised management of patient safety data in line with the sponsor organisation COVID-19 guidance.
- That supports the implementation and expansion of virtual/remote monitoring of research studies by sponsor organisations.

Defining the recovery approach

- Defining the Trust's staged recovery approach for healthcare research that prioritises patient/donor benefit, risk, safety and rights. This will need to incorporate all Trust managed healthcare research, linking to and collaborating with the recovery plans of the Trust's other divisions and services.

5.5 Corporate Departments

5.5.1 Workforce & Organisational Development

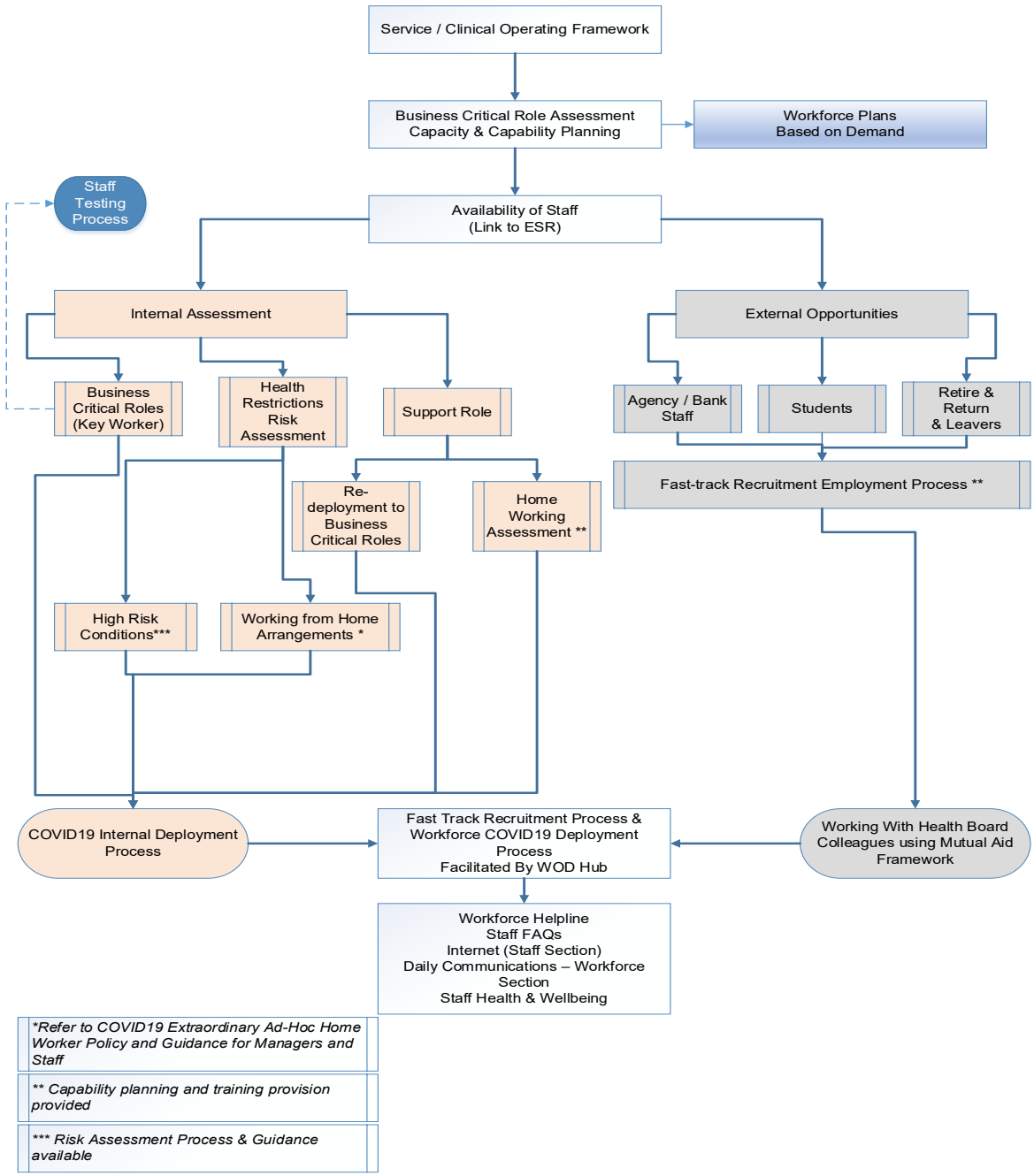
5.5.1.1 Summary of Current Situation as at week commencing 11 May 2020

The Workforce Operational Plan for Q1 has been re-focused in response to COVID-19 to establish a workforce hub to support additional recruitment, deployment of staff, manage the flow of workforce information, and ensure the provision of an effective infrastructure for staff wellbeing. The hub is supported by a workforce helpline to provide additional guidance, help and support to staff.

The Workforce Hub reports through the VUNHST COVID-19 incident command structure. In addition, a Workforce cell has been established, which includes representation from our Trade Union colleagues, to ensure the ongoing management of the workforce infrastructure during COVID-19, the dashboard below is used to monitor, assess the availability and wellbeing of the workforce.

In response to COVID-19 the Workforce Team has been working within the following Operating Framework to respond to changing service requirements and needs, to ensure staff's wellbeing is managed effectively and supply mechanisms are in place to recruit and deploy staff as required

Workforce Operating Framework to Support COVID19 Service Continuity



COVID-19 Workforce Programme

The Operating Framework focuses on the effective (1) Availability of staff and (2) Supporting Staff Wellbeing.

Availability of the Workforce
To support the organisation a Workforce Hub has been established. The Hub has been responsible for Recruitment, Deployment, and Training of additional staff to support service need. To support service demand external recruitment supply chains have been established to recruitment, via our fast track process, to the Trust Bank 43 Health Care Support Workers including Porters, Clinical Support Staff and Catering Staff. Medical Students were also recruited to the Bank as Clinical Support Assistants. Utilising the all Wales COVID-19 Hub 4 final year nursing students were deployed to the Cancer Centre. The bank staff are available to deploy as and when required as demand requires.

An integral assessment of business critical roles was undertaken in the Trust and through our internal deployment hub staff have been deployed to support business critical areas 34 deployments have been managed. VUNHST is also working with C&VUHB to ensure, via mutual aid, staff, in particular medical consultants, are supporting the demand in the Health Board.

Providing support and information to staff is key Staff at higher risk have been assessed and alternative working arrangements put in place.

A weekly meeting with staff side colleagues has been established and partnership working in key areas to communicate use of PPE and social distancing rules is ongoing.

Staff absence (COVID-19 related is 4.6%) Staff testing is in place to ensure staff are tested and return to work in a timely manner, 124 staff have been tested and returned to date**.**

Plan for Q1

Q1	Action	Timeline
	Working in Partnership monitor Staff Safety ensuring: Risk Assessment for High Risk staff are completed and updated	June 2020
	Working from home arrangements are monitored and updated, supporting staff re-entering the workforce from home working	June 2020
	Process for staff testing is managed, monitored and communicated	June 2020
	Development of guidance to support managers implement social distancing guidance	May 2020
	Working with planning colleagues assess the workforce demand and utilise the existing supply channels as required	Ongoing to June 2020 and beyond

5.5.1.2 Workforce wellbeing

To support staff wellbeing the Trust has put in place the following:

- Workforce COVID-19 Helpline providing support to managers and staff (started 7 days a week, now 5 days a week due to demand)
- Development and implementation of flexible working policies and practices:
    - Extraordinary Ad Hoc Home Working Policy and Procedure for Managers and Staff
    - Manager Guidance for People Shielding and Protecting
    - Carry-over of annual leave extension of number of days and roll over 2 years
    - Increase of days available for special leave
    - Flexible working practices – e.g. rota changes / times of working to support childcare
    - Temporary deployment guidance
    - Extension of period for Childcare Subsidy Scheme
    - Development of thorough Risk Assessment for staff, including responding to national guidance re BAME; also development of manager guidance
- Provision of training and inductions for newly appointed staff
- Supporting recording of competencies on ESR to ensure staff safety and wellbeing
- Organisation and communication of H&WB resources and interventions available to all staff:
    - Daily wellbeing updates in Trust communications to signpost internal and external interventions and resources, this includes webinars; support lines; tools; resources for families
    - Creation of the Trust H&WB internet and intranet pages to support all staff during and after the pandemic, ranging from Self Care, EAP, Financial Wellbeing, Manager Support
    - Staff support via the Psychology Team – Maggie's Relax and Recharge Hub; 1-2-1 support; including support to colleagues not based at VCC; Virtual sessions for managers on supporting your team (delivered via MS Teams)
    - Manager Support section created on the H&WB pages with advice on looking after their own H&WB, and supporting H&WB of their teams. Also includes WOD support available via interventions such as coaching
    - Offering staff places to recharge – Maggie's / Wellbeing Room at WBS
    - WOD & Psychology Team developing a session for managers on 'Identifying the Signs of Stress / Anxiety and Having those conversations with your team'
    - EAP reminder to staff included in Trust Communications and outlined clearly on H&WB pages (including Manager Assist)

Plan for Q1

Q1	Action	Timeline
	Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas,	June 2020
	Working in partnership develop surveys based on feedback to improve staff communication and partnership working	June 2020
	Developing H&WB plan into recovery phase where staff are more likely to require support (based upon CARE model – create, assist, rapid, engage)	June 2020
	Ongoing Communication on wellbeing offer to staff via all stakeholders routes	June 2020
	Management development to support effective team management incorporating a blended delivery approach – building on our Manager Development Programme	June 2020

A range of initiatives have been developed by the Trust and implemented within the divisions to support the wellbeing of staff and to help meet the challenges of the current COVID-19 health emergency. These actions are listed below:

5.5.1.3 Use of Temporary workforce

Ongoing management during COVID-19 Peaks

A workforce cell has been established to flex to meet workforce demand and will focus on matters relating to testing, social distancing and wellbeing

- Developing competent workforce with a focus on Strong and Flexible Leaders and Managers through Technology Enabled Learning (building on the COVID-19 experience)
- Building on our extended Wellbeing offer during COVID-19 to support Business as Usual
- Working with Planning Colleagues to support the development of our workforce plans

COVID-19/Business as Usual – Delivering the IMTP

As we flex back to Business as usual the focus for Workforce, building on the COVID-19 work, will be to support its IMTP workforce programmes including:

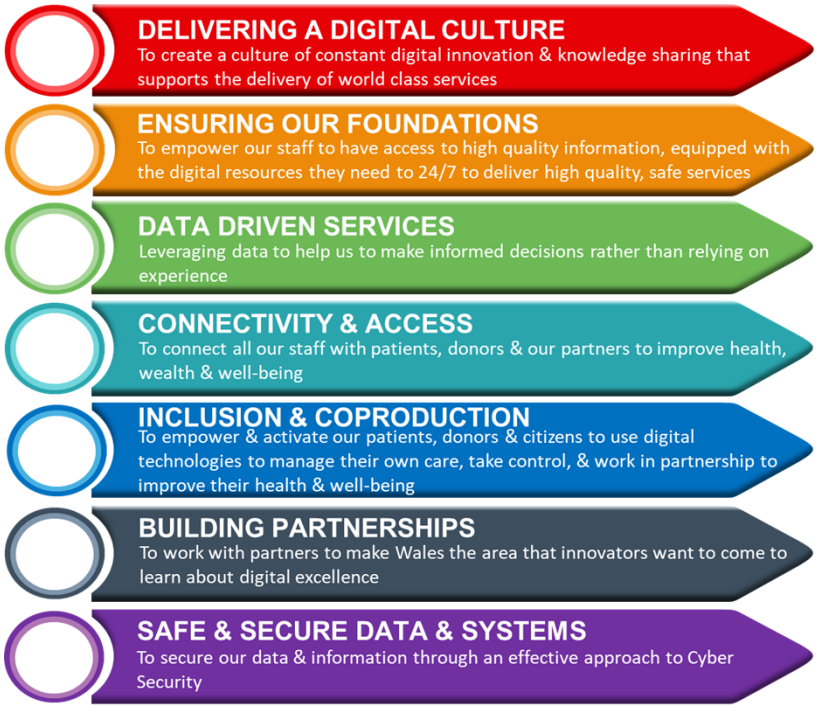
IMTP Theme (Q1)	Action	Timeline
Culture of Transformation	Beyond Business as Usual Programme – Programme Plan completed and initiated	June 2020
Skilled and Development Workforce	First Steps Management Development Programme completed	June 2020
	Leadership review completed and plan for Leadership communicated	June 2020
	Development of Virtual enabled learning (inc. HR App)	June 2020 (to be reviewed)
Health and Engaged Workforce	Launch of Working In Confidence Platform to gain feedback on staff requirements for wellbeing	June 2020
	Working with Psychology to continue to develop the Workforce Wellbeing Plan for COVID-19	June 2020
Workforce Information	Enhance the workforce information report in line with Trust performance management dashboard	June 2020
	Undertake workforce modelling data based on Division demand	June 2020

5.5.2 Digital

5.5.2.1 Summary of Current Situation as at week commencing 11 May 2020

Velindre University NHS Trust has developed a Digital Vision and Programme with the concept of *"Digital Connectivity"* at the heart of the way services are provided in the future. The Digital programme aims to identify, evaluate and implement scalable new ways of working (i.e. mobile, agile & integrated) at pace.

As outlined in our Integrated Medium Term Plan, the Programme has been developed using a collaborative evidence based approach to delivering transformation for all stakeholders, patients, donors, clinicians, citizens and partners.



Key Drivers for Digital

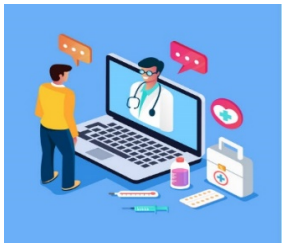
In delivering this programme, the Trust will introduce new digital capabilities that will enable transformative ways of delivering cancer and blood services to all stakeholders and it will integrate and complement existing and planned digital programmes across Wales.

The outbreak of the COVID-19 virus and the unprecedented events that followed, have prompted the Trust to consider innovative digital solutions to ensure patients and donors continue to receive the best possible services and care.

These services are increasingly being provided via remote contact, monitoring of health and well-being and direct consultations, to reduce the need for patients to attend clinics. The Trust is also very aware of the impact that remote working and consultations can have, and is committed to ensuring that any solutions improve access to the services and at the same time, reduce the risk on a persons' well-being and risk of exclusion.

100% of our staff were fully migrated to Office 365 by the 1st April 2020

30% of staff commenced remote working by 1st April 2020



30% of New Outpatient Appointments are managed via Video Consultation Technology by 1st April 2020

100% Rollout and availability of the Welsh Clinical Portal Mobile App by 1st April 2020

5.5.2.2 New ways of working

The Digital team has identified a series of roles and functions that are required to maintain existing work priorities in response to COVID-19 and take forward key digital projects and initiatives such as robotic process automation and the connectivity agenda for staff and patients. This capacity is essential to deliver the technology required to deliver the supportive care and outpatient service programmes and their capacity plan responses to COVID-19.

These roles and functions will further enhance our ability to adopt and deliver our service requirements at a pace and scale in keeping with the response to COVID-19.

Virtual meetings and consultation are fast becoming the “new normal”. As a Trust/Healthcare provider in NHS Wales, we were the first to fully adopt the Office 365 suite for its entire workforce. We now need to build on this and ensure the connectivity of our staff through solutions such as Microsoft Teams is embedded in the way we work going forward.

5.5.2.3 Reintroducing Routine services

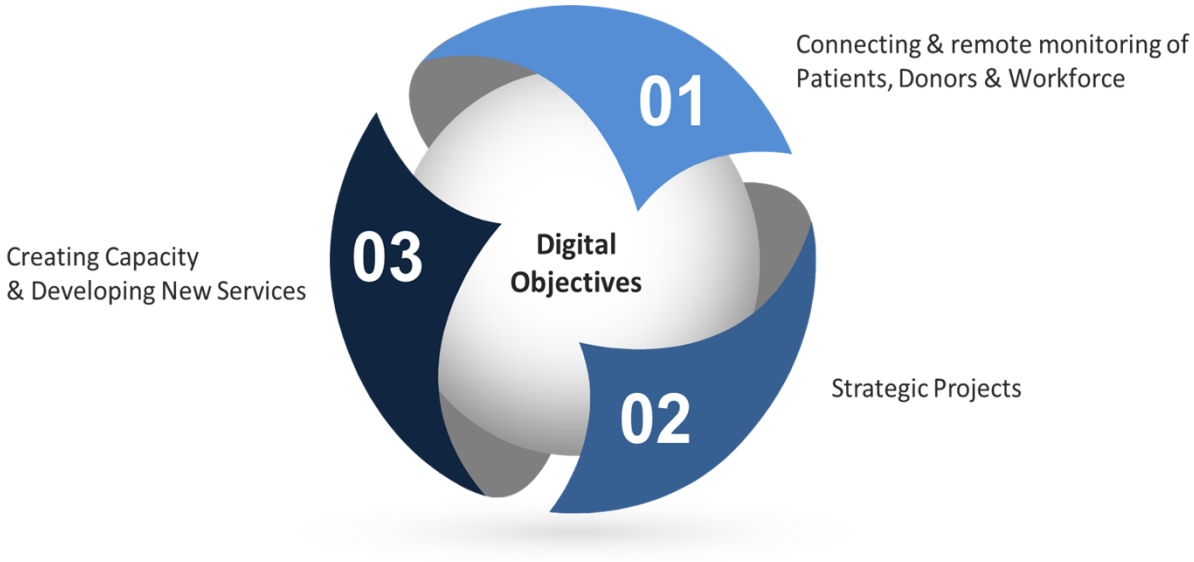
During the COVID-19 outbreak, Digital Services have continued to deliver its routine day to day services while accelerating aspects of its connectivity, remote working, and mobile device rollout projects. In order to prioritise these projects some of its core projects outlined within the Integrated Medium Term Plan have needed to be paused.

The most significant Digital change project impacted by the outbreak has been the Canisc replacement project. While Canisc remains a significant risk to the Trust, various operational resources that had been allocated to the project have had to return to their operational day jobs.

An assessment has been performed against all of our original key projects and at the time of writing it is anticipated that none of the key projects can be restarted until July 2020 at the earliest. However the Trust is planning to recommence the Cancer Informatics Solution project as soon as operational resources can be made available again and/or new resources can be identified.

5.5.2.4 Q1 Operational Plan

Building on the key drivers outlined within our Integrated Medium Term Plan, the current operational plan for digital can be broken down into three key objectives.



Under the following objectives, aligned to our overarching strategic direction, the following digital projects are being taken forward in Q1.

	Action	Lead	Timeframe
Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Virtual Consultation / Attend Anywhere	Adam Lukaszewicz	Q2
Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Primary / Secondary & Tertiary Connectivity / Consultant Connect	Dr Mick Button	Q2
Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Remote Monitoring Apps	Suzanne Rodgers	Q2
Q1	Strategic Projects: Office 365 / Microsoft Teams & Power Apps	Elin Griffiths	Q4
Q1	Strategic Projects: Cancer Informatics Solution	Stuart Morris Dr Jacob Tanguay	2021/2022
Q1	Strategic Projects: Patient Held Record	Elin Griffiths	Q4
Q1	Strategic Projects: Blood Establishment Computer System Enhancements in response to COVID-19 / Convalescent Plasma	David Mason-Hawes	Q3
Q1	Strategic Projects: Integrated Radiotherapy Solution	Philip Richards	2022
Q2	Creating Capacity & Developing New Services: Robotic Process Automation	Stuart Morris	2022
Q2	Creating Capacity & Developing New Services: eRostering	Anna Harries	Q3
Q2	Creating Capacity & Developing New Services: eConsent	Dr Jacob Tanguay	Q3

5.5.3 Communications

5.5.3.1 Summary of Current Situation as at week commencing 11 May 2020

Since the coronavirus outbreak, we have focused on communicating and informing staff and the public about news, information relevant to them. From a staff perspective, this has led to:

- The introduction of a daily all-staff bulletin
- Updated and dedicated intranet pages to the outbreak with delegated responsibilities for categories of information
- Information videos e.g. on PPE
- Focus on well-being messages
- Password protected web pages to enable access to information off-site
- The introduction of the TEXT messaging system for signposting and supporting
- The introduction of using platforms, e.g. Teams, to engage more widely across the Trust, with senior managers and executives speaking in live events directly with staff to address their key questions and concerns

For patients and donors, the corporate messaging has been focused on:

- Sign-posting to key Public Health Wales Guidance and explaining what this means for our divisions

5.5.3.2 New ways of working

- More regular direct communication with staff
- Use of videos for key information
- Use of digital – e.g. Microsoft Teams for live events

5.5.3.3 Q1 Operational Plan

Plan for delivery by end June:

	Action	Lead	Timeframe
Q1.	Link in with cancer services campaign, led by WG	Lauren Fear	30th June 2020
Q1.	Continue direct communication on key topics, e.g. well-being, PPE	Lauren Fear	30th June 2020
Q1	Start to effectively use and embed TEXT messaging service, use of Teams for live events	Lauren Fear	30th June 2020
Q1.	Creation of a Request for Information tracker (RFI) – with support from our military colleagues in the design - launch this as a way of all staff questions, concerns and answers being transparent and accessible to all	Lauren Fear	29th May 2020
Q1.	Start to use the social media Trust feeds more effectively, beyond sign-posting only. Start with direct support for those Execs already active on social	Lauren Fear	30th June 2020
Q1.	Returning to work – planning internal communications about helping staff return to work	Lauren Fear	30th June 2020

5.5.4 Nursing and Quality

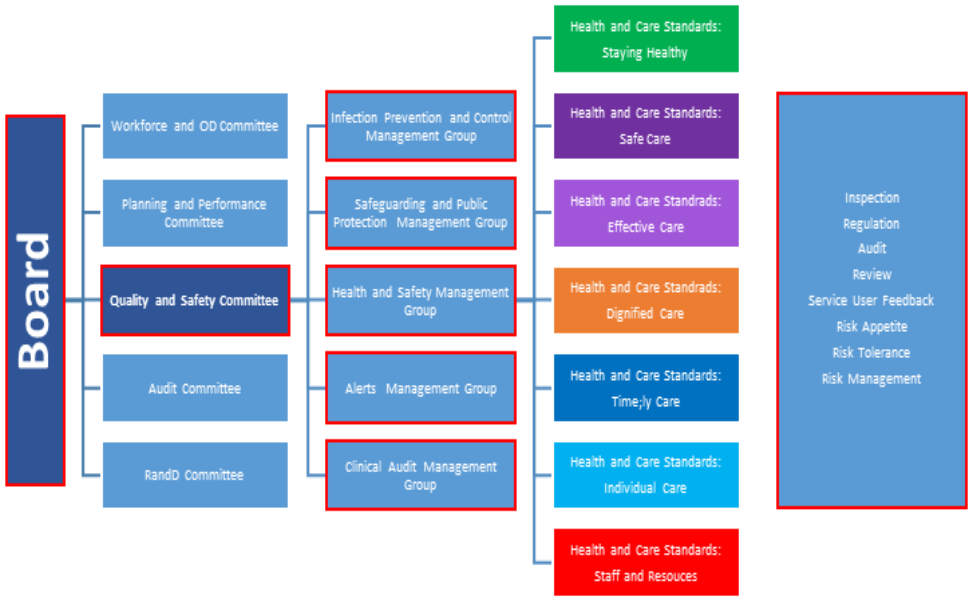
5.5.4.1 Summary of Current Situation as at week commencing 11 May 2020

We are committed to continuous quality improvement of our services and strive to always ensure that we achieve our aim of providing 'excellent care for our patients, donors, families and carers'. This means providing person-centred care that is safe, effective, dignified, timely, and individual.

It is our intention to support and enable our staff to always strive for excellence, through an ongoing cycle of review, learning and improvement of the services we provide. Organisationally our quality aims can be categorised as:

- Fostering a culture of safety and quality improvement
- Providing safe care, and learning when things go wrong
- Using data to measure performance and inform improvement
- Recruiting and retaining skilled, competent and compassionate staff.

The Trust Board is accountable for ensuring the quality and safety of all services we provide, and assurance is obtained via the Board's Quality and Safety Committee. The Committee meets every three months and discusses reports on matters that fall within its terms of reference.



Our workforce is integral to the delivery of high quality, person centred and safe services. We know that improving the levels of our staff satisfaction and making our organisation a good place to work goes hand in hand with the experiences of our patients and donors. We expect all of our staff to model our organisational values in their everyday work.

5.5.4.2 Q1 Operational Plan nursing AHP, Health Scientist & Quality & Safety

The quality improvement priorities identified within the Operational Plan have been progressed in the following ways in Q1, taking account of the impact of COVID-19

The COVID-19 pandemic has had an impact on delivery of Q1 priorities as identified in the IMTP submission. An update against these have been provided through to the Trust planning team under separate cover. In summary, although all original intentions still apply, some areas have been progressed as planned, timescales for delivery of others have been affected by the pandemic. These be phased into business as we move into the recovery phase and progress will be depended on the emerging pandemic. (**See Appendix 1)**

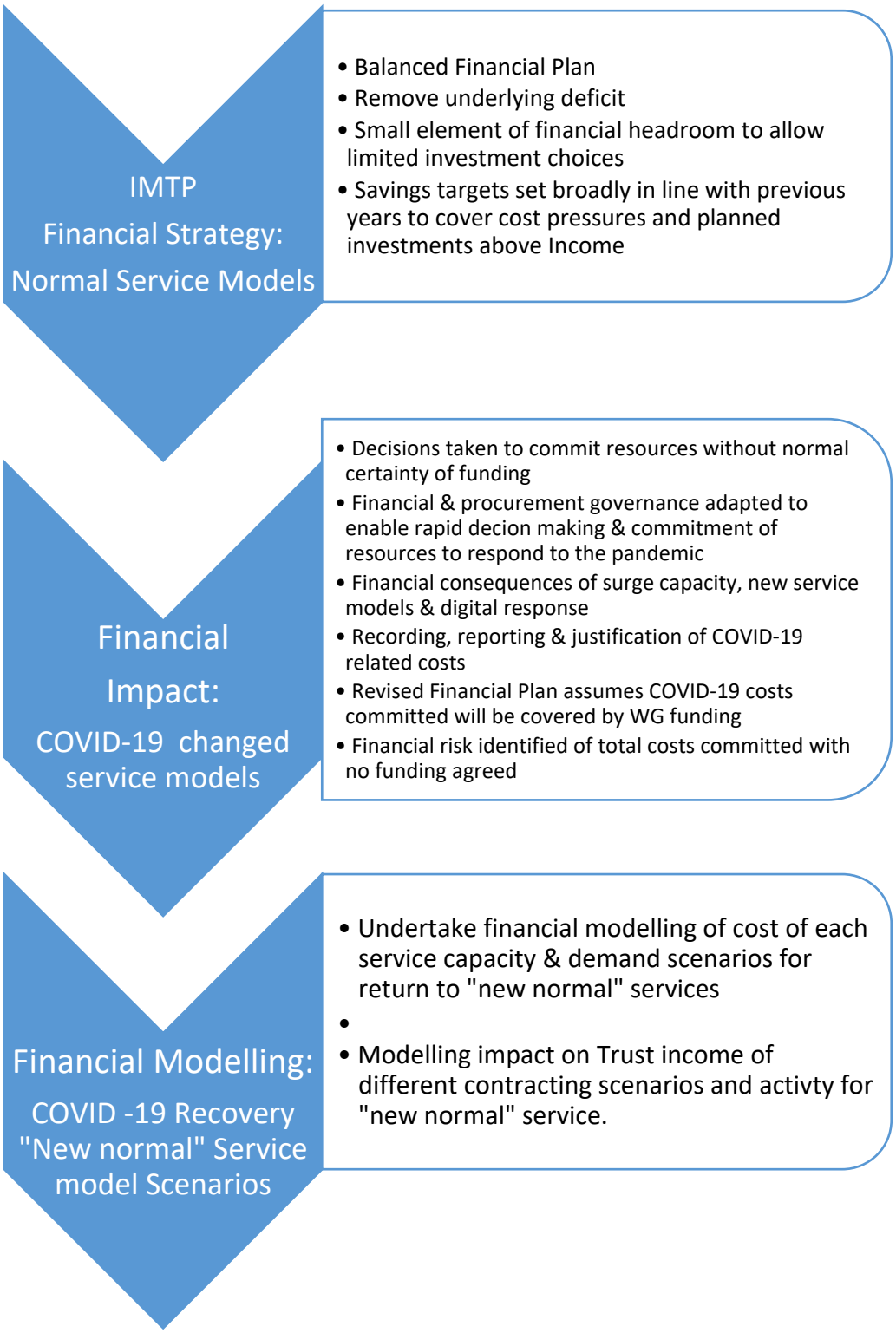
However, in addition, the pandemic has brought new challenges and the requirement to commence different pieces or work that were not previously identified within the IMTP. These are outlined in the table below:

	Action	Lead	Timeframe
Q1.	**Infection prevention & control and public health** There is insufficient capacity & capability within the Trusts Infection Prevention & Control and public health infrastructure to meet the ongoing public health and infection prevention needs throughout this pandemic. Teams needs to be strengthened by the appointment of: • A Respiratory Protection Advisor – PPE Lead & trainer • Infection Prevention & Control Support Worker – Support ICNs in ongoing audit & assurance in relation to IC & PPE practices- will release ICNs to take on core role / decontamination requirements (work on top of licence) • Increase current band 3 IPC administrator from 20 to 30 hours a week again to support ICN's to work at top of licence • PHW ICD / Microbiology SLA to be reviewed (due in April 2020) – to increase from 1 to 3 sessions / week of onsite ICD support– role & function to be described • Agree with PHW how Trust can obtain increased dedicated Public Health Support • A dedicated / trained IC Champion in each Team / department across the Trust – has dedicated training programme / IC Shadow time and competency framework.	Quality & Safety	In place by end of Q1 – funding needs identification
Q1	**VCC Electronic Nurse Rostering** Implement Allocate electronic rostering system & bank management system during June 2020 – All Wales procurement delayed due to COVID-19	Nursing	End of Q1
Q1	Quality & Safety Framework to be completed and implementation commenced Commence recruitment of Quality & Safety Project Manager	Quality & Safety	End of Q1

Q1	Develop COVID-19 'Cells' to deliver the core COVID-19 requirements across the Trust. To report through to EMB / relevant Board Committee. 8 cells in place currently: PPE; Q&S; End of Life / Death Processes; Staff & patient testing; Digital; Workforce; planning; & information / performance	Quality & Safety	Throughout Q1
Q1	Realign all Q&S investigative & reporting mechanisms to ensure all requirements of COVID-19 are met i.e. processes for: death of an employee diagnosed with COVID-19; reporting & investigating incidences of staff being diagnosed with COVID-19; & reporting & Investigating incidences of patients being diagnosed with COVID-19.	Quality & Safety	End of Q1
Q1	Develop systems / processes and mechanisms for ongoing review in line with developing pandemic clinical prioritisation processes in line with national guidelines and patient needs	Quality & Safety	Ongoing throughout pandemic
Q1	Establish a Clinical Ethics Committee	Quality & Safety	End of Q1

5.5.5 Finance

Summary of Financial Strategy & Plan Phases



5.5.5.1 Summary of Current Situation

The Trust IMTP sets out the financial strategy and plan for the Trust revenue and capital, including our assumptions around income and expenditure, anticipated cost pressures, planned investments and financial risks.

The expectation is that the Trust will achieve a balanced financial positon in 2020-21 as indicated in the IMTP. However, this is based on the assumption now that the new financial risk of committed COVID-19 expenditure (revenue & capital) will be funded by Welsh Government.

Table 13 A summary of the Q1 forecast revenue financial position is shown below:-

	Apr '20 Actual £'000	May '20 Forecast £'000	Jun '20 Forecast £'000	Q1 Total Forecast £'000
Net Surplus / (Deficit)	4	0	0	4

5.5.5.2 New ways of working

The financial impacts of new service models to respond to COVID-19 have been captured. Actual costs for April ’20 are known and we have developed forecasts for May & June 2020/21.

Further discussions over the next six weeks will be held on the financial implications for Welsh Blood Service and Velindre Cancer Centre to ensure all financial implications of the changed service models have been captured in the Q1 costs.

Table 14 Summary of COVID19 Revenue & Capital Financial Expenditure & Commitments for Q1

	REVENUE					CAPITAL				
Division	APRIL	MAY	JUNE	Q1 Total	Forecast to 31.3.21 Total	APRIL	MAY	JUNE	Q1 Total	Forecast to 31.3.21 Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
VCC	117	195	117	429	567	161	462	0	623	623
RD&I	3	9	9	21	103	0	0	0		0
WBS	67	124	176	367	1,382	0	207	0	207	207
Corp.	27	33	40	100	164	238	166	0	403	403
Total	214	361	342	918	2,216	399	834	0	1,233	1,233

Table 15 COVID-19 Revenue Financial Expenditure / Commitments for Q1 and Forecast by expenditure type

Financial Impact Grouping	April '20	May '20	June '20	Total Q1	Forecast year-end
	£'000	£'000	£'000	£'000	£'000
Establishment & Bank Additional Hours	29	97	150	276	791
Agency	11	16	16	43	49
Returners	9	9	9	28	28
Students	-	-	-	-	-
Other Temp Staff	-	5	13	17	83
Sub-total Pay	50	127	188	364	950
Estates / Security Expenditure (Revenue Only)	27	34	16	77	77
M&SE Consumables	33	20	10	63	330
COVID-19 Testing Units				0	208
Cleaning	16	8	7	30	33
PPE (not from National Supply)	19	36	6	61	61
Transportation	2	16	12	30	41
IT & Software Licences	7	0	0	7	7
Venue Hire	13	13	13	38	38
Equipment	8	27	0	35	35
Other–Training, provide services externally	4	2	1	7	8
Reduction in non-pay - reduced activity	-50	-40	-30	-120	-120
Sub-total Non-Pay	79	114	34	227	718
Sub-total Additional Cost	129	241	222	591	1,668
External Income Loss	40	75	75	189	274
Unachieved Savings (Workforce Related)	46	46	46	138	275
TOTAL	214	361	342	918	2,217

Key Issues:-

1. A financial return was submitted to WG for revenue costs on the 17th April and Capital costs on the 27th April in accordance with their deadlines
2. Further updates of COVID-19 costs will be submitted as part of the normal monthly financial monitoring process as per the following:-

Schedule of monitoring dates

Organisations are required to submit their year to date and forecast financial position information of the 5th working day, for Months 2 to 12. A brief explanation has to be provided on the template, for any movement in year-end outturn since the previous month.

The main monitoring returns are required on the 9th working day of each month, with the exception of Month 12.

For period ended	Day 5 Submission Date	Day 9 Submission Date
Month 1 - 30th April	Not Required	18th May
Month 2 - 31st May	5th June	11th June
Month 3 - 30th June	7th July	13th July

3. To date there has been no confirmation of funding from WG for any of the COVID-19 costs, apart from £92,100 of capital for IT devices - Tablets. WG has indicated that at this stage, there is no certainty of funding beyond the specific areas of;
- set-up costs and committed running costs of the field hospitals (funding to be confirmed during May);

Funding will be allocated for these specific areas of support as costs are confirmed;
- costs of student and returning staff;
- provision of PPE;
- support for early discharge arrangements, and
- the costs of the testing programme

A risk assessment has been completed of the impact and likelihood the financial risk that COVID-19 committed and forecast costs expose the Trust to. The risk has been scored as 12, a significant risk as the financial risk is possible (3) and would have a major impact (4) on the Trust ability to meet its statutory financial duty to break-even. Actions will be taken over the next 3 months to control or mitigate the financial risk.

4. The DoF & Deputy DoF have reviewed all items included within the above table to test the justification of the expenditure in relation to COVID-19. This has resulted in some items of expenditure being transferred into Trust normal expenditure and requirement to be funded from core budgets

5. The above does not include costs of additional capacity required above that in place to accommodate the “new normal” service models that will need to deal with the backlog activity and future demand assumptions as the Trust re-introduces routine services and ensures the maintenance of its essential services as it moves into recovery.

5.5.5.3 Reintroducing Routine services

In order to forecast COVID-19 related expenditure for the rest of the financial year the Finance team are working with service and planning colleagues to model the service scenarios in terms

of activity, capacity and demand assumptions etc. and their impact of workforce, non-pay & outsourcing costs.

5.5.5.4 Q1 Operational plan

IMTP Financial Strategy & Plan

The 2020 – 2023 IMTP sets out the financial strategy & plan for the Trust revenue and capital. It identifies the assumptions around income and expenditure, anticipated cost pressures, planned investments, financial risks. The expectation is that the Trust will achieve a balanced financial positon in 2020-21 as indicated in the IMTP.

The IMTP balanced financial plan was agreed prior to the COVID-19 pandemic outbreak. The Trust has incurred additional expenditure in its response to the pandemic. If the Trust is to now deliver a balanced financial position in 2020-21 there is an assumption that the additional COVID-19 expenditure incurred in April ’20 and costs forecast for May ’20 to Mar ‘21 (revenue & capital) will be funded by Welsh Government.

New ways of working

The actual costs of managing COVID-19 for April ’20 are known and we have developed forecasts for May ‘20 & June ‘20, but these need to be reviewed following the completion of the work to assess additional capacity requirements and whether any of this additional capacity will be commenced in May or June. This may lead to an increase in the May & June COVID-19 forecast expenditure.

The financial implications of WBS (Section 1.4.10) and VCC (Section 1.5.9) operational plans are covered in the main by the Trust IMTP Income. The additional costs of managing COVID-19 have been identified / estimated in the table in 5.3.5.2. As stated above, these do not yet reflect the costs of the additional capacity required to re-introduce routine services and maintain essential services.

Reintroducing Routine services – the “New normal”

One of the key pieces of work for the finance team is to forecast COVID-19 related expenditure for the whole financial year. A fundamental element of this forecast is the cost of the additional capacity (Internal and External) above that in place that will be required to accommodate the “new normal” service models.

These “new normal” service models will need to be implemented to deal with the backlog activity and enable capacity to be flexed in an agile way to provide resilience against uncertain future demand as the Trust re-introduces routine services and ensures the maintenance of its essential services as it moves into recovery. The Finance Team will be modelling the cost of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell)

Identified Divisional Risks

There are risks identified in the Division sections of this operational plan that should they crystallise could lead to additional cost / or further loss of income above that reflected in the

Q1 COVID-19 forecast or Trust annual forecast. The Trust will actively work to mitigate or remove these risks, but should they crystallise the forecast costs will be updated to reflect them.

Summary

At this stage the core underlying financial plan contained within our IMTP submitted to WG in March has not changed substantially. What has changed is the greater uncertainty and financial risks surrounding our activity levels and capacity implications as we move into the recovery phase and potential future spikes of further COVID-19.

The more significant risks are:

Table 16

Financial Risk	Mitigating Actions	Lead
Reduced contracting income from activity levels	Seek clarity through DoF forum and DoF NHS Wales whether the current "Block Contract" arrangement will continue and anticipated time period	DoF
Non reimbursement of certain COVID-19 costs	Seek confirmation from WG the revenue & capital funding the Trust will receive to cover COVID-19 financial implications	Chief Exec & DoF
Non reimbursement of costs of additional internal capacity or outsourcing to address future capacity constraints from "new normal" service models	Future service models to be developed and identify financial impact to cover COVID-19 financial implications	Chief Exec & DoF
Non delivery of savings	Seek confirmation from WG of what revenue & capital funding the Trust will receive impact to cover COVID-19 financial implications	Chief Exec & DoF

Summary of Finance Team Key Actions for Q1

	Action	Lead	Timeframe
Q1	Providing governance support to NWSSP & NWIS to enable rapid procurement of essential equipment & services to respond to COVID-19 at an All Wales level	DoF & Deputy DoF	Apr – June '20 & ongoing
Q1	Monthly management of charity applications and production & reporting of financial position	Financial Planning & Reporting Manager	Monthly
Q1	LTAs with all HB's & WHSSC signed securing core income – although operating block arrangement in Q1 as per National DoF agreement	Deputy DoF	01.04.20

	Action	Lead	Timeframe
Q1	Development of revised RD&I Financial Strategy & Plan	DoF & Finance Manger RD&I	30.06.20
Q1	Ensure WG are clear that the revenue (£0.918m Q1) & capital (£1.233m) financial sums the Trust has already incurred / committed in its response to COVID-19, and that the Trust Financial Plan assumes that these costs will be funded.	Chief Executive & DoF	31.05.20
Q1	Undertake financial modelling of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell) to enable the Trust to flex capacity in an agile way, provide resilience against uncertain demand and ensure patient and staff safety is maintained through social distancing.	DoF, Deputy DoF & Head of Finance Business Partnering	30.06.20
Q1	Month end close down and production of financial position (Revenue & Capital) for reporting to WG and internally, including COVID-19 expenditure and financial impacts	Deputy DoF & Head of Finance Business Partnering	Monthly
Q1	Procurement of VCC Integrated Radiotherapy Solution Bidder Response & Dialogue days Financial Model	Deputy DoF & Head of Finance Business Partnering	June ’20 and ongoing
Q1	Financial & Business support to WBS Convalescent Plasma service development	Head of Finance Business Partnering	April – June ’20 & ongoing
Q1	Production of Year End Accounts, responding to associated Audit queries and presentation of accounts to Audit Committee	Head of Financial Operations	30.06.20
Q1	Development of Q2 – Q4 Action Plans	DoF, Deputy DoF	30.06.20

The essential day to day areas of finance work not included in the above table of key actions continue to be provided to support the Trust in delivering its Strategic and operational plans.

6. Key Risks

Table 17 Key risk areas	Key actions	Exec Lead
Workforce Capacity/capability • COVID-19 Related Workforce Absence	• Implementing of Staff testing policies • BAME Risk assessment	Chief Operating Officer
Workforce Well-being • Impact on staff mental health/burn-out concerns	• Supporting staff's health and well-being for home workers	Director of Workforce and OD
PPE	• Maintain appropriate stock levels Ensure consistent application of NHS Wales Guidance	Chief Operating Officer
Digital capacity/capability • Infrastructure capacity (national) to support home working now staff are at home • Responsiveness/effectiveness of enabling functions when working at home	• Supporting digital services to facilitate remote working • Sustaining changes to support new ways of working	
Blood supply (donors/venues) • Impact of changing venue and social distancing on collections • Increasing demand from Health Boards as routine services are re-introduced	• Developing revised blood collection plan • Working with Health boards to understand changes in demand for blood products • Working with Health Boards to implement consistent guidance of use of blood products	Chief Operating Officer
Change in upstream clinical pathways/capacity • Increasing demand from Health Boards as routine services are re-introduced • Impact of suppressed demand representing as increased demand and /or changes pathways	• Working together with Cancer Network and Health Boards to ensure clarity across the cancer community on the level of cancer services being provided are providing • Ensuring clinical protocols are consistent with advice from Cancer Network	Director of Transformation, Planning and Digital
System unable to cope with forecast demand/acuity & impact on cancer patients/staff	• Developing capacity proposals (additional capacity) in partnership with Cancer Network, Delivery Unit and Health Boards	Director of Transformation, Planning and Digital

7. Approval Process by Trust Board

This Operational Plan Q1 for 2020/21 has been considered by the Trust Board at a special briefing meeting on 15th May prior to submission to Welsh Government. It will be submitted formally to the Trust Board meeting on Thursday 4th June for approval

Appendices

APPENDIX 1

Progress Report Against Quality Improvement IMTP Action Plan 2020/21

Quality Improvement IMTP Priorities 2020/21		
Strategic Objectives	**Detailed Actions**	**Progress in Q1**
Strengthen our quality and safety governance and assurance processes	Develop and embed a Board Assurance Framework (BAF) and revised risk management system and processes.	Work ongoing – some delays due to COVID-19. Q&S Committee frequency increased from quarterly to monthly to enhance governance and 8 Trust wide COVID-19 'cells' established to ensure delivery of key COVID-19 related requirements
	Complete development and commence implementation of our Quality and Safety Framework, business intelligence / performance indicators and metrics.	Work ongoing – some delays due to COVID-19.
	Identify a clinical and a governance lead to engage with the all Wales NICE Health Network which will enable a systematic approach to implementation of NICE guidance, and provide opportunity to identify priority areas for quality improvement on a 'once for Wales' basis.	Work ongoing – some delays due to COVID-19.
	Update the Trust Datix system and ways of working in advance of implementing the Once for Wales RLDatix system	Implementation 80% complete – WBS & Risk model implementation not yet completed. All Wales once for wales system roll out delayed at present due to COVID-19.
	Implement a system of robust Executive led and Board assurance visits.	Delayed due to COVID-19.
	Review our processes to embed learning from concerns, external reviews, and audits via a Shared Listening and Learning Sub-Committee (acting as a formal sub-Committee of the Quality and Safety Committee).	Two committees held- on hold at present due to COVID-19 priorities- planned to re-start in August 2020
	Implement and evaluate a revised methodology and bespoke database to support Divisional and Trust-wide self-assessment against the Health and Care Standards.	Database in place- further database updates and H&CS process review underway.
	Update the Trusts Quality and Safety Website page.	Work ongoing
	Respond to 90% or > of formal complaints within 30 working days	Q4 compliance 96%, overall 2019/20 compliance of 76% increase from 68% previous yr.
	Ensure all Serious Incident investigations are concluded within 60 days	100% compliance for q4 & q1 to date.

	Develop a quality and safety training strategy, undertake a training needs analysis, training delivery plan and mechanisms for monitoring	Work ongoing – some delays due to COVID-19.
Improve information available to patients, donors and the public	Implement a real time patient / donor feedback system across the Trust	awaiting once for wales system- delays due to COVID-19
	Developing a directory of services for patients attending Velindre Cancer Centre.	Work ongoing – some delays due to COVID-19.
	Update the 'Before You Donate' information leaflet for blood donors.	Work ongoing – some delays due to COVID-19.
	Implement 'memory mates' information and support for patients with memory loss who are attending the Cancer Centre.	Work ongoing – some delays due to COVID-19.
	Implement a bereavement support service.	End of life cell currently scoping out the need – there is some bereavement support in place – gaps are being determined at present
Strengthen systems and processes within the Welsh Blood Service	Reposition the quality assurance function within Welsh Blood to focus on supporting change and improvement rather than inspection and enforcement.	Work ongoing – some delays due to COVID-19.
	Review the Quality Management System, including review of controlled documents and the change management process, and focussing on service user outcomes in addition to legal and regulatory compliance.	Work ongoing – some delays due to COVID-19.
	Define what 'quality' is across all services provided by WBS.	Work ongoing – some delays due to COVID-19.
	Ensure work streams are aligned with the National Blood Health Plan objectives to redesign the collection and use of blood and related products.	Work ongoing – some delays due to COVID-19.
Improve safety, quality and patient outcomes at Velindre Cancer Centre	Deliver transformational change / improvement programme across outpatient services.	There is a Programme Board set up to deliver and monitor the outpatient improvements detailed in the IMTP, there are some delays due to COVID-19 e.g. refurbishment of clinic rooms, other ambitions have been expedited as a result of COVID-19 e.g. virtual clinics
	Deliver transformation change / improvement programme across radiotherapy services, including shortening the principle time to treatment target to 21-days to support implementation of the Single Cancer Pathway.	Work ongoing – some delays due to COVID-19.
	Consistently achieve 95% or > compliance with recognition of a deteriorating patient and sepsis metrics across assessment and inpatient areas.	On target.
	Achieve a position of zero avoidable healthcare acquired pressure ulcers.	Data is submitted to planning and performance management

		on a monthly basis including a narrative, a pressure ulcer scrutiny panel has been established at VCC, each incident is reported in Datix and a full RCA completed with lessons learned identified.
	Achieve 95% or > compliance with catheter, cannula and line care bundles.	On target.
	Ensure 100% of nurses delivering SACT assessed as competent with revised SACT Competency framework.	On target, new recruits take approximately 3 months to achieve the necessary competencies, there have been some minor changes to the delivery of the SACT passport training due to COVID-19.
	Achieve a reduction in the number of inpatient falls that result in harm (Nov 2019 – Oct 2020) when compared to rates for the same period 2019-20.	Data is submitted to planning and performance management on a monthly basis including a narrative, individual falls are reported and investigated using a full RCA approach including whether a fall was avoidable.
	Achieve a reduction in the number of all medication management related incidents reported via the Datix system (Nov 2019 – Oct 2020) when compared to rates for the same period 2019-20.	On target
	Maximise antimicrobial stewardship through improved performance against the 'Start Smart and Then Focus' standards; ensuring in all cases that there is documentary evidence	On target
	Review mortality review processes	A review has been undertaken with the process now being managed through the Significant Clinical Incident Forum in partnership with the clinical audit department.
	Ensure 85% of staff who have direct patient contact to have completed dementia training at an appropriate level.	This training has been included in the mandatory and statutory training for nursing staff, face to face training has been cancelled during the COVID-19 period where possible E based learning is available as an alternative.
	Implement an end of life training programme for all staff working within Assessment Unit and First Floor ward	On target.

Appendix 2

New Ways of Working Cancer – Velindre Cancer Services

Area	Key Changes and New Ways of Working at VCC
All	Activity for the majority of Site Specific Teams (SSTs) has declined in line with the reduced number of referrals as cancer diagnosis, screening and surgery activity has fallen.
	Implementation of social distancing measures across VCC To maintain safety of workforce at VCC through facilitating and promoting home working, departmental spacing, change of shift patterns, introduction of rotas, use of digital technology, restricting numbers in clinical/treatment areas. Other specific measures include: • Patients attending Radiotherapy encouraged to wait in their own vehicles • Oral SACT medications delivered to patients in their vehicles • Access of visitors to buildings restricted – any patient can attend with one other person if such support is deemed clinically necessary • *Amazon*-style locker system introduced which allows patients to collect enteral feeds and equipment out of hours to ensure flexibility and support social distancing
	Implementation of site triage system. Intensive pre-treatment triage measures include: • Telephone triage of patients on day prior to scheduled appointment • Additional triaging of patients on arrival at Radiotherapy and SACT day case treatments • Implementation of pathway for COVID-19 suspected patients attending Outpatients department
	Revised patient education and follow-up facilitating remote delivery of services. Specific measures include: • Chemotherapy education information made available as videos posted on *YouTube* and VCC internet page • Pre-treatment education for Radiotherapy patients conducted remotely Workforce re-alignment to support critical business service delivery, working from home support in place for shielding staff, and workforce have been re-aligned to support the critical elements

Radiotherapy	Halted prostate brachytherapy services and developed contingency plans for gynaecological brachytherapy treatments should the Cardiff and Vale UHB anaesthetic and theatre staff be unable to support VCC services during the pandemic
	Managed deferral of treatment of prostate cancer patients
	Deferment of non-urgent Basal Cell Carcinoma (BCC), low-grade Glioma and benign Deferment of category 2 suspected/ positive COVID-19 patients
	Introduction of processes to enable remote consent to treatment and plan approval
	Designated linear accelerator (Linac) for the treatment of suspected or COVID-19 positive patients
	Designated CT (simulator) time to reduce potential patient exposure
	Introduced an extended working day intended to smooth flow and reduce footfall
	Breast cancer treatment protocols have been amended to reflect hypo fractionation. This will reduce the number of attendances per patient whilst maintaining treatment efficacy
	Working with WHSCC on increasing the capacity for Stereotactic Ablative Radiotherapy (SABR) for lung cancer, given the reduced thoracic surgery capacity
SACT	With exception of 2 SACT delivery sessions delivered via Tenovus mobile unit, repatriation of SACT Outreach activity to VCC (includes lung SACT service managed by C&VUHB). This was undertaken to enable health boards to respond to the initial projected peaks in demand for their acute services to support COVID-19
	Increased supportive care capacity implemented to address increased need for procedures such as paracentesis
	VCC is part of a national initiative for End of Life medicines including the medicines supply chain from Just in Case medicines to Just in Time via the new NHS Wales
	Pharmacists and technicians undertaking remote medicine reconciliation to reduce contact and footfall within inpatient areas
	Implementation of Virtual Assessment Patient Pathway (VAPP) project to assess patients and determine if clinically inappropriate for the patient to continue with SACT treatment

	Encouraged use of oral treatments, where this is deemed a suitable alternative
	VCC's Medicines at Home Service continues to provide home delivery for many and VCC has expanded capacity in this service for 50 new patients by engaging an additional third party supplier
Outpatients	Significantly reduced face-to-face consultations. Specific measures include: • Extensive utilisation of virtual and telephone clinics • Implementation of processes to enable consent to treatment to delivered remotely • MDT meetings conducted remotely
	Repatriation of Outreach activity delivered in outreach contexts to VCC
	Implementation of dedicated phlebotomy clinics at VCC in response to GP closures
	Treatment protocols have been amended and modified to reduce risks of contracting COVID-19 infection
Inpatients	Created physical capacity to accommodate up to 47 inpatient and 8 Assessment Unit beds
	Managing COVID-19 patients in a dedicated area
	Refreshed admission criteria to reflect COVID-19 and VCC's support to the wider NHS and agreed appropriate escalation procedures with health boards for implementation during the pandemic
	All Therapy teams working over a 7-day timetable and trained in vital signs and interpretation of NEWS. This reduces the requirement for other staff members to enter areas where there is an elevated risk of infection
Radiology and Nuclear Medicine	Radionuclide Therapy (e.g. Radium 223 and Iodine 131) has been paused
	The number of days on which scans in Nuclear Medicine are undertaken at VCC reduced. The reduction of capacity at VCC supports the wider NHS system where staff shortages in radio-pharmacy are prevalent
	Home reporting workstations and a Radiology dedicated VPN enable reporting of complex studies remotely
	Radiology referrals have been reviewed and routine scans have been deferred where appropriate

	Radiographic justification of referrals to improve workflow which will reduce referral to scan times and reduce unnecessary interaction with consultant group
	Radiographic role extension for MR reporting and ultrasound training in place which will increase resilience and improve service provision

Appendix 3

Master Action Log for VUNHST Operational Plan 2020/21 Q1

ID	Q	Action:	Lead	Timeframe
WB1	Q1	Recommendations from the Risk assessment will be implemented, including where appropriate Perspex screens and PPE	Head of Labs	June 2020
WB2	Q1	Establish internal Programme Board to progress implementation of Convalescent Plasma	Head of QA	May 2020
WB3	Q1	Continue to support Health Boards to manage COVID-19 patients through collecting convalescent plasma for their use. NB: none has been transfused to date	BSC lead, Collections	Ongoing
WB4	Q1	Scope and develop the programme of work to support roll out of the convalescent plasma programme	Head of QA	May 2020
WB5	Q1	Submission of Business Case to Welsh Government to support expansion of convalescent plasma Programme	Head of QA	May 2020
WB6	Q1	WBS will continue to work with Health Boards to ensure clear understanding of plans regarding utilisation of 'field hospitals and impact on blood and blood products'	Head of Labs	May 2020
WB7	Q1	Develop an agreed workforce plan to support each clinic option	BSC Lead, Collections	June 2020
WB8	Q1	Work with health boards to understand plans for recovery	Blood Health Team	May 2020
WB9	Q1	Work with Health Boards to actively progress prudent use of blood and the use of alternatives to prevent demand outstripping supply when routine services are re-introduced.	Blood Health Team/Medical Director	June 2020
WB10	Q1	Work with independent sector to understand plans for recovery, impact on availability of fixed capacity and additional clinic capacity	BSC Lead, Collections	Ongoing
WB11	Q1	Explore options to reduce minimum time required to recruit and train new workforce for collection clinics.	BSC Lead Collections	June 2020
WB12		Blood Health National Oversight Group has written to Health Boards requesting they implement blood conservation methods to prevent blood shortage when non-essential work reintroduced.	Blood Health Team/Medical Director	May 2020

WB13	Q1	Work with C&VUHB to understand plans/timelines for UHW to restart solid organ transplant	Head of Labs	Ongoing
WB14	Q1	Work with Welsh Government, C&V UHB, PHW and NHSBT to roll out convalescent plasma phase 1	Head of QA	Q2 2020
WB15	Q1	Work with Welsh Government, NHS Wales and linking closely with UK blood services to scope phase 2 of the Programme of work (Plasmapheresis).	Head of QA	June 2020
WB16	Q1	Continue to participate in weekly briefings with national Organ Donation Teams (ODT) as part of recovery planning.	WTAIL	Ongoing
WB17	Q1	Meet with Transfusion Lab Managers/Transfusion appropriate use of blood in HBs	Blood Health Team	Ongoing
WB18	Q1	WBS to work with Health Board to understand how independent hospitals fit into recovery plans and if there will be an impact on demand for blood and blood products to Health Boards.	Blood health Team	May 2020
WB19	Q2	Ensure recovery plans for collection clinics take into consideration loss of current independent venue capacity as the venues move towards 'business as usual' and workforce due to shielding	BSC Lead Collections	May 2020
WB20	Q1	WBS need to understand plans from health boards for re-introducing surgery and addressing any surgical backlog	Blood Health Team	May 2020
WB21	Q1	Blood Health National Oversight Group has written to HB's requesting them to implement blood conservation methods to prevent blood shortage when non-essential work reintroduced.	Blood Health Team/Medial director	May 2020
WB22	Q1	Continue to address issues raised by donors, utilising direct and indirect channels of communication	Donor engagement	Ongoing
WB23	Q1	Continue to work with the media to cascade core messages to donors.	Donor engagement	Ongoing
VC1	Q1	Planning permission submitted to Cardiff City Council for the enabling works and nVCC	nVCC Project Director	May/June 2020
VC2	Q1	Receipt of initial solutions from bidders for integrated radiotherapy solution	Director of Transformation, Planning and Digital	May 2020

VC3	Q1	Completion of procurement documents and commercial strategy for nVCC	nVCC Project Director	June 2020
VC4	Q1	Completion of OBC nVCC	nVCC Project Director	June 2020
VC5	Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Virtual Consultation / Attend Anywhere	Adam Lukaszewicz	Q2
VC6	Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Primary / Secondary & Tertiary Connectivity / Consultant Connect	Dr Mick Button	Q2
VC7	Q1	Connecting & Remote Monitoring of Patients, Donors & Workforce: Remote Monitoring Apps	Suzanne Rodgers	Q2
VC8	Q1	Strategic Projects: Office 365 / Microsoft Teams & Power Apps	Elin Griffiths	Q4
VC9	Q1	Strategic Projects: Cancer Informatics Solution	Stuart Morris Dr Jacob Tanguay	2021/2022
VC10	Q1	Strategic Projects: Patient Held Record	Elin Griffiths	Q4
VC11	Q1	Strategic Projects: Blood Establishment Computer System Enhancements in response to COVID-19 / Convalescent Plasma	David Mason-Hawes	Q3
VC12	Q1	Strategic Projects: Integrated Radiotherapy Solution	Philip Richards	2022
VC13	Q2	Creating Capacity & Developing New Services: Robotic Process Automation	Stuart Morris	2022
VC14	Q2	Creating Capacity & Developing New Services: eRostering	Anna Harries	Q3
VC15	Q2	Creating Capacity & Developing New Services: eConsent	Dr Jacob Tanguay	Q3
VC16	Q1	Link in with cancer services campaign, led by WG	Lauren Fear	30th June 2020
VC17	Q1	Continue direct communication on key topics, e.g. well-being, PPE	Lauren Fear	30th June 2020
VC18	Q1	Start to effectively use and embed TEXT messaging service, use of Teams for live events	Lauren Fear	30th June 2020
VC19	Q1	Creation of a Request for Information tracker (RFI) – with support from our military colleagues in the design - launch this as a way of all staff questions, concerns and answers being transparent and accessible to all	Lauren Fear	29th May 2020
VC20	Q1	Start to use the social media Trust feeds more effectively, beyond sign-posting only. Start with direct support for those Execs already active on social	Lauren Fear	30th June 2020

VC21	Q1	Returning to work – planning internal communications about helping staff return to work	Lauren Fear	30th June 2020
CO1	Q1	Working in Partnership monitor Staff Safety ensuring: Risk Assessment for High Risk staff are completed and updated	Workforce Director	June 2020
CO2	Q1	Working from home arrangements are monitored and updated, supporting staff re-entering the workforce from home working	Workforce Director	June 2020
CO3	Q1	Process for staff testing is managed, monitored and communicated	Workforce Director	June 2020
CO4	Q1	Development of guidance to support managers implement social distancing guidance	Workforce Director	May 2020
CO5	Q1	Working with planning colleagues assess the workforce demand and utilise the existing supply channels as required	Workforce Director	Ongoing to June 2020 and beyond
CO6	Q1	Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas,	Workforce Director	June 2020
CO7	Q1	Working in partnership develop surveys based on feedback to improve staff communication and partnership working	Workforce Director	June 2020
CO8	Q1	Developing H&WB plan into recovery phase where staff are more likely to require support (based upon CARE model – create, assist, rapid, engage)	Workforce Director	June 2020
CO9	Q1	Ongoing Communication on wellbeing offer to staff via all stakeholders routes	Workforce Director	June 2020
CO10	Q1	Management development to support effective team management incorporating a blended delivery approach – building on our Manager Development Programme	Workforce Director	June 2020
CO11	Q1	Beyond Business as Usual Programme – Programme Plan completed and initiated	Workforce Director	June 2020
CO12	Q1	First Steps Management Development Programme completed	Workforce Director	June 2020
CO13	Q1	Leadership review completed and plan for Leadership communicated	Workforce Director	June 2020
CO14	Q1	Development of Virtual enabled learning (inc. HR App)	Workforce Director	June 2020 (to be reviewed)

CO15	Q1	Launch of Working In Confidence Platform to gain feedback on staff requirements for wellbeing	Workforce Director	June 2020
CO16	Q1	Working with Psychology to continue to develop the Workforce Wellbeing Plan for COVID-19	Workforce Director	June 2020
CO17	Q1	Enhance the workforce information report in line with Trust performance management dashboard	Workforce Director	June 2020
CO18	Q1	Undertake workforce modelling data based on Division demand	Workforce Director	June 2020
CO19	Q1	Providing governance support to NWSSP & NWIS to enable rapid procurement of essential equipment & services to respond to COVID-19 at an All Wales level	DoF & Deputy DoF	Apr – June '20 & ongoing
CO20	Q1	Monthly management of charity applications and production & reporting of financial position	Financial Planning & Reporting Manager	Monthly
C021	Q1	LTAs with all HB's & WHSSC signed securing core income – although operating block arrangement in Q1 as per National DoF agreement	Deputy DoF	01.04.20
C022	Q1	Development of revised RD&I Financial Strategy & Plan	DoF & Finance Manger RD&I	30.06.20
C023	Q1	Ensure WG are clear that the revenue (£0.918m Q1) & capital (£1.233m) financial sums the Trust has already incurred / committed in its response to COVID-19, and that the Trust Financial Plan assumes that these costs will be funded.	Chief Executive & DoF	31.05.20
C024	Q1	Undertake financial modelling of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell) to enable the Trust to flex capacity in an agile way, provide resilience against uncertain demand and ensure patient and staff safety is maintained through social distancing.	DoF, Deputy DoF & Head of Finance Business Partnering	30.06.20
CO25	Q1	Month end close down and production of financial position (Revenue & Capital) for reporting to WG and internally, including COVID-19 expenditure and financial impacts	Deputy DoF & Head of Finance Business Partnering	Monthly
CO26	Q1	Procurement of VCC Integrated Radiotherapy Solution Bidder Response & Dialogue days Financial Model	Deputy DoF & Head of Finance Business Partnering	June '20 and ongoing

CO27	Q1	Financial & Business support to WBS Convalescent Plasma service development	Head of Finance Business Partnering	April – June '20 & ongoing
CO28	Q1	Production of Year End Accounts, responding to associated Audit queries and presentation of accounts to Audit Committee	Head of Financial Operations	30.06.20
CO29	Q1	Development of Q2 – Q4 Action Plans	DoF, Deputy DoF	30.06.20
N1	Q1	**Infection prevention & control and public health** There is insufficient capacity & capability within the Trusts Infection Prevention & Control and public health infrastructure to meet the ongoing public health and infection prevention needs throughout this pandemic. Teams needs to be strengthened by the appointment of: • A Respiratory Protection Advisor – PPE Lead & trainer • Infection Prevention & Control Support Worker – Support ICNs in ongoing audit & assurance in relation to IC & PPE practices- will release ICNs to take on core role / decontamination requirements (work on top of licence) • Increase current band 3 IPC administrator from 20 to 30 hours a week again to support ICN's to work at top of licence • PHW ICD / Microbiology SLA to be reviewed (due in April 2020) – to increase from 1 to 3 sessions / week of onsite ICD support– role & function to be described • Agree with PHW how Trust can obtain increased dedicated Public Health Support • A dedicated / trained IC Champion in each Team / department across the Trust – has dedicated training programme / IC Shadow time and competency framework.	Quality & Safety	In place by end of Q1 – funding needs identification
N2	Q1	**VCC Electronic Nurse Rostering** Implement Allocate electronic rostering system & bank management system during June 2020 – All Wales procurement delayed due to COVID-19	Nursing	End of Q1

N3	Q1	Quality & Safety Framework to be completed and implementation commenced Commence recruitment of Quality & Safety Project Manager	Quality & Safety	End of Q1
N4	Q1	Develop COVID-19 'Cells' to deliver the core COVID-19 requirements across the Trust. To report through to EMB / relevant Board Committee. 8 cells in place currently: PPE; Q&S; End of Life / Death Processes; Staff & patient testing; Digital; Workforce; planning; & information / performance	Quality & Safety	Throughout Q1
N5	Q1	Realign all Q&S investigative & reporting mechanisms to ensure all requirements of COVID-19 are met i.e. processes for: death of an employee diagnosed with COVID-19; reporting & investigating incidences of staff being diagnosed with COVID-19; & reporting & Investigating incidences of patients being diagnosed with COVID-19.	Quality & Safety	End of Q1
N6	Q1	Develop systems / processes and mechanisms for ongoing review in line with developing pandemic clinical prioritisation processes in line with national guidelines and patient needs	Quality & Safety	Ongoing throughout pandemic
N7	Q1	Establish a Clinical Ethics Committee	Quality & Safety	End of Q1

Financial Plan 2020/21

Update for Board – 4 June 2020

FINANCIAL PLAN 2020-21
(As submitted within the IMTP 2020-23)
Main Points to Note

Funding for Pay Inflation agreed - £1,683k: circa 3% Uplift for 2020-21 (Final year of 3 year deal)

Discretionary uplift agreed with Commissioners - £633k (1%)

Forecast increase in costs for NICE/AWMSG approved drugs agreed with Commissioners - £7,262k (These are pass through costs and therefore we are directly reimbursed based on actual costs incurred).

Forecast increase in costs of WBS Commercial Blood Products agreed with Commissioners - £3,762k.(These are pass through costs and therefore we are directly reimbursed based on actual costs incurred).

Commissioners signed LTA documentation on the basis of committing to operating under the new contracting model once certain conditions were met (although the financial values within the plan have been based on the old Model at this point).

This enabled us to achieve

- A balanced financial plan
- Elimination of the underlying deficit
- Provide a small element of financial headroom to allow limited investment choices
- An achievable savings targets set broadly in line with previous years.

Summary Trust Income & Expenditure

INCOME SOURCES

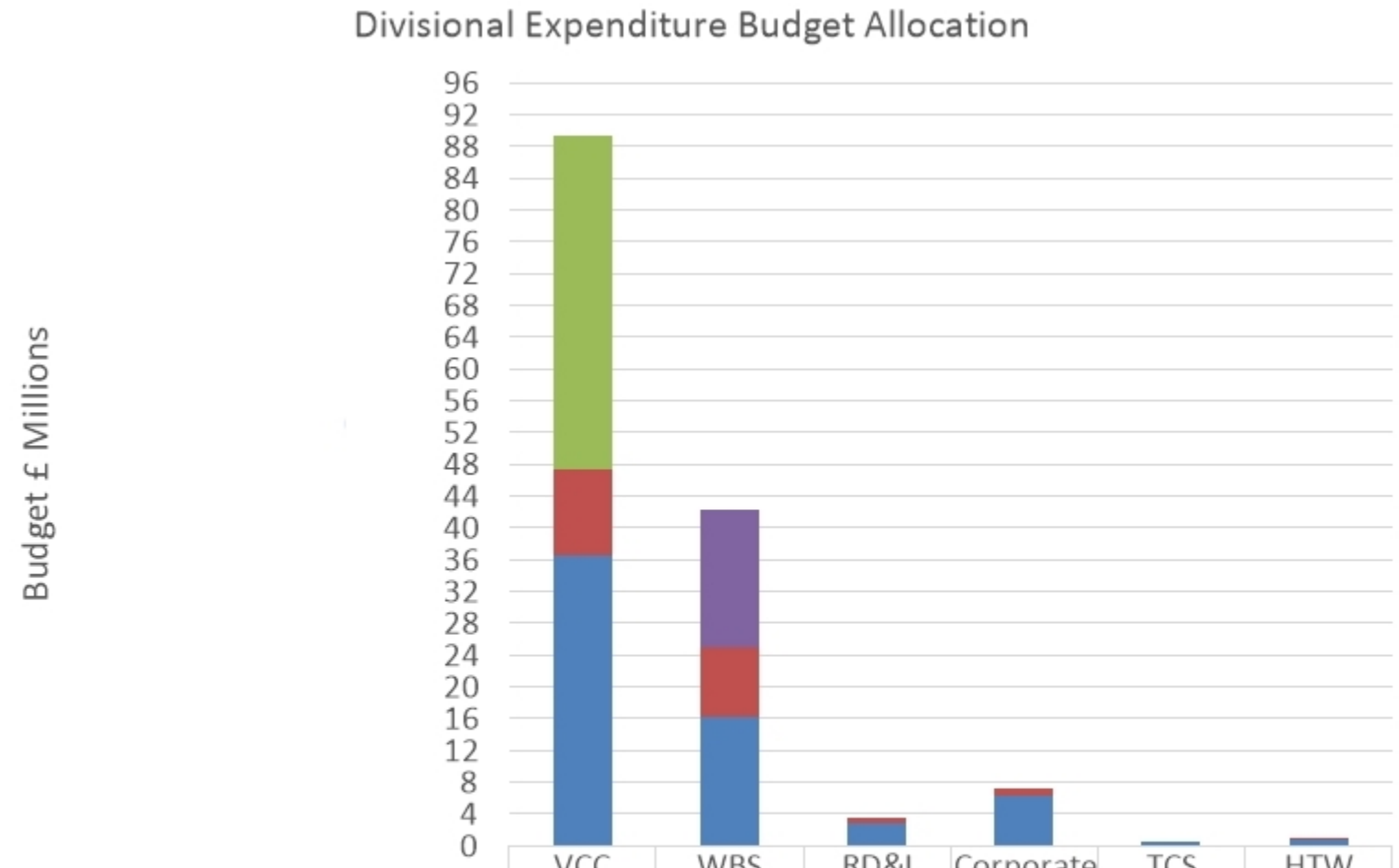
	£'M
Health Board	86.993
WHSSC	47.570
Welsh Government	5.087
Other e.g. staff recharges, charity, RD&I, private patients	13.045
Total Income	**152.695**

EXPENDITURE ALLOCATION

	£M
Pay	63.665
Non Pay	28.613
Sub-total	92.278
NICE /HCD	42.164
Commercial Blood Products	17.325
Sub-total	59.489
Unallocated Budget	0.406
Emergency Reserve	0.522
Total Budget Allocation	**152.695**

Divisional Budget Allocations

- The Division Gross Expenditure Budgets are funded through:-
  - Trust Income:
    - Commissioner LTA Income
  - Division Income:
    - Commissioner pass through funding for NICE/HCD & Commercial Blood products on actual usage
    - Other Income e.g. staff recharges, charity, RD&I, private patients etc.



	VCC	WBS	RD&I	Corporate	TCS	HTW
WBS Commercial Blood Products		17.325				
VCC NICE / HCD	42.164					
Non Pay	10.761	8.754	0.643	0.925		0.237
Pay	36.459	16.150	2.744	6.358	0.439	0.763

Update on Contracting Arrangements with our Commissioners

As part of LTA agreements, Commissioners have committed to operating under the new contracting model once certain conditions are met. The principle conditions being:

The cost base underpinning the new framework is updated to 2019-20 (expected July 2020) and all LHB commissioners are satisfied with their understanding of the technical aspects of the transfer of services and transition to their new baseline.	The provision of timely minimum data sets	Cost neutralisation adjustment to be actioned (via WG allocations).	An agreed risk sharing arrangement regarding the increase in potential costs to Commissioners during the first year of operation	There will be a mid-year review in October 2020 to assess the behavior of the new framework alongside expected values and the historical model.

Contracting Arrangements - Developments since Covid19

Due to the uncertainties associated with Covid 19 a revised approach has been agreed to ensure providers are not financially de-stabalised as a result of the likely non-delivery of planned care.

The all Wales Directors of Finance have agreed to a simple approach to LTA & SLA funds flow during the first quarter of 2020-21.

For Velindre this means that for quarter 1, contracting income will be based on the 2019-20 outturn plus the agreed baseline uplifts.

At this point no agreement has been reached on the arrangements from 1 July 2020.

Due to the complexities and uncertainties around forecasting future activity levels and contracting arrangements we are currently planning on a neutral impact regarding our Marginal activity income.

Covid 19 – Costs and Financial Risks

Costs directly associated with Covid 19 are captured and reported separately within our monthly monitoring returns made to WG.

Current assumptions are that these costs will be reimbursed by WG.

At the outset of the Pandemic WG stated that:	*Finance will not be a barrier to delivering the operational needs in response to Covid 19.*
	Where an organisation has a need to incur specific additional costs associated with the local response, then WG will consider making additional revenue funding available*.*
	Implementation of actions should not be delayed whilst waiting for WG funding confirmation.

However more recently WG have increasingly been referring to the scrutiny that will be undertaken and it is not guaranteed that full reimbursement will be made.

Summary of Covid 19 Costs and Forecast Potential Commitments

	REVENUE					CAPITAL				
Division	APRIL	MAY	JUNE		Forecast to 31.3.21 Total	APRIL	MAY	JUNE		Forecast to 31.3.21 Total
	£	£	£		£	£	£	£		£
VCC	117	195	117		**567**	161	462	0		**623**
RD&I	3	9	9		**103**	0	0	0		**0**
WBS	67	124	176		**1,382**	0	207	0		**207**
Corporate	27	33	40		**164**	238	166	0		**403**
Total	**214**	**361**	**342**		**2,216**	**399**	**835**	**0**		**1,233**

Summary – Revenue Budget 2020-21
As at 4 June 2020

No substantial changes made to the financial plan submitted as part of our IMTP to WG.

Forecast remains to breakeven.

However there is greater uncertainty and risks have increased. The more significant risks being:	Contracting income and activity levels
	Non reimbursement of additional direct costs associated with Covid 19
	Additional costs of outsourcing to address potential capacity constraints if/when we experience significant increases in activity and demand
	Non delivery of savings

Going forward into June and beyond a priority will be to seek greater certainty around WG funding position for Covid related costs and contracting arrangements with our Commissioners.

Demand and capacity modelling will be key to inform future financial decisions and management of the overall financial plan.

CAPITAL

All Wales Capital Programme

Current approved schemes

	£k
▪ IT – WPAS (Canisc replacement phase 2)	800
▪ CT Sim replacement	1,957
▪ Radiotherapy procurement solution	548
▪ DNA Extracting Kit	50
▪ Foetal D	54
▪ Treatment planning system	44

Total	**3,541**

Major Schemes in Development

- VCC – PBC (compliance and safety issues prior to opening of the new hospital)
- Fire Safety – c **£700k**
- Ventilation – **c £2m**
- WBS PBC – Mechanical / Electrical infrastructure – c **£21m over 4 years**

Discretionary Allocation

The Welsh Government provide the Trust with a discretionary allocation each year. The current baseline is **£1.9m** and is to be used primarily for:

Statutory and regulatory compliance
General Estates work
Replacement of equipment
etc

Currently in the process of prioritising the 2020-21 programme.

Risks associated with the Capital Programme

- Significant capital requirements identified across the Trust
- Unlikely to be 100% successful with bids to the All Wales Programme
- Currently using Discretionary funds to support the TCS programme
- Expenditure directly related to Covid-19 estimated to be circa £1.233m. Reimbursement not guaranteed.
- Uncertainty over funding creates delays in decision making for use of Discretionary funds and impacts on deliverability.

TRUST BOARD

HIGHIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY COMMITTEE

DATE OF MEETING	27.04.2020 and 14.05.2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Katie Foward, TCS Programme Coordinator
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	
nVCC	New Velindre Cancer Centre
TCS	Transforming Cancer Services
VCC	Velindre Cancer Centre
MiM	Mutual Investment Model
The Council	Cardiff County Council
TCS	Transforming Cancer Services

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the TCS Programme Scrutiny Committee at its Public meetings on 27th April 2020 and 14th May 2020.

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

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	**Board Approval for Timing Submission of Planning Applications** It was noted that Mr. David Powell, Director of the nVCC Project, had met with Welsh Government in the week prior to the meeting to establish their availability to continue with the Project works. It was advised that Cardiff County Council plan to reopen their planning process towards the end of May (now confirmed to be the 18th May 2020). The Project Director and his Team are in contact with Cardiff County Council to ensure that the revised planning application for the nVCC site remains a priority for the planning department. Mr. David Powell advised the Committee that The Board will be asked to Approve the halting of works and a reset of the Project Plan. The Scrutiny Committee Noted the progress of the Projects to date and Endorsed the Paper for Board Approval.
ADVISE	**Training, Support and Education for Staff** Training and creative input sessions to be arranged for Board Members to cover the nVCC and MiM procurement and wider TSC Programme value add elements, including sustainability. These modules will be made available to all Board members.
ASSURE	**Trust Risk Register** The Programme risk register will be reviewed and further work will be taken forward as part of the corporate risk review to ensure future alignment with the Trust risk register. The Programme work is planned to recommence on the 1st June 2020 and the register review will be undertaken as part of this work.

INFORM	
APPENDICES	**NOT APPLICABLE**

PUBLIC TRUST BOARD

ASSURANCE REPORT FROM THE CHAIR OF THE VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

Meeting Date:	30 May 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust
Report Presented by:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust

Trust Resolution to: (please tick)							
APPROVE:		**REVIEW:**		**INFORM:**	☑	**ASSURE:**	☑
Recommendation:	For the Board to review and **NOTE**.						

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) ☑	
Equitable and timely services	☑
Providing evidence based care and research which is clinically effective	
Supporting our staff to excel	
Safe and reliable services	☑
First class patient/donor experience	
Spending every pound well	☑
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SMT – Senior Management Team	WAO – Wales Audit Office IMTP – Integrated Medium Term Plan NHAIS – National Health Application and Infrastructure Services
Executive Summary:	
This paper has been prepared to provide the Velindre Trust Board with details of the key issues considered by the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on 28 April 2020. The Board is requested to **NOTE** the contents of the report and actions being taken. Key assurances and highlights from the meeting are reported overleaf:	

VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NWSSP
ASSURANCE REPORT

1. CEFNDIR/BACKGROUND

The Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership (Audit Committee) provides assurance to the Velindre Trust Board on the issues delegated to them through the Trust and NWSSP Standing Orders. A summary of the business matters discussed at the meeting held on 28 April 2020, is outlined below:

ALERT	No matters to alert/escalate.
ADVISE	It was advised that the NWSSP Local Counter Fraud Specialist had been temporarily redeployed to the Dragon's Heart Field Hospital and therefore the Committee would receive the following Counter Fraud reports at the June 2020 meeting; NWSSP Counter Fraud Annual Report 2019-20, Self-Review Submission Tool Review and Work Plan 2020-21.
ASSURE	**Governance and Assurance Matters During COVID-19 Pandemic** The Committee received a comprehensive verbal update from NWSSP Managing Director and NWSSP Director of Finance and Corporate Services in relation to the handling of COVID0-19 matters and the impact on the organisation. They provided insight and highlighted the importance of the challenging and complex work being undertaken by NWSSP staff across the board, ranging from Procurement going above and beyond to source, acquire and deliver PPE for frontline care, Informatics migrating 1500 staff to Microsoft Office365 and delivery of our business critical services to ensure NHS Wales staff are recruited and paid, as well as suppliers, contractors, GPs and opticians. NWSSP identified critical business services in the first instance, as being Accounts Payable, Procurement and PCS and recognised the importance of providing transactional, administrative and office based staff with the equipment needed to effective work from home as a matter of urgency, in line with Government guidance. Buildings management and the safeguarding of staff has taken high precedence with implementing various controls at sites to comply with social distancing measures and reduce the risks arising. The Committee formally noted and recognised how helpful and flexible the Velindre Trust Board have been in adapting to the exceptional circumstances and turning around NWSSP requests rapidly, in order to assist in obtaining vital equipment. The Committee received an extraordinary report in relation to NWSSP financial expenditure and the changes to governance arrangements, as a result of COVID-19, including the changes made to the delegated limits for urgent COVID-19 expenditure and the establishment of a Finance and Governance Committee to monitor the overarching contracts and ensure due diligence for robust and complex arrangements, chaired by the Director of Audit and Assurance Services. Further, the NWSSP COVID-19 advance payment log for purchases and checklist was tabled at the Committee, which included a detailed breakdown of updates on goods received, to include planned delivery schedules, as informed by Procurement. The Committee received a number of items for information and assurance, as shared with the NHS Wales Board Secretaries to highlight the importance of maintaining effective governance arrangements in difficult times, namely: • Letter from Richard Bevan (ABUHB) to Dr Andrew Goodall regarding proposals from NHS Wales Board Secretaries and Director of Corporate Governance for COVID-19, dated 18032020;

	• Response to Letter from NHS Wales Board Secretaries and Director of Corporate Governance for COVID-19, dated 26032020; and • Letter from Dr Andrew Goodall to Chief Executives and Accountable regarding COVID19 Decision Making Financial Guidance, dated 30032020, with attached Financial Guidance.
ASSURE	**External Audit** Wales Audit Office (WAO) Position Statement was presented and set out an update on current and planned audit work, together with the Auditor General's planned programme of related studies and national events that may be of interest to the Committee, which would be held remotely in the current circumstances. The majority planned audit work for NWSSP was complete before COVID-19 and that the WAO Nationally Hosted NHS IT Systems and WAO Management Letter audits would be rescheduled to take place later in 2020. There were no significant issues of concern to report to the Committee.

ASSURE	**Internal Audit**
	The Committee received a comprehensive update from Internal Audit and in addition to the Position Statement, which highlighted progress of the 2019/20 Internal Audit Plan, together with an overview of other activity undertaken since the previous meeting. It was advised that good progress had been made and there would be an anticipated delay in finalising audits due to the current challenges faced in NWSSP, surrounding COVID-19. In addition, the Committee received the following reports for consideration:
	
	• *Primary Care Services Contractor Payments Internal Audit Report*
	  ○ Achieved substantial assurance and did not identify any issues that would be classified as a weakness in the system control or design.
	• *Stores (IP5) Internal Audit Report*
	  ○ Achieved substantial assurance and did not identify any issues that would be classified as a weakness in the system control or design.
	• *Business Case Scrutiny Internal Audit Report*
	  ○ Achieved reasonable assurance, with two medium priority recommendations for action.
	• *Cyber Security Internal Audit Report*
	  ○ Achieved reasonable assurance, with one high and four medium priority recommendations for action.
	• *Staff Expenses Internal Audit Report*
	  ○ Achieved reasonable assurance, with one high, two medium and one low priority recommendations for action.
	• *Purchase to Pay (P2P) Accounts Payable Internal Audit Report*
	  ○ Achieved reasonable assurance, with five medium priority recommendations for action.
	• *Contact Centres Internal Audit Advisory Review*
	  ○ It was noted that whilst the Advisory Review assignment is not allocated an assurance rating, advice and recommendations were provided to facilitate change and improvement, with the findings highlighting 3 recommendations for action.
	
	The Committee received the Head of Internal Audit Opinion and Annual Report 2019-20, which awarded an overall opinion of reasonable assurance, together with summarised results of the internal audit work performed during the year. The report included a summary of audit performance in comparison to the plan and an assessment of compliance with the Public Sector Internal Audit Standards (PSIAS). 20 internal audit reviews were undertaken during the year, of which; 8 achieved substantial assurance, 10 achieved reasonable assurance and 2 were categorised as advisory reports, with assurance being not applicable. There had been no limited assurance reports generated during the financial year and advised that where no assurance opinion was awarded, this was by design, due to an advisory or investigative piece of work and the plan was informed on a risk basis.

	The Committee received a helpful Internal Audit Planning Paper for 2020-21, setting out the steps taken by Audit and Assurance Services to support NHS Wales as it deals with COVID-19. For example, ensuring Internal Audit remain in a position to provide Opinions for 2019/20, taking into account the significant operational pressures that organisations are under and progressing where possible whilst working remotely and continuing to provide advice to organisations on maintaining appropriate governance and financial controls, whilst ensuring that front line services receive the staff and equipment they need. It was anticipated that limited internal audit work would be undertaken as NHS Wales deals with COVID-19 over the coming months, with a full programme of audit and assurance recommending, possibly in the second quarter of 2020/21, at the earliest. It was agreed that the Committee would approve final sign-off at the June 2020 meeting.
ASSURE	**Assurance, Risk and Governance** The Draft Annual Governance Statement (AGS) for 2019-20 was presented for comment and it was noted that it paints a positive picture overall with nothing contentious to report. The document was currently in draft format and would be brought back in June for final approval. For assurance, the SMT had approved the AGS in its draft format. The Corporate Risk Register highlighted four existing red risks, six amber risks, three yellow risks and one green risks in the Risks for Action section of the Register. There remained one yellow risk in the Risks for Monitoring section and the Committee was reminded that the Register is reviewed at each SSPC, Audit Committee and Formal SMT meeting. The existing four red risks were summarised as follows: • The costs of responding to COVID-19 cannot be contained within available funding; • Threat to the supplies of medical consumables and equipment; • The Northern Ireland model procured to replace the NHAIS system fails to deliver the anticipated benefits within required timescales impacting the ability to pay GPs; and • NHS Digital withdrawing the Ophthalmics Payment service from the end of March 2020. The Risk Management Protocol and Risk Appetite Statement were presented for Committee approval, following a refresh being undertaken. The Protocol was last approved at the June 2018 meeting and the Statement last approved at the October 2018 meeting. There were no significant changes made to either document since that time and they had been recently re-approved by the SMT at the January 2020 meeting. The Committee was content to approve the Protocol and Statement. In relation to the tracking of Audit Recommendations, progress was reported as 196 total recommendations, of which, 194 were implemented, one was not yet due (medium priority) and one proposed revised deadline of 31/03/2021, which was agreed by the Committee.
INFORM	The following items were received for Committee information: • Audit Committee Forward Plan 2020-21 • Audit Committee Effectiveness Action Plan • NWSSP Integrated Medium Term Plan Summary 2020-23

2. ARGYMHELLIAD/RECOMMENDATION

The Board are asked to:

- **NOTE** the Assurance Report

PUBLIC TRUST BOARD

REVIEW OF THE NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE STANDING ORDERS (SSPC SOs)

Meeting Date:	4 June 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Andy Butler, Director of Finance and Corporate Services, NWSSP
Report Presented by:	Andy Butler, Director of Finance and Corporate Services, NWSSP

Trust Resolution to: (please tick)							
APPROVE:	☑	**REVIEW:**		**INFORM:**		**ASSURE:**	☑
Recommendation:	For the Board to **APPROVE** and **NOTE**.						

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) ☑	
Equitable and timely services	☑
Providing evidence based care and research which is clinically effective	
Supporting our staff to excel	
Safe and reliable services	☑
First class patient/donor experience	
Spending every pound well	☑
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SMT – Senior Management Team	
Executive Summary:	
This paper has been prepared to provide the Trust Board with details of the proposed amended version of the SSPC Standing Orders, following review to ensure they remain relevant and fit for purpose following recent developments, which are summarised in the body of this report, for **APPROVAL**, as endorsed by the SSPC at the meeting on 21 May 2020.	

REVIEW OF SSPC STANDING ORDERS

1. INTRODUCTION

To ensure effective, robust and up to date governance arrangements are in place for the SSPC, the SOs are reviewed on an annual basis and were last updated and approved by the SSPC in March 2019. Amendments have been made to the document since its last publication date and a summary of the amendments proposed are set out at **Appendix 1**. The fully updated document is included at **Appendix 2**, for **APPROVAL**. In accordance with our local environmental sustainability commitments, once approved, A5 bounded hard copies will be provided upon request only.

2. GOVERNANCE AND ASSURANCE

Annual revision of the document is a key element of the corporate governance arrangements of the SSPC and provides assurance that the SOs are compliant with Welsh Government directives and Model Standing Orders, up to date with emerging legislation and regulatory guidance and ensures consistency in managing the business of Committee. The updated SOs will be presented to the Velindre University NHS Trust Board, once approved by the SSPC.

Section 10.0.1 of the SSPC SOs state:

"*These Shared Services SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in Shared Services SOs, including the Equality Impact Assessment.*"

Section 9.0.3 of Welsh Government's Model Standing Orders for NHS bodies states:

"Assurances in respect of the Shared Services shall primarily be achieved by the reports of the Managing Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Managing Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the HB."

3. RECOMMENDATION

- The Committee are asked to **APPROVE** the amended SSPC SOs.

Appendix 1 – Summary of Amendments to SSPC SOs (May 2020)

Page(s)	Amendment
Various	General housekeeping for consistency, to include formatting, page number amendments, as appropriate. Further, to include references to updated status of Velindre University NHS Trust, references to Health Education Improvement Wales (HEIW) as a Special Health Authority, references to Cwm Taf Morgannwg University Health Board and updating of job titles, to reflect current arrangements within NWSSP, throughout.
62-64	Minor amendments to the Operational Responsibility for Directors and Officers, to bring this in line with current working arrangements, for the categories of General, Chair's Action on Urgent Matters to state Board Secretary Governance Support and Working In Partnership to state Deputy Director of Finance and Corporate Services; Amendment to high level delegation for approval of clinical negligence and personal injury claims to the NWSSP Managing Director and/or Director of Finance and Corporate Services.
70-74	To include amendments to Schemes of Budgetary Delegation, such as removal of reference to secure printing and franking machine contracts from Primary Care Services and the removal of delegation limits set out historically for Workforce Education Development Services' (WEDS) Education and Training Contracts which have transferred to HEIW. Further, we propose the introduction of a delegated limit for All Wales Contracts whereby NWSSP is required to incur expenditure on behalf of NHS Wales. Similar arrangements exist NHS Wales Informatics Service (NWIS) for All Wales Contracts, who are also hosted organisation under Velindre University NHS Trust (Page 70). Capital expenditure limit increase proposed for NWSSP Managing Director and/or Chair to £1m, NWSSP Managing Director to £500k and Director of Finance and Corporate Services of £100k. (Page 70). Increased limit for intra-NHS invoices and payments (included but not limited to pharmacy rebates, NWSSP distribution, etc), to £750k for the NWSSP Managing Director and Director of Finance and Corporate Services (Page 71). To include amendments to job titles for Deputy Director and Assistant Director of Finance and Corporate Services, Director of Legal and Risk Services and Welsh Risk Pool, Head of Safety and Learning, to reflect current arrangements; removal of explicit column to reference to Powys Teaching Health Board explicitly, as these and Former Health Authority Claims are now dealt with by Legal and Risk Services (page 72). Amendments to Procurement Services delegated limits, to state IP5, Newport in place of Cwmbran Stores, following relocation in October 2019 (Page 73). Sets out the agreed NWSSP Scheme of Delegation for COVID-19 and pandemic expenditure, which was approved at the Velindre University NHS Trust Board meeting of 18 March 2020 and 30 March 2020. It was initially agreed to increase the delegated authorisation limits for the Chair and Managing Director for COVID 19 expenditure to £2M. This was subsequently increased to £5M from 30 March 2020. However, contracts and orders for COVID expenditure in excess of £5M will still require approval of the Velindre Trust Board, which for expedience may need to be through the existing mechanism of Chair's action. It was agreed that these increased limits for COVID expenditure would be reviewed on 30 June 2020. The introduction of a Scheme of Delegation for the Existing Liabilities Scheme Limits and arrangements with Medical and Dental Defence Union of Scotland, as set out in the letter dated 12 May 2020, sent from Mr Steve Elliott, Deputy Director of Finance at Welsh Government, to Mr Neil Frow, Managing Director of NWSSP, which confirms their acceptance of the proposed Scheme of Delegation from 1 July 2020, when oversight of the Existing Liability Scheme transfers to NWSSP, noting that any value

	of damages decisions greater than £1m will require written Welsh Government approval (Page 74).
76-99	To include updated Terms of Reference for Welsh Risk Pool Committee (Pages 76-82) NWSSP Audit Committee (Pages 83-93) and Evidence Based Procurement Board (EBPB) (Pages 94-99), to ensure they reflect current working arrangements in place for the Committees and Advisory Board.

Annexe 4

STANDING ORDERS FOR THE OPERATION OF THE SHARED SERVICES PARTNERSHIP COMMITTEE

This Annexe forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Originally Introduced June 2015
(updated May 2020)

Foreword

These Model Standing Orders are issued by Welsh Ministers to Local Health Boards using powers of direction provided in section 12(3) of the National Health Services (Wales) Act 2006. Velindre University NHS Trust (Velindre) must agree Standing Orders (SOs) for the regulation of the Shared Services Partnership Committee's (the SSPC) proceedings and business. These SSPC SOs form an Annexe to Velindre's own SOs, and have effect as if incorporated within them. They are designed to translate the statutory requirements set out in the Velindre University NHS Trust Shared Services (Wales) Regulations 2012 (2012/1261

(W.156)) and Velindre's Standing Order 3 into day to day operating practice. Together with the adoption of a scheme of decisions reserved to the SSPC; a scheme of delegation to NHS Wales Shared Services Partnership officers and others; and in conjunction with Velindre University NHS Trust Standing Financial Instructions (SFIs), they provide the regulatory framework for the business conduct of the SSPC.

These documents, together with the NWSSP Memorandum of Co-operation dated **[June 2012]** made between the seven Health Boards and three Trusts and Special Health Authority within NHS Wales, that defines the obligations of the eleven NHS bodies (the Partners) to participate in the SSPC and to take collective responsibility for the delivery of the services, a Hosting Agreement dated **[June 2012]** between the Partners that provides for the terms on which Velindre will host the NHS Wales Shared Services Partnership (NWSSP) and the Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of NWSSP (as the Accountable Officer for NWSSP) dated **[June 2012]** that defines the respective roles of the two Accountable Officers, form the basis upon which the SSPC governance and accountability framework is developed. Together with the adoption of a Standards of Behaviour Framework, this is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

All SSPC members, NWSSP staff and Velindre staff must be made aware of these Standing Orders and, where appropriate, should be familiar with their detailed content. The Head of Finance and Business Improvement, NWSSP (acting Board Secretary for the SSPC) will be able to provide further advice and guidance on any aspect of the SOs or the wider governance arrangements for the SSPC. Further information on governance in the NHS in Wales may be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

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Section: A – Introduction

Statutory Framework

i) Velindre University National Health Service Trust (Velindre) is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (1993/2838)** (the Establishment Order).

ii) The Velindre University NHS Trust Shared Services Partnership Committee (to be known as the SSPC for operational purposes) was established under the **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (2012/1261 (W.156))** (the Shared Services Regulations). The Shared Services Regulations define Shared Services at regulation 2 and the functions of the SSPC at regulation 4. The SSPC functions are subject to variations to those functions agreed from time to time by the SSPC**.** The SSPC is hosted by Velindre on behalf of each of the seven Health Boards, three Trusts and Special Health Authority within NHS Wales (the Partners).

iii) The principal place of business of the SSPC is:

NHS Wales Shared Services Partnership
4-5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7QZ

iv) All business shall be conducted in the name of the NHS Wales Shared Services Partnership on behalf of the Partners.

v) Velindre is a corporate body and its functions must be carried out in accordance with its statutory powers and duties. Velindre's statutory powers and duties are mainly contained in the **NHS (Wales) Act 2006 (c.42)** which is the principal legislation relating to the NHS in Wales. Whilst the **NHS Act 2006 (c.41)** applies equivalent legislation to the NHS in England, it also contains some legislation that applies to both England and Wales. The NHS (Wales) Act 2006 and the NHS Act 2006 are a consolidation of the NHS Act 1977 and other health legislation, which has now been repealed. The NHS (Wales) Act 2006 contains various powers of the Welsh Ministers to make subordinate legislation and details how NHS Trusts are governed and their functions.

vi) **The National Health Service Trusts (Membership and Procedure) Regulations 1990 (1990/2024)**, as amended (the Membership

Regulations) set out the membership and procedural arrangements of the Trust.

vii) Sections 18 and 19 of Annexe 3 to the NHS (Wales) Act 2006 provide for Welsh Ministers to confer functions on NHS Trusts and to give Directions about how they exercise those functions. Trusts must act in accordance with those Directions. Velindre's statutory functions are set out in its Establishment Order but many functions are also contained in other legislation such as the NHS (Wales) Act 2006.

viii) However, in some cases, the relevant function may be contained in other legislation. In exercising its powers, Velindre must be clear about the statutory basis for exercising such powers.

ix) Under powers in paragraph 4(1)(f) of Annexe 3 to the NHS (Wales) Act 2006 the Minister has made the Shared Services Regulations which set out the constitution and membership arrangements of the Shared Services Partnership Committee. Certain provisions of the Membership Regulations will also apply to the operations of the SSPC, as appropriate.

x) In addition to Directions, the Welsh Ministers may from time to time issue guidance relating to the activities of the SSPC, which the Partners must take into account when exercising any function.

xi) Velindre shall issue an indemnity to the NWSSP Chair, on behalf of the Partners.

NHS Framework

xii) In addition to the statutory requirements set out above, the SSPC, on behalf of each of the Partners, must carry out all its business in a manner that enables it to contribute fully to the achievement of the Minister's vision for the NHS in Wales and its standards for public service delivery. The governance standards set for the NHS in Wales are based upon the Assembly's Citizen Centred Governance Principles. These principles provide the framework for good governance and embody the values and standards of behaviour that is expected at all levels of the service, locally and nationally.

xiii) Adoption of the principles will better equip the SSPC to take a balanced, holistic view of its work and its capacity to deliver high quality, safe healthcare services on behalf of all citizens in Wales within the NHS framework set nationally.

xiv) The overarching NHS governance and accountability framework within which the SSPC must work incorporates Velindre's SOs; Annexes of

Powers reserved for the Board and Delegation to others and SFIs, together with a range of other frameworks designed to cover specific aspects. These include the NHS Values and Standards of Behaviour Framework; the *'Doing Well, Doing Better: Standards for Health Services in Wales' and 'a Healthier Wales'*, the NHS Risk and Assurance Framework, and the NHS planning and performance management systems.

xv) The Assembly, reflecting its constitutional obligations, has stated that sustainable development should be the central organising principle for the public sector and a core objective for the restructured NHS in all it does.

xvi) Full, up to date details of the other requirements that fall within the NHS framework – as well as further information on the Welsh Government's Citizen Centred Governance principles - are provided on the NHS Wales Governance e-manual which can be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

Directions or guidance on specific aspects of Trusts' business are also issued in hard copy, usually under cover of a Ministerial letter.

Shared Services Partnership Committee Framework

xvii) The specific governance and accountability arrangements established for the SSPC are set out within the following documents (which is not an exhaustive list):

- these SSPC SOs and Annexe 1: Scheme of Powers reserved for the SSPC and Delegation to others;
- the Velindre University NHS Trust SFIs;
- a Memorandum of Co-operation that defines the obligations of the Partners to participate in the SSPC and to take collective responsibility for the delivery of the services defining the respective roles of the Partners;
- a Hosting Agreement between the Partners that provides for the terms on which Velindre will host NWSSP;
- an Interface Agreement between the Chief Executive of Velindre (as the Accountable Officer for the organisation) and the Managing Director of Shared Services (as the Accountable Officer for NWSSP) that defines the respective roles of the two Accountable Officers; and
- an Accountability Agreement between the Chair of the SSPC and the Managing Director of Shared Services (as the Accountable Officer for NWSSP).

xviii) Annexe 2 to these SOs provides details of the key documents that, together with these SOs, make up the SSPC's governance and accountability framework. These documents must be read in conjunction

with these SSPC SOs.

xix) The SSPC may from time to time, subject to the prior approval of Velindre's Board, agree operating procedures which apply to SSPC members and/or members of NWSSP staff and others. The decisions to approve these operating procedures will be recorded in an appropriate SSPC minute and, where appropriate, will also be considered to be an integral part of these SSPC SOs and SFIs. Details of the SSPC's key operating procedures are also included in Annexe 2 of these SOs.

Applying Shared Services Standing Orders

xx) These SSPC SOs (together with the Velindre University NHS Trust SFIs and other documents making up the governance and accountability framework) will, as far as they are applicable, also apply to meetings of any Sub-Committees established by the SSPC, including any Advisory Groups. These SSPC SOs may be amended or adapted for the Sub-Committees or Advisory Groups as appropriate, with the approval of the SSPC. Further details on Sub-Committees and Advisory Groups may be found in Annexes 3 and 4 of these NWSSP, respectively.

xxi) Full details of any non-compliance with these SSPC SOs, including an explanation of the reasons and circumstances must be reported in the first instance to the Head of Finance and Business Improvement, who will ask the Velindre Audit Committee to formally consider the matter and make proposals to the SSPC on any action to be taken. All SSPC members and SSPC officers have a duty to report any non-compliance to the Head of Finance and Business Improvement as soon as they are aware of any circumstance that has not previously been reported. **Ultimately, failure to comply with SSPC SOs is a disciplinary matter.**

Variation and amendment of SSPC Standing Orders

xxii) Although SOs are subject to regular, annual review there may, exceptionally, be an occasion where the SSPC determines that it is necessary to vary or amend the SOs during the year. In these circumstances, the Chair of the SSPC, advised by the Head of Finance and Business Improvement, shall submit a formal report to the Velindre Trust Board, setting out the nature and rationale for the proposed variation or amendment. Such a decision may only be made if:

- Each of the SSPC members are in favour of the amendment; or
- In the event that agreement cannot be reached, the Velindre Trust Board determine that the amendment should be approved.

Interpretation

xxiii) During any SSPC meeting where there is doubt as to the applicability or interpretation of the SSPC SOs, the Chair of the SSPC shall have the final say, provided that their decision does not conflict with rights, liabilities or duties as prescribed by law. In doing so, the Chair should take appropriate advice from the Board Secretary support function.

xxiv) The terms and provisions contained within these SOs aim to reflect those covered within all applicable health legislation. The legislation takes precedence over these SSPC SOs, when interpreting any term or provision covered by legislation.

Relationship with Velindre University NHS Trust Standing Orders

xxv) These SSPC SOs form an Annexe to Velindre's own SOs, and shall have effect as if incorporated within them.

The Role of the Board Secretary Support Function

xxvi) The role of the Board Secretary support function is crucial to the ongoing development and maintenance of a strong governance framework within the SSPC, and is a key source of advice and support to the Chair and SSPC members. Independent of the SSPC, the Board Secretary support function will act as the guardian of good governance within the SSPC and shall ensure that the functions outlined below are delivered:

- providing advice to the SSPC as a whole and to individual Committee members on all aspects of governance;
- facilitating the effective conduct of SSPC business through meetings of the SSPC, its Sub-Committees and Advisory Groups;
- ensuring that SSPC members have the right information to enable them to make informed decisions and fulfil their responsibilities in accordance with the provisions of these SOs;
- ensuring that in all its dealings, the SSPC acts fairly, with integrity, and without prejudice or discrimination;
- contributing to the development of an organisational culture that embodies NHS values and standards of behaviour; and
- monitoring the SSPC's compliance with the law, Shared Services SOs and the framework set by Velindre and Welsh Ministers.

xxvii) As advisor to the SSPC, the Board Secretary support function role does not affect the specific responsibilities of SSPC members for governing the Committee's operations. The Board Secretary Support role is directly accountable for the conduct of their role to the Chair of the SSPC and reports to the Managing Director of NWSSP on a regular basis.

Section B – Shared Services Partnership Committee Standing Orders

1. THE SHARED SERVICES PARTNERSHIP COMMITTEE (SSPC)

1.1 Purpose, Role, Responsibilities and Delegated Functions

1.1.1 The SSPC has been established for the purpose of exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Boards, Trusts and Special Health Authority in Wales.

1.1.2 The purpose of the SSPC is to:

- set the policy and strategy for NWSSP;
- monitor the delivery of Shared Services, through the Managing Director of NWSSP;
- seek to improve the approach to delivering Shared Services, which are effective, efficient and provide value for money for Partners;
- ensure the efficient and effective leadership direction and control of NWSSP; and
- ensure a strong focus on delivering savings that can be re-invested in direct patient care.

1.1.3 The role of the SSPC is to:

- take into account NHS Wales organisations' plans and objectives when considering the strategy of NWSSP;
- encourage and support the aims and objectives of NWSSP;
- identify synergies between each of the Shared Services and ensure that future strategies incorporate synergistic opportunities;
- foster and encourage partnership working between all key stakeholders and staff;
- oversee the identification and sharing of financial benefits to NHS Wales' organisations on a fair basis that minimises administrative costs and financial transactional arrangements;
- seek to identify potential opportunities for further collaboration across the wider public sector;
- consider implications for Shared Services in relation to any reviews / reports undertaken by internal auditors, external auditors and regulators, including Healthcare Inspectorate Wales; and
- seek assurance, through the Managing Director of NWSSP, on the adequacy and robustness of systems, processes, procedures and risk management, staffing issues and that risks and benefits are shared on an equitable basis in relation to Shared Services.

1.1.4 The responsibilities of the SSPC are to:

- produce an Integrated Medium Term Plan, including the balanced Medium Term Financial Plan for agreement by the Committee, following the publication of the individual Health Board, Trust and Special Health Authority Integrated Medium Term Plans;
- agree, on an annual basis, Service Improvement Plans (prepared by the Managing Director of NWSSP) for the delivery by services;
- be accountable for the development and agreement of policies and strategies in relation to Shared Services and for monitoring the performance and delivery of agreed targets for Shared Services through the Managing Director of NWSSP;
- take the lead in overseeing the effective and efficient use of the resources of Shared Services;
- benchmark the performance of Shared Services against the best in class;
- consider extended-scope opportunities for Shared Services;
- monitor compliance of best practice within Shared Services with NHS Wales recommended best practice;
- oversee the identification and delivery of “invest to save” opportunities; and
- explore future Shared Services organisational delivery models across the NHS and the broader public sector.
- embed NWSSP’s strategic objectives and priorities through the conduct of its business and in so doing, and transacting its business shall ensure that adequate consideration has been given to the sustainable development principle and in meeting the requirements of the Well-Being of Future Generations (Wales) Act 2015, the Welsh Government Guidance on Ethical Procurement and the Code of Practice on Ethical Employment in Supply Chains.

1.1.5 The SSPC must ensure that all its activities are in exercise of these functions or any other functions that may be conferred on it. Each Health Board, Trust and Special Health Authority, shall be bound by the decisions of the SSPC in the exercise of its roles. In the event that the SSPC is unable to reach unanimous agreement in relation to the funding levels to be provided by each Health Board, Trust and Special Health Authority, then this matter shall be escalated to the Welsh Government for resolution ultimately by Welsh Ministers.

1.1.6 To fulfil its functions, the SSPC shall lead and scrutinise the operations, functions and decision making of the NWSSP Senior Management Team (SMT) undertaken at the direction of the SSPC.

1.1.7 The SSPC shall work with all its Partners and stakeholders in the best

interests of its population across Wales.

1.2 Membership of the SSPC

1.2.1 The membership of the SSPC shall be 12 voting members, comprising:

- the Chair (appointed by the SSPC in accordance with the Chair Selection Process at Annexe 5 to these SOs):
- the Chief Executives of each of the Health Boards, Trusts and Special Health Authority (or their nominated representatives); and
- the Managing Director of NWSSP, who has been designated as the Accountable Officer for Shared Services.

1.2.2 *Vice Chair* – The SSPC shall appoint a Vice Chair from one of the Chief Executives (or their nominated representative) SSPC members. A Vice Chair cannot be appointed if the current Chair is employed by the same Partner organisation.

1.2.3 *Nominated Representatives* – Nominated deputies for Chief Executives should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights.

1.2.4 *Co-opted Members* – The SSPC may also co-opt additional independent 'external' members from outside NHS Wales to provide specialist skills, knowledge and expertise. Co-opted members will not be entitled to vote.

1.2.5 *Attendees* – The NWSSP Director of Finance and Corporate Services / Deputy Director of Finance and Corporate Services, NWSSP Director of Workforce & Organisational Development (or nominated representative) may attend the SSPC meetings but will not be entitled to vote. Other NWSSP Service Directors / Heads of Service may only attend SSPC meetings, as and when invited.

1.2.6 *Use of the Term Independent Member* - For the purposes of these SPC SOs, use of the term 'Independent Member' refers to the non-officer members of a Health Board or the independent members of a Trust, or Special Health Authority.

1.3 Member and Staff Responsibilities and Accountability

1.3.1 The SSPC will function as a decision-making body, all voting members being full and equal members and sharing corporate responsibility for all the decisions of the SSPC.

1.3.2 All members must comply with the terms of their appointment to the SSPC. They must equip themselves to fulfil the breadth of their

responsibilities on the SSPC by participating in relevant personal and organisational development programmes, engaging fully in the activities of the SSPC and promoting understanding of its work.

The Chair

1.3.3 The Chair of the SSPC must act in a balanced manner, ensuring that any opinion expressed is impartial and based upon the best interests of the health service across Wales.

1.3.4 The Chair is responsible for the effective operation of the SSPC:

- chairing SSPC meetings;
- establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all SSPC business is conducted in accordance with these SSPC SOs; and
- developing positive and professional relationships amongst the SSPC's membership and between the SSPC and each Health Board, Trust and Special Health Authority's Board.

1.3.5 The Chair shall work in close harmony with the Chief Executives of each of the Health Board, Trust and Special Health Authority (or their nominated representatives) and, supported by the Head of Finance and Business Improvement, shall ensure that key and appropriate issues are discussed by the SSPC in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

1.3.6 The Chair is accountable to the SSPC in relation to the delivery of the functions exercised by the SSPC on its behalf and, through Velindre's Chair, as the hosting organisation, for the conduct of business in accordance with the defined governance and operating framework.

The Vice Chair

1.3.7 The Vice Chair shall deputise for the Chair in their absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

1.3.8 The Vice Chair is accountable to the Chair for their performance as Vice Chair.

Managing Director of NWSSP and the Chief Executive of Velindre

1.3.9 **Managing Director of NWSSP** – The Managing Director of NWSSP, as head of the Senior Management Team, reports to the Chair and is

responsible for the overall performance of NWSSP. The Managing Director of NWSSP is the designated Accountable Officer for NWSSP (see 1.3.11 below). The Managing Director of NWSSP is accountable to the SSPC in relation to those functions delegated to them by the SSPC. The Managing Director of NWSSP is also accountable to the Chief Executive of Velindre University NHS Trust in respect of the hosting arrangements supporting the operation of NWSSP.

1.3.10 **Chief Executive of Velindre** – The Chief Executive of Velindre University NHS Trust is responsible for the overall performance of the executive functions of the Trust and is the designated Accountable Officer for the Trust (see 1.3.11 below). As the host organisation, the Chief Executive (and the Velindre Trust Board) has a legitimate interest in the activities of NWSSP and has certain statutory responsibilities as the legal entity hosting NWSSP.

1.3.11 **Accountable Officers** – The Managing Director of NWSSP (as the Accountable Officer for NWSSP) and the Chief Executive of Velindre (as the Accountable Officer for the Trust) shall be responsible for meeting all the responsibilities of their roles, as set out in their respective Accountable Officer Memoranda. Both Accountable Officers shall co-operate with each other so as to ensure that full accountability for the activities of the NWSSP and Velindre is afforded to the Welsh Ministers whilst minimising duplication.

Senior Management Team

1.3.12 The Managing Director of NWSSP will lead a SMT to deliver the SSPC's annual Business Plan. The SMT will be determined by the Managing Director of NWSSP.

1.4 Appointment and tenure of Shared Services Partnership Committee (SSPC) members

1.4.1 The ***Chair,*** is appointed by the SSPC in accordance with the appointment process outlined in Annexe 5 and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Chair can be reappointed but may not serve as the Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in the term. Through the appointment process, the SSPC must satisfy itself that the person appointed has the necessary skills and experience to perform the duties. In accordance with the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012, the first chair of the Committee would be appointed by Velindre for a period of six months.

1.4.2 The ***Vice Chair*** is appointed by the SSPC from its Chief Executive (or their nominated representatives) members and shall be appointed for a period specified by the SSPC, but for no longer than 4 years in any one term. The Vice Chair may not serve as the Vice Chair of the SSPC for a total period of more than 8 years. Time served need not be consecutive and will still be counted towards the total period even where there is a break in term.

1.4.3 The appointment and removal process for the Chair and Vice Chair shall be determined by the SSPC. In making these appointments, the SSPC must ensure:

- a balanced knowledge and understanding amongst the membership of the needs of all geographical areas served by the SSPC;
- that wherever possible, the overall membership of the SSPC reflects the diversity of the population;
- potential conflicts of interest are kept to a minimum;
- the Vice Chair is not employed by the same Partner organisation as the Chair; and
- that the person has the necessary skills and experience to perform the duties of the chair.

1.5 Termination of Appointment of SSPC Chair and Vice Chair

1.5.1 The Committee may remove the SSPC Chair or Vice Chair by the process outlined in Annexe 5 to these SOs if it determines:

- It is not in the interests of the SSPC; or
- It is not conducive to good management of the SSPC

for that Chair or Vice Chair to continue to hold office.

1.5.2 All SSPC members' tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements set for their role, so far as they are applicable, and as specified in the relevant Regulations. Any member must inform the SSPC Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on their eligibility to hold office.

1.5.3 The SSPC will require its Chair and members to confirm their continued eligibility on an annual basis in writing.

1.6 Appointment of NWSSP Staff

1.6.1 The NWSSP staff shall be appointed by Velindre. The appointments

process shall be in line with the workforce policies and procedures of Velindre and any directions made by the Welsh Ministers.

1.7 Responsibilities and Relationships with each Health Board, Trust and Special Health Authority's Board, Velindre University NHS Trust as the Host and Others

1.7.1 The SSPC is not a separate legal entity from each of the Health Boards, Trusts and Special Health Authority. It shall report to each Health Board, Trust and Special Health Authority Board on its activities, to which it is formally accountable in respect of the exercise of the Shared Services functions carried out on their behalf. Velindre's Trust Board will not be responsible or accountable for exercising Velindre's functions in relation to NWSSP, including the setting of policy and strategy and the management and provision of Shared Services to Health Board, Trust and Special Health Authority. Velindre's Board, as the host organisation, shall be responsible for ensuring that NWSSP staff act in accordance with the administrative policies and procedures agreed between Velindre and the SSPC.

1.7.2 Each Health Board, Trust and Special Health Authority shall determine the arrangements for any meetings with the Managing Director of NWSSP and their organisation through the SSPC.

1.7.3 The Health Board, Trust and Special Health Authority Chairs, through the lead Chair, shall put in place arrangements to meet with the SSPC Chair on a regular basis to discuss the SSPC's activities and operation.

2 RESERVATION AND DELEGATION OF SHARED SERVICES FUNCTIONS

Within the framework agreed by Velindre, and set out within these SSPC SOs, and subject to any directions that may be given by the Welsh Ministers, the SSPC may make arrangements for certain functions to be carried out on its behalf so that the day to day business of the SSPC may be carried out effectively and in a manner that secures the achievement of its aims and objectives. In doing so, the SSPC must set out clearly the terms and conditions upon which any delegation is being made.

The SSPC's determination of those matters that it will retain, and those that will be delegated to others shall be set out in a:

i Scheme of matters reserved to the SSPC;
ii Scheme of Delegation to Sub-Committees of the SSPC and others; and
iii Scheme of Delegation, including financial limits, to Velindre

all of which must be formally agreed by Velindre and adopted by the SSPC.

The SSPC retains full responsibility for any functions delegated to others to carry out on its behalf.

2.1 Chair's Action on Urgent Matters

2.1.1 There may, occasionally, be circumstances where decisions which would normally be made by the SSPC need to be taken between scheduled meetings, and it is not practicable to call a meeting of the SSPC. In these circumstances, the SSPC Chair and the Managing Director of NWSSP may deal with the matter on behalf of the SSPC - after first consulting with at least one other Health Board, Trust or Special Health Authority Chief Executive (or their representative). The Head of Finance and Business Improvement must ensure that any such action is formally recorded and reported to the next meeting of the SSPC for consideration and ratification.

2.2 Delegation to Sub-Committees and Others

2.2.1 The SSPC shall agree the delegation of any of their functions to Sub-Committees or others (including networks), setting any conditions and restrictions it considers necessary and following any directions agreed by Velindre.

2.2.2 The SSPC shall agree and formally approve the delegation of specific powers to be exercised by Sub-Committees which it has formally constituted or to others.

2.3 Delegation to Officers

2.3.1 The SSPC will delegate certain functions to the Managing Director of NWSSP. For these aspects, the Managing Director of NWSSP, when compiling the Scheme of Delegation, shall set out proposals for those functions they will perform personally and shall nominate other Velindre officers to undertake the remaining functions. The Managing Director of NWSSP will still be accountable to the SSPC for all functions delegated to them, irrespective of any further delegation to other Velindre officers.

2.3.2 This must be considered and approved by the SSPC (subject to any amendment agreed during the discussion) and agreed by Velindre. The Managing Director of NWSSP may periodically propose amendment to the Scheme of Delegation and any such amendments must also be considered and approved by the SSPC and agreed by Velindre.

2.3.3 Individual members of the NWSSP SMT are in turn responsible for delegation within their own teams in accordance with the framework established by the Managing Director of NWSSP and agreed by the SSPC and Velindre.

3 SUB-COMMITTEES

In accordance with SSPC Standing Order 4.0.3, the SSPC may and, where directed by Velindre must, appoint Sub-Committees of the SSPC either to undertake specific functions on the SSPC's behalf or to provide advice and assurance to others (whether directly to the SSPC, or on behalf of the SSPC). Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs. NWSSP officers may only be appointed to serve as members on any committee, where that committee does not have the function of holding that officer to account.

These may consist wholly or partly of SSPC members or of persons who are not SSPC members.

3.1 Sub-Committees Established by the SSPC

The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or utilise Velindre's Committee arrangements to assist it in discharging its governance responsibilities. The SSPC shall ensure its Sub-Committee structure meets the needs of Velindre University NHS Trust, as the host organisation, and also the needs of its Partners. As a minimum, it shall ensure arrangements are in place to cover the following aspects of SSPC business:

- Quality and Safety
- Audit

3.1.1 The SSPC may make arrangements to receive and provide assurance to others through the establishment and operation of its own Sub-Committees or by placing responsibility with Velindre, as the host. Where responsibility is placed with Velindre, the arrangement shall be detailed within the Hosting Agreement between the SSPC and Velindre as the host organisation and/or the Interface Agreement between the Managing Director of NWSSP (as the Accountable Officer for NWSSP) and Velindre's Chief Executive (as Accountable Officer for the Trust).

The SSPC has the following Sub-Committees:

- Velindre Audit Committee for SSPC
- Welsh Risk Pool Committee

Full details of the Sub-Committee structure established by the SSPC, including detailed Terms of Reference for each of these Sub-Committees, are set out in Annexe 3 of these SSPC SOs.

3.1.2 Each Sub-Committee established by or on behalf of the SSPC must have its own Terms of Reference and operating arrangements, which must be formally approved by the SSPC and agreed by Velindre. These must establish its governance and ways of working, setting out, as a minimum:

- the scope of its work (including its purpose and any delegated powers and authority);
- membership and quorum;
- meeting arrangements;
- relationships and accountabilities with others;
- any budget and financial responsibility, where appropriate;
- secretariat and other support;
- training, development and performance; and
- reporting and assurance arrangements.

3.1.3 In doing so, the SSPC shall specify which aspects of these SSPC SOs are not applicable to the operation of the Sub-Committee, keeping any such aspects to the minimum necessary.

3.1.4 The membership of any such Sub-Committees - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre. Depending on the Sub-Committee's defined role and remit, membership may be drawn from the SSPC or Velindre staff (subject to the conditions set in NWSSP Standing Order 3.1.5) or others.

3.1.5 Velindre's NWSSP officers should not normally be appointed as Sub-Committee Chairs, nor should they be appointed to serve as members on any committee set up to review the exercise of functions delegated to NWSSP officers. Designated NWSSP Directors or Heads of Services or other NWSSP officers shall, however, be in attendance at such Sub-Committees, as appropriate.

3.2 Other Groups

3.2.1 The SSPC may also establish other groups to help it in the conduct of its business.

3.3 Reporting Activity to the Shared Services Partnership Committee

3.3.1 The SSPC must ensure that the Chairs of all Sub-Committees and other bodies or groups operating on its behalf report formally, regularly and on a timely basis to the SSPC on their activities. Sub-Committee Chairs' shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

3.3.2 Each Sub-Committee shall also submit an annual report to the SSPC through the Chair within 3 months of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

4 EXPERT PANEL AND OTHER ADVISORY GROUPS

4.1.1 The SSPC may appoint an Expert Panel and other Advisory Groups to provide it with advice in the exercise of its functions. Full details of the Expert Panel and other Advisory Groups established by the SSPC, including detailed terms of reference are set out in Annexe 4 of these Shared Services SOs.

4.1 Expert Panels and Advisory Groups Established by the SSPC

- Evidence Based Procurement Board

4.2 Confidentiality

4.2.1 Advisory Group members and attendees must not disclose any matter dealt with by or brought before a Group in confidence without the permission of the Advisory Group Chair.

4.3 Reporting Activity

4.3.1 The SSPC shall ensure that the Chairs of any Expert Panel or Advisory Group reports formally, regularly and on a timely basis to the SSPC on their activities. Expert Panel or Advisory Group Chairs shall bring to the SSPC's specific attention any significant matters under consideration and report on the totality of its activities through the production of minutes or other written reports.

4.3.2 Any Expert Panel or Advisory Group shall also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and detailing the results of a review of its performance and that of any sub groups it has established.

4.3.3 Each Advisory Group shall report regularly on its activities to those whose interests they represent.

4.4 Terms of Reference and Operating Arrangements

4.4.1 The SSPC and the Velindre Board must formally approve terms of reference and operating arrangements in respect of any. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership and quorum;
- Meeting arrangements;
- Relationships and accountabilities with others;
- Any budget and financial responsibility, where appropriate;
- Secretariat and other support;
- Training, development and performance; and
- Reporting and assurance arrangements.

4.4.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the Expert Panel or Advisory Group, keeping any such aspects to the minimum necessary.

4.4.3 The membership of any Expert Panel or Advisory Group - including the designation of Chair; definition of member roles and powers and terms and conditions of appointment (including remuneration and reimbursement) - will usually be determined by the SSPC, subject to any specific requirements or directions agreed by Velindre.

4.4.4 The SSPC may determine that any Advisory Group it has set up should be supported by sub-groups to assist it in the conduct of its work, or the Advisory Group may itself determine such arrangements, provided that the SSPC approves such action.

4.5 The Local Partnership Forum (LPF)

4.5.1 The LPF's role is to provide a formal mechanism where the SSPC, as employer, and trade unions/professional bodies representing NWSSP's employees (hereafter referred to as staff organisations) work together to improve health services for the citizens served by the NWSSP – achieved through a regular and timely process of consultation, negotiation and communication. In doing so, the LPF must effectively represent the views and interests of the NWSSP workforce.

4.5.2 It is the forum where the NWSSP and staff organisations will engage with each other to inform, debate and seek to agree local priorities on

workforce and health service issues; and inform thinking around national priorities on health matters.

4.5.3 NWSSP may specifically request advice and feedback from the LPF on any aspect of its business, and the LPF may also offer advice and feedback even if not specifically requested by NWSSP. The LPF may provide advice to the SSPC:

- In written advice; or
- In any other form specified by the Board.

4.6 Terms of Reference and Operating Arrangements

4.6.1 The SSPC must formally approve terms of reference and operating arrangements for the LPF. These must establish its governance and ways of working, setting out, as a minimum:

- The scope of its work (including its purpose and any delegated powers and authority);
- Membership (including member appointment and removal, role,responsibilities and accountability, and terms and conditions of office);
- Meeting arrangements;
- Communications;
- Relationships and accountabilities with others (including the Board, its Committees and Advisory Groups, and other relevant local and national groups);
- Any budget and financial responsibility (where appropriate);
- Secretariat and other support; and
- Reporting and assurance arrangements.

4.6.2 In doing so, the SSPC shall specify which aspects of these SOs are not applicable to the operation of the LPF, keeping any such aspects to the minimum necessary. The LPF will also operate in accordance with the TUC six principles of partnership working.

4.6.3 The LPF may establish sub-fora to assist it in the conduct of its work, to facilitate:

- Ongoing dialogue, communication and consultation on service and operational management issues specific to Divisions/Directorates/Service areas; and/or
- Detailed discussion in relation to a specific issue(s).

4.7 Membership

4.7.1 NWSSP shall agree the overall size and composition of the LPF in consultation with those staff organisations it recognises for collective bargaining. As a minimum, the membership of the LPF shall comprise:

- Management Representatives;
- Managing Director;
- Director of Finance & Corporate Services; and
- Director of Workforce and Organisational Development.

together with the following:

- General Managers/Divisional Managers; and
- Workforce and Organisational Development staff

4.7.2 The Trust may determine that other Executive Directors or others may act as members or be co-opted to the LPF.

Staff Representatives

4.7.3 The maximum number of staff representatives shall be *agreed by the LPF* comprising representation from those staff organisations recognised by NWSSP.

In attendance

4.7.4 The Trade Union member of the Board shall attend LPF meetings in an ex officio capacity.

4.7.5 The LPF may determine that full time officers from those staff organisations recognised by the Trust shall be invited to attend LPF meetings.

4.8 Member Responsibilities and Accountability

Joint Chairs

4.8.1 The LPF shall have two Chairs, on a rotational basis, one of whom shall be drawn from the management representative membership, and one from the staff representative membership.

4.8.2 The Chairs shall be jointly responsible for the effective operation of the LPF:

- Chairing meetings, rotated equally between the Staff

Representative and Management Representative Chairs;

- Establishing and ensuring adherence to the standards of good governance set for the NHS in Wales, ensuring that all business is conducted in accordance with its agreed operating framework; and
- Developing positive and professional relationships amongst the Forum's membership and between the Forum and the SSPC.

4.8.3 The Chairs shall work in partnership with each other and, as appropriate, with the Chairs of the Trust's other advisory groups. Supported by the Board Secretary, Chairs shall ensure that key and appropriate issues are discussed by the Forum in a timely manner with all the necessary information and advice being made available to members to inform the debate and ultimate resolutions.

4.8.4 The Chairs are accountable to the Board for the conduct of business in accordance with the governance and operating framework set by the Trust.

Joint Vice Chairs

4.8.5 The LPF shall have two Vice Chairs, one of whom shall be drawn from the Management Representative membership, and one from the staff representative membership.

4.8.6 Each Vice Chair shall deputise for their Chair in that Chair's absence for any reason, and will do so until either the existing Chair resumes their duties or a new Chair is appointed.

4.8.7 The Vice Chair is accountable to their Chair for their performance as Vice Chair.

Members

4.8.8 All members of the LPF are full and equal members and collectively share responsibility for its decisions.

4.8.9 All members must:

- Be prepared to engage with and contribute to the LPF's activities and in a manner that upholds the standards of good governance set for the NHS in Wales;
- Comply with their terms and conditions of appointment;
- Equip themselves to fulfil the breadth of their responsibilities by participating in appropriate personal and organisational development programmes; and
- Promote the work of the LPF within the professional disciplinethey

represent.

4.9 Appointment and Terms of Office

4.9.1 Management representative members shall be determined by the SSPC.

4.9.2 Staff representatives shall be determined by the staff organisations recognised by the NWSSP, subject to the following conditions:

- Staff representatives must be employed by **NWSSP** and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by **NWSSP** or cease to be a member of their nominating trade union.

4.9.3 The *Management Representative Chair* shall be appointed by the LPF.

4.9.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.9.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.9.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.9.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.10 Removal, Suspension and Replacement of Members

4.10.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and
(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.10.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.10.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.10.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.11 Relationship with the SSPC and others

4.11.1 The LPF's main link with the SSPC is through the Managerial members of the LPF.

4.11.2 The Senior Management Team may determine that designated SMT members or NWSSP staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of SMT members or Trust staff, subject to the agreement of the Chair.

4.11.3 The SMT shall determine the arrangements for any joint meetings between the SMT and the LPF's staff representative members.

4.11.4 The Managing Director shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.11.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

4.12 Support to the LPF

4.12.1 The LPF's work shall be supported by two designated Secretaries, one of whom shall support the staff representative members and one shall support the management representative members.

4.12.2 The Director of Workforce and Organisational Development will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.12.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.12.4 Both Secretaries shall work closely with the NWSSP Head of Finance and Business Improvement who is responsible for the overall planning and co-ordination of the programme of SMT and Committee business, including that of its Advisory Groups.

5 WORKING IN PARTNERSHIP

5.1.1 The SSPC shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

5.1.2 The Chair shall ensure that the SSPC has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the NWSSP through:

- NWSSP's own structures and operating arrangements, e.g., Advisory Groups;

5.1.3 The SMT shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6 MEETINGS

6.1 Putting Citizens first

6.1.1 The SSPC's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other

stakeholders. The SSPC, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- active communication of forthcoming business and activities;
- the selection of accessible, suitable venues for meetings;
- the availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- requesting that attendees notify the Committee Secretariat of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and

where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Equality Act 2010 (Statutory Duties) (Wales) Regulations, Welsh Language (Health Sector) Regulations; as well as NWSSP's Communication Strategy and Velindre's Welsh Language Scheme.

6.1.2 The SSPC Chair will ensure that, in determining the matters to be considered by the SSPC, full account is taken of the views and interests of all citizens served by the SSPC on behalf of each Health Boards, Trust and Special Health Authority, including any views expressed formally. The Chair will ensure that, in determining the matters to be considered by the Committee, full account is taken of the views and interests of the Committee's stakeholders, including any views expressed formally to the Committee, e.g. through Community Health Councils.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretariat, on behalf of the SSPC Chair, shall produce an annual Business Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Business Plan shall also set out any standing items that shall appear on every SSPC agenda.

6.2.2 The Business Plan shall set out the arrangements in place to enable the SSPC to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing SSPC members to contribute in either English or Welsh languages, where appropriate.

6.2.3 The Business Plan shall also incorporate formal SSPC meetings, regular Committee development sessions and, where appropriate, and the planned activities of Sub-Committees, Expert Panel and Advisory Groups.

6.2.4 The SSPC shall agree the Business Plan for the forthcoming year by the end of March.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the SSPC, the SSPC Chair may call a meeting of the SSPC at any time. An individual SSPC member may request that the SSPC Chair call a meeting, provided that in at least one third of the whole number of Committee members supports such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from SSPC members, then those SSPC members may themselves call a meeting.

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The SSPC Chair, in consultation with the Committee Secretariat and Managing Director of NWSSP, will set the agenda. In doing so, they will take account of the planned activity set in the annual cycle of SSPC business; any standing items agreed by the SSPC; any applicable items received from Sub-Committees and other groups as well as the priorities facing the SSPC. The SSPC Chair must ensure that all relevant matters are brought before the SSPC on a timely basis.

6.4.2 Any SSPC member may request that a matter is placed on the agenda by writing to the SSPC Chair, copied to the Committee Secretariat, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of SSPC business.

Notifying and equipping SSPC members

6.4.3 SSPC members should be sent an agenda and a complete set of supporting papers at least 10 calendar days before a formal SSPC meeting. This information may be provided to SSPC members electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided after this time, provided that the SSPC Chair is satisfied that the SSPC's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the SSPC unless the SSPC Chair is satisfied (subject to advice from the Committee Secretariat, as appropriate) that the information contained within it is sufficient to enable the SSPC to take a reasonable decision. Equality Integrated Impact Assessments (EqIIAs) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the SSPC, and the outcome of that EqIIA shall be included within the report to the SSPC, to enable the SSPC to make an informed decision.

6.4.5 In the event that at least half of the SSPC members do not receive the agenda and papers for the meeting as set out above, the SSPC Chair must consider whether or not the SSPC would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the SSPC Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by SSPC members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with SSPC Standing Order 6.4, at least 10 calendar days before each meeting of the SSPC a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- at the SSPC's principal sites;
- on the SSPC's website, together with the papers supporting the public part of the agenda; as well as
- through other methods of communication as set out in the SSPC's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, the SSPC shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.5 Conducting Shared Services Partnership Committee Meetings

Admission of the public, the press and other observers

6.5.1 The SSPC shall encourage attendance at its formal SSPC meetings by the public and members of the press as well as officers or representatives

from organisations who have an interest in the business of the SSPC. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility such as an induction loop system.

6.5.2 The SSPC shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter affecting a NWSSP officer, a patient or a procurement contract. In such cases, the Chair (advised by the NWSSP Head of Finance and Business Improvement, where appropriate) shall Annexe these issues accordingly and requires that any observers withdraw from the meeting. In doing so, the SSPC shall resolve:

"That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" [Section 1(2) Public Bodies (Admission to Meetings) Act 1960].

6.5.3 In these circumstances, when the SSPC is not meeting in public session, it shall operate in private session, formally reporting any decisions taken to the next meeting of the SSPC in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a SSPC meeting held in public session.

6.5.4 The NWSSP Head of Finance and Business Improvement, on behalf of the SSPC Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal SSPC meetings from members of the public and others, the SSPC shall make clear that attendees are welcomed as observers. The SSPC Chair shall take all necessary steps to ensure that the SSPC's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting. In doing so, the SSPC shall resolve:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the SSPC to reconvene the meeting and to complete business without the presence of the public".

6.5.6 Unless the SSPC has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the SSPC, its Sub-Committees, Expert Panel or Advisory Groups

6.5.7 The SSPC shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the SSPC, its Sub-Committees, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the SSPC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the SSPC (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing SSPC Meetings

6.5.8 The Chair of the SSPC will preside at any meeting of the SSPC unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent then no formal business shall take place.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the SSPC to reach effective decisions on the matters before it. This includes ensuring that SSPC members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the SSPC must have access to appropriate advice on the conduct of the meeting through the attendance of the Head of Finance and Business Improvement. The Chair has the final say on any matter relating to the conduct of SSPC business.

Quorum

6.5.10 At least 6 voting members, at least 4 of whom are Health Board, Trust or Special Health Authority Chief Executives (or their nominated representatives) and one is either the Chair or the Vice Chair, must be present to allow any formal business to take place at an SSPC meeting. If the Managing Director of NWSSP is not present, then no formal business should be transacted unless there is, in attendance, a properly authorised deputy for the Managing Director.

6.5.11 If a Health Board, Trust or Special Health Authority Chief Executive (or their nominated representative) or the Managing Director of NWSSP is unable to attend a SSPC meeting, then a nominated deputy may attend in their absence which should be an Executive Director of the same organisation and will formally contribute to the quorum and have

delegated voting rights, provided that the Chair has agreed the nomination before the meeting.

6.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any SSPC member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.13 In the normal course of SSPC business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a SSPC member may put forward a motion proposing that a formal review of that service area is undertaken. The Board Secretary support role will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the SSPC unless moved by a SSPC member and seconded by another SSPC member (including the SSPC Chair).

6.5.14 **Proposing a formal notice of Motion –** Any SSPC member wishing to propose a motion must notify the SSPC Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the SSPC Chair has determined that the proposed motion is relevant to the SSPC's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the SSPC Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.15 The SSPC Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of SSPC business.

6.5.16 **Amendments -** Any SSPC member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the SSPC alongside the motion.

6.5.17 If there are a number of proposed amendments to the Motion, each amendment will be considered in turn, and if passed, the amended Motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.5.18 **Motions under discussion –** When a motion is under discussion, any SSPC member may propose that:

- the motion be amended;
- the meeting should be adjourned;
- the discussion should be adjourned and the meeting proceed to the next item of business;
- a SSPC member may not be heard further;
- the SSPC decides upon the motion before them;
- an ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.20 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconded and the SSPC Chair.

6.5.21 **Motion to rescind a resolution –** The SSPC may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months unless the motion is supported by the (simple) majority of SSPC members.

6.5.22 A motion that has been decided upon by the SSPC cannot be proposed again within six months except by the SSPC Chair, unless the motion relates to the receipt of a report or the recommendations of a Sub-Committee/Managing Director of NWSSP to which a matter has been referred.

Voting

6.5.23 The SSPC Chair will determine whether SSPC members' decisions should be expressed orally, through a show of hands, or by secret ballot or by recorded vote. The SSPC Chair must require a secret ballot if the majority of voting SSPC members request it. Where voting on any question is conducted, a record shall be maintained. In the case of a

secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the minutes shall record the name of the individual and the way in which they voted.

6.5.24 In determining every question at a meeting, the SSPC members must take account, where relevant, of the views expressed and representations made by individuals who represent the interests of citizens in Wales. Such views may be presented to the SSPC through the Chairs of any Expert Panel, Advisory Group and/or the Community Health Council representative(s).

6.5.25 Except for decisions related to the overall funding contribution from each of the Health Boards, Trusts or Special Health Authority, the SSPC will make decisions subject to a 2/3 majority of voting. In no circumstances may an absent SSPC member (or their nominated deputy) vote by proxy. Absence is defined as being absent at the time of the vote.

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal SSPC meetings (and any other meetings of the SSPC where the SSPC members determine) shall be drawn up as 'minutes'. These minutes shall include a record of SSPC member attendance (including the SSPC Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the SSPC, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with SSPC members' wishes, and, where providing a record of a formal SSPC meeting shall be made available to the public on the NWSSP website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act, the SSPC's Communication Strategy and Velindre's Welsh Language Scheme.

6.7 Confidentiality

6.7.1 All SSPC members, together with members of any Sub-Committee, Expert Panel or Advisory Group established by or on behalf of the SSPC and SSPC members and/or Health Board/Trust/Special Health Authority officials must respect the confidentiality of all matters considered by the SSPC in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the SSPC Chair or relevant Sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Standards of

Behaviour Framework or legislation such as the Freedom of Information Act 2000, etc.

7 VALUES AND STANDARDS OF BEHAVIOUR

The SSPC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the SSPC, including SSPC members, Velindre NWSSP officers and others, as appropriate. The Framework adopted by the SSPC will form part of these SOs.

7.1 Declaring and Recording Shared Services Partnership Committee Members' Interests

7.1.1 **Declaration of interests –** It is a requirement that all SSPC members should declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a SSPC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the SSPC's business. SSPC members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. SSPC members must notify the SSPC of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as SSPC members.

7.1.2 SSPC members must also declare any interests held by family members or persons or bodies with which they are connected. The NWSSP Head of Finance and Business Improvement will provide advice to the SSPC Chair and the SSPC on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour Framework. If individual SSPC members are in any doubt about what may be considered as an interest, they should seek advice from the NWSSP Head of Finance and Business Improvement. However, the onus regarding declaration will reside with the individual SSPC member.

7.1.3 **Register of interests –** The Managing Director of NWSSP, through the NWSSP Head of Finance and Business Improvement, will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all SSPC members. The register will include details of all Directorships and other relevant and material interests which have been declared by SSPC members.

7.1.4 The register will be held by the NWSSP Head of Finance and Business Improvement, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by SSPC members. The NWSSP Head of Finance and Business Improvement will also arrange an annual review of the register, through which SSPC members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the SSPC's commitment to openness and transparency, the NWSSP Head of Finance and Business Improvement must take reasonable steps to ensure that citizens served by the SSPC are made aware of, and have access to view the Register of Interests. This will include publication on the NWSSP website.

7.1.6 **Publication of declared interests in Annual Review –** SSPC members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each Shared Services' Annual Review.

7.2 Dealing with Members' interests during Shared Services Partnership Committee meetings

7.2.1 The SSPC Chair, advised by the NWSSP Head of Finance and Business Improvement, must ensure that the SSPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the SSPC's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the SSPC and as a member of the Board of a Health Board, Trust or Special Health Authority.

7.2.2 Where individual SSPC members identify an interest in relation to any aspect of SSPC business set out in the SSPC's meeting agenda, that member must declare an interest at the start of the SSPC meeting. SSPC members should seek advice from the SSPC Chair, through the NWSSP Head of Finance and Business Improvement before the start of the SSPC meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the SSPCs minutes.

7.2.3 It is the responsibility of the SSPC Chair, on behalf of the SSPC, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i the declaration is formally noted and recorded, but that the SSPC member should participate fully in the SSPC's discussion and decision, including voting

ii the declaration is formally noted and recorded, and the SSPC member participates fully in the SSPC's discussion, but takes no part in the SSPC's decision;

iii the declaration is formally noted and recorded, and the SSPC member takes no part in the SSPC discussion or decision;

iv the declaration is formally noted and recorded, and the SSPC member is excluded for that part of the meeting when the matter is being discussed. A SSPC member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the SSPC.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a SSPC member is compatible with an identified conflict of interest.

7.2.5 Where the SSPC Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the SSPC.

7.2.6 In all cases the decision of the SSPC Chair (or the Vice Chair in the case of an interest declared by the SSPC Chair) is binding on all SSPC members. The SSPC Chair should take advice from the NWSSP Head of Finance and Business Improvement when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a SSPC member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The SSPC may determine that the SSPC member concerned shall be excluded from that part of the meeting.

7.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SSPC SOs must be interpreted in accordance with these definitions.

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other

7.2.9 **Members with Professional Interests –** During the conduct of a SSPC meeting, an individual SSPC member may establish a clear conflict of interest between their role as a SSPC member and that of their professional role outside of the SSPC. In any such circumstance, the SSPC shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the NWSSP Head of Finance and Business Improvement.

7.3 Dealing with Officers' Interests

7.3.1 The SSPC must ensure that the NWSSP Head of Finance and Business Improvement, on behalf of the Managing Director of NWSSP, establishes and maintains a system for the declaration, recording and handling of NWSSP officers' interests in accordance with the Standards of Behaviour Framework.

7.4 Reviewing How Interests are Handled

7.4.1 The SSPC's Audit Committee will review and report to the Health Boards, Trusts and Special Health Authority upon the adequacy of the arrangements for declaring, registering and handling interests at least annually.

7.5 Dealing with Offers of Gifts[2] and Hospitality

7.5.1 The Committee will adopt the Values and Standards of Behaviour Framework Policy of Velindre University NHS Trust, which prohibits SSPC members and NWSSP officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any SSPC member or NWSSP officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a SSPC member or NWSSP officer. Compliance with the Velindre University NHS Trust Standards of Behaviour Framework is mandatory for all Trust employees.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from

[2] The term gift refers also to any reward or benefit

the NWSSP Head of Finance and Business Improvement as appropriate. In assessing whether an offer should be accepted, individuals must take into account:

- **Relationship:** Contacts which are made for the purpose of information gathering are generally less likely to cause problems than those which could result in a contractual relationship, in which case, accepting a gift or hospitality could cause embarrassment or be seen as giving rise to an obligation;

- **Legitimate Interest:** Regard should be paid to the reason for the contact on both sides and whether it is a contact that is likely to benefit the SSPC;

- **Value:** Gifts and benefits of a trivial or inexpensive seasonal nature, e.g. diaries/calendars, are more likely to be acceptable and can be distinguished from more substantial offers. Similarly, hospitality in the form of a working lunch would not be treated in the same way as more expensive social functions, travel or accommodation (although in some circumstances these may also be accepted);

- **Frequency:** Acceptance of frequent or regular invitations particularly from the same source would breach the required standards of conduct. Isolated acceptance of, for example, meals, tickets to public, sporting, cultural or social events would only be acceptable if attendance is justifiable in that it benefits the SSPC; and

- **Reputation:** If the body concerned is known to be under investigation by or has been publicly criticised by a public body, regulators or inspectors, acceptance of a gift or hospitality might be seen as supporting the body or affecting in some way the investigation or negotiations and it must always be declined.

7.5.4 A distinction shall be drawn between items offered as hospitality and items offered in substitution for fees for broadcasts, speeches, lectures or other work done. There may be circumstances where the latter may be accepted if they can be used for official purposes.

7.6 Register of Gifts and Hospitality

7.6.1 The NWSSP Head of Finance and Business Improvement, on behalf of the SSPC Chair, will maintain a Register of Gifts and Hospitality to record offers of gifts and hospitality made to SSPC members. NWSSP Director of Finance and Corporate Services together with Heads of Service, will adopt the Velindre University NHS Trust Policy on Gifts and Hospitality in relation to NWSSP officers working within their areas.

7.6.2 Every SSPC member and NWSSP officer has a personal responsibility to volunteer information in relation to offers of gifts and hospitality made in their capacity as SSPC members, including those offers that have been refused. The NWSSP Head of Finance and Business Improvement, on behalf of the SSPC Chair and Managing Director of NWSSP, will ensure the incidence and patterns of offers and receipt of gifts and hospitality is kept under active review, taking appropriate action where necessary.

7.6.3 When determining what should be included in the register, NWSSP Officers must apply the principles as set out in the Velindre University NHS Trust Policy on gifts and hospitality.

7.6.4 SSPC members and NWSSP officers may accept the occasional offer of modest and proportionate hospitality but in doing so must consider whether the following conditions are met:

- acceptance would further the aims of the SSPC;
- the level of hospitality is reasonable in the circumstances;
- it has been openly offered; and,
- it could not be construed as any form of inducement and will not put the individual under any obligation to those offering it.

7.6.5 The NWSSP Head of Finance and Business Improvement will arrange for a full report of all offers of Gifts and Hospitality recorded by the SSPC to be submitted to Velindre's Audit Committee at least annually. The Audit Committee will then review and report to the SSPC and the Velindre Trust Board upon the adequacy of the SSPCs arrangements for dealing with offers of gifts and hospitality.

7.6.6 Detailed arrangements for the handling of gifts and hospitality are set out within the Velindre University NHS Trust Standards of Behaviour Framework and its policy on Gifts and Hospitality.

8 SIGNING AND SEALING DOCUMENTS

The Common Seal of NWSSP's host is primarily used to seal legal documents such as transfers of land, lease agreements and other important/key contracts. The seal may only be fixed to a document if the Board has determined it shall be sealed, or if a transaction to which the document relates has been approved by the Board.

Where the Velindre Trust Board has decided that a NWSSP document shall be sealed it shall be fixed in the presence of the Chair or Vice Chair (or other

authorised Independent Member) and the Chief Executive (or another authorised individual) both of whom witness the seal.

8.1 Register of Sealing

8.1.1 The NWSSP Head of Finance and Business Improvement shall keep a register that records the sealing of every NWSSP document. Each entry must be signed by the person who approved and authorised the document and who witnessed the seal. A report of all sealing shall be presented to the SSPC at least biennially.

8.2 Signature of Documents

8.2.1 Where a signature is required for any document connected with legal proceedings involving the NWSSP, it shall normally be signed by the Managing Director, except where the SSPC has been otherwise directed to allow or require another person to provide a signature.

8.2.2 The Managing Director or nominated officers may be authorised by the SSPC to sign on behalf of the NWSSP any agreement or other document (not required to be executed as a deed) where the subject matter has been approved by the SSPC.

8.3 Custody of Seal

8.3.1 The Common Seal of NWSSP's host is kept securely by the Board Secretary.at Velindre University NHS Trust.

9 GAINING ASSURANCE ON THE CONDUCT OF SHARED SERVICES PARTNERSHIP COMMITTEE BUSINESS

The SSPC shall set out explicitly, within a Risk and Assurance Framework, how it will gain assurance, and how it will in turn provide assurance to Velindre on the conduct of SSPC business, its governance and the effective management of risks in pursuance of its aims and objectives. It shall set out clearly the various sources of assurance, and where and when that assurance will be provided, in accordance with any requirements determined by the Welsh Ministers.

The SSPC shall ensure that its assurance arrangements are operating effectively, advised by Velindre's Audit Committee.

9.1 The Role of Internal Audit in Providing Independent Internal assurance

9.1.1 The SSPC shall ensure the effective provision of an independent internal audit function as a key source of its internal assurance arrangements, in accordance with NHS Wales Internal Auditing Standards and any other requirements determined by the Welsh Ministers.

9.1.2 The SSPC shall set out the relationship between the Head of Internal Audit (HIA), the Audit Committee (or equivalent) and the SSPC. It shall:

- Approve the Internal Audit Charter (incorporating the definition of internal audit) and adopt the Internal Auditing Standards (incorporating the code of ethics);

- Ensure the HIA communicates and interacts directly with the Audit Committee facilitating direct and unrestricted access;
- Require Internal Audit to confirm its independence annually; and
- Ensure that the Head of Internal Audit reports periodically to the SSPC on its activities, including its purpose, authority, responsibility and performance. Such reporting will include governance issues and significant risk exposures.

9.2 Reviewing the Performance of the Shared Services Partnership Committee, its Sub-Committees, Expert Panel and Advisory Groups

9.2.1 The SSPC shall introduce a process of regular and rigorous self-assessment and evaluation of its own operations and performance and that of its Sub-Committees, Expert Panel and any other Advisory Groups. Where appropriate, the SSPC may determine that such evaluation may be independently facilitated.

9.2.2 Each Sub-Committee and, where appropriate, Expert Panel and any other Advisory Group must also submit an annual report to the SSPC through the Chair within 1 month of the end of the reporting year setting out its activities during the year and including the review of its performance and that of any sub-groups it has established.

9.2.3 The SSPC shall use the information from this evaluation activity to inform:

- the ongoing development of its governance arrangements, including its structures and processes;
- its Committee Development Programme, as part of an overall Organisation Development framework; and
- inform its Partners through its annual report of its alignment with the Assembly Government's Citizen Centred Governance Principles, completed as part of its ongoing review and reporting arrangements.

9.3 External Assurance

9.3.1 The SSPC shall ensure it develops effective working arrangements and relationships with those bodies that have a role in providing independent, external assurance to the public and others on its operations, e.g. the Wales Audit Office and Healthcare Inspectorate Wales.

9.3.2 The SSPC may be assured, from the work carried out by external audit and others, on the adequacy of its own assurance framework, but that external assurance activity shall not form part of, or replace its own internal assurance arrangements, except in relation to any additional work that the SSPC itself may commission specifically for that purpose.

9.3.3 The SSPC shall keep under review and ensure that, where appropriate, the SSPC implements any recommendations relevant to its business made by the National Assembly for Wales Commission Audit and Risk Assurance Committee, the Public Accounts Committee or other appropriate bodies.

9.3.4 The SSPC shall provide the Auditor General for Wales with assistance, information and explanation which the Auditor General thinks necessary for the discharge of their statutory powers and responsibilities under section 145 of and paragraph 17 to Annexe 8 to the Government of Wales Act 2006 (C.42).

10 DEMONSTRATING ACCOUNTABILITY

10.1.1 Taking account of the arrangements set out within these SSPC SOs, the SSPC shall demonstrate to its Partners, citizens and other stakeholders and to Velindre, as host, a clear framework of accountability within which it:

- conducts its business internally;
- works collaboratively with NHS colleagues, Partners, service providers and others; and
- responds to the views and representations made by those who represent the interests of the citizens it serves and its own NWSSP officers.

10.1.2 The SSPC shall also facilitate effective scrutiny of its operations through the publication of regular reports on activity and performance, including publication of an Annual Report of the SSPC.

10.1.3 The SSPC shall also facilitate effective scrutiny of NWSSP's operations through the publication of regular reports on activity and performance,

including publication of an Annual Review document providing a summary of annual performance.

10.1.4 The SSPC shall ensure that within the NWSSP staff, individuals at all levels are supported in their roles, and held to account for their personal performance through effective performance management arrangements.

11 SUPPORT FOR THE SHARED SERVICES PARTNERSHIP COMMITTEE

11.1.1 The NWSSP Head of Finance and Business Improvement, on behalf of the SSPC Chair, will ensure that the SSPC is properly equipped to carry out its role by:

- overseeing the process of nomination and appointment to the SSPC;
- co-ordinating and facilitating appropriate induction and organisational development activity;
- ensuring the provision of governance advice and support to the SSPC Chair on the conduct of its business and its relationship with its Partners, Velindre, as the host and others;
- ensuring the provision of secretariat support for SSPC meetings;
- ensuring that the SSPC receives the information it needs on a timely basis;
- ensuring strong links to communities/groups;
- ensuring an effective relationship between the SSPC and Velindre as its host; and
- facilitating effective reporting to each Health Board, Trust and Special Health Authority

thereby enabling each Health Board, Trust and Special Health Authority's Board to gain assurance on the conduct of business carried out by SSPC on their behalf.

12 REVIEW OF STANDING ORDERS

12.1.1 These SSPC SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Trust Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in SSPC SOs, including the Equality Integrated Impact Assessment.

Annexe 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Partnership Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

As set out in Standing Order 2, the SSPC - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the NWSSP may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The SSPC may delegate functions to:

i A Committee, e.g., Audit Committee;
ii A Sub-Committee,
iii A Joint-Committee or Joint Sub-Committee, e.g., with other Health Boards established to take forward matters relating to specialist services; and
iv Officers of NWSSP (who may, subject to the SSPC's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the SSPC is notified of any matters that may affect the operation and/or reputation of NWSSP.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Annexe of matters reserved to SSPC;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officer.

all of which form part of the SSPC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The SSPC will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the SSPC unless it is specificallydelegated in accordance with the requirements set out in SOs or SFIs.
- The SSPC must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management.
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility.
- The SSPC must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development.
- The SSPC must take appropriate action to assure itself that all matters delegated are effectively carried out.
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.
- Except where explicitly set out, the SSPC retains the right to decide upon any matter for which it has responsibility, even if that matter has been delegated to others.
- The SSPC may delegate authority to act, but retains overall responsibility and accountability.
- When delegating powers, the SSPC will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Shared Services Partnership Committee (SSPC)

The SSPC will formally agree, review and, where appropriate revise Annexes of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Managing Director

The Managing Director will propose a Scheme of Delegation to officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The SSPC must formally agree this scheme.

In preparing the scheme of delegation to officers, the Managing Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive,
- NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Managing Director may re-assume any of the powers they have delegated to others at any time.

Board Secretary Governance Support/The NWSSP Head of Finance and Business Improvement

The Board Secretary Governance Support/the NWSSP Head of Finance and Business Improvement will support the SSPC in its handling of reservations and delegations by ensuring that:

- A proposed Annexe of matters reserved for decision by the SSPC is presented to the SSPC for its formal agreement;
- Effective arrangements are in place for the delegation of NWSSP's functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the SSPC, Audit Committee and Velindre Trust Board for revision and approval, as appropriate.

The Velindre University NHS Trust Audit Committee for NWSSP

The Velindre University NHS Trust Audit Committee for NWSSP will provide assurance to the SSPC and Velindre University NHS Trust Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity;and
- Exercising any powers delegated to them in a manner that accords with the Velindre University NHS Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary providing governance support to the SSPC of their concern, as soon as possible, so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the SSPC has set out alternative arrangements.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within NWSSP. The Scheme is to be used in conjunction with the system of control and other established procedures within NWSSP.

SECTION 1

ANNEXE OF MATTERS RESERVED TO THE SSPC[3]

SSPC		AREA	DECISIONS RESERVED TO THE SSPC
1	FULL	GENERAL	The SSPC may determine any matter for which it has statutory or delegated authority, in accordance with NWSSP SOs.
2	FULL	GENERAL	The SSPC must determine any matter that will be reserved to the whole SSPC in accordance with statutory and Welsh Government guidance.
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the SSPC, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ NWSSP SOs ; ▪ NWSSP SFIs; ▪ Annexe of matters reserved to the SSPC; ▪ Scheme of delegation to SSPC others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[3] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements

5	FULL	OPERATING ARRANGEMENTS	Approve the SSPC Values and Standards of Behaviour Framework, including NWSSP's mission statement.
6	FULL	OPERATING ARRANGEMENTS	Approve the SSPC framework for performance management, risk and assurance.
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the SSPC determines it so based upon its contribution/impact on the achievement of the SSPC's aims, objectives and priorities.
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Managing Director in accordance with NWSSP Standing Order requirements.
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with NWSSP SOs.
10	FULL	OPERATING ARRANGEMENTS	Approve procedures for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with NWSSP SFIs.
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write-off of losses or making of special payments above the limits of delegation to the Managing Director and officers.
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the NWSSP.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the Management Team and any other SMT level appointments, e.g., the Committee Secretary.

15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of NWSSP members' interests, in accordance with advice received, e.g. From Audit Committee.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the NWSSP's top level organisation structure and SSPC policies.
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss SSPC sub-Committees, including any joint sub-Committees directly accountable to the SSPC.
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the SSPC.
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the SSPC on outside bodies and groups.
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the SSPC.
19	FULL	STRATEGY & PLANNING	Determine the SSPCs strategic aims, objectives and priorities.
20	FULL	STRATEGY & PLANNING	Approve the SSPCs Integrated Medium Term Plan, including the balanced Medium Term Financial Plan.
21	FULL	STRATEGY & PLANNING	Approve the SSPCs Risk Management Strategy, including risk appetite, risk tolerance levels and treatment plans and managing risks in relation to public confidence.
22	FULL	STRATEGY & PLANNING	Approve the SSPCs citizen engagement and involvement strategy, including communication.

23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies.
24	FULL	STRATEGY & PLANNING	Approve NWSSP's key strategies and programmes related to: ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪ Primary Care ▪ Communications & Engagement
25	FULL	STRATEGY & PLANNING	Approve the SSPCs budget and financial framework (including overall distribution of year end surplus/deficits including risk sharing agreements.
26	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Managing Director set out in the NWSSP SFIs.
27	FULL	PERFORMANCE & ASSURANCE	Approve the SSPCs audit and assurance arrangements.
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPCs NWSSP Directors on progress and performance in the delivery of the SSPCs strategic aims, objectives and priorities and approve action required, including improvement plans.

29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPCs Sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans.
30	FULL	PERFORMANCE & ASSURANCE	Receive reports on the SSPC's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc) that raise issue or concerns impacting on the NWSSP's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of SSPC sub-Committees (as appropriate).
31	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the SSPC's Head of Internal Audit and approve action required, including improvement plans.
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the SSPC's external auditor and approve action required, including improvement plans.
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the SSPC's performance against the Health and Care Standards for Wales and approve action required, including improvement plans.
34	FULL	PERFORMANCE & ASSURANCE	Approval of the Risk and Assurance Framework.
35	FULL	REPORTING	Approve the SSPC's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government.
36	FULL	REPORTING	Receive, approve and ensure the publication of SSPC reports, including its Annual Report.

SECTION 2

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Under Standing Order Section 2 it provides that the SSPC may delegate powers to SSPC Committees, Sub-Committees and others. In doing so, the SSPC has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others;

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

Subject to Clauses within the Trust Standing Orders and to such directions as may be given by the Welsh Government, the SSPC may appoint ad-hoc committees of the NWSSP, whose membership can be wholly or partly of the Chairman and Directors of the NWSSP, or persons who are not Directors of the NWSSP.

A committee appointed under this regulation may subject to such directions as may be given by the Welsh Government or the SSPC appoint ad hoc Sub-Committees consisting wholly or partly of members of the committee (whether or not they are Directors of NWSSP) or wholly of persons who are not members of the committee (whether or not they include Directors of the NWSSP).

The Standing Orders, with appropriate alterations, apply to a committee or Sub-Committee and to a committee or Sub-Committee as they apply to the SSPC and apply to a member of such committee or sub-committee (whether or not they are a Director of the NWSSP) as it applies to a Director of the NWSSP.

The SSPC may make, vary and revoke Standing Orders relating to the quorum, proceedings and place of meetings of a committee or Sub-Committee but, this shall be carried out in accordance with the identified procedures laid down for these changes as outlined in these Standing Orders.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the SSPC's Scheme of Delegation to Committees.

The SSPC has delegated a range of its powers to the following Sub-Committees and others:

- Welsh Risk Pool Committee
- Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Summary of matters delegated to Sub-Committees:

Sub-Committee: Welsh Risk Pool Committee **Delegated Matters:**
The Sub-Committee will: 1. To approve the payment and reimbursement of claims and impose penalties in accordance with the WRPS Claims Reimbursement Procedure. 2. To enact the risk sharing arrangements as agreed by the NWSSP. 3. To receive and consider the annual statements of account. 4. To receive and consider the annual assessment reports and to approve recommendations for any necessary action. 5. To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action. 6. To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately. 7. To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk. 8. To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis. 9. To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

Sub-Committee: Velindre University NHS Trust Audit Committee for NWSSP **Delegated Matters:**
The Committee will: 1. Approve any variation to, review annually and monitor compliance with Standing Orders and Standing Financial Instructions. 2. Review and report to the SSPC upon the adequacy of the arrangements for declaring, registering and handling interests at least annually. 3. Receive a full report of all offers of Gifts and Hospitality recorded by the NWSSP and review the adequacy of NWSSP's arrangements for dealing with offers of gifts and hospitality. 4. Advise the Velindre Trust Board on the adequacy that its assurance arrangements are operating effectively. 5. Review and approve Internal Audit Strategy, Charter, operational plan, programme of work. 6. Review effectiveness of internal audit. 7. Review policies and procedures in respect of fraud and bribery set out in the Welsh Government Directions and to receive the Counter Fraud Annual Report and Plan. 8. Approve write-off of losses or making of special payments within delegated limits determined by the Welsh Ministers. 9. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities. 10. Review the assurance gained through the development of a Risk and Assurance Framework and to consider gaps in control and gaps in assurance and report results to the Board. 11. Review the adequacy of all risk and control related disclosure statements, including the Annual Governance Statement. 12. Receive quarterly assurance of Post Payment Verification (PPV) reports.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the NWSSP's Scheme of Delegation to Committees.

SECTION 3

ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS

The SSPC SOs, alongside the Trust SOs and the SFIs specify certain key responsibilities of the Chief Executive Velindre University NHS Trust, the Managing Director of NWSSP, Directors, Heads of Service and other officers. The Chief Executive and Managing Director of NWSSP Job Descriptions, together with their Accountable Officer Memorandums set out their specific responsibilities, and the individual job descriptions determined for Directors and Heads of Service level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the Annexe of additional delegations below and the associated financial delegations set out in the Velindre Trust SFIs form the basis of the Scheme of Delegation to Officers.

Standing Orders – List of Delegated Matters

SO REF	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
GENERAL			
	Non-compliance and variation of Standing Orders Final interpretation of Standing Orders Responsibility for providing advice to the Board on all aspects of governance/committee services	Head of Finance and Business Improvement Chair Head of Finance and Business Improvement	Board Secretary Support
CHAIR'S ACTION ON URGENT MATTERS			
SO 2.1	Use of Chair's Action and onward reporting to	Chair & Managing Director	Board Secretary Support
DELEGATION TO OFFICERS			
SO 2.3.1	Compilation of Scheme of Delegation for functions	Managing Director	Head of Finance and Business

	delegated to Managing Director for consideration and approval by the SSPC		Improvement
SO 2.3.1	Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Directors
WORKING IN PARTNERSHIP			
SO 5.0.2	Identification and engagement with all key partners and regular review of effectiveness	Chair	Deputy Director of Finance and Corporate Services
MEETINGS			
SO 6.2	Development of the Annual Plan of SSPC Business	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.4	Preparation of SSPC meetings	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.5	Report decisions made & review NWSSP business conducted in private session	Chair	Head of Finance and Business Improvement
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Head of Finance and Business Improvement
SO 6.6	A record of proceedings of SSPC meetings	Chair (Vice Chair in Chair's absence)	Chair (Vice Chair in Chair's absence) / Head of Finance

			and Business Improvement
VALUES AND STANDARDS OF BEHAVIOUR			
SO 7.1	Establishment, maintenance and annual review of a Register of Interests declared by all SSPC members	Managing Director	Head of Finance and Business Improvement
SO 7.6	Establishment, maintenance and annual review of a Register of Gifts and Hospitality in respect of SSPC business for all SSPC members	Chair	Head of Finance and Business Improvement
SO 7.6	Establishment maintenance and annual review of a Register of Gifts and Hospitality for NWSSP Officers	Managing Director/Directors	Head of Finance and Business Improvement
SIGNING AND SEALING DOCUMENTS			
SO 8.1	Establishment, maintenance and bi-annual reporting of a Register of Sealings undertaken by the Velindre NHS Trust Board for NWSSP business	Managing Director	Head of Finance and Business Improvement

This scheme only relates to matters delegated by the Velindre Board and the SSPC to the Managing Director and Directors, together with certain other specific matters referred to in SFIs. Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annexe of Additional Delegations

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Trust Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Managing Director of Shared Services	Nominated deputy	In absence of Director of Shared Services
Staff re-grading and awarding of incremental points	NWSSP Director of W&OD	Yes	Written authority to suitably qualified HR staff
Approval of overtime	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures

Approval of leave without pay	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Managing Director of NWSSP NWSSP Directors	 No Yes	 Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Managing Director NWSSP/ NWSSP Director of W&OD	No	
Approval of relocation costs	NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • NWSSP Directors • Other staff	Managing Director of NWSSP NWSSP Finance Director	 No No	
Approval of redundancy, early retirement and ill-health retirement	Managing Director of NWSSP	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Managing Director of NWSSP and NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of NWSSP	Nominated deputy	In absence of the Managing Director of NWSSP
Approval to commission services from	Managing Director of	Yes	Authorisation matrix. Commissioning policies &

other NHS bodies	NWSSP		procedures
Approval to commission services from voluntary sector	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from private and independent providers	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Management and Control of Stocks	NWSSP Director (Head of Procurement Services)/ NWSSP Director of Finance	Yes	Authorisation matrix
Work in relation to counter fraud and corruption	Trust Director of Finance/ NWSSP Director of Finance	Yes	Authorisation matrix Fraud & Corruption policies and procedures
Authorisation of sponsorship	Managing Director of NWSSP	No	Sponsorship policies & procedures
Approval of research projects	Managing Director of NWSSP	Yes	Research policies & procedures
Management of complaints	NWSSP Director of Finance	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	NWSSP Directors / Trust Board Secretary	Yes	Communication policies & procedures
Approval for use of charitable funds	Trust Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose of equipment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation	Managing Director of	No	Within authorised limits set by WG.

(except for personal effects)	NWSSP		
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	 Trust Small Claims Panel Managing Director of NWSSP Approval by WG	 No No No No	
Approval of clinical negligence and personal injury claims	Managing Director of NWSSP / NWSSP Director of Finance	Yes	Authorisation matrix and within limits set by WAG.
Approval of capital expenditure	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	NWSSP Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Managing Director of NWSSP	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Managing Director of NWSSP& NWSSP Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Heads of Service.

This scheme only relates to matters delegated by the SSPC to the Managing Director of NWSSP and the NWSSP Directors and Heads of Service, together with certain other specific matters referred to in SFIs. Each NWSSP Director and Head of Service is responsible for delegation within their department. They shall produce a Scheme of Delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SECTION 4

ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Velindre University NHS Trust Standing Financial Instructions detail the requirements for Budgetary Control, including:

5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Income and Expenditure budgetary responsibility for the NHS Wales Shared Services Partnership has been delegated to the Managing Director of NWSSP.

The Managing Director of NWSSP and other NWSSP Directors will, in turn, delegate budgetary responsibility to other Heads of Service and managers. The detailed Annexe of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Managing Director of NWSSP and the Senior Management Team as part of the annual Financial Strategy and Budget Setting process. Within the budgetary delegation there are delegated powers of budget virement:

- between Divisions must be approved by the Managing Director of NWSSP.
- between budgets within the same Division must be approved by the relevant Director / Heads of Service.
- between staff and non-staff within the same budget must be approved by the Budget Holder.

These delegated powers of virement, from the Managing Director of NWSSP to Heads of Service and Budget Holders, assume that the NWSSP is achieving its financial targets and can be revised, in year, by the Managing Director of NWSSP in the light of adverse financial performance. Budget virements within Divisions can be authorised by the Head of Service and Director of Finance up to the limit of £60,000.

SECTION 5

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION

Financial Limits (All Values exclude VAT)	Revenue	Capital	Charitable Funds	All Wales Contracts**
	£000	£000	£000	£000
Velindre:				
Trust Board	No Limit	No Limit	0	No Limit
Charitable Funds Committee	0	0	No Limit	0
NWSSP (excluding all Wales Procurement Contracts):				
Managing Director and NWSSP Chair	200	~~750~~1m	0	1m
Managing Director of NWSSP	100	~~100~~500	N/A	500
Director of Finance and Corporate Services	80	100~~80~~	N/A	100
Director of Workforce and Organisational Development	50	50	N/A	N/A
Service Directors/Heads of Services (within own area)	25	0	N/A	N/A
Service Directors/Heads of Service's Nominee (within Agreed area)	10	10	N/A	N/A
Heads of Function (within own area)	7.5	7.5	N/A	N/A
Deputy Director of Finance and Corporate Services	10	10	N/A	N/A
Assistant Director of Finance and Corporate Services	10	10	N/A	N/A
Delegated Budget Holders (within own area) Level 1	5	0	N/A	N/A
Delegated Budget Holders (within own area) Level 2	1	0	N/A	N/A
Notes:				
***Represents contracts where expenditure is directly incurred in respect of All Wales Contracts*				

Welsh Infected Blood Support Services Limits

Scheme Designation	Payments to Claimants (£)
Managing Director/NWSSP Chair	Over 100k
Managing Director	Up to 100k
Director of Finance and Corporate Services	Up to 80k
Deputy Director of Finance and Corporate Services	Up to 50k
Head of Function (WIBSS Manager)	Up to 10k

Corporate Areas

Scheme Designation	Area	Limits (£)
Managing Director/Director of Finance and Corporate Services	ESR Recharges	Up to 750k
Managing Director/Director of Finance and Corporate Services	Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution)	Up to ~~500k~~750k

Legal & Risks Services Limits

Scheme Designation	Reimbursement of claims following Advisory Board approval (£)	WRP Managed Claims (£)
NWSSP Chair	Over 2m	Over 2m
Managing Director of NWSSP	Up to 2m	Up to 2m
Director of Finance and Corporate Services	Up to 1m	Up to 1m
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k	Up to 500k
Deputy Director of Finance and Corporate Services	Up to 100k	Up to 100k
WRP Claims Support (Head of Safety and Learning)		£20k
Note:		
All reimbursement claims are reviewed by the Advisory Board prior to approval and claims above £1m are reviewed by Welsh Government prior to the Advisory Board. *Claims above £2m will also be signed by the Managing Director of NWSSP and NWSSP Chair.		

Procurement Services Limits

Scheme Designation	*COVID Expenditure	Contracts for and on behalf of NHS Wales (£)	NWSSP Stock Requisitions and Invoices (£)	NWSSP Stock Write offs (£)
Trust Board	Over £5m			
Chair and Managing Director / Director of Finance & Corporate Services	Up to £5m			
Managing Director of NWSSP and NWSSP Chair		Over 1m	Over 2m	Over 50k
Managing Director of NWSSP		Up to 1m	Up to 100k	Up to 50k
Director of Finance and Corporate Services NWSSP		Up to 750k	Up to 60k	Up to 25k
Director of Procurement Services		Up to 750k	Up to 50k	Up to 25k
Senior Manager Procurement Services (Logistics)			Up to 25k	Up to 10k
Regional Supply Chain Manager				Up to 5k
Warehouse Manager (Bridgend/Denbigh) / Storage and Distribution Manager (IP5)				Up to 1k
Assistant Warehouse Manager (Bridgend/Denbigh) / Shift Manager (IP5)				Up to 1k
Note:				
**Limits to be reviewed again by 30 June 2020*				

Existing Liabilities Scheme Limits

Scheme Designation	Damages Limit (£)
Welsh Government	1M and over
Managing Director and NWSSP Chair	Up to 1M
Managing Director	Up to 500k
Director of Finance & Corporate Services	Up to 100k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 100k
Deputy Director of Finance & Corporate Services	Up to 50k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 50k
Head of Function - GMPI Team Leader	Up to 10k
Note:	
Claims and payments will be made by NWSSP and approved in line with the above scheme of delegation. Any value of damages decisions greater than £1 million will require written Welsh Government approval. All other value of claims decisions below £1million will be approved in line with the Scheme of Delegation.	

Annexe 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

Shared Services Partnership Committee Framework

The SSPC's governance and accountability framework comprises these SSPC SOs, incorporating Annexes of Powers reserved for the SSPC and Delegation to others, together with the following documents agreed by the SSPC.

These documents must be read in conjunction with the SSPC SOs and will have the same effect as if the details within them were incorporated within the SSPC SOs themselves:

- Standing Financial Instructions (SFIs);
- Values and Standards of Behaviour Framework;
- Risk and Assurance Framework;
- SSPC Annual Plan of Committee Business;
- Welsh Language Scheme;
- Complaints Management Protocol;
- Annual Governance Statement; and
- Annual Review,

These documents may be accessed by viewing NWSSP's website (www.nwssp.wales.nhs.uk/opendoc/326169).

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at http://www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of SSPC business are also issued in hard copy, usually under cover of a Ministerial Letter.

Annexe 3

SHARED SERVICES PARTNERSHIP COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. *Welsh Risk Pool Committee - Terms of Reference*

2. *Velindre University NHS Trust Audit Committee For NHS Wales Shared Service Partnership - Terms of Reference*

1. Welsh Risk Pool Committee
Terms of Reference (September 2019)

1. Background

1.01 On 1 April 2019, the National Health Service Clinical Negligence Scheme Wales Regulations 2019 came into force. The Regulations create a Scheme for Clinical Negligence Claims in Wales and were brought into force inter alia for the management of clinical negligence claims against primary care providers in Wales, operating under sections 41, 42 and 50 of the National Health Service Wales Act 2006.

1.02 The scheme is operated by NHS Wales Shared Service Partnership (NWSSP) through Legal and Risk Services with the support of WRP using its powers as a shared service function under the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

1.03 NWSSP has responsibility for the administration of the Welsh Risk Pool Service including the management of the Welsh Risk Pool Budget.

1.04 The aim of the WRPS budget management is to align the financial governance relating to claims and Redress cases with the corporate and quality governance agenda.

1.05 The Welsh Risk Pool Services has responsibility for reimbursement of claims over £25,000 (the £25,000 threshold does not apply to GMPI matters) and reimbursement of permitted costs and damages arising from Redress cases. It is also required to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff.

1.06 In line with standing orders the Committee has resolved to establish a sub-committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub-committee of the NWSSP Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

2.01 The membership of the WRPC shall be determined by the NWSSPC, taking account of the balance of skills and expertise necessary to deliver the WRPC's remit and subject to any specific requirements or directions made by the Welsh Government.

2.02 The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services and the Welsh Government. The membership includes:

Chairman:	Chairman of NWSSP
Members:	Managing Director, NWSSP
	Director Legal & Risk Services, NWSSP
	Director of Finance & Corporate Services, NWSSP
	Health Board or Trust Chair (1)
	Health Board or Trust Chief Executive (1)
	Health Board or Trust Medical Director (1)
	Health Board or Trust Director of Nursing (1)
	Health Board or Trust Director of Finance (1)
	Health Board Director of Therapies & Health Science (1)
	Health Board or Trust Chair Audit Committee Chair (1)
	Health Board or Trust Board Secretary (1)
	Health Board Director of Primary Care and Mental Health
	Welsh Government (2)
	Health Board Associate Medical Director – Primary Care
	GP Advisor
In attendance:	
	NWSSP – WRPS Head of Finance
	NWSSP - WRPS Head of Safety and Learning
	WRPS Operations Team
	WRPS Safety and Learning Team

2.03 Other individuals may be involved at the discretion of the Chairman (e.g. representatives from NSAGs as appropriate). The WRPC shall appoint a vice chairman from the agreed membership. The vice-chair shall deputise for the Chair in their absence for any reason.

2.04 In the event that a member of the WRPC is unable to attend a meeting he/she is required to seek a suitable person to attend on their behalf.

3. Dealing with Members' interests during meetings

3.01 The Chair, advised by the Committee Secretariat, must ensure that the WRPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must demonstrate, through their actions, that their contribution to the WRPC's decision making is based upon the best interests of the NHS in Wales.

3.02 Where individual members identify an interest in relation to any aspect of business set out in the meeting agenda, that member must declare an interest at

the start of the meeting. Members should seek advice from the Chair, through the Committee Secretariat before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the minutes. It is responsibility of the chair, on behalf of the Committee, to determine the action to be taken in response to the declaration of interest, this can include excluding the member, where they have a direct or indirect financial interest or participating fully in the discussion but taking no part in the WRPC decision.

4. Quorum

4.01 A quorum shall be the Chairman or Vice Chair and at least 4 other representatives, 2 of which must be officer members of shared services and 2 of which must be NHS Trust or LHB representatives.
Repeated non-attendance will be reported to the NWSSP Committee.

5. Frequency of Meetings

5.01 Meetings will be held at least 8 times per year, with additional meetings held if considered necessary.

6. Authority

6.01 The Accountable Officer for NWSSP is authorised to carry out any activity within the terms of reference and the scheme of delegation. In the normal course of WRPC business items included on the agenda are subject to discussion and decisions based on consensus. Decisions made by the Accountable Officer against that recommended by the WRPC will be reported to the NWSSP Committee and the Velindre NHS Trust Audit Committee for Shared Services.

6.02 The WRPC may, establish sub groups or task and finish groups as appropriate to address specific issues and to carry out on its behalf specific aspects of business.

7. Responsibilities of the WRPC

7.01 It is important that there is clarity between the role of the WRPC and that of the NWSSP Committee. The NWSSP Committee will have overall responsibility for overseeing the governance arrangements within WRPS and in support of this function the minutes of the WRPC will be forwarded for information and assurance including the highlighting of matters of significance.

7.02 The role of the WRPC is to:

a) Receive assurance on the management of delegations for areas of

responsibility detailed within this Terms of Reference and to report regularly to the Shared Services Partnership Committee on performance;

b) Undertake actions reserved specifically for the WRPC;
c) To provide advice and guidance to the NWSSP Accountable Officer on claims reimbursement decisions; and
d) To support and promote a learning culture within NHS Wales.

8. WRPS areas of responsibility

8.01 The main areas of responsibility for which WRPS will be held to account by the WRPC are:

- To present key financial and performance information.
- To develop an effective and efficient process including technical notes for the receipt of claims and reimbursement of monies to NHS Wales.
- To ensure that there are effective processes for the forecasting of resource requirements over the short and medium term and that there is sufficient liquidity to meet obligations.
- To ensure that the transactions of the WRPS are fully recorded and that financial accounts are produced in accordance with the timetable set by the Welsh Government.
- To undertake regular assessments of the arrangements for the management of Concerns and Claims by NHS Wales.
- To undertake regular assessments of the arrangements for the management of GMPI claims by NHS Wales.
- To undertake the assessments of high risk clinical areas as required by Chief Executives of NHS Wales Bodies.
- To develop processes for learning from events and cascading information to all NHS Wales Bodies including undertaking detailed reviews of claims and identifying trends arising from claims.
- To undertake project work as required by the WRPC.
- To develop a process for the scrutiny of claims and Redress cases presented to each WRPC to provide assurance across NHS Wales that appropriate action has been taken to reduce the risk of recurrence. This process should have regard for the number and complexity of claims being presented to ensure that sufficient consideration is given to issues arising.
- To develop an effective and efficient process for handling and responding to enquiries in relation to indemnity and reimbursement matters.

9. WRPC reserved matters

- To approve the reimbursement of claims and Redress cases and impose penalties in accordance with the Reimbursement Procedures

- To enact the risk sharing arrangements (not currently applicable to GMPI and Redress) as agreed by the NWSSP
- To receive and consider the annual statements of account
- To receive and consider the annual assessment reports and to approve recommendations for any necessary action.
- To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
- To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
- To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
- To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis.
- To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

10. Support and promote a learning culture across NHS Wales

10.1 The members of the WRPC will have collective responsibility for ensuring that the learning from events is formally considered and that a culture of improvement across NHS Wales is fostered. This will include providing advice and guidance at each meeting and where necessary taking action to address weaknesses identified, either at an individual organisational level or at a more strategic level.

11. Reporting Arrangements

11.01 Minutes shall be taken at each meeting and circulated to all members of the WRPC and to the NWSSP Committee for information.

11.02 Risk sharing arrangements will be agreed by the NWSSP Committee.

11.03 Regular financial reports on the risk sharing forecasting will be considered by the Shared Services Committee and provide to Welsh Government as and when required.

11.04 Annual presentations will be made to the groups identified by the WRPC (e.g. Chief Executives, Directors of Finance, Directors of Nursing and Medical Directors).

12. Audit Arrangements

12.01The WRPS will be subject to audit by both internal and external auditors. The external auditors of Velindre NHS Trust will ensure that there is overall audit coverage of claims management across the NHS in Wales.

13. Associated documents

- All Wales Policy on Indemnity and Insurance
- Scope of the Risk Pooling Arrangements
- WRPS Reimbursement Procedures

2. Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership - Terms of Reference July 2019

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

*"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or **utilise Velindre's Committee arrangements** to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

In 2012, it was agreed that the Velindre Audit Committee would be utilised to act on behalf of NWSSP Committee, that there would be a clear distinction between these two areas/functions and that they would be addressed separately under the Audit Committee arrangements. This 'functional split' allows for clear consideration of the issues relating specifically to the business of the nationally run systems and national services that are provided by NWSSP and avoids the boundaries between the governance considerations of the hosting relationship and the governance considerations of NWSSP being blurred.

The functional split can be illustrated overleaf:

(a) Governance (Host Relationship)	(b) Nationally Run Systems & Services
1 Velindre University NHS Trust 2 Audit Committee	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend if there is anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

This document goes on to outline the Terms of Reference for **(b)**, above.

2. INTRODUCTION

2.1 Velindre University NHS Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference, as detailed in the NHS Wales Audit Committee Handbook, June 2012.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:
  - NWSSP's ability to achieve its objectives;
  - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;
  - The reliability, integrity, safety and security of the information collected and used by the organisation;
  - The efficiency, effectiveness and economic use of resources; and
  - The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity, via

monitoring of NWSSP's Audit Action Plan;
- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances), prior to endorsement by the SSPC;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Protect.

4.3 In carrying out this work, the Audit Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

4.5 To achieve this, the Audit Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- The work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

4.7 The Audit Committee is authorised by the SSPC to obtain external legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers it necessary, in accordance with the SSPC's procurement, budgetary and other requirements.

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

4.9 The Audit Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist, without the presence of officials, on at least one occasion each year.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre Trust Board.

The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager
NWSSP Head of Finance and Business Development
NWSSP Corporate Services Manager
Representative of Velindre University NHS Trust
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors will attend as required by the Committee Chair

By invitation The Committee Chair may invite:

- any other Partnership officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary As determined by the Accountable Officer

Member Appointments

5.3 The membership of the Audit Committee shall be determined by the Velindre Trust Board, based on the recommendation of the Trust Chair; taking account of the balance of skills and expertise necessary to deliver the Audit Committee's remit and subject to any specific requirements or directions made by Welsh Government.

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role
- Ensure that Committee agenda and supporting papers are issued 5 working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

6.1 At least two members must be present to ensure the quorum of the Audit Committee, one of whom should be the Audit Committee Chair or Vice Chair.

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may

request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

6.3 The Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual work plans.

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

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Audit Committee's self-assessment and evaluation.

8.3 The Velindre Trust Board and SSPC may also require the Audit Committee Chair to report upon the Audit Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Audit Committee's assurance role relates to a joint or shared responsibility.

8.4 The NWSSP Head of Finance and Business Development and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

9.1 The requirements for the conduct of business as set out in the NWSSP's Standing Orders are equally applicable to the operation of the Audit Committee, except in the following areas:

- Quorum *(as per section on Committee meetings)*

- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre Trust Board.

Annexe 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. Evidence Based Procurement Board (EBPB)

1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP) (August 2018)

1. Aims and Objectives

The Board shall be known as the 'Evidence Based Procurement Board' (EBPB), and will consist of professionals from across various disciplines within NHS Wales and appropriate research bodies, making recommendations and guidance for implementation by the Welsh NHS**.**

The EBPB advises, promotes, develops and implements value and evidence based procurement of medical technologies for NHS Wales. The group will assist with rationalisation and standardisation in line with Prudent healthcare principles, underpinned with the "*Once for Wales*" philosophy, and will assess whether NHS Wales should discard devices/technologies if they are deemed inappropriate or wasteful.

The EBPB will produce advice and guidance to support planning and decision making in Local Health Boards and Trusts.

The EBPB shall provide advice, guidance and recommendations to the Shared Services Committee and the WG Efficiency Healthcare Value & Improvement Group.

The EBPB will support NHS Wales core values through the assessment of quality and safety elements of medical technologies; using this to provide high value evidence based care whilst reducing harm. In addition, through the rationalisation and standardisation programme, the EBPB will enable reduced variation and waste. It also specifically supports the 2018 report "*A Healthier Wales: our Plan for Health and Social Care*" principles of "Higher value" (better outcomes, better experience at reduced cost, less variation and no harm) and "Evidence driven" (the use of research, knowledge and information to understand what works).

In line with the emphasis of "Value" in "*A Healthier Wales*", the EBPB will play a key role in assisting the delivery of the Value Based Health Care agenda across the NHS in Wales.

It is acknowledged that there will be some areas that will be of mutual interest to Health Technology Wales (HTW) and these will be addressed through discussion with appropriate representatives.

2. MEMBERSHIP

Membership will be endorsed by Welsh Government and made up of senior

professionals from NHS Wales and academia. The EBPB will consist of both voting and non-voting members. Membership is as follows;

- Chair - Medical Director/Assistant MD - Stephen Edwards
- NWSSP Director (SRO) - Mark Roscrow
- Finance Director - Hywel Jones
- Health Economist - Pippa Anderson
- Director of SMTL - Pete Phillips
- Health Technology Wales - Susan Myles
- Procurement Services - Andy Smallwood
- Deputy Executive Nurse Director - Jason Roberts
- Secondary Care Clinician - Paul Morgan
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician - Dr Sally Lewis
- Value Based Care/National Lead VBP - Adele Cahill
- Academic Clinician - Prof Haray
- Academia - Sam Evans
- NWSSP MD - Neil Frow

Non-voting members may be invited to attend as and when appropriate;

- Individuals co-opted for advice on specialist category areas, including Clinical networks and clinicians locally.
- Nominated experts from Evidence Research Group

Secretariat

- NHS Wales Shared Services Partnership – Procurement Services
- NHS Wales staff may request to attend as observers by writing in advance to the Chair.

Deputies

In the event of a voting member not being in attendance, an agreed named deputy should attend. The EBPB will approve deputies for all voting members of the group, (Chair excluded). A Vice Chair will be appointed in accordance with *Point 4.*

3. OFFICERS

The Chair will normally be a Medical Director/ Assistant Medical Director, appointed by the EBPB and approved by Welsh Government whose term of office shall normally be between 1-5 years. They will be eligible for re-appointment for an additional term of office, but the total period cannot exceed 10 years.
A Vice-Chair will be elected from the voting members. The Vice Chair or in their

absence, another voting member may preside over meetings in the absence of the Chair.

4. MEETINGS

The EBPB will meet a minimum of 4 times per year, and roles and responsibilities of members should be readily available to any relevant party on request.

5. DECLARATION OF INTEREST

Members MUST declare, in advance any financial and/or personal interests, to any related matter that is subject of consideration. Any declarations made and/or actions taken will be noted in the minutes.

6. VOTING

Any issues/questions should be resolved by consensus. Only voting members will have voting rights. Deputies will be eligible to vote. The Chair will not normally vote on matters however in the case of equality of votes, the Chair or person presiding as Chair will have the casting vote. Members with a conflict of interest in a specific Topic, including members who have had a significant role in the preparation of the submissions being considered, will not cast a vote for that Topic.

7. QUORUM

Quorum will be 50% of voting members.

8. VALIDITY OF PROCEEDINGS/MEMBERSHIP VACANCIES

Validity of proceedings of the EBPB is not affected by a vacancy or defect in the appointment of a member of deputy. Membership of the EBPB shall end if;

- Members resign by giving notice in writing to the Chair of the EBPB
- Absenteeism from 3 consecutive ordinary meetings; unless the EBPB is satisfied that absence is due to reasonable cause
- Ceases to belong to the body they represent
- Term of office expires

9. EVIDENCE REVIEW GROUP (ERG)

The ERG is a standing committee which reports to the EBPB. Staff from SMTL and ProcS form the core membership who will undertake the day to day workload for the ERG.

The ERG will also include experts in Health Economics and Human Factors from

Swansea University as and when required.

The ERG will liaise with other researchers and analysts as and when required, including partnering with HTW staff.

Expert Membership - The ERG will recruit expert members as and when required to provide clinical and domain-specific advice and expertise. Expert members may include Clinical experts from NHS Wales and Welsh Government National Special Advisory Groups (NSAGs).

10. POWERS OF THE EBPB

- The EBPB may require the Evidence Review Group (ERG) to convene meetings of expert advisors.
- The work and meetings of the ERG and expert advisors should be reported to the EBPB.
- The ERG should operate in an advisory role to the EBPB.
- The EBPB may seek independent advice as and when appropriate.
- The EBPB may commission external bodies to evaluate evidence in relation to products.
- The EBPB and ERG will incur the minimum necessary expenditure to enable their work to be carried out. These expenses will be considered and administered by NWSSP Shared Services Procurement Services.
- Nominated experts from the ERG may be required to attend meetings of the EBPB.

11. GOVERNANCE AND ACCOUNTABILITY

The EBPB is accountable to the NWSSP committee and will utilise NWSSP's governance structures.

12. ROLES AND RESPONSIBILITIES

- Support the rationalisation and standardisation agenda in line with prudent Healthcare principles.
- Review evaluations and evidence assessments of medical technologies.
- Develop a work programme determined by Health Boards/Trusts, Welsh Risk Pool and other stakeholders.
- Provide advice to stakeholders regarding new or innovative products for use across NHS Wales in consultation with HTW.
- Liaise with Academia on the EBPB work programme, including product development initiatives where appropriate.
- Participate in horizon scanning with other agencies such as HTW and advise on the potential impact for the NHS.

- Provide advice on clinical pathways/treatments where devices and consumables are part of the clinical process, complimenting and supporting the work of NICE.
- Receive for consideration into the work programme topics referred by WG and other key stakeholders. This will include liaison with HTW's Front Door Group.
- Liaise and engage with professional peers.
- Produce an Annual report for review by NHS Wales and Shared Services Partnership Committee.
- Consider NICE guidance and Do Not Do recommendations when developing the work programme.
- Develop mechanisms to audit adoption of the EBPB advice.

13. GROUP STRUCTURE & METHODS

A separate document is available detailing the structure and working methodology of the EBPB and other structures.

Annexe 5

Process for the Selection, Appointment and Termination of the Chair of the SSPC

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

The Shared Services Partnership Committee (SSPC) has the responsibility for appointing the Chair of the SSPC. Whist the appointment is not a Ministerial appointment the planned process will take account of the appointment principles outlined in the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

MAIN BODY

In line with the Governance Code on Public Appointments to Public Bodies 2016 the principles of public appointments are summarised below:

A. **Ministerial responsibility** - The ultimate responsibility for appointments and thus the selection of those appointed rests with Ministers who are accountable to Parliament for their decisions and actions. Welsh Ministers are accountable to Welsh Government.

B. **Selflessness** - Ministers when making appointments should act solely in terms of the public interest.

C. **Integrity** - Ministers when making appointments must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

D. **Merit** - All public appointments should be governed by the principle of appointment on merit. This means providing Ministers with a choice of high quality candidates, drawn from a strong, diverse field, whose skills, experiences and qualities have been judged to meet the needs of the public body or statutory office in question.

E. **Openness** - Processes for making public appointments should be open and transparent.

F. **Diversity** - Public appointments should reflect the diversity of the society in which we live and appointments should be made taking account of the need to appoint boards which include a balance of skills and backgrounds.

The essential features of the process will include the following:

- A panel must be set up to oversee the appointments process;
- The panel must be chaired by an independent assessor;
- An agreed selection process, selection criteria and publicity strategy for a successful appointment;
- A panel report must be prepared, signed by the chair of the appointment panel; and
- The appointment of the successful candidate must be publicised.

It is important that all public appointees uphold the standards of conduct set out in the Committee on Standards in Public Life's Seven Principles of Public Life. The panel must satisfy itself that all candidates for appointment can meet these standards and have no conflicts of interest that would call into question their ability to perform the role.

The selection panel will comprise of the following members:

- 3 members of the SSPC; and
- NWSSP Director of Workforce and Organisational Development

The appointment process is managed by the NWSSP Director of Workforce and Organisational Development .

A suite of supporting documentation has been developed to support the process.

The job **advertisement.** It is proposed that, in line with the practice adopted by Welsh Government for all other public appoints this post is advertised on Job Wales which is the Western Mail and Daily Post on-line publication.

The candidate application **form**. The content and format very closely mirrors the application form currently used by the Welsh Government for Ministerial Public Appointments.

A **briefing pack** for candidates. This includes details of the role profile and person specification.

Governance and Risk Issues

Whist the appointment is not a Ministerial appointment the planned process will

take account of the appointment principles outlined in the “Governance Code on Public Appointments” which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

The appointment documentation and processes has been reviewed and agreed by the Director of Governance & Corporate Services/Board Secretary at Cwm Taf Morgannwg UHB who is a member of the SSPC; and has also been provided to the Director of Corporate Governance/Board Secretary at Velindre University NHS Trust to ensure that the appointment aligns to Velindre’s governance requirements.

The selection process will be repeated following each maximum term of office for the Chair of the SSPC, or when the Chair resigns, or following removal of the Chair by termination.

Suspension and Termination

Should the circumstances laid down in the draft regulations at 9. (1), 9.(3), 9.(5) or 10.(1) emerge, and the removal (i.e. suspension or termination) of the Chair is deemed necessary, the Committee will agree the reasons for the decision to do so and formally submit these reasons to a panel constituted as that described for the selection process above.

The panel will then make a recommendation to Velindre University NHS Trust to suspend or remove the Chair. Velindre University NHS Trust will then take the necessary action and subsequently provide the Welsh Ministers with the reasons agreed as per section 9.(2) (termination) or 10.(2) (suspension) of the Regulations.

PUBLIC TRUST BOARD

Proposed Payment Process for Existing Liability Scheme (NWSSP)

Meeting Date:	4 June 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Andy Butler, Director of Finance and Corporate Services, NWSSP
Report Presented by:	Andy Butler, Director of Finance and Corporate Services, NWSSP

Trust Resolution to: (please tick)							
APPROVE:	☑	**REVIEW:**		**INFORM:**		**ASSURE:**	☑
Recommendation:	For the Board to **Approve** and **Note**.						

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) ☑	
Equitable and timely services	☑
Providing evidence based care and research which is clinically effective	
Supporting our staff to excel	
Safe and reliable services	☑
First class patient/donor experience	
Spending every pound well	☑
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SMT – Senior Management Team HSS - Delivery and Performance Division Health & Social Services Group MDO - Medical Defence Organisation WIBSS – Welsh Infected Blood Support Scheme	ELS – Existing Liability Scheme MPS – Medical Protection Society MDDUS - Medical and Dental Defence Union of Scotland L&R – Legal and Risk Services GMPI – General Medical Practice Indemnity WRP - Welsh Risk Pool
Executive Summary:	
To provide the Trust Board with background and information on the proposed payment process for the Existing Liability Scheme for NWSSP, as presented to the SSPC on 21 May 2020 for endorsement and approval. There is an additional paper on the Trust Board agenda, entitled Review of NWSSP SSPC Standing Orders, which also details the changes to the Scheme of Delegation to take account of the introduction of the Existing Liability Scheme, for which this paper provides the background, context and assurance, together with Appendices A and B. The paper is presented for **APPROVAL** and there is requirement for payments to go live as at 1 July 2020.	

Proposed Payment Process for Existing Liability Scheme

Background

The Welsh Government has delegated to NWSSP the function of oversight of the Existing Liabilities Scheme (ELS) and certain claims handling responsibilities to be undertaken by the Medical Protection Society (MPS) and Medical and Dental Defence Union of Scotland (MDDUS). Neil Frow will act as Accountable Officer for this delegated function.

A copy of the delegation letter is enclosed as Appendix A.

The Legal and Risk Services (L&R) Division of NHS Wales Shared Services Partnership (NWSSP) will deliver this service on a day-to-day operational basis under the leadership of Heather Grimbaldeston as General Medical Services Indemnity Team Leader. Mark Harris, Director L&R, will provide oversight.

As an additional level of assurance, L&R will follow NWSSP performance reporting arrangements. This includes regular update reports from L&R to our Senior Management Team, written and oral scrutiny on a quarterly basis on the Division's performance against agreed objectives and Key Performance Indicators.

NWSSP also reports quarterly by exception on performance against agreed objectives and KPIs to the Delivery and Performance Division Health & Social Services (HSS) Group.

This oversight function does not involve making payments to either of the Medical Defence Organisations (MDOs) nor direct payments to claimants or to those providing services to defend claims such as Counsel or expert opinion. The Welsh Government HSS Finance team solely handles payments to MDOs. The MDOs make the direct payments to claimants and to those involved in defending the claim.

Change in function

From 1 April 2021 the role of NWSSP will change and it will become responsible for the management of ELS claims, and this will be confirmed in a future delegation letter.

MDDUS has indicated a preference to transfer responsibility for the management of claims from 1 July 2020.

Welsh Government HSS Finance has asked NWSSP to consider if it can also take on responsibility for the direct payment process as part of the change in function. There are two potential scenarios that may then be in operation alongside each other:

- **Scenario 1**
  External solicitors previously engaged by the MDOs will continue to handle some of the claims once L&R has assumed responsibility for the management of the claims.

  In this scenario, L&R will provide instructions. Authorisation and payment of the external solicitors' costs and disbursements will be approved in line with the Scheme of Delegation.

- **Scenario 2**
  L&R solicitors handle some of the claims with no external solicitor involvement. In this scenario members of the GMPI team would then be instructing experts, counsel, cost draftsmen and incurring court fees.

  In this scenario the Director or Deputy Director of L&R will approve claims decisions. Payment request will be approved in line with the Scheme of Delegation.

Annex 1 to this report summarises the process that will operate.

3 Proposed Payment Process for Existing Liability Scheme

Proposal

For NWSSP to take on responsibility for processing direct payments there are three key considerations:

1) Scheme of delegation

The current NWSSP Scheme of delegation will need to be updated to reflect the change in responsibility.

The following proposal reflects similar arrangements put in place for the administration of the Welsh Infected Blood Support Scheme (WIBSS), on behalf of the Welsh Government.

A letter of delegation from the Welsh Government HSS Finance team will be required to support this way forward.

Separately then the following Scheme of Delegation is proposed relating to payment approvals within NWWSP:

Scheme Designation	Damages Limit
Welsh Government	£1M and over
Managing Director and NWSSP Chairman	Up to £1M
Managing Director	Up to £500k
Director of Finance & Corporate Services	Up to £100k
Director of L&R	Up to £100k
Deputy Director of Finance & Corporate Services	Up to £50k
Deputy Director of L&R	Up to £50k
Head of Function - GMPI Team Leader	Up to £10k

Existing Liability Limits - proposal

2) Reporting

The Welsh Risk Pool Committee has no role in the administration or oversight of the Existing Liability Scheme.

It is proposed that NWSSP would provide to the Welsh Government every quarter end a report. This report would include:

- Number of live cases.
- Total estimated value of live cases split by damages/claimant costs/defence costs.
- Indicative settlement date.
- Probability of the claim being successful.
- Summary total of payments made in the last quarter and year to date.

Whilst learning from events is not a requirement prior to a claims decision or payment under the Existing Liability Scheme Regulations, it would nonetheless be considered good practice.

A learning from events form will be completed, logged on the database and incorporated into the wider sharing of learning from GMPI through case studies, training and newsletters.

3) Payments and reimbursement

If adopted it is proposed that claims and payments would be made by NWSSP and approved in line with the above scheme of delegation.

Any value of damages decisions >£1M will require written (email acceptable) Welsh Government approval.

All other value of claims decisions <£1M will be approved in line with the Scheme of Delegation.

With no payment history to rely upon it is difficult to predict with any certainty the volume or value of ELS payments to be processed by NWSSP. It is proposed that initially NWSSP will seek reimbursement for claims payments on a quarterly basis via invoice; similar to the WIBSS process.

It is acknowledged that in the event there is a significant value of payment to be made in any one month, an ad hoc cash draw down may be required from the Welsh Government HSS Finance approval. The L&R Finance Manager will liaise directly with Welsh Government HSS Finance team when this scenario arises.

This initial proposal will be kept under review, and amended if required with the agreement of Welsh Government HSS Finance, to a more frequent reimbursement arrangement.

Conclusion

The Welsh Government HSS Finance team has agreed the above proposal, and a delegation letter will follow confirming the financial limits.

These proposed new arrangements will take effect from 1 July 2020 and be reviewed no later than 1 December 2020.

Recommendation

The Committee is asked to:

- **Note** the content of the report and the change to the Scheme of Delegation, as endorsed by SSPC at their meeting on 21 May 2020; and
- **Agree** the proposed payment process for the Existing Liability Scheme, NWSSP.

5 Proposed Payment Process for Existing Liability Scheme

Annex 1 Existing Liability Scheme Payments – Internal Process

Overview

1) Any decision on value of claims >£1M approval must be sought in writing by the GMPI Team Leader from Steve.elliot@wales.nhs.uk at Welsh Government; cc john.evans@wales.nhs.uk.

2) Any decision on value of claims<£1M must be overseen by the GMPI Team Leader and a referral form completed for approval by the Director of L&R or Deputy.

3) GMPI solicitor instructs NWSSP finance to make payments for either an interim payment or final payment for damages or costs.

   GMPI Team Leader will be cc'd into the request by the solicitor. This request may come from an external solicitor previously appointed by MDOs or from one of the L&R solicitors.

   Director of L&R will be cc'd into requests made by the Team Leader for their own cases.

   Team Leader will instruct NWSSP finance to make payments relating to L&R solicitors.

4) NWSSP finance will complete a dataload spreadsheet in a pro-forma format (to enable upload by Velindre NHS Trust).

   The dataload detailed spreadsheet will include:
   a. Name of the case
   b. Case reference
   c. Bank account details
   d. Invoice date
   e. Invoice number
   f. Amount incl. VAT
   g. Cost Centre
   h. Subjective Code
   i. Invoice received date
   j. VAT type (exempt/reclaimable)
   k. Claimant Name
   l. Email address of recipient for remittance

   The VAT detail is significant because VAT is reclaimable on expert fees except where they have been paid as part of the claimant costs.

5) NWSSP finance will complete a batch control sheet total for all claims to be paid since the last batch.

6) The Batch control sheet will be signed by NWSSP Finance and checked by a second person before being sent to the appropriate Authorising Signatory in line with the scheme of delegation.

   Electronic signatures are permissible if sent from the authorising email account.

7) NWSSP Finance then sends the Batch control sheet and the dataload spreadsheet for payment to Accounts Payable.

   All supporting invoices for costs, including experts and barrister fees, should accompany the dataload spreadsheet.

   Damages payment requests are supported by the email from the solicitor instructing the payment to be made following negotiation of the damages settlement.

   Claimant costs to be paid are supported by email from the solicitor instructing payment following the negotiation of the costs settlement.

8) When payment has been confirmed, NWSSP finance will update the Finance detailed spreadsheet to confirm.

   The Finance spreadsheet would contain the detail of all open cases with brought forward balances at the beginning of the year.

   - The detail includes probability of loss to determine whether the case is a provision or a contingent liability, case ref and provision balances.
   - Payments during the year are added so the closing balances are adjusted for in year utilisation
   - The summary sheet shows the closing position which will reconcile to the yearend statements and can be used as a supporting document for the yearend audit.

9) Learning from events form completed, logged on the data base and incorporated into the wider sharing of learning from GMPI through case studies, training and newsletters.

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Neil Frow
Managing Director
NHS Wales Shared Services Partnership
4/5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7Q7

February 2020

Dear Neil

DELEGATION OF OVERSIGHT OF THE EXISTING LIABILITIES SCHEME ARRANGEMENTS WITH MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND

I am writing to you, as Managing Director of the NHS Wales Shared Services Partnership (SSP), in my role as Director, Primary Care and Health Science, and SRO for the Indemnity Project to formally delegate to Shared Services Partnership Legal and Risk Services (SSP LARS), the function of oversight of the Existing Liabilities Scheme (ELS) and certain claims handling responsibilities to be undertaken by the Medical and Dental Defence Union of Scotland.

We have previously discussed this approach with SSP LARS building on your appointment as operator of the Future Liabilities Scheme (General Medical Practice Indemnity).

I would draw your attention to the specific responsibilities that are delegated in the Interim Arrangements Deed and the Framework Agreement. For ease of reference, the oversight arrangements are set out in the **Annex** this letter.

In summary the oversight arrangements requires SSP LARS to comply with the obligations of Administrator as set out in the Interim Arrangements Deed (Schedule 5, Interim Business Handling, clause 9; Reporting clause 6; Forecasting and Reporting clause 7 ;Monthly Governance Committee clause 18) and the Framework Agreement (Migration clause 12; Schedule 6 Migration). Additionally you will work with HSS to put in place arrangements to ensure valid claim payments can be paid and to monitor the implementation and performance of the arrangements.

I would be grateful if you can confirm acceptance of this delegation letter in writing as soon as possible, please include specifically how you will manage the scheme.

Yours sincerely

Frances Duffy
Cyfarwyddwr, Gofal Sylfaenol a Gwyddor Iechyd
Director, Primary Care and Health Science

Y Grŵp Iechyd a Gwasanaethau Cymdeithasol
Health & Social Services Group

Llywodraeth Cymru
Welsh Government

Neil Frow
Managing Director
NHS Wales Shared Services Partnership
4/5 Charnwood Court
Heol Billingsley
Parc Nantgarw
Cardiff
CF15 7Q7

Our Ref: JE12520
Your Ref:
12 May 2020

Dear Neil,

SCHEME OF DELEGATION –FINANCIAL ARRANGEMENTS

DELEGATION OF OVERSIGHT OF THE EXISTING LIABILITIES SCHEME ARRANGEMENTS WITH MEDICAL AND DENTAL DEFENCE UNION OF SCOTLAND -

In February 2020, Frances Duffy, Director Primary Care and Health Science, wrote to you, in relation to the Delegation of oversight of the Existing Liabilities Scheme and arrangements with Medical and Dental Defence Union of Scotland. The letter stated:

“In summary the oversight arrangements requires SSP LARS to comply with the obligations of Administrator as set out in the Interim Arrangements Deed (Schedule 5, Interim Business Handling, clause 9; Reporting clause 6; Forecasting and Reporting clause 7 ;Monthly Governance Committee clause 18) and the Framework Agreement (Migration clause 12; Schedule 6 Migration).

Additionally you will work with HSS to put in place arrangements to ensure valid claim payments can be paid and to monitor the implementation and performance of the arrangements.”

This letter now confirms that Welsh Government is content with the proposals which are set out in Alison Ramsey’s letter of 28 April and the proposed Scheme of Delegation highlighted in the table below is considered appropriate and will be applicable for approval of payments from 1 July 2020 when oversight of the Existing Liabilities Scheme transfers to NWSSP.

Scheme Designation	Damages Limit
Welsh Government	£1M and over
Managing Director and NWSSP Chairman	Up to £1M
Managing Director	Up to £500k
Director of Finance & Corporate Services	Up to £100k
Director of L&R	Up to £100k
Deputy Director of Finance & Corporate Services	Up to £50k
Deputy Director of L&R	Up to £50k
Head of Function - GMPI Team Leader	Up to £10k

Claims and payments would be made by NWSSP and approved in line with the above scheme of delegation.

Any value of damages decisions greater than £1 million will require written Welsh Government approval.

All other value of claims decisions below £1million will be approved in line with the Scheme of Delegation.

Initially, NWSSP may seek reimbursement for claims payments on a quarterly basis, invoicing Welsh Government. In the event there is a significant value of payment to be made in any one month, an ad hoc cash draw down can be arranged from the Welsh Government with HSS Finance approval. The L&R Finance Manager should liaise directly with Welsh Government HSS Finance team if this scenario arises.

This initial proposal will be kept under review, and amended if required following consultation between Welsh Government HSS Finance and NWSSP.

I would be grateful if you can confirm acceptance of this scheme of delegation letter in writing as soon as possible.

Yours sincerely

SR Elliot

Steve Elliot

Diprwy Cyfarwyddwr Cyllid | Deputy Director of Finance

Cc Frances Duffy, Director Primary Care and Health Science, Welsh Government