

- 1.0.0 10:00 - 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)

Welcome:
Bernadette Rowlands - Aneurin Bevan Community Health Council Member
- 1.3.0 DECLARATIONS OF INTEREST
Led by Prof Donna Mead (Chair)
- 1.4.0 MATTERS ARISING
Led by Prof Donna Mead (Chair)
- 1.4.1 10:05 - Action Log
Led by Prof Donna Mead (Chair)
 - 1.4.1 Action Log updated from 30_07_2020 V2 CAC.docx RG.docx
 - 1.4.1 a appendix to action log.pdf
- 2.0.0 10:15 - CONSENT ITEMS
Led by Prof Donna Mead (Chair)

***The consent part of the agenda considers routine Committee business as a single agenda item.*
*Note: Members may ask for items to be moved to the main agenda if a fuller discussion is required***
- 2.1.0 FOR APPROVAL
- 2.1.1 Minutes from the Public Trust Board meeting held on the 30th July 2020
Led by Prof Donna Mead (Chair)
 - 2.1.1 Draft Minutes Public Trust Board 30_07_2020 CAC V3.docx RG.docx DM.docx
- 2.1.2 Contract Acceptance & Expected Urgent Decisions over £100,000
Led by Mark Osland, Director of Finance
 - TB Proc Submission Summary Sept 20.pdf
 - App 1 Bacterial Arm Cleansing system.pdf
 - App 2 Samlet Road, Swansea – Health Courier Services Transport Hub Development.pdf
 - App 3 Contract Extension - Value Increase Request.pdf
 - App 4 Data Centre Services DC 1 Final.pdf
- 2.1.3 Chairs Urgent Action Endorsements
Led by Prof Donna Mead (Chair)
 - 2.1.3 24 September 2020 Trust Board Report on Chairs Urgent Action.docx
- 2.1.4 NWSSP Delegated Authority Extension
Led by Mark Osland, Director of Finance

*The Board **APPROVE** a further extension to the financial scheme of delegation in respect of COVID 19 related contracts allowing the Chair and either the Managing Director or the Director of Finance and Corporate Services of NWSSP to continue to approve contracts up to £5m, until 31 March 2021*
 - 2.1.4 NWSSP - Scheme of delegation. v16-08_10_19 - _ .docx
- 2.1.5 Trust Seal Report
Led by Prof Donna Mead (Chair)
 - 2.1.5 Trust Seal Report May - August 2020.docx
- 2.1.6 Approved Policies Update
Led by Lauren Fear, Interim Director of Corporate Governance
 - 2.1.6 Policies for Approval Cover Report.docx
 - 2.1.6 a PP13 Low Voltage Policy.docx

- [2.1.6 b PP01 Fire Safety Policy.docx](#)
[2.1.6 c Close Personal Relationships in the Workplace Policy - Final.docx](#)
- 2.1.7 Welsh Language Annual Report
Executive Director of OD & Workforce
[2.1.7 Welsh Language Annual report cover paper 24th Sep Board.docx](#)
[2.1.7a Annual report 19-20 for WL Commissioner Final.pdf](#)
- 2.1.8 NWIS Wales Informatics Service - Velindre Exit
Led by Mark Osland, Director of Finance
[2.1.8 NWIS Transition - Bank Account F-01.docx](#)
[2.1.8 appendix 1.pdf](#)
[2.1.8 appendix 2.pdf](#)
- 2.1.9 Annual Quality Statement (AQS)
Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists
[2.1.9 AQS cover paper.docx](#)
[2.1.9 final version 14.9.2020.pdf](#)
- 2.2.0 FOR NOTING
- 2.2.1 Calloboration Leadership Forum Minutes
Led by Lauren Fear, Interim Director of Corporate Governance
*Following the meeting of the Collaborative Leadership Forum held on 28 July, please find attached a copy of the final approved minutes of the meeting held on 15 January. These are for reporting to all Health Boards and Trusts, as part of the Collaborative's agreed governance arrangements - **for NOTING**.*
[2.2.1 LF-2007-01 - Approved Minutes of CLF 150120 v1.docx](#)
- 2.2.2 Workforce Planning Guidance
Led by Sarah Morley, Executive Director of OD & Workforce
[2.2.2 Board cover paper Workforce Planning Guidance 2020 - August 24th 2020.docx](#)
[2.2.2 Velindre NHS Trust Workforce Planning Toolkit.xlsx](#)
[2.2.2 Velindre Strategic Workforce Plan Template.finaldoc.doc](#)
[2.2.2 Workforce Planning Guidance. Final 30th July 2020.docx](#)
- 2.2.3 10:20 - Advanced Therapies (Cell & Gene) status update: Advanced Therapies Wales / Midland -Wales
 Advanced Therapies Treatment Centre Precision Medicine Service
Led by Cath O'Brien, Interim Chief Operating Officer
[2.2.3 ATW MWATTC PM VUNHST Board Status summary COB 17 Sept 2020.docx](#)
[2.2.3a Appendix 1.pdf](#)
[2.2.3b Appendix 2.pdf](#)
- 2.2.4 Convalscent Plasma Highlight Report
Led by Cath O'Brien, Interim Chief Operating Officer
[2.2.4 Convalescent Plasma Project Update.docx](#)
- 3.0.0 10:20 - KEY REPORTS
- 3.1.0 Chairs Update
Led by Prof Donna Mead (Chair)
[3.1.0 Chair report Sept 2020 - Final.docx](#)
- 3.2.0 CEO Update
Led by Steve Ham, CEO
[3.2.0 CEO Update Report - Sept 2020 -draft.docx](#)
- 4.0.0 QUALITY & SAFETY
- 4.1.0 10:30 - Quality and Safety Highlight Report
Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists
[4.1.0 Q&SC highlight report Final.docx](#)
- 4.2.0 10:35 - Development of Velindre University Risk Strategy, Appetite and Assurance Framework
Led by Lauren Fear, Interim Director of Corporate Governance
[September TCS programme and Trust board paper-final.docx](#)
[Appendix 1 - VUNHST Risk Management Framework - vfinaldraft.docx](#)

[Appendix 2 - Risk Management Process vfinaldraft.docx](#)

[Appendix 3 - Risk Appetite Strategy.docx](#)

[Appendix 4 - Trust Assurance Framework -vfinaldraftdocx.docx](#)

5.0.0 10:45 - ****COMFORT BREAK****

6.0.0 INTEGRATED GOVERNANCE

6.1.0 11:00 - Velindre University Committee Structure Development

Led by Lauren Fear, Interim Director of Corporate Governance

[Board and Committees Structure - Trust Board 24 09 2020 2020 - FINAL.docx](#)

[Board and Committees Structure v.08 - Appendix Diagram.docx](#)

[Appendix 1 Quality Safety and Performance Committee DRAFT Terms of Reference - September 2020.docx](#)

[Appendix 2 Final Draft Quality Safety Performance Committee Cycle of Business 2020-21.docx](#)

[Appendix 3 Strategic Development Committee TOR - DRAFT - September 2020.doc](#)

[Appendix 4 Final Draft Strategic Development Committee Cycle of Business 2020-21.docx](#)

[Appendix 5 Audit Committee - TOR Review September 2020.docx](#)

[Appendix 6 Remuneration Committee - TOR Review September 2020.docx](#)

[Appendix 7 Charitable Funds Committee - TOR Review September 2020.docx](#)

[Appendix 8 TCS Programme Scrutiny Sub Committee - TOR Review September 2020.docx](#)

[Appendix 9 RDI Sub Committee - TOR Review - September 2020 \(002\) -LF.doc](#)

6.2.0 11:10 - Local Partnership Forum Highlight Report

Led by Sarah Morley, Executive Director of OD & Workforce

[6.2.0 PARTNERSHIP MEETING Highlight Report -29.07.2020.docx](#)

7.0.0 PLANNING & PERFORMANCE

7.1.0 11:15 - Delivering Excellence Performance Report

Led by Cath O'Brien, Chief Operating Officer

[7.1.0 Final Delivering Excellence Performance Report - sept 2020 \(002\).docx v2.docx](#)

[7.1.0a VCC Performance Report - July 2020 \(Trust Board\) - update.pdf](#)

[7.1.0b WBS July 2020 SMT PMF Report.pdf](#)

[7.1.0c WOD Performance Report July 2020.docx](#)

7.2.0 11:25 - Progress Report: Quarter 3/4 Plans (including Winter Plans)

[7.2.0 Quarter 3 and Quarter 4 Operating Plan - Progress Update - Trust Board Update 24th Sept 2020.docx](#)

7.3.0 11:35 - Project Review - Well-being of Future Generations (Wales) Act (2015) & Blood Supply Chain 2020

Led by Cath O'Brien, Interim Chief Operating Officer

[7.3 0 WBFGA Review BSC20 V1.0 16.09.2020 Trust Board.docx](#)

[7.3 1. A Globally Responsible Wales v0.1 13.08.2020.pdf](#)

[7.3 2. A Healthier Wales v0.1 13.08.2020.pdf](#)

[7.3 3. A Resilient Wales v0.1 13.08.2020.pdf](#)

[7.3 4. A Prosperous Wales v0.1 13.08.2020.pdf](#)

[7.3 5. A More Equal Wales v0.1 13.08.2020 \(1\).pdf](#)

[7.3 6. A Wales of Cohesive Cultures v0.1 13.08.2020.pdf](#)

7.4.0 11:45 - Financial Report

Led by Mark Osland, Director of Finance

[7.4 20-21 Month 5 Finance Report Cover Paper Final.docx](#)

[7.4 M5 VELINDRE NHS TRUST FINANCIAL POSITION TO AUGUST 2020 - TRUST BOARD Final.docx](#)

7.5.0 11:55 - TCS Programme Committee Update

Led by the CEO, Mr Steve Ham

Oral Update due to Committee only taking place on the 17/9/2020

7.6.0 12:05 - TCS Programme Communication & Engagement Update

Led by Lauren Fear, Interim Director of Corporate Governance

8.0.0 12:15 - ANY OTHER BUSINESS

Prior Approval By the Chairman Required

9.0.0 12:20 - DATE AND TIME OF THE NEXT MEETING

Annual General Meeting 22nd October 2020 @ 2pm (Details will follow)

Next Trust Board Meeting is the 26th November 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 UPDATED 30th JULY 2020

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
Public Trust Board 28.11.2019				
7.3	Radiotherapy Performance COB and MO will keep the Board apprised of the management of the financial risk. The detailed operational plan will be kept at operational level.	UPDATE JULY 2020 CLOSED for 2019/20 position: 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. OPEN for 2019/20 position: The Trust is currently engaging in active discussions for the financial year 2020-2021	COB	CLOSED for 2019/20 position OPEN for 2019/20 position – Update due in September 2020

		as part of the ongoing commissioning dialogue.		
28-09-17 4.3	Velindre NHS Trust Risk Appetite Statement <ul style="list-style-type: none"> Action: Collect emerging themes and report back to the Board in 6 months. Action: Training event and practical plan to implement this process <p>The Board APPROVED on the basis that the above comments are noted and the actions taken forward.</p>	UPDATE JULY 2020 Risk Appetite workshop scheduled with the Board for 27 th August, as part of the Board Briefing. All IM-Exec lead pre-meets now scheduled. Consideration for approval of new Risk Appetite strategy and refreshed risk appetite statements then scheduled for 24 th September Trust Board.	LF	CLOSED September 2020
19.12.2019 – Extraordinary Public Trust Board				
2.0	Urgent Decisions Over £100k <ol style="list-style-type: none"> 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 SEPTEMBER 2020 A plan has been being drawn up to include a full review of the whole process and to determine procedural responsibilities. This action is expected to be closed by November Board. To also note that the work will feed into wider development of the decision making process across the Trust.	MO/LF	OPEN September 2020

30.04.2020 Public Trust Board				
	1. 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.	UPDATE JULY 2020 This action relates to the Letter of Accountability and Update was given at the 25 th June Board with the intention to align this with the Q2 plan submission	SH	OPEN July 2020
25.06.2020 Public Trust Board				
4.3.0	COVID-19 Update 2. Include the capacity and demand modelling for radiotherapy (RT) and wider service on the Board Briefing agenda for the 9th July.	CLOSED On agenda for 27 th August Board Briefing	CJ	CLOSED
7.1.0	Q2 VUNSHT Operational Plan 1. Mr Carl James agreed to meet with CHC to agree reporting templates for Q2 and performance reports.	CLOSED Phil Hodson held a meeting with the CHC on 29/07/2020, a follow up on 11/08/2020 and another meeting took place for 18/09/2020	CJ	CLOSED
30.07.2020 Public Trust Board				
2.1.5	Review of the NHS Wales Shared Services Partnership Committee Standing Orders 1. Mrs Lauren Fear to inform NWSSP of the error in their Standing Orders that circular ends March 2021 not 2020.	CLOSED AND ATTACHED FOR COMPLETENESS (see appendix)  Standing Orders for Operation of SSI	LF	

6.1.0	Velindre Cancer Centre Excellence Performance Report <ol style="list-style-type: none"> Mrs Cath O'Brien to ensure future reports have a clear indication on treatment 35 day breach. Mrs Cath O'Brien to provide further information to the September 2020 Committee on the work being undertaken to review Unwell and Unscheduled Care Services. 	CLOSED – captured in the PMF papers 24/9/2020	COB	CLOSED
8.1.0	Academic Partnership Board Highlight Report <ol style="list-style-type: none"> Terms of Reference to be updated to remove the need for Trust Board to approve the Terms of Reference, as confirmed in the meeting. 	CLOSED Updated ToR included in the Board & Committee updated item 6.1.0 24/9/2020	LF	CLOSED
10.0.0	Any Other Business <ol style="list-style-type: none"> A request to approve a spend of £100k to be sent to the Trust Board 'Out of Committee'. 	CLOSED The TCS Programme Communication and Engagement request was considered under Chairs Urgent Action, as discussed in Trust Board Part A meeting 30/7/2020 and will be included in the Chairs Urgent Report at the September Board Circulated 20/8/2020	LF	
	<ol style="list-style-type: none"> Sophie Howe's letter and Annual Report on Wellbeing & Future Generations to be shared with the Trust Board for Information 	CLOSED Circulated 20/8/2020	RG	

**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

Annexe 4: Shared Services Partnership Committee Standing Orders (SSPC SOs)
Status: Effective
30 July 2020

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Originally Introduced June 2015

(updated 30 July 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

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee

Annexe 4: Shared Services Partnership Committee Standing Orders (SSPC SOs)

Status: Effective
30 July 2020

Page 2 of 104

(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>

TABLE OF CONTENTS

Foreword	2
<u>Section: A – Introduction</u>	<u>7</u>
Statutory Framework	7
NHS Framework	8
Shared Services Partnership Committee Framework	9
Applying SSPC Standing Orders	10
Variation and amendment of SSPC Standing Orders	10
Interpretation	11
Relationship with Velindre University NHS Trust Standing Orders	11
The Role of the Board Secretary Support Function	11
<u>Section: B – Shared Services Partnership Committee Standing Orders</u>	<u>12</u>
<u>1. The Shared Services Partnership Committee</u>	<u>12</u>
1.1 Purpose, Role, Responsibilities and Delegated Functions	12
1.2 Membership of the SSPC	14
1.3 Member and Staff Responsibilities and Accountability	14
1.4 Appointment and tenure of SSPC members	16
1.5 Termination of Appointment of SSPC Chair and Vice Chair	17
1.6 Appointment of NWSSP Staff	18
1.7 Responsibilities and Relationships with each Health Board, Trust and Special Health Authority Board, Velindre University NHS Trust as the Host and Others	18
<u>2. Reservation and Delegation of the Shared Services Functions</u>	<u>18</u>
2.1. Chair's Action on Urgent Matters	19
2.2 Delegation to Sub-Committees and others	19
2.3 Delegation to Officers	19
<u>3. Sub-Committees</u>	<u>20</u>
3.1 Sub-Committees Established by the SSPC	20
3.2 Other Groups	22
3.3 Reporting Activity to the SSPC	22
<u>4. Expert Panel and Other Advisory Panels</u>	<u>22</u>
4.1 Expert Panels and Advisory Groups Established by the SSPC	22
4.2 Confidentiality	22
4.3 Reporting Activity	22
4.4 Terms of Reference and Operating Arrangements	23
4.5 The Local Partnership Forum (LPF)	23
4.6 Terms of Reference and Operating Arrangements	24
4.7 Membership	25

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee

Annexe 4: Shared Services Partnership Committee Standing Orders (SSPC SOs)

Status: Effective

30 July 2020

Page 4 of 104

4.8 Member Responsibilities and Accountability	25
4.9 Appointment and Terms of Office	27
4.10 Removal, Suspension and Replacement of Members	27
4.11 Relationship with the SSPC and Others	28
4.12 Support to the LPF	28
<u>5. Working in Partnership</u>	<u>29</u>
<u>6. Meetings</u>	<u>30</u>
6.1 Putting Citizens First	30
6.2 Annual Plan of Committee Business	30
6.3 Calling Meetings	31
6.4 Preparing for Meetings	31
6.5 Conducting SSPC Meetings	33
6.6 Record of Proceedings	37
6.7 Confidentiality	38
<u>7. Values and Standards of Behaviour</u>	<u>38</u>
7.1 Declaring and Recording SSPC Members' Interests	38
7.2 Dealing with Members' interests during SSPC meetings	39
7.3 Dealing with Officers' Interests	41
7.4 Reviewing How Interests are Handled	41
7.5 Dealing with Offers of Gifts and Hospitality	41
7.6 Register of Gifts and Hospitality	43
<u>8. Signing and Sealing Documents</u>	<u>44</u>
8.1 Register of Sealing	44
8.2 Signature of Documents	44
8.3 Custody of Seal	44
<u>9. Gaining Assurance on the Conduct of Shared Services Partnership Committee Business</u>	<u>44</u>
9.1 The role of Internal Audit in Providing Independent Internal assurance	45
9.2 Reviewing the performance of the SSPC, its Sub- Committees, Expert Panel and Advisory Groups	45
9.3 External Assurance	46
<u>10. Demonstrating Accountability</u>	<u>46</u>
<u>11. Support for The Shared Services Partnership Committee</u>	<u>47</u>
<u>12. Review of Standing Orders</u>	<u>47</u>
<u>Annexe 1 Model Scheme of Reservation and Delegation of Powers</u>	<u>49</u>
Model Scheme of Reservation and Delegation of Powers	50
Deciding What to Retain and What to Delegate: Guiding Principles	51
Handling Arrangements for the Reservation and Delegation of Powers: Who Does What	52

Scope of These Arrangements for the Reservation and Delegation of Powers	<u>54</u>
Section 1 Annexe of Matters Reserved to the SSPC	<u>55</u>
Section 2 Annexe of Delegation of Powers to Committees and Others	<u>60</u>
Section 3 Annexe of Scheme of Delegation to NWSSP Directors and Officers	<u>63</u>
Section 4 Annexe of Delegation of Budgetary Responsibility	<u>70</u>
Section 5 NHS Wales NWSSP Scheme of Budgetary Delegation	<u>71</u>
<u>Annexe 2 Key Guidance, Instructions and Other Related Documents</u>	<u>76</u>
<u>Annexe 3 Shared Services Partnership Sub-Committee Arrangements</u>	<u>77</u>
1. Welsh Risk Pool Committee Terms of Reference	78
2. Velindre University NHS Trust Audit Committee for NHS Wales	84
Shared Services Partnership Terms of Reference	
<u>Annexe 4 Terms of Reference</u>	<u>95</u>
1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP)	93
<u>Annexe 5 Process for the Selection, Appointment and Termination of the Chair of the SSPC</u>	<u>101</u>

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, with the exception of those appointed or re-appointed in accordance with Regulation 3 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020. The amendments will cease to have effect on 31 March 2021, or at the end of the term of appointment made in accordance with the amendments, whichever is the later. 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 NWSSP officers and non-NWSSP officers

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 discipline they 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 Annex 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 with¹ has any direct or indirect

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

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.

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 Gifts² 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.

²The term gift refers also to any reward or benefit

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 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.

**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**

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee

Annexe 4: Shared Services Partnership Committee Standing Orders (SSPC SOs)
Status: Effective
30 July 2020

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 specifically delegated 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 SSPC³

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: <ul style="list-style-type: none">▪ 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.

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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.

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies.
24	FULL	STRATEGY & PLANNING	<p>Approve NWSSP's key strategies and programmes related to:</p> <ul style="list-style-type: none"> ▪ 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.

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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.

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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: <ol style="list-style-type: none">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	Head of Finance and Business Improvement	Board Secretary Support
	Final interpretation of Standing Orders	Chair	
	Responsibility for providing advice to the Board on all aspects of governance/committee services	Head of Finance and Business Improvement	
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

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

SO 2.3.1	delegated to Managing Director for consideration and approval by the SSPC Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Improvement 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

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 other NHS bodies	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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 (except for personal effects)	Managing Director of NWSSP	No	Within authorised limits set by WG.

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

Approval of compensation for staff and patients personal effects <ul style="list-style-type: none"> 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	1m	0	1m
Managing Director of NWSSP	100	500	N/A	500
Director of Finance and Corporate Services	80	100	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:				
<i>**Represents contracts where expenditure is directly incurred in respect of All Wales Contracts</i>				

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 2020

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 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:				
<i>*Limits to be reviewed again by 30 September 2020</i>				

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

Status: Effective
30 July 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.	

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.

**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

12.01 The 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:

Standing Orders, Reservation and Delegation of Powers for the
Shared Services Partnership Committee
Annexe 4: Shared Services Standing Orders

- **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
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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.

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.

Process for the Selection, Appointment and Termination of the Chair of the SSPC
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This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs
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The Shared Services Partnership Committee (SSPC) has the responsibility for appointing the Chair of the SSPC. Whilst 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

Whilst 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.

Reappointment and Tenure

The SSPC SOs form part of the Velindre University NHS Trust Standing Orders, which must take account of the provisions of the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 and the disapplication of these Regulations with regard to the tenure of the Chair and Vice Chair.

On 5 July 2020, in response to the suspension of recruitment to public appointments in Wales, the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020 came into force. The purpose of these Regulations (“the Regulations”) is to dis-apply the maximum tenure of office contained in the specified regulations for NHS Committee non-Officer members for a time limited period.

Due to the temporary suspension of all public appointments in March 2020 in Wales and the time required to re-start the appointment process as the restrictions are lifted, the Regulations will ensure that during such a critical and challenging period for the health sector in responding and recovering from the impact of COVID-19, Committees do not to carry vacancies, allowing them to function properly and support good and effective governance.

The Regulations will dis-apply the statutory maximum tenure of office to ensure any Committee member who is nearing the end of their statutory maximum tenure of office is eligible for re-appointment. Any reappointments will be made in accordance with the Commissioner for Public Appointments’ Governance Code, which includes allowing an appointee to hold office for a maximum of ten years.

The amendments will cease to have effect on 31 March 2021, or at the end of the term of appointment made in accordance with the amendments, whichever is the later. The Regulations temporarily dis-apply Regulation 8(5) of the Velindre

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.

MINUTES OF THE PUBLIC TRUST BOARD – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/TEAMS/LIVE STREAMED THURSDAY 30TH JULY 2020 @ 10:00

PRESENT:

Professor Donna Mead	Chair (Chair)
Mr Stephen Harries	Interim Vice Chair
Ms Janet Pickles	Independent Member
Mr Martin Veale	Independent Member
Mrs Hilary Jones	Independent Member
Mr Gareth Jones	Independent Member
Professor Donald Fraser	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:

Mrs Lauren Fear	Interim Director of Corporate Governance
Mr Stephen Allen	Community Health Council (CHC) Representative
Ms Cath O'Brien	Interim Chief Operating Officer
Mrs Katrina Febry	Relationships Manager, Audit Wales
Mr Phillip Hodson	Deputy Director of Planning & Performance
Mrs Rebecca Goode	Secretariat
Mrs Catherine Currier	Secretariat

1.0.0	STANDARD BUSINESS Led by Professor Donna Mead (Chair) Professor Donna Mead welcomed everyone to the first Trust Board Meeting being live streamed to the public, 30th July 2020. Mrs Lauren Fear provided information on the format of the Trust Board.	
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1.1.0	<p>APOLOGIES Led by Professor Donna Mead (Chair)</p> <p>Apologies were received from:</p> <ul style="list-style-type: none"> • Mr Carl James, Director of Strategic Transformation, Planning & Digital • Dr Jacinta Abraham, Medical Director • Mr David Cogan, Patient Liaison Group (PLG) 	
1.2.0	<p>IN ATTENDANCE Led by Professor Donna Mead (Chair)</p> <ul style="list-style-type: none"> • Brenda Chamberlain, Vice-Chair, South Glamorgan Community Health Council 	
1.3.0	<p>DECLARATIONS OF INTEREST Led by Professor Donna Mead (Chair)</p> <p>No declarations of interest were declared.</p>	
1.4.0	<p>MATTERS ARISING</p>	
1.4.1	<p>Action Log Led by Professor Donna Mead (Chair)</p> <p>The action log was reviewed and updated.</p> <p>The Board DISCUSSED and UPDATED the action log.</p>	
2.0.0	<p>CONSENT ITEMS Led by Professor Donna Mead (Chair)</p> <p>The consent part of the agenda considers routine committee business as a single agenda item. Note: Members may ask for items to be moved to the main agenda if a fuller discussion is required.</p>	
2.1.0	<p>FOR APPROVAL Led by Professor Donna Mead (Chair)</p>	
2.1.1	<p>Minutes from the Public Trust Board meeting held on the 25th June 2020 Led by Professor Donna Mead (Chair)</p> <p>The consent agenda was reviewed and items 2.1.1. Minutes of the Public Trust Board meeting held on the 24th June 2020, 2.1.3 Chairs Urgent Action Endorsements and Policies for Approval were APPROVED.</p>	

2.1.2	<p>Contract Acceptance & Expected Urgent Decisions over £100,000 (Procurement) Led by Mr Mark Osland, Executive Director of Finance</p> <p>The Board AUTHORISED 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 AUTHORISED the Chief Executive to APPROVED requisitions for expenditure under the named agreement.</p>	
2.1.3	<p>Quarter 2 Operating Plan Update Led by Mr Phil Hodson, Assistant Director of Planning</p> <p>The Board APPROVED the Quarter 2 Operating Plan.</p>	
2.1.4	<p>Velindre University NHS Trust – Amendment to Standing Orders</p> <p>Led by Mrs Lauren Fear, Interim Director of Corporate Governance.</p> <p>The Trust Board APPROVED the amendments to the Trust Standing Orders as tracked.</p>	
2.1.5	<p>Review of the NHS Wales Shared Services Partnership Committee Standing Orders Led by Mrs Lauren Fear, Interim Director of Corporate Governance</p> <p>This item was taken out of the Consent Agenda for discussion.</p> <p>Professor Donna Mead noted an error on page 103 Annex 5 were NWSSP cited circular ending in March 2020 not March 2021 when period of extension ends. Mrs Lauren Fear agreed to inform NWSSP of the error.</p> <p>The Trust Board APPROVED the amendments, as reflected in in the NWSSP Standing Orders, on the basis that the above error will be corrected.</p>	LF
2.1.6	<p>Chairs Urgent Action (Period 25th June - 24th July) Led by Mrs Lauren Fear, Interim Director of Governance</p> <p>The Board APPROVED the Chairs urgent action taken since the January 2020 Trust Board Meeting.</p>	

2.2.0	<p>FOR NOTING</p> <p>There were no items for noting.</p>	
3.0.0	<p>PRESENTATION - CHALLENGES / NEXT STEPS / Q3 PLAN Presentation led by Mr Steve Ham, CEO</p> <p>Mr Steve Ham explained that following a discussion with Professor Donna Mead it was agreed to share, with the Board, the extensive work programme and the need for flexibility. Key message were highlighted as:</p> <ul style="list-style-type: none"> • Develop Q3, Q4 and next year's plan and how this can be done as one work project. • Strategic direction of the Trust. • Reshaping how the Trust works. <p>The importance of remembering the Trust has been responding to COVID-19 for the last 6 months, which has been really intense.</p> <p>In terms of developing operational plans, the need for flexibility as the pandemic develops i.e. changes to quarantine rules and any second wave was highlighted. This would need to be balanced with demands to return to pre-COVID activity levels and for the Trust to be able to respond to any changes, as Health Board services are restarted. The impact of social distancing has provided challenges on how and where services are provided and the Trust would continue to work in partnership with patients and the CHC to resolve these challenges. Alongside this, the Trust would be restarting work that had been put in abeyance in March 2020 due to COVID-19.</p> <p>The Trust will continue to work with Welsh Government and NHS Welsh Informatics Service to establish the new Digital Special Health Authority.</p> <p>Lastly, the Trust will be refocusing on reshaping the organisation through the lens of COVID, including how we build upon the agility in decision making into normal ways of working; reviewing committee structures; recommencing the organisational development programme; arrangements around the Interim Chief Operating Officer to get full benefit in having this role in place; how we work across the Trust to ensure cohesion; the governance arrangements on how do we delegate across the Trust.</p>	

	<p>Professor Donna Mead noted the importance of setting out framework on how this work would progress. Mr Steve Ham confirmed this aligned with the Q2 and Q3 plans and provided details of the underlying ethos.</p> <p>The Board NOTED the contents of the presentation.</p>	
4.0.0	KEY REPORTS	
4.1.0	<p>Chairs Update Led by Professor Donna Mead (Chair)</p> <p>The Chair updated the Board and confirmed the report was for noting and highlighted the following items:</p> <ul style="list-style-type: none"> • The Board Briefing Session (9th July 2020 received a presentation from Mrs Nicola Williams and Mr Stephen Allen on the implications of Quality and Engagement Wales Bill, which was due spring 2022. It also discussed the potential future direction of the committee structure. An update on the proposed committee Structure will be received at the September 2020 Trust Board. • The Integrated Governance Group was held on 9th July 2020, which provided the Vice-Chair and Independent Members with an opportunity to be briefed on what was happening across the whole of the Board and focused on exploring the Independent Member's role, Champions and the new Committee structure. • A Board Briefing Session is scheduled for the end of August 2020 and would focus on the Trust's risk appetite and provide an opportunity to further discuss the Board Champion role. • The Trust held the inaugural meeting of the Academic Partnership Board. This is a requirement of the Trust's University status. A virtual meeting was held and attended by representatives from 5 Universities and Welsh Government. A formal highlight report from the Academic Partnership Board has been included in the papers for this Trust Board. <p>The Board NOTED the content of this update report.</p>	
4.2.0	<p>CEO Update Led by Mr Steve Ham, CEO</p> <p>Mr Steve Ham summarised the report and highlighted the following:</p> <ul style="list-style-type: none"> • The progress made around the Radiotherapy Satellite Centre in Nevill Hall Hospital, which remains on target. 	

	<ul style="list-style-type: none"> Mrs Georgina Galletly, Director of Corporate Governance has been permanently recruited to Cwm Taf University Health Board and the Trust will commence the process to recruit a permanent replacement. <p>The Board NOTED the content of the report from the CEO.</p>	
5.0.0	QUALITY & SAFETY	
5.1.0	<p>Quality and Safety Highlight Report Led by Ms Janet Pickles, Chair of the Quality & Safety Committee</p> <p>Ms Janet Pickles highlighted that since March 2020 the Quality & Safety Committee had been held monthly, in response to COVID-19. At the start of each meeting the Committee receives a presentation from staff on their experience of working during the pandemic. The highlight report provided, for this meeting, demonstrates the range for quality and safety topics from fire training, to how the Trust is responding to COVID-19 and the experiences of staff and staff wellbeing.</p> <p>Ms Janet Pickles provided an update on the Advancing Radiotherapy Funding Charitable Meeting (Moondance), which also illustrated the experience of people working in the Trust during COVID-19 and the changes in services. Ms Janet Pickles highlighted an example of a change from a surgical treatment to an alternative radiotherapy treatment, which does not require anaesthetic or inpatient bed. This change in treatment has proved so successful that WHSSC are considering this as a future treatment. The Board thanked Ms Jan Pickles for highlighting a positive improvement in changes to service, as a result of the pandemic.</p> <p>The Board requested an update on mitigating action around the oxygen rich environment. Mr Steve Ham confirmed that a business case was under development and pre-submission discussions had taken place with Welsh Government. Prof Donna Mead asked if all appropriate mitigation actions had been undertaken and Mr Stephen Ham noted a risk assessment process was being completed, which would be presented to the Quality & Safety Committee.</p> <p>Mrs Nicola Williams highlighted the Putting Things Right Annual Report, which was appended to the highlight report. Prof Donna Mead noted the annual report was very easy to read and noted the improvements in 30 day target which was welcome. Mrs Nicola Williams highlighted how the annual report illustrates how the Trust, Services and Divisions have responded and learnt from complaints, incidents and donors/patient feedback.</p>	

	<p>Mr Stephen Allen agreed and thanked the Trust for the really detailed report and in particular highlighted the 'you said and we did' section, which gives a clear indication on how the Trust had responded, learnt from conversations and concerns and congratulated the team on the report.</p> <p>The Board NOTED the update from the Quality & Safety Committee.</p>	
5.2.0	<p>Trust Risk Register Led by Mrs Lauren Fear, Interim Director of Corporate Governance</p> <p>Mrs Lauren Fear presented the report and the Brexit Risk Assessment. It was noted that the full Trust Risk Register had been received at the June 2020 meeting. It had been agreed following the introduction of monthly meetings the July report would be by exception and the work on the development of the risk framework will be brought to the September 2020 meeting.</p> <p>The Trust Board APPROVED the Trust Risk Register Exception Report.</p>	
5.2.1	<p>Trust Risk - EU Exit - Risk 14860 Led by Mrs Cath O'Brien, Interim Chief Operating Officer</p> <p>Mrs Cath O'Brien took the Board through a request to change the Brexit Risk Assessment score. The Trust Brexit Group were planning to undertake a complex risk assessment, in light of continued negotiations around Brexit. It was planned to overlay the impact of Brexit, as further information, with risks around COVID-19 and the impact on the supply chain. It was noted that 18 months ago, as part of Brexit preparations, the Brexit Group undertook review of the supply chain and identified who suppliers were, how supplies were routed and this work would continue to be updated and monitored. In addition, they are seeking assurance from 3rd party suppliers on their Brexit/COVID-19 plans.</p> <p>Mr Martin Veale thanked Mrs Cath O'Brien for the update and the information, which helped to understand the specific issues.</p> <p>The Trust Board NOTED the work being undertaken to mitigate any risks around Brexit and the impact of COVID-19 and APPROVED the inclusion of this risk on the register.</p>	

6.0.0	PLANNING & PERFORMANCE: Apologies were noted at this time for the technical hitch.	
6.1.0	<p>Delivering Excellence Performance Report Period Led by Mrs Cath O'Brien, Chief Operating Officer Prof Donna Mead highlighted the cover paper, which introduced the performance reports noted that the contextualised content was very helpful for independent members and the public.</p> <p><u>Velindre Cancer Centre</u></p> <p>Mrs Cath O'Brien highlighted the complexity of demand on radiotherapy and the impact the COVID-19 has had on capacity. It was noted that patients are being reviewed, in line with agreed clinical principles, the timely provision of radiotherapy, the psychological impact on patients and ensuring ongoing additional support was available for patients.</p> <p>Prof Donna Mead asked for confirmation that the reference in the table of the number of days. Where it is stated that the patient breached by 35 days, was this a 35 day breach or 7 days over the target of 28 days. It was confirmed that the delay was 7 days over the target. It was agreed this would be clarified in future reports.</p> <p>Mr Stephen Allen asked if patients, who have breached targets, are being provided with comfort calls, or contacted to provide assurance, or given any indication when they would recommence treatment. Mrs Cath O'Brien confirmed processes were in place to contact patients, but did not have an exact understanding in terms of what was received from a patient's perspective. Mrs Cath O'Brien offered to ascertain this information and to provide additional information for Mr Stephen Allen.</p> <p>The Board noted the level of performance achieved by the Trust during the extra-ordinary times of COVID-19.</p> <p>Mr Stephen Harries mentioned that some of the existing radiotherapy equipment had been in place for a considerable time and that work to develop a replacement programme was ongoing. It was requested that, in future, to include an indication on lost time due to machines failing and routine maintenance within the report. Mrs Cath O'Brien agreed with this suggestion and noted work was ongoing to add new parameters to the report and would request this information was included.</p>	<p>COB</p> <p>COB</p>

	<p><u>Welsh Blood Service</u></p> <p>The Welsh Blood Service acknowledged the tremendous support from the public, both existing and new donors, during the pandemic to keep stock at the required levels.</p> <p>It was confirmed sickness absence was being measured closely and it was noted the Trust was running at slightly raised absence figures and assurance was provided of continued review for COVID and non-COVID related absence; the impact on staff in terms of wellbeing and mental health. It was noted a range of interventions were available and the focus remains on supporting staff to return to the workplace, in a safe way. For those staff shielding, an individual approach is being proposed to support staff back into the workplace.</p> <p>Professor Donna Mead highlighted the benefits of access to Maggie's facility during the pandemic and requested an update on alternatives being sought following the handback of the facilities. Mrs Sarah Morley confirmed the Senior Management Team were working to identify an alternative. In addition the Trust was developing a business case to provide dedicated staff psychology support. Mrs Cath O'Brien confirmed a space had been identified at the rear of the postgraduate building, which was Cardiff & Vale University Health Board property. It was hoped to construct a number of pods and to provide additional benching around the Cancer Centre.</p> <p>Mrs Sarah Morley provided an indication that there were 5 members of staff, who were absent due to COVID-19.</p> <p>Mr Martin Veale noted the information on numbers of staff who are shielding was not included in the matrix and a system for capturing this information was required. Mrs Sarah Morley confirmed that there were 26 members of staff in this category, across the organisation, and the Trust was working with each individual to understand their own situation, as the situation evolves. Mr Gareth Jones highlighted the need for the shielding information to be included within the report, which was agreed.</p> <p>Professor Donald Fraser requested an update on the review of acutely unwell and unscheduled care services, whilst acknowledging the current extra-ordinary circumstances. Mrs Cath O'Brien confirmed work was ongoing; however a report was not ready and provided background information on the individual circumstance. It was confirmed no patient had come to harm. Mrs Cath O'Brien agreed to provide an update at the next Trust Board meeting.</p>	<p>COB</p>
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	<p>Professor Donna Mead highlighted the contradiction in the report, which notes the labs have been impacted by lower collections, changes to hospital demands; and the establishment of the Ambient Hold, which has resulted in an increased resource requirements. Mrs Cath O'Brien explained this related to the additional resource required to introduce the Ambient Hold facility; however the savings would be reflected in other areas of the process. It was noted the Ambient Hold facility had been brought forward to ensure the components being collected were used in the most efficient way during the pandemic. The service was planning to undertake an analysis of how the Ambient Hold affects the efficiency of the laboratory service.</p> <p>Mr Stephen Allen raised the number of Velindre Acquired Pressure Ulcers and whilst these are low numbers, there had been a spike in April and June; however nothing had been reported to Welsh Government, as a Serious Incident. Mrs Nicola Williams noted there was a clear categorisation for reporting Serious Incidents to Welsh Government, which required Grade 3 and 4 incidents to be reported. Mrs Nicola Williams provided assurance that the Velindre Cancer Centre had established a Pressure Ulcer Scrutiny Panel, where all pressure ulcers are scrutinised and this was overseen by the Head of Nursing. Professor Donna Mead noted the addition of Tissue Viability Wound Healing Nurse and requested an update on the relationship with the Welsh Wound Healing Centre. Mrs Nicola Williams confirmed the relationship continues, however the Trust has a Service Level Agreement with Cardiff & Vale University Health Board for sessional time of the Tissue Viability Wound Healing Nurse, who also supports the Scrutiny Panel to give level of specialist oversight.</p> <p>Professor Donna Mead requested Mrs Cath O'Brien to maintain the level of detail in the cover report, as this was very reassuring and answered questions, which would otherwise have been raised, thereby assisting with the smooth running of Trust Board.</p> <p>The Trust Board DISCUSSED the contents of the performance reports.</p>	
6.2.0	<p>Financial Report Period - Month 3 Led by Mr Mark Osland, Executive Director of Finance</p> <p>Mr Mark Osland indicated the report showed the initial position at end of June 2020 and highlighted the following key messages:</p>	

	<p><u>Revenue</u></p> <ul style="list-style-type: none"> • The Exec Summary shows a small overspend across the Trust and maintaining compliance with payment targets. • An underachievement on savings and efficiency targets was reported. • It was noted the small net overspend does not include the impact of COVID additional costs. • The Trust continues to forecast a breakeven position for the year end, depending on funding from Welsh Government for COVID costs. There is an assumption the Trust will receive financial reimbursement for the additional costs; however there has been no formal agreement from Welsh Government to date. • The report contains detail around COVID-19 costs including net spend to the end of June 2020 and a forecast for the year. This has been increased to a Welsh Government request to include an estimate for additional capacity, which may be needed for later in the year when demand is expected. • Convalescent Plasma costs have been included within the report and it was confirmed the Trust had secured a formal funding agreement from Welsh Government for costs incurred on the project. • The savings target is forecasted to be underachieved due to the significant amount of service resourcing, workforce etc. It will be difficult to achieve the savings target under the currently climate and the Trust was expecting a shortfall, as a result of COVID. • The contracting arrangements with Commissioners had been confirmed for Quarter 2, as a Block Contract approach, as an extension to Quarter 1. • Whilst the Trust was expecting to breakeven for year-end; it was noted this was dependent on Directors and Budget Holders achieving delegated budget control limits and receipt of further funding for COVID-19 and there being no penalty for underachievement of targets. <p><u>Capital</u></p> <ul style="list-style-type: none"> • The Capital requirements information related to the TCS Programme and the capital requirements to deliver the programme. It was noted the Trust has not secured a budget from Welsh Government for the programme and dialogue with Welsh Government continues. It was believed the delay was due to Welsh Government focusing on responding to COVID-19. • Capital costs for responding to COVID-19 was included within the report. 	
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	<ul style="list-style-type: none"> It was noted that the Discretionary Budget was being used as a temporary measure to support the TCS Programme and as such, has not been allocated. <p>Mr Mark Osland noted the positive impact of the previous cover report, which highlighted key messages and will follow a similar approach in future.</p> <p>Mr Gareth Jones raised the possibility of reimbursement from Welsh Government for the funding of the COVID-19 costs and asked if there was any indication on when this may be forthcoming. Mr Mark Osland responded there had been no indication from Welsh Government on when the decision would be made. The delay was felt to be due to Welsh Government finalising their budgetary position for their Health & Social Service portfolio with the UK government.</p> <p>Mr Martin Veale noted it was disappointing that confirmation on the TCS Programme's longer term funding for the capital funding, as this was a recurrent issue. The Trust Board noted this was a position which affected the whole of the NHS and was not a specific Velindre University NHS Trust issue. Mr Stephen Ham offered to include the TCS funding in his Accountability Officer Letter to Welsh Government.</p> <p>The Trust Board NOTED the contents of the report.</p>	
6.3.0	<p>Transformation Cancer Services Programme Scrutiny Highlight Report</p> <p>Led by Mr Stephen Harries, Chair of the TCS Scrutiny Committee</p> <p>Mr Stephen Harries provided an oral update, as the meeting had only met last week and would provide a written update at the next meeting. The Trust Board was reminded the TCS Scrutiny Committee had been established to scrutinise the entire TCS Programme and provided information on the programme work streams.</p> <p>The meeting received an updated and refreshed risk register and it was noted that a number of activities that had previously been paused or slowed due to COVID-19 were being recommenced.</p> <p>It was highlighted the recent submission of the two planning applications had generated considerable social media and a helpful public debate. These discussions may lead to a delay in the delivery of the new Velindre Cancer Centre. It was noted the delivery of the new hospital was linked to the Radiotherapy Procurement, which would extend the capacity of Linac</p>	

	<p>Accelerators. Mr Stephen Harries provided information on the Radiotherapy Procurement.</p> <p>Professor Donna Mead thanked Mr Stephen Harries for the oral update.</p> <p>The Trust Board NOTED the oral update.</p>	
6.4.0	<p>Transforming Cancer Services Communications and Engagement Update</p> <p>Led by Mrs Lauren Fear, Interim Director of Corporate Governance.</p> <p>Mrs Lauren Fear highlighted the following key messages:</p> <ul style="list-style-type: none"> • Since June 2020 the focus had been on supporting the Outreach and the Enabling Works workstreams. • Outreach for the delivery of SACT and outpatient service in the local community and patient homes was now in the consultation phase. • The 2 planning applications for access roads to the site had been delayed to COVID-19. • The report provided an update on communication and engagement in response to the growth in community voices to the new site. Engagement with the Community had been face-to-face, where possible, through social media and digital events. The Trust felt it was important to listening really carefully to highly important stakeholder and engagement messages. • The Trust's commitment to the green agenda was emphasised. • Future work includes engagement with the Community Health Council, Outreach Project and with Aneurin Bevan University Health Board regarding the Radiotherapy Satellite Centre. <p>Professor Donna Mead noted the extensive engagement work and welcomed the extensive detailed questions the Trust had received from the Community. It was noted the Trust had held two virtual public meetings, which had gone well.</p> <p>Mr Stephen Allen raised the need to consider the rewording in the report as the term 'consultation' has a defined definition by Welsh Government, which may give the wrong impression as the Trust was in the engagement phase. Mr Stephen Allen offered to help with any reconsideration of the wording. Professor Donna Mead noted the helpful advice and provided background to the consultation process previously undertaken and thanked Mr Stephen Allen for the important point raised.</p>	

	<p>Mr Stephen Ham acknowledged the need to be clear about what we mean by this language.</p> <p>The Board NOTED the update.</p>	
7.0.0	WORKFORCE & ORGANISATIONAL DEVELOPMENT	
7.1.0	<p>Trade Union Partnership - Update Led by Mrs Sarah Morley, Executive Director of Workforce & OD.</p> <p>Mrs Sarah Morley thanked Trade Union Colleagues for their involvement in the weekly Partnership meetings and it was noted the last one had been held yesterday. The meeting had focused on quarantine arrangements, the support for taking of annual leave and the guidelines released this week. It had been agreed to close down the weekly meetings as the Trust-wide Local Partnership Forum would commence from September 2020 and the Trade Unions were involved in both Divisional Partnership meeting.</p> <p>Professor Donna Mead was pleased to note the positive working with the Trade Unions and the support they have provided to staff.</p> <p>The Trust Board NOTED the oral update</p>	
7.2.0	<p>Remuneration Committee Highlight Report Led by the Chair, Professor Donna Mead.</p> <p>Professor Donna Mead explained she chairs the Remuneration Committee, which meet on a bi-monthly basis but due to the pandemic the meetings had been paused.</p> <p>The Committee had met recently to discuss an anonymous letter, which had been processed via the Trust's Anonymous Letter process. It was noted the action plan from this letter, would be combined with the action log from a previously received anonymous letter. In addition the Committee was informed of the recruitment process for the new Director of Corporate Governance.</p> <p>Mr Martin Veale acknowledged Mrs Georgina Galletly's new appointment and thanked Mrs Galletly for her work with the Trust Board and the Trust, as a whole. This was endorsed by the Chair and the full Board.</p> <p>The Trust Board NOTED the oral update.</p>	

8.0.0	RESEARCH, DEVELOPMENT AND INNOVATION	
8.1.0	<p>Academic Partnership Board Highlight Report Led by the Chair, Professor Donna Mead</p> <p>Professor Donna Mead provided the Trust Board with an update on the Academic Partnership Board. It was noted the Terms of Reference had been included for information, as this was not a sub-committee. The Academic Partnership Board had been well attended with representatives from 5 Universities, Welsh Government and other stakeholders. The Trust took the opportunity to present a number of Trust initiatives under Research, Education, Development and Innovation and our ambitions in these areas.</p> <p>It was agreed another meeting would be scheduled, using a similar format, to allow our Partners to inform the Trust of the work they are doing and their aspirations. Following this, it was planned for the collective to meet once a year and twice yearly with individual partners.</p> <p>It was confirmed a triennial review by Welsh Government was being scheduled, as the Trust's university status will be reviewed every 3 years. Professor Donna Mead provided background information on the review process.</p> <p>Mr Gareth Jones noted that as it had been agreed that the Trust Board did not need to approval the Terms of Reference, this needed to be reflected in the document.</p> <p>The Trust Board NOTED the oral of the Highlight Report.</p>	LF
9.0.0	INTEGRATED GOVERNANCE	
9.1.0	<p>Audit Committee Highlight Report Led by Mr Martin Veale, Chair of Audit Committee</p> <p>Mr Martin Veale explained two highlight reports had been provided: one each for NHS Wales Shared Services Partnership and the Trust. The following key messages were highlighted:</p> <ul style="list-style-type: none"> • It was noted there had been a 'slowdown' in responding to Internal Audit Committee Recommendations, as the Trust responded to COVID-19. This would be the focus of the work prior to the October 2020 Audit Committee. • NHS Wales Information Service move to become a Strategic Health Authority had been delayed to 1st April 2021, due to the pandemic. Formal updates will be provided to future Audit Committees. 	

	<ul style="list-style-type: none"> Four Internal Audit reports were received: 3 for NHS Wales Information Service and 1 for the Velindre Cancer Centre. The Audit Committee had prompted areas to respond quickly to the audit recommendations. A Counter Fraud Wales Audit Office Report was received today. <p>The Trust Board NOTED the contents of the Highlight Reports.</p>	
9.2.0	<p>NHS Wales Shared Services Partnership - Audit Committee Assurance Report Led by Mr Martin Veale, Chair of Audit Committee</p> <p>Mr Martin Veale noted this report had been provided for information. Mr Stephen Ham confirmed discussions with colleagues in NHS Wales Informatics Service had taken place and further discussion were planned.</p> <p>The Trust Board NOTED the contents of the Highlight Report.</p>	
10.0.0	<p>ANY OTHER BUSINESS Prior Approval By the Chair Required</p> <ol style="list-style-type: none"> Professor Donna Mead noted that the Trust Board would be asked to make a decision 'Out of Committee' on a request to spend £100k. Professor Donna Mead acknowledged receipt of a letter from Sophie Howe, Wellbeing and Future Generations Wellbeing Commissioner, and confirmed that in her Annual Report the Trust was highlighted as having very good examples of compliance with legislation. Professor Donna Mead would arrange for the letter and report to be circulated to Trust Board members. <p>The Trust Board NOTED these updates.</p>	<p>LF</p> <p>RG</p>
11.0.0	<p>DATE AND TIME OF THE NEXT MEETING The next Trust Board meeting and AGM is the 24th September 2020 - timing and schedule to follow</p> <p>Professor Donna Mead thanked all for their attendance and apologised for the technical issues. It was noted on the whole the 'live streaming' had worked well and the Trust was grateful to all involved for helping to set up and supporting the meeting.</p>	
12.0.0	<p>CLOSE</p> <p>The Board is asked to adopt the following resolution:</p>	

	<p>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).</p>	
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DRAFT

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENTS EXCEEDING £100k FOR THE PERIOD 24th September 2020 to 25th November 2020

DATE OF MEETING	24 th September 2020
PREPARED BY	Helen James
PRESENTED BY	Mark Osland
EXECUTIVE SPONSOR	Mark Osland

REPORT PURPOSE	For approval.
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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),
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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	Baterial Arm Cleansing System	1 st October 2020 – 31 st December 2021	£299,666
2	NWSSP	Samlet Road, Swansea – Health Courier Services Transport Hub Development	1 st October 2020 – 30 th September 2030	£415,000
3	NWIS	Extension to the Procurement of Specialist Resources to Expedite Office365 Roll Out – P642.06	1 st May 2020 – 31 st January 2021 option to extend upto 30 th April 2021. Proposed further extension upto 31st October 2021.	£1,536,725
4	NWIS	Data centre services	01 November 2020 - 31 October 2027	£9,100,000

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:

Bacterial Arm Cleansing System ('Chloroprep' swabs)

2. CONTRACT DETAILS

2.1. Description of Goods

This requirement is for antibacterial substance in a pre-prepared swab applicator. They are used by WBS Blood Collection Teams to cleanse the site of the donor's arm prior to inserting the blood donation cannula.

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

Extension of existing service originally approved by Trust Board in July 2016.

2.3. Procurement Route

WBS purchase swabs under a current NHSBT agreement that expires on 30th September 2020. Due to delays with Covid-19, NHSBT have confirmed that they will extend the current agreement for a further 14 months, until December 2021 when a new framework will be awarded.



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By WBS extending their contract under the NHSBT will enable access to competitive pricing, resulting from the greater commercial opportunity generated by the aggregate spend of NHSBT and WBS.

This Trust Board paper is being submitted for the approval of spend to cover the 14 month extension of the current contract (October 2020-November 2021).

2.4. Timescales for implementation

Not applicable

2.5. Period of Contract

The period of extension will be for a further 14 months. Original contract duration was 4 years. Total contract period of contract will be 62 months.

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).

The values in the table below is comprised of previous years purchasing commitments.

Title	Original contract period 4 years £ (excl VAT)	Fy20/21 (EXTENSION PERIOD) £ (excl VAT)	Total £ (Inc. VAT)
Arm Cleansing Device	£268,000	£58,000	
Total			£299,666

2.7. Source of Funds

This contract shall be funded by revenue.



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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

07/09/2020

Service Area:

WELSH BLOOD SERVICE.

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. TITLE OF SCHEME/CONTRACT:

Samlet Road, Swansea – Health Courier Services Transport Hub Development

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

The present site at Cwmbwrla Ambulance station is provided under the legacy arrangement with Welsh Ambulance Services NHS Trust (WAST) and the site is currently planned for redevelopment by WAST

We have been advised we will be displaced as a result and will require alternate accommodation, and expecting notice to vacate to be given shortly.

Following work undertaken with Specialist estates, a location at Samlet Rd, Swansea has been identified as suitable to relocate the Swansea HCS services. The unit is a constructed from steel frame and brickwork, and will be supplied as a shell for conversion to suitable accommodation. The proposed lease is a 10 year arrangement with 5 year breakout clause

The unit has a gated secure goods yard to ensure security of vehicles.

Due its location, it has excellent access to the major roads network.

- Benefits of the relocation to Samlet Rd, Swansea will include:
 - Secure Goods yard to park vehicles
 - Fit for purpose Post Room to manage internal mail within the Health Board Area plus to receive internal mail, patient notes and medical records form other Health Board area and support exchange of Primary Care Service documents
 - Provide a fit for purpose transport scheduling office for Supply Chain, Logistics & Transport to concentrate on both HCS & Supply chain regional requirements.
 - Provide access to a training area for staff to promote continuous professional development

- Provide Welfare facilities for staff that are currently unavailable in Cwmbrwla e.g. lockers and adequate rest facilities
- Provide meeting room facilities
- Provide a large 'open plan' office for other users and 'Hot Desk' capability
- Relocation to be closer to the M4 corridor and major road infrastructure
- Provide 'future proofing' with a building that will allow HCS to expand and develop its support to NHS Partners and allow access to training facilities
- Will allow the ability to accept delivery of items as a staging site, for onward delivery from its goods/store holding area

2.2. Nature of Contract

(Please complete either 2.2.1 or 2.2.2).

Building Lease

2.2.1. New/First time contract

New

▪ Date of Board approval of business case

To be approved by NWSSP Committee on 17th September 2020.

▪ 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

No – Planning has been applied for and approved

2.2.2. Contract Renewal/Extension

Not Applicable

2.3. Procurement Route

Sourced with Specialist Estates with agents providing a limited list of suitable locations

2.4. Timescales for implementation

October 2020 for sign off. Occupation not expected until late March 2021

2.5. Period of Contract

The lease is a 10 year arrangement with 5 year breakout clause

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

Years 1-5

Title	FY20/21 £ (excl VAT)	FY21/22 £ (excl VAT)	FY22/23 £ (excl VAT)	FY23/24 £ (excl VAT)	FY24/25 £ (excl VAT)	Total @ Y5 (excl VAT)
Lease Costs	£51k	£51k	£51k	£51k	£51k	255,000
Total	£51k	£51k	£51k	£51k	£51k	255,000

Years 5-10

Title	Fy25/26 £(excl VAT)	FY26/27 £ (excl VAT)	FY27/28 £ (excl VAT)	FY28/29 £ (excl VAT)	FY29/30 £ (excl VAT)	Years 5-10	Total £ (Excl. VAT) 10 years
Lease Costs	£32k	£32k	£32k	£32k	£32k	160,000	415,000
Total	£32k	£32k	£32k	£32k	£32k	160,000	415,000

***Contract is for the above cost, and excludes rates payable to government**

2.6. Source of Funds

This is funded via existing revenue and recurring budget has been allocated

It should be noted that Covid-19 pandemic has caused slippage in the project, and that the above figures are based on a Capital contribution to offset the cost of the works

Should further delays be encountered, we may not be able to fund the capital contribution this financial year, and this will mean that additional revenue expenditure will be used to fund years 1-5 as part of the lease arrangement; and this could incur an additional revenue cost of up to £16,500 per annum for years 1-5

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:

Service Area: NWSSP Procurement Services

AGREEMENT TO CONSIDER A CONTRACT EXTENSION AND INCREASE IN CONTRACT VALUE

Contract Title:	Procurement of Specialist Resources to Expedite Office365 Roll Out – P642.06
Original Contract Duration:	Nine (9) months, with the option to extend for a further three (3) months
Current Contract Value:	£1,436,725.00 ex VAT
Additional Value:	£100,000.00 ex VAT
Estimated Total Value (incl. extensions):	£1,536,725.00 ex VAT

1. Was the contract advertised to include an option to extend?

Due to the PCR2015 dispensation due to the COVID-19 pandemic (as set out in section 4 below), a VEAT notice was issued to the market, via Sell2Wales, setting out the rationale for the direct award.

The scope of the procurement was to provision a team of specialist resources to expedite the rollout of Office365 and to undertake other technical work required. The objective was to make working from home using Office365 for NHS Trust staff across Wales resilient as the effects of COVID-19 developed. By adopting this approach a resilient service was provided to those working from home to undertake their daily activities. Other aspects of the solution to be rolled out included applications to manage communication to all staff in relation to latest news on COVID-19, a self-diagnosis tool to ease pressure on NHS Wales and Frequently asked questions.

The VEAT did include an option to extend for a further three (3) months.

2. What extension duration was included in the OJEU?

The VEAT notice included the option to extend for three (3) months.

3. How much of the extension do you plan to utilise?

NWIS is seeking to exercise the three (3) month extension, and this paper also seeks to extend the contract term for a further six (6) months. This equates to additional expenditure of £100,000.00 ex VAT.

4. Background (overview of contract)

Due to the limited number of suppliers available to support the deployment of the MS Office 365 Suite at the scale which NHS Wales required as a result of the pandemic, the procurement was conducted via a Single Tender approach. The Single tender process that was undertaken from a procurement perspective was in accordance with the Public Contract Regulations ("PCR") 2015's article 32 below:

In accordance with article 32 of the European procurement rules "in so far as is strictly necessary where, for reasons of extreme urgency brought about by events unforeseeable by the contracting authority, the time limits for the open or restricted procedures or competitive procedures with negotiation cannot be complied with. The circumstances invoked to justify extreme urgency shall not in any event be attributable to the contracting authority".

A Voluntary Ex-Ante Transparency (VEAT) Notice was published on 7th April 2020 via Sell2Wales in order to comply with the Regulatory requirement to advertise Contracts Awarded in accordance with regulation 32 of the PCR15. The Director of NWIS and Velindre University NHS Trust's Director of Finance endorsed this

approach via the required governance mechanisms as set out in Trust Standing Orders and SOP-COM-007, Authorisation processes for procurements of goods and services during exceptional circumstances.

The original STA covered the immediate work that was directly attributable to the NHS Wales response to COVID-19 but was only the work that had been requested in the initial work package. The immediacy to start work, to have locally based support and to be able to utilise the skills and demonstrable experience of a supplier, who had successfully deployed an Office 365 roll out to Welsh Government Teams, and that also had well established links with Microsoft was critical to the delivery of the accelerated implementation plan. Moreover, the Contractor, RedCortex Ltd, had worked previously on the deployment of these Services under contract by Microsoft for customers across the private and public sector within Wales. At the time of the scoping of the initial requirements at the height of the pandemic NWIS was uncertain of the scope and scale of the requirements and the period over which employees would be requiring such technology and ensure that the business needs of NWIS including the tasks of the SHA requirements need to be met.

The additional work is related to the National Finance 365 rollout and its current dependency on Qlikview and the consequential additional licensing costs associated with its link into the Oracle systems. Over the last month, together with the technical experts in the national team, NWIS has drawn out the current and future financial technology landscapes to understand the fit and implication for the linkages with Oracle. NWIS is establishing new ledgers as part of its move to the Strategic Health Authority ("SHA") and as a consequence has designed new modernized reports using BI. This additional support will achieve two things:

- 1) Provide additional technical support for 20 days to pilot the NWIS solution within the Oracle landscape with a technical BI expert
- 2) Provide a further 80 days that will take the outcome of the NWIS solution and apply the learning to other financial applications working within the finance team to ensure we embed the learning and sustainability of the solutions.

Given the circumstances set out above, an extension of the current contract is required for a further period of six (6) months, for the purpose of completing the National Finance 365 rollout.

The recommended approach, is to modify the contract by extending it under the grounds permitted in Regulation 72(1)(b) and/or (c) of PCR2015. This allows modification of existing contracts where a change of contractor would present serious technical difficulties, or where the modification is due to unforeseen circumstances. In order to pursue this option, the following documentation needs to be developed and signed off:

- Exemption from Standing Orders whilst ensuring the appropriate governance mechanisms are followed; and
- A modification notice to be published in the Official Journal of the EU ("OJEU") summarising the changes, the additional expenditure and stating the Reg. 72 ground(s) relied on.

There is a "cap" on the value of the modification under regulation 72, such that it must not exceed 50% of the original contract value. The additional extension and resources will not exceed this threshold.

The potential exclusion options detailed in the PCR2015 have been reviewed and it has been concluded that NWIS are able to extend the contract beyond its intended term under Regulation 72(1)(b) additional services necessary which cannot be carried out by a separate contractor and (c) where the modification is due to unforeseen circumstances.

Regulation 72(1)(b) applies where:

- The Contractor cannot be changed for economic or technical reasons – this could be because e.g. the contractor owns intellectual property rights in the system, or it would be technically too difficult for another contractor to complete the implementation, or it would lead to disproportionate cost to do so; and
- It would cause significant inconvenience or duplication of costs to employ a separate contractor to do it.
- The value of the modification cannot exceed 50% of the original contract value.

- As long as an Authority is not modifying the agreement outside the original scope of the Agreement intended.

Regulation 72(1)(c) applies where:

- The modification has been brought about by circumstances, which a diligent authority could not have foreseen. It will be important to document the reasons for the subsequent changes to the contract. Provided these were not reasonably foreseeable (you will be able to rely on them) and;
- The modification must not change the overall nature/scope of the contract.

The total contract value for the Roll out of O365 is £1,436,725.00 ex VAT. The anticipated costs for the six (6) month extension period and additional resources required will be £100,000.00 ex VAT. This will bring the overall contract value to £1,536,725.00 ex VAT.

5. Current status (including any previous extension details)

The current contract is for nine (9) months, with the option to extend for a further three (3) months.

6. Please set out the rationale for this proposed extension/increase

The procurement risk of challenge is being managed/mitigated as follows:

- Utilising the appropriate PCR2015 regulation – Modification as set out above

Next Steps:

- Publish the modification notice via Sell2Wales

7. How would you seek approval of Trusts to this?

Not Applicable.

Prepared by:	Laura Panes	Date:	8 September 2020
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Agreed by Director of Informatics Service:		Date:	9 September 2020
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Agreed by Chief Executive Velindre NHS Trust:	_____	Date:	_____
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Agreed by Director of Finance for Velindre NHS Trust:	_____	Date:	_____
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BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. SCHEME TITLE

DATA CENTRE SERVICES (Data Centre 1)

2. CONTRACT DETAILS

2.1. Description of Goods / Services/ Works/Lease

The on-premise Infrastructure that supports NHS Wales National Services managed by NHS Wales Informatics Service (“NWIS”) is mainly housed in two data centres, one at Blaenavon (Data Centre 1) and one at Newport (Data Centre 2).

In 2010, NWIS executed an Agreement with SRS to provide co-location services for the hosting of networking and server equipment at the Blaenavon site. The Agreement was for a period of ten (10) years, which commenced on 01 November 2010, and is due to conclude on 31st October 2020.

Following the recent decision by SRS to cease provision of the co-location data centre services at the Blaenavon site, NWIS has been provided with an extension until 31st March 2021. This procurement aims to procure replacement Data Centre 1 co-location capacity elsewhere in Wales, along with transition services to assist with moving equipment from the Blaenavon Data Centre to the new location.

The requirement has been structured within several lots, please see the detail below:

- Lot A (mandatory) provides for a basic level of data centre colocation capacity (rack footprints and cabling) to replace much of the existing Blaenavon capacity;
- Lot B (mandatory) provides for transition services to assist with moving equipment to the new location;
- Lot C (optional) provides for further colocation capacity which is anticipated over the life of the project and for rack equipment where this is not provided by the supplier, or where it is not practical to move existing equipment from Blaenavon as part of the migration;
- Lot D (optional) provides for additional technical support and implementation resources on a “day rate” basis.

The new Agreement will afford NWIS the flexibility for future growth: i.e. new services can be supplied by allowing for additional capacity to be purchased in addition to the initial requirement, during the term of the Agreement.

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.

2.2.2. Contract Renewal/Extension

- **Description of Assessment undertaken to justify continuation of service requirement.**

The current Agreement expires on 31st March 2021 and NWIS is seeking to commence the procurement process with immediate effect to ensure that the provision of this critical service continues during the transition to the new data centre.

- **Details of any matters that may be considered as Novel or contentious**

Not Applicable.

2.3. Procurement Route

This Agreement will be procured by undertaking a cross lot competition via the Crown Commercial Services, Technology Services 2 Framework, Lot 2 Transition and Transformation and Lot 3b Operational Services – Operational Management (RM3804/L2/3b).

2.4. Timescales for implementation

The implementation timescales will vary depending on the outcome of the mini competition. There will be a transition period, however, the timescales for this will become clearer when the contract is awarded. However, the implementation planning will need to be in accordance with the exit date from Blaenavon as set out above.

2.5. **Period of Contract**

It is anticipated that the contract will be for a period of up to seven (7) years, to commence 01 November 2020 and expire on 31 October 2027.

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).**

Description	Annual Cost exc VAT	Total Price exc VAT	Total Price inc VAT
Initial Contract Term – Anticipated costs from 01 November 2020 to 31 October 2025 (based on 60 Racks – core requirements of 40 racks and Option to purchase 20 additional racks, plus relocation services and consultancy services)	£1,300,000	£9,100,000	£10,920,000
Total Cost		£9,100,000	£10,920,000

*Please Note: The costs are based on £20,000 per rack per annum, which are calculated based on last year's pricing taking into consideration potential increases as a result of RPI.

The breakdown of the costs per rack are shown below:

Price per footprint @ Power rating		+ Power	Total Bundled Price*
@6KW/h	£7,000	£13,000	£20,000

* Power costs include the cost for power in a 6kW bundle which is a constituent of a standard rack bundle. The cost of this includes not only the cost of 6kW of power but also the PUE (Power Usage Efficiency) which has been averaged over the two data centres that NWIS currently occupy.

The costs also include the transition services required as well as the option to call off additional racks and consultancy services, over the term of the agreement.

2.7. Source of Funds

NWIS is currently engaging with Ifan Evans Director – Technology, Digital & Transformation Welsh Government and it is anticipated that whilst the ongoing revenue costs will be comparable to those for the current Blaenavon Data Centre any non-recurrent transitional revenue and capital funding (e.g. for planning, undertaking the move or new circuits) will be centrally funded.

3. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

- 3.1. The lead Director, by providing email confirmation to seek Board approval, is making a **declaration that all procurement rules, Standing Orders and Standing Financial Instructions have been complied with**. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name: Helen Thomas

Service Area: NHS Wales Informatics Service



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TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	24/09/2020	
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	04/08/2020	Approved
Trust Board Members – Via Email	14/08/2020	Approved
ACRONYMS		
TCS	Transforming Cancer Services Programme	
NWSSP	NHS Wales Shared Services Partnership	

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 The Vice-Chair was invited and agreed to attend the NWSSP Financial Governance Group that has been established to oversee and scrutinise NWSSP procurement requests in response to COVID 19 PPE requirements. The Board has agreed that due to the role performed by the Vice-Chair on this group, the Vice-Chair will abstain from any approval requests sought via Chairs Urgent Action involving NWSSP procurement decisions.
- 1.4 This report details Chair's Urgent Action taken since the last Trust Board meeting held on the 30 July 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.



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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 30 July 2020 Trust Board Meeting as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. Transforming Cancer Services Programme

The Trust Board were sent an email on the 31 July 2020, inviting the Board to **AUTHORISE** the extension of an existing contract from 31 July 2020 to 30 September 2020 for the procurement of a programme consultant to support Transforming Cancer Services.

Due to the urgency of this matter it could not wait until the 24 September 2020 Trust Board meeting.

Recommendation Approved:

Mr. Stephen Harries, Acting Chair
Mr. Steve Ham, Chief Executive Officer
Mr. Martin Veale, Independent Member
Mrs. Hilary Jones, Independent Member
Ms. Sarah Morley, Executive Director of Organisational Development & Workforce
Mr. Mark Osland, Executive Director of Finance

No objections to approval received.

2. Fire Safety Business Justification Case (BJC)

The Trust Board were sent an email on 14 August 2020, inviting the Board to **AUTHORISE** the submission of the Fire Safety BJC for submission to Welsh Government to seek support and funding for the implementation of a series of fire safety prevention measures across the Trust estate.

Due to the urgency of the above activity, this matter could not wait until the 24 September 2020 Trust Board meeting.

Recommendation Approved:

Mr. Stephen Harries, Acting Chair
Mr. Carl James, Acting Chief Executive Officer
Mr. Martin Veale, Independent Member
Mr. Gareth Jones, Independent Member
Mrs. Jan Pickles, Independent Member

No objections to approval received.



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TRUST BOARD

NHS WALES SHARED SERVICES – FURTHER EXTENSION OF INCREASED FINANCIAL DELEGATION

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Andy Butler, Director of Finance & Corporate Services - NWSSP
PRESENTED BY	Mark Osland, Executive Director of Finance & Informatics
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance & Informatics

REPORT PURPOSE	FOR APPROVAL
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS

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1. SITUATION/BACKGROUND

- 1.1 Temporary adjustments were made to the financial limits delegated to NWSSP in respect of COVID19 and pandemic related expenditure incurred on behalf of NHS Wales by the Velindre University NHS Trust Board on 18 and 30 March 2020.

Subsequent to that agreement by the Velindre Board, a NWSSP Finance Governance Group was also established to oversee COVID19 related expenditure incurred on behalf of NHS Wales that required payments in advance and approval by the Velindre Board. The Executive Director of Finance and the Vice Chair of Velindre University NHS Trust are members of the Finance Governance Group.

- 1.2 It was initially agreed on 18 March 2020 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.

Welsh Government approval is still required on all orders over £1m or advanced payments worth 25% or more of the contract value.

The Trust Board agreed to extend these limits to 30 September 2020 at its June meeting.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The COVID-19 pandemic brought unprecedented challenges to health and social care provision and required significant and sometimes difficult decisions at pace.

It was recognised and appreciated that established governance and finance procedures may be disrupted by the need to act swiftly to secure the goods and services required to respond effectively to the national emergency and Welsh Government priorities. Welsh Government identified four main priorities that needed an effective supply chain:

- 1). Personal Protective Equipment (PPE);
- 2). Beds;
- 3). Ventilators; and
- 4). Oxygen.

Since early March, NWSSP has issued over 293 million items of PPE to the health and social care sectors in Wales. Over 140 million of these items have been issued to local authorities for onward distribution to social care settings. While there were initial concerns on shortages, the level of supply was maintained at the most challenging time with no stock-outs.

The NWSSP Finance Governance Group meetings have demonstrated a fair and robust governance process is operating, that has helped to expedite key procurement decisions to support the NHS in Wales. It has also helped to pre-empt questions that might reasonably be raised by the Velindre Board in its consideration of risks and appropriate mitigation.

NWSSP is still operating in a market where we are competing for supply against demand from across Europe and beyond. The very high levels of demand in the priority areas experienced since March have settled, but the following key risks remain:

- The market conditions are improving but they remain fragile. Current market prices and the reliability of supply, in terms of both quality and required volumes, have not yet returned to anywhere near pre-COVID19 levels. The potential for a no deal Brexit continues to represent a major risk in respect of continuity of supply

We are working to secure a reliable supply of PPE to meet current and projected demand from health and social care sectors until the end of March 2021 and continue to build back up pandemic (COVID and Flu), Brexit and Business as Usual supplies.

Throughout the pandemic, focus on the use of suppliers; especially Welsh suppliers, has played a significant role and supported through engagement with the Life Sciences Hub. A number of Welsh Manufacturers are now being used for certain PPE lines.

- There remains uncertainty about the timing of a potential 'Second Wave' as we enter the winter period and consequent impact on the availability and price of the above listed priority areas. Health Boards and Trusts are developing their local Winter Protection Plans, and there is an expectation that demand will increase significantly as elective work is reintroduced in hospitals.

We have not yet finalised demand plans with Health Boards and Trusts, but we anticipate there could yet be a small number of large orders required in the next quarter to get us through the winter period. We have developed a system to accurately track PPE usage and model future demand, to anticipate and respond to a potential second

spike of COVID 19 cases, winter pressures demand, potential Brexit implications and changes to user demand profiles.

- NWSSP has been asked to provide PPE to social care, and to other primary and community based practitioners.

We are working with relevant partners to ensure that the required PPE is distributed effectively to health and social care settings, including GPs and dental and optometry contractors, as needed. We are also securing appropriate warehouse capacity to hold a stockpile of critical products.

There remains a limit on the certainty we can have about the assumptions we have built into our future demand model and stock holding levels.

As we move into the next phase of our response to the pandemic, it is clear that this is not a short term crisis. We would advise that it would be prudent to extend the temporary limits to remain in place until 31 March 2021. This extension would allow current work on the Winter Protection Plan and associated demand for the next 6 months to be completed.

The Public Contract Regulations 2015 through Regulation 32 (2) (c) provides for the direct award of business above threshold “for reasons of extreme urgency brought about by events unforeseeable by the contracting authority”. We would seek to continue to rely on this regulation given the extreme nature of the COVID-19 situation, the uncertain timing of a second wave and the current priority to prepare resilience through Winter Protection Plans.

2.2 Internal Audit Review

We have commissioned Internal Audit to undertake a review which will assess the adequacy and effectiveness of internal financial controls in operation during the Covid-19 pandemic, with particular regard to the role of the Finance Governance Group and the early payment process implemented, in ensuring that value for money is maintained.

The findings of this review are positive and will be reported to the NWSSP Audit Committee on 20 October 2020.

2.3 Winter Protection Plan Project Group

In addition NWSSP is leading the work on PPE that forms part of the Winter Protection Plan for NHS Wales. A PPE Winter Protection Plan project group has been established supported by four work streams:

- **Work stream 1 - Finance, Resources & Performance Reporting**

Manage existing and future reporting.

Ensure financial controls and governance are maintained.

Support the controls and management of resources (Project & Operational)

Support demand and capacity planning activity

- **Work stream 2 - Product & Procurement**

Maintain critical product order pipeline based on agreed demand and capacity data.

- **Work stream 3 - Logistics**

Provide transportation of goods to and from host and end user locations as identified throughout the scheme.

- **Work stream 4 - Warehouse**

Primary objective to host critical products.

It is likely that further PPE expenditure will be incurred as a result of this work.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

	All resource requirements to be fully reimbursed by Welsh Government
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4. RECOMMENDATION

- 4.1 The Board APPROVE a further extension to the financial scheme of delegation in respect of COVID 19 related contracts allowing the Chair and either of the Managing Director or the Director of Finance and Corporate Services of NWSSP to continue to approve contracts up to £5m, until 31 March 2021.



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TRUST BOARD

TRUST SEAL REPORT - MAY 2020 – AUGUST 2020

DATE OF MEETING	24/09/2020	
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 May-August 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 outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	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.



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Appendix 1 – Seal Register

Date	Document Details	Signed
31 st July 2020	Deed of Grant and Covenant relating to the land at Asda Cardiff, Coryton Supercenter	Prof Donna Mead, Chair Mr. Steve Ham, CEO
24 th August 2020	Collateral warranty for the mechanical and electrical design:- 1) KGA (UK) Ltd 2) Velindre University NHS Trust (Beneficiary) 3) Mojo 2 Ltd (Client)	Prof Donna Mead, Chair Mr. Steve Ham, CEO



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TRUST BOARD

POLICIES FOR APPROVAL

DATE OF MEETING

24/09/2020

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

Not applicable

(DD/MM/YYYY)

Choose an item.

ACRONYMS

EMB

Executive Management Board

1. SITUATION/BACKGROUND

- 1.1 In accordance with the “Policy for the Management of Policies, Procedures and other Written Control Documents”, the Trust Board will receive all approved policy documents for information under the consent agenda.
- 1.2 The purpose of this report is for the Trust Board to note the policies that have been approved since the last report received at the July Trust Board meeting.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 As agreed in the Recovery Plan approach in April, various matters of business that would have ordinarily been dealt with in one of the Committees that are currently paused, has instead been transferred to the Trust Board. Approval is therefore sought from Trust Board for the following Policies:

Policy Title	Policy Lead / Function	Approving Committee	Effective Date If Approved
PP 13 Electrical Low Voltage Policy	Strategic Transformation, Planning and Digital	Executive Management Board	14 th August 2020
PP 01 Fire Safety Policy	Planning & Performance	Executive Management Board	14 th August 2020
WF 21 Close Personal Relationships in the Workplace Policy	Organisational Development & Workforce	Executive Management Board	17 th August 2020

- 2.2 The Board is requested to note that WF 21 Close Personal Relationships in the Workplace Policy, is a new Velindre University NHS Trust policy, which has been through formal consultation process and has been endorsed by Trade Union partners and the Executive Management Board. The Policy has been subject to the Equality Impact Assessment process where potential negative impact of the policy has been recognised in relation to equality and social economic impacts and potential disclosure of sensitive personal information. Options for employees to disclose to staff other than the direct line manager has been included in the policy to mitigate this and to protect individuals’ right to maintain privacy.

The Policy will be reviewed after the first 6 months, to respond to any unforeseen implementation issues, if applicable.



3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Trust Board is asked to **APPROVE** the following Policies:

- PP 13 Electrical Low Voltage Policy
- PP 01 Fire Safety Policy
- WF 21 Close Personal Relationships in the Workplace Policy

Ref: PP 13

ELECTRICAL LOW VOLTAGE POLICY

Executive Sponsor & Function	Director of Transformation, Planning and Digital
Document Author:	Alun Evans (Environmental Officer)
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	1 st April 2020
Equality Impact Assessment Outcome:	Approved
Review Date:	3 years from approval date
Version:	1

Contents

Section		Page
1	Policy Statement	3
2	Scope of Policy	3
3	Aims and Objectives	3
4	Responsibilities	3, 4, 5 + 6
5	Definitions	7
6	Training	7 + 8
7	Implementation/Policy Compliance	8
8	Equality Impact Assessment Statement	8
9	Legislation and References	9 + 10
10	Audit and Monitoring	10
11	Policy Conformance / Non Conformance	10

1. Policy Statement

The organisation recognises and accepts its responsibilities and legal obligations in accordance with current legislation and is committed to protecting the rights of its patients, visitors and staff in respect of the operation of electrical systems.

Velindre University NHS Trust, will ensure that all electrical systems, are installed, inspected, serviced and maintained in accordance with all Statutory Instruments, NHS Guidelines, Health Technical Memoranda or similar, to ensure that such equipment does not pose a health or operational risk to either, staff, patients or members of the public.

2. Scope of Policy

This policy applies to all persons (staff, contractors, patients and members of the public) who may be affected by any electrical activity arising from works (including use or contact with equipment) carried out on Trust premises or leased property. It also applies to all electrical activities undertaken by employees and/or contractors when working at other locations.

3. Aims and Objectives

This document will detail the Trust's policy to achieve safety in all its electrical activities in compliance with its legal and statutory obligations and to ensure that all electrical equipment and systems are maintained in a safe condition and that only competent persons are permitted to work with, repair or maintain electrical systems or apparatus.

4. Responsibilities

The Trust has a management responsibility to ensure inspection, service and maintenance activities are carried out safely without hazard to staff, patients or members of the public.

4.1 The Chief Executive

The Chief Executive has overall responsibility for ensuring that sufficient and suitable procedures are in place to manage and maintain the Trust's electrical systems. In particular, he/she must ensure that suitably qualified personnel are employed to implement, manage and review this activity.

4.2 Director of Transformation, Planning and Digital

The Executive Director will be charged with being the Designated Person, under HTM 06-02. He/she is responsible for delivering the policy aims and aspirations. Has

overall authority and responsibility for the low voltage systems within the Trust and who has a duty under the Health & Safety at Work Act, Subsidiary Regulations and HTM's.

He/she should:

- Set out the standards and quality of service to be provided.
- Ensure that sufficient and competent staff and resources are applied to investment, design, maintenance and performance monitoring of systems covered by this policy.
- Appoint an Authorising Engineer for Low Voltage Electricity (AE(LV)).

4.3 Estates Manager

The Estates Manager is responsible for ensuring that all electrical systems are inspected, serviced, verified, maintained and tested in a safe manner without hazard to staff, patients or members of the public.

The Estates Manager shall ensure that:

- All systems are identified and subjected to testing by an Authorised person.
- Maintain a register of Authorised Persons.
- Ensure that appropriate reactive and planned preventative maintenance arrangements are put in place to deliver to the aims of this policy.
- Have in place a procedure for assessing Competent Persons.
- Ensure that only individuals assessed as being competent and included on the register are used by sub-contractors. i.e. it is the individual not the contractor that needs to be assessed.
- Ensure that competent persons undertake regular maintenance on electrical systems and equipment.
- Ensure that the policy and procedures are implemented by a range of in-house or contracted services.
- Audit the effectiveness of the arrangements and arrange corrective action.
- Report any deficiencies which cannot be addressed within delegated limits of resource and authority.
- Ensure that electrical systems are independently verified annually in accordance with H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems.
- Arrange for any adverse incident to be investigated by the Authorising Engineer and for the dissemination of related advice.

4.4 Project Managers

Have the responsibilities to ensure that:

- All new installations meet the latest legal and technical standards.
- A suitably qualified person is involved in the design of all new installations and that commissioning and performance checks are undertaken and documented.
- All new installations are accessible and maintainable without resort to specialist access equipment or the need for removal of finishes/infrastructure.
- That maintenance teams have comprehensive operations and maintenance manuals (O&M), handed over on completion of schemes.
- That appropriate training and familiarisation is provided to in house and contract teams.
- That all new designs or major modification to existing systems are checked by the Authorising Engineer prior to the commencement of work.
- That all new installations are independently validated prior to contract completion.
- That all variations from the standards set out within H.T.M 06-02 Electrical Safety Guidance for Low Voltage Systems, are listed and agreed in writing by the Authorising Engineer / Estates Manager, prior to implementation.

4.5 Authorising Engineer (Low Voltage) (AE(LV))

Is defined as a person designated by management to provide independent auditing and advice on Low Voltage electrical systems and to review and witness documentation on validation/verification.

He/she shall:

- Provide a service in accordance with H.T.M 00 Policies and Principles of Healthcare Engineering.
- Advise on technical compliance with H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Advise on interpretation of H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.
- Assess and make recommendations for the appointment of Authorised Persons.
- Monitor the performance of the service and undertake an annual audit.
- To investigate any adverse incident and report on any findings.
- Advise on the consequences of any proposed variation from the standards given within H.T.M 06-02 Electrical Safety guidance for Low Voltage Systems.

4.6 Authorised Person (Low Voltage) (AP(LV))

Will be an individual possessing adequate technical knowledge and having received appropriate training, appointed in writing (following advice from the AE (LV)), who is responsible for the implementation and operation of Management's safety policy and procedures relating to the engineering aspects of Low Voltage Electrical systems.

4.7 Competent Person (Low Voltage) (CP(LV))

Is a person with adequate knowledge and training to undertake work on systems as designed by engineering managers. In particular:

- Carry out planned preventative maintenance (PPM) routines and repairs as instructed by the Estates Manager and provide feedback on performance and maintenance issues.
- To ensure all health and safety, COSHH, Trust policies and procedures and risk assessments are adhered to at all times.
- To leave work areas clean and tidy.
- To report any maintenance defects or required changes to PPM routines or asset data.
- Record work carried out on individual Low Voltage Electrical systems, in system log books.
- Ensure that appropriate records are kept for maintenance, testing and validation work, in a format readily retrievable for audit purposes.

4.8 Accompanying Safety Person

Is an individual not directly involved with the work or test, should have adequate knowledge, experience and the ability to avoid danger. They are required to keep watch, prevent unauthorised interruption of the work or test, be able to apply first aid and summon help.

4.9 User

The person responsible for the management of the unit in which the electrical system is installed, for example, head of department, operating theatre manager, head of laboratory, production pharmacist, head of research or any other responsible person.

5. Definitions

5.1 Limitation-of-access

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a person in charge of work to be carried out in an area or location which is under the control of an Authorised Person (LV) and for which a permit-to-work (LV) is not appropriate.

5.2 Permit-to-work (electrical LV)

This is a safety document, which is a form of declaration, signed and issued by an Authorised Person (LV) to a Competent Person (LV) in charge of work to be carried out. It defines the scope of the work to be undertaken and makes known exactly what equipment is dead, isolated from all live circuit conductors and safe to work on.

5.3 Safety signs

- **Caution sign** is a temporary, non-metallic sign bearing the words “caution – persons working on equipment” and “do not touch” which is to be used at a point-of-isolation.
- **Danger sign** is a temporary, non-metallic sign bearing the words “danger live equipment” and “do not touch” which is to be used where there is adjacent live equipment at the place of work.
- **Switchroom sign** is a permanent, no-metallic sign bearing the words, “electrical Switchroom” and “no unauthorised access”

5.4 Voltage range

- **Extra low voltage**, a potential not exceeding 50V ac or 120 V ripple-free dc whether between conductors or to earth.
- **Low voltage (LV)**, a potential not exceeding 1000V ac or 1500 V dc between conductors, or 600V ac or 900V dc between a conductor and earth.
- **High voltage (HV)**, a potential normally exceeding low voltage.

6. Training and other resource implications for this policy

Training should be of an appropriate level, depending on roles and responsibilities, and outlined in the Divisions/Hosted Organisations local procedures. Managers have the responsibility to inform relevant employees and contractors of any hazards that may exist when carrying out maintenance work, operation, testing or other repairs to equipment within their department. All staff, whether working for the Trust or as partners who have duties under this policy should receive appropriate training.

Tradespersons are to be made aware of the dangers from electrical shock, injury or burns. The information given should include: -

- The nature and type of risks to health where applicable
- Control measures employed
- Working procedures/policies

All records of training are to be maintained by the Estates Directorate.

Arrangements shall be made by the appropriate manager to ensure: -

- i. That all employees concerned with particular work activities are adequately informed as to the systems, plant and apparatus that are affected, and instructed in all safety procedures.
- ii. So far as is reasonably practicable, that other persons who are not employees but may be affected by the work activities also receive adequate information and/or instruction.

7. Implementation/Policy Compliance

The Trust Board expects those tasked with managing aspects of electrical safety to:

- diligently discharge their responsibilities as benefits their position;
- have in place a clearly defined management structure for the delivery, control and monitoring of electrical works;
- have in place a programme for the assessment and review of electrical risks
- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate electrical risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
- develop and disseminate appropriate action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment, in regard to working on and using electrical equipment;
- develop and implement a programme of appropriate electrical safety training for all relevant staff;
- develop and implement monitoring and reporting mechanisms appropriate to the management of electrical safety.

8. Equality Impact Assessment Statement

A summary of the outcome of the EIA must be present on the front cover of the document.:

Either

This policy has been screened for relevance to equality. No potential negative impact has been identified.

Or

This policy has been subject to a full equality impact assessment and some issues have been identified and highlighted to ensure that due regard and weight is given to them in carrying out this policy.

9. **Main Relevant Legislation and References**

Statutory

- Confined Spaces Regulations 1997.
- Construction Design and Management Regulations 2015.
- Electricity at Work Regulations 1989.
- Electricity Safety, Quality and Continuity Regulations 2002.
- Health and Safety (Safety Signs and Signals) Regulations 1996.
- Health and Safety at Work etc. Act 1974.
- Management of Health and Safety at Work Regulations 1999.
- Manual Handling Operations Regulations 1992 (as amended 2002).
- Personal Protective Equipment at Work Regulations 1992 (as amended 2002).
- Provision and Use of Work Equipment Regulations 1998.
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Workplace (Health, Safety and Welfare) Regulations 1992.
- Dangerous Substances and Explosive Atmosphere Regulations 2002.

Guidance

- The Department of Health:
 - a. Health Technical Memorandum 00 – Policies and Principles.
 - b. Health Technical Memorandum 06-02 – Electrical safety guidance for low voltage systems.
 - c. Health Technical Memorandum 06-03 – Electrical safety code for high voltage systems.
- The Institution of Electrical Engineers:
 - d. Code of practice for in-service inspection and testing of electrical equipment.
 - e. Guidance Note 3 – Inspection and testing.
- The Health & Safety Executive's:
 - f. Avoidance of danger from overhead electric lines GS6.

- g. Avoiding danger from underground services HSG47.
- h. Electrical safety on construction sites HSG141.
- i. Electrical test equipment for use by electricians GS38.
- j. Electricity at work: safe working practices HSG85.
- k. Health and Safety (First Aid) Regulations 1981, Approved Code of Practice and Guidance.
- l. Keeping electrical switchgear safe HSG230.
- m. Maintaining portable and transportable electrical equipment HSG107.
- n. Memorandum of guidance on the Electricity at Work Regulations 1989 HSR25.
- o. Safety in electrical testing at work INDG354.

10. Audit and Monitoring

- The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

11. Policy Conformance / Non Compliance

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



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Ref: PP01

FIRE SAFETY POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance and Estates
Document Author:	Trust Fire Safety Manager
Approved by:	Executive Management Board
Approval Date:	14 th September 2020
Date of Equality Impact Assessment:	30th November 2016
Equality Impact Assessment Outcome:	No negative impact
Review Date:	February 2021
Version:	03

Contents

1	Policy Statement	3
2	Purpose	3
3	Scope	3
4	Aims and Objectives	3
5	Roles and Responsibilities	5
6	Equality	7
7	Training	8
8	Resources	8
9	Implementation	8
10	Audit and Monitoring	9
11	Policy Conformance / Non Compliance	9
12	Distribution	9
13	Review	9
14	Legislation	9
15	Further Information	10
16	References	11

Introduction

1. Policy Statement

- 1.1. To provide an unequivocal statement of fire safety policy applicable in any premises owned, managed or under the control of Velindre University NHS Trust or its hosted bodies excluding a single private dwelling.

2. Purpose

- 2.1. To ensure that the Trust and its hosted bodies comply with their Statutory duties under the *Regulatory Reform (Fire Safety) Order 2005 (the Order)* and their Mandatory duties under the Welsh Assembly Government's *NHS Wales Fire Safety Policy* (issued under cover of WHC (2006)74) and *(W)HTM 05 – Fire safety in the NHS (Firecode)*.

3. Scope

- 3.1 This policy applies wherever Velindre University NHS Trust or its hosted bodies have a duty of care to service users, staff or other individuals.

4. Aims and Objectives

- 4.1. This policy aims to minimise the incident of fire throughout all activities provided by or on behalf of Velindre University NHS Trust or its hosted bodies.

This policy also aims to, so far as reasonably practicable reduce the number of unnecessary fire alarm activations in premises owned, managed or under the control of the Trust or its hosted organisations.

- 4.2. Where fire occurs, this policy aims to minimise the impact of fire and unnecessary fire alarm activations on building users, the delivery of services, the environment and assets.

5. Roles and Responsibilities

- 5.1. *All staff, contract staff and volunteers*

- 5.1.1. Whilst on premises owned, managed or under the control of the Trust or its hosted organisations, all staff, contractors and volunteers should:

- take reasonable care for themselves and others who may be affected by their acts or omissions at work;
- comply with the trust's fire safety protocols and fire procedures and those set by others such as landlords etc;
- participate in fire safety training and fire evacuation exercises where applicable;
- inform their manager of any work situation or matter that represents a serious or imminent danger;
- report deficiencies and/or shortcomings in fire safety arrangements to the appropriate person(s) such as line manager, Fire Wardens, estates/facilities etc;
- report fire incidents and false alarm signals in accordance with trust's protocols and procedures;

- ensure the promotion of fire safety at all times to help reduce the occurrence of fire and unwanted fire alarm signals;
- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5.2. *Trust Board*

5.2.1. The Trust Board holds overall accountability for fire safety and discharges the responsibility for fire safety through the Chief Executive.

5.2.2. The Board must assure itself that the requirements of current fire safety legislation, the Welsh Government's fire safety policy for the NHS in Wales and the objectives of relevant fire safety guidance including, where appropriate, Firecode ((W)HTM 05) are being met.

5.2.3. The Trust Board will:

- discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;
- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;
- facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

5.3. *Chief Executive*

5.3.1. On behalf of the Board, the Chief Executive is responsible for ensuring that current fire legislation is complied with and appropriate, fire safety guidance is implemented in all premises owned, occupied or under the control of the Trust.

5.3.2. The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Director with fire safety responsibility.

5.4. *Board Level Director (FIRE)*

5.4.1. The Board Level Director (FIRE) is responsible for ensuring that fire safety issues are highlighted at Board level; this responsibility extends to the proposal of programmes of work relating to fire safety for consideration as part of the business planning process and the management of the fire-related components of the capital programme and future allocation of funding.

5.4.2. At an operational level the Board Level Director (FIRE) will:

- ensure that the trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;
- seek assurance that all work that has implications for fire precautions in new and existing trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements (including Firecode);

- seek assurance that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought;
- seek assurance that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;
- seek assurance that suitable arrangements are in place regarding cooperation between other employers where two or more share trust premises;
- seek assurance through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;
- ensure that agreed programmes of investment in fire precautions are properly accounted for in the trust's annual business plan;
- ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;
- fully support the Fire Safety Manager function.

5.4.3. In line with delegated authority, the Director with fire safety responsibility devolves day-to-day fire safety duties to the Fire Safety Manager.

5.5. *Fire Safety Manager*

5.5.1. The Trust Fire Safety Manager is responsible for developing and implementing an effective fire safety management system on behalf of the Trust and acting as the focus for all fire safety matters across the Trust.

5.5.2. At an operational level the Fire Safety Manager is responsible for:

- the development, implementation, monitoring and review of the organisation's fire safety management system;
- the development, implementation and review of the organisation's fire safety policy and protocols;
- reporting of non-compliance with legislation, policies and procedures to the Director with fire safety responsibility;
- raising awareness of all fire safety features and their purpose throughout the trust;
- providing expert advice on fire legislation;
- providing expert technical advice on the application and interpretation of fire safety guidance, including Firecode;
- the assessment of fire risks within premises owned, occupied or under the control of the trust including the undertaking and recording and of fire risk assessments and development of action plans;
- ensuring that risks identified in the fire risk assessments are included in the trust's risk register as appropriate;
- the operational management of fire safety risks identified by the risk assessments;

- the development, implementation and review of the organisation's fire emergency action plan including the preparation of fire prevention and emergency action plans where appropriate;
- ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place;
- the development, delivery and audit of an effective fire safety training programme;
- the investigation and reporting of all fire-related incidents and fire alarm actuations in accordance with trust policy and external requirements;
- monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals;
- liaison with the enforcing authorities on technical issues;
- liaison with managers and staff on fire safety issues;
- liaison with NWSSP – Specialist Estates Service – the Trust's Authorising Engineer (Fire);
- monitoring the inspection and maintenance of fire safety systems to ensure it is carried out;
- ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported;
- providing a link to the relevant trust committees;
- ensuring an appropriate level of management is always available by the establishment of Fire Response Teams for trust sites or premises.

5.6. *Local Management*

5.6.1. Heads of service and departmental managers have responsibility for:

- monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place;
- ensuring local fire risk assessments are undertaken and maintained up-to-date;
- notifying the Fire Safety Manager and others of any proposals for "change of use", including temporary works that may impact on the risk assessment, within their area;
- reporting any defects in the fire precautions and equipment in their area and ensuring that appropriate remedial action is taken;
- ensuring that local fire emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness;
- ensuring that local fire emergency action plan is revised in response to changes, including temporary works, which may affect response procedures;

- ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan;
- ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings;
- ensuring that every member of their staff attends fire safety training as set out in the trust's fire safety training matrix;
- ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:
 - local fire procedures and evacuation plan
 - means of escape
 - location of fire alarm manual call points
 - fire-fighting equipment
 - any fire risks identified;
- keeping a record of staff induction and attendance at fire safety training;
- ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols;
- ensuring that the staff record is completed and returned denoting how this document has been brought to the attention of staff;
- where appropriate, ensuring that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility.

5.7. *Fire Wardens*

5.7.1. Based on the size and complexity of the building, an appropriate number of Fire Wardens should be appointed. Although they do not have an enforcing role, the Wardens will report issues or concerns regarding local fire safety to their head of service or departmental managers and if necessary to the Fire Safety Manager.

5.7.2. Fire Wardens will:

- act as the focal point on fire safety issues for the local staff;
- organise and assist in the fire safety regime within local areas;
- raise issues regarding local fire safety with their line management;
- support line managers in their fire safety issues.

6. **Equality**

6.1. The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its Employees reflects their individual needs and does not discriminate against individuals or groups.

6.2. The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or

civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

- 6.3. The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

With regard to fire safety, the Trust recognises that during some religious festivals, there is a use of candles and lights, therefore naked flames, i.e. Advent/Christmas and Diwali, the Trust would recommend that staff, patients, donors and visitors, that wish to celebrate use electronic (battery powered) candles; additionally, any electronic main adapter lights are subject to PAT testing.

7. Training – (Full guidance is provided in the fire safety training protocol)

- 7.1. All staff must receive fire safety training appropriate to their role and responsibilities. The Trust has undertaken a Training Needs Analysis for fire safety which requires:

- All new starters receive essential fire safety information as part of their local induction.
- All new starters undertake essential fire safety training within 1 month of their start date
- Staff undertake the appropriate refresher training as follows:
 - Clinical staff and WBS Blood Collection Team staff - *Annually*
 - Non-clinical staff – *3-yearly*
 - Fire Wardens and Fire Response Team members - *Annually*

- 7.2. In support of fire safety training, all staff should participate in a fire evacuation drill/exercise once every *12 months as a minimum*.

8. Resources

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

9. Implementation

- 9.1. The Trust Board expects those tasked with managing aspects of fire safety to:
- diligently discharge their fire safety responsibilities as benefits their position;
 - have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;
 - have in place a programme for the assessment and review of fire risks
 - develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;
 - develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants,

protect the delivery of service and, as far as reasonably practicable, defend the property and environment;

- develop and implement a programme of appropriate fire safety training for all relevant staff;
- develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

10. Audit and Monitoring

10.1. The Trust Board will monitor the implementation of this policy through:

- periodic review of fire and Unwanted Fire Signal (UwFS) reports;
- periodic reviews of fire safety training records;
- periodic review of fire service notices and communications;
- receipt of annual fire safety audit report;
- periodic independent reviews of fire safety by NWSSP – Specialist Estates Services.

11. Policy Conformance / Non Compliance

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

12. Distribution

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

13. Review

13.1. The Fire Safety Manager and Trust Fire Safety Management Group will review the operation of the policy as necessary; at least once every **12 months**.

14. Legislation

14.1. The main Acts and Regulations, which relate to premises owned, managed or under the control of the Trust or its hosted organisations are:

- The Regulatory Reform (Fire Safety) Order 2005
- The Health and Safety at Work etc Act 1974
- The Building Act 1984
- The Housing Act 2004
- The Equality Act 2005
- The Fire and Rescue Services Act 2004
- The Construction (Design and Management) Regulations 2015
- The Smoke-Free Premises etc.(Wales) Regulations 2007

- The Management of Health and Safety at Work Regulations 1999 (as amended)
- The Dangerous Substances and Explosive Atmospheres Regulations 2002

15. Further Information

15.1. Contact

Further information and support is available from the Trust Fire Safety Manager (robin.weaver@wales.nhs.uk) on 029 2061 5888 (ext. 4156) / WHTN 01875 4156.

15.2. Key guidance

The Firecode suite of documents (Health Technical Memorandum 05 - fire safety in the NHS) builds upon the Welsh Assembly Government's Fire Safety Policy statement. Firecode comprises:

- 05-01: Managing healthcare fire safety (Welsh Edition).
- 05-02: Guidance in support of functional provisions for healthcare premises
- 05-03: Operational provisions (Parts A to L)

The Trust will also implement:

- Other Health Technical Memorandums
- Relevant Department of Health and NWSSP - Facilities Services Health Building Notes

(W)HTM 05 (Firecode) relates mainly to premises classified as 'healthcare' buildings (such as premises where patients are provided with medical care by a clinician.) and a majority of the premises that the Trust manage, occupy or use fall outside this definition. Therefore, the Trust will also adopt the relevant HM Government Fire Risk Assessment Guidance document relevant for the property type, including:

- Offices & Shops
- Places of Assembly (small)
- Places of Assembly (large)
- Sleeping Accommodation

Additionally, the Trust will also adopt the necessary Health and Safety Executive Approved Codes of Practice and Guidance Documents and other Approved Codes of Practice (i.e. British Standards).

15.3. Supporting Documents

In support of this policy, a number of fire safety protocols have been developed that support implementation of this policy, including:

- Fire prevention including the management of arson
- Fire risk assessment/audit strategy
- Emergency planning and procedures
- Fire safety training including training needs analysis and strategy for delivery

- Development of local fire safety information including fire strategies, fire manuals, fire drawings and information for attending fire crews
- Fire safety during construction and refurbishment projects
- Unnecessary fire alarm activations
- Passive fire protection
- Maintenance of fire safety systems and equipment.

16. References

- 16.1. HEALTH TECHNICAL MEMORANDUM 05-01 FIRECODE: Guidance in support of functional provisions for healthcare premises (Various publication dates) - Wales edition.

Ref: WF21

Close Personal Relationships in the Workplace Policy

Executive Sponsor & Function	Sarah Morley, Executive Director of OD and Workforce
Document Author:	Beverley Palmer, Assistant Director of Workforce & OD, NWSSP
Approved by:	Trust Board
Approval Date:	September 2020
Date of Equality Impact Assessment:	September 2019
Equality Impact Assessment Outcome:	<p>Potential negative impact of the policy has been recognised in relation to equality and social economic impacts and potential disclosure of sensitive personal information. Options have been included in the policy to mitigate and to protect individuals' right to maintain privacy.</p> <p>The Policy will be reviewed after the first 6 months, to respond to any unforeseen implementation issues, if applicable</p>
Review Date:	February 2021

Version:	1
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Contents

1. INTRODUCTION.....	2
2. PURPOSE.....	3
3. SCOPE OF POLICY	3
4. DEFINITIONS	3
4.1 CLOSE PERSONAL RELATIONSHIP.....	3
4.2 TEAM / DEPARTMENT	3
5. EXAMPLES OF POTENTIAL CONFLICT OF INTEREST / BIAS.....	3
6. AIM OF THE POLICY	4
7. RESPONSIBILITIES.....	4
7.1 MANAGERS	4
7.2 EMPLOYEES;	4
8. PRINCIPLES.....	5
9. EXISTING RELATIONSHIPS BETWEEN EMPLOYEES	6
10. PRE-EMPLOYMENT, RECRUITMENT AND APPOINTMENT.....	6
10.1 LINE MANAGEMENT CHAIN	6
10.2 TEAM MEMBERS	7
11. DURING EMPLOYMENT	7
11.1 LINE MANAGEMENT CHAIN	7
11.2 TEAM MEMBERS	8
11.3 EXECUTIVES AND VERY SENIOR OFFICERS OF THE TRUST	8
11.4 CONDUCT AND BEHAVIOUR.....	9
12. TRANSFER OF EMPLOYEES.....	9
13. RELATIONSHIP BREAK DOWN	10
14. RELATIONSHIPS BETWEEN A PATIENT, DONOR, SERVICE USER AND AN EMPLOYEE	10
15. LINKS WITH GRIEVANCE POLICY AND DIGNITY AT WORK PROCEDURE	10
16. MONITORING AND REVIEW.....	10
17. ASSOCIATED POLICIES	10
18. EQUALITY.....	11
18.1 EQUALITY IMPACT ASSESSMENT STATEMENT.....	11
APPENDIX 1 - CLOSE PERSONAL RELATIONSHIP RISK ASSESSMENT FORM	12
APPENDIX 2 - CLOSE PERSONAL RELATIONSHIPS IN THE WORKPLACE DECLARATION FORM.....	13

1. Introduction

Velindre University NHS Trust (including hosted organisations) recognises that close personal relationships may exist or develop within the workplace. The Trusts' values relies upon the professionalism and integrity of its employees, and whilst it does not wish to interfere with these relationships, it is necessary to ensure that all employees behave in an appropriate and professional manner at work

It is expected that where a personal relationship exists, employees will behave responsibly and not put themselves into a situation where their relationship may impact adversely on their position, work or on the Trust.

2. Purpose

The purpose of the policy is:-

- To provide guidance and protection to employees where close personal relationships overlap with working relationships, to ensure that employees cannot be accused of impropriety, bias, abuse or conflict of interest or be the subject of allegations.
- To ensure all employees understand the implications and requirement to inform the appropriate person/department of any close personal relationships which exist or have developed between employees. The employee should inform their line manager, department manager or workforce team as appropriate to the circumstances of the relationship and the individual.

3. Scope of Policy

This policy applies to all employees of Velindre NHS Trust and hosted organisations and to job applicants during the recruitment process.

The policy applies in the following circumstances:

- Pre-employment;
- Existing relationships between line manager and team member or between team members/co-workers in the same department;
- Relationships that develop between line manager and team member or between team members / co-workers in the same department;
- Relationships with Executives / Directors and very senior managers.

4. Definitions

4.1 Close Personal Relationship

In the context of this document, a close personal relationship is defined as;

- Current spouses, civil partners, those who are involved in a romantic, emotional or physical relationship and or in a co-habiting arrangement, which

previously existed outside of work, or where it has developed in work;

- Immediate family members, including step parents, e.g. parent, child, sibling grandparent;
- Extended family members such as aunts, uncles, cousins, in laws (where the individual is aware of them being employed by the Trust).

4.2 Team / Department

For the purposes of this policy the team / department means employee's reporting directly to the same line manager.

5. Examples of Potential Conflict of Interest / Bias

Situations where a close personal relationship may expose employees to actual or perceived conflict of interest or bias include, but are not restricted to, the following:

- Perceived or alleged breaches of probity*;
- Unfair advantage / favouritism;
- Breach of confidentiality;
- Harassment or bullying;
- Employee relations issues

*In terms of the probity of those who may have a personal relationship with outside contractors or those bidding for contracts within the Trust, the [Standards of Business Conduct](#) apply and employees must declare any such interest.

6. Aim of the Policy

The aim of this policy is to:-

- Enable managers to deal sensitively and effectively with situations of personal relationships at work whilst maintaining confidentiality;
- Ensure employees are aware of their responsibilities in respect of close personal relationships at work;
- Ensure that all employees feel confident that they will receive fair treatment and that no employee will receive more or less favourable treatment or advantage due to a close personal relationship in the workplace;
- To provide guidance to protect employees and managers from perceptions of favouritism and unfair advantage.

7. Responsibilities

To support individual rights to confidentiality any disclosures made under this policy can be made outside the immediate working environment to a member of the workforce team who will work with the staff involved to support them on an individual basis.

7.1 Managers

- To take the required action promptly and sensitively in situations involving close personal relationships in the workplace, in order to protect staff;
- To conduct matters involving close personal relationships at work in a fair

and consistent way;

- To maintain the confidentiality of the parties at all times and agree with the individuals what information others in the team may need to know;
- To undertake risk assessments to ensure that such relationships are managed appropriately (**Appendix 1**).
- To seek workforce and wellbeing support from the workforce team if dealing with a matter under the disciplinary or grievance policies which relate to one member of a relationship whilst still managing the other person.

7.2 Employees;

- To bring to the attention of their manager, department manager or workforce team as appropriate to the circumstances of the relationship and the individual, any situations in which a close personal relationship exists or develops, whether or not they feel that it has a bearing on their work;
- To work with their manager, department manager or workforce team to identify suitable alternative working arrangements where appropriate to ensure that their close personal relationship does not interfere with or compromise their employment or put them at risk of being accused of impropriety, bias, abuse or conflict of interest or be the subject of allegations;
- To behave in an appropriate and professional manner at work.

8. Principles

Although the existence of a close personal relationship between employees does not necessarily constitute a bar to the employment or promotion of either party, employees must inform their manager, department manager or workforce team, of any close personal relationships which may give rise to an actual or perceived conflict of interest, breach of confidentiality or unfair advantage or disadvantage, in order that this can be considered in the context of the application. In particular, relationships between employees and those in very senior positions within the Trust may create such a perception with the public and thus it is imperative that such relationships are noted and managed with transparency.

- In all circumstances, where employees have a close personal relationship to an Executive Officer of the Board or to a Divisional Director, whether or not they work within the same functional area / department etc., both parties must inform their manager, department manager or workforce team as appropriate of this relationship.
- For employees within NWSSP, where employees have a close personal relationship to members of the Shared Service Committee, Senior Management Team or to Service Directors, whether or not they work within the same service area, both parties must inform their manager, department manager or workforce team as appropriate of this relationship.
- For employees within NWIS, where employees have a close personal relationship to a Director, Head of Department or senior manager, whether or

not they work within the same Directorate, both parties must inform their manager, department manager or workforce team as appropriate of this relationship.

Where a personal relationship exists, a prospective member of staff will not be appointed into a post which results in a first or second tier line management relationship with someone with whom they have a close personal relationship (see also section 10).

- Employees who have a close personal relationship (as defined above) outside of work and who are working in the same team/department must inform their line manager, department manager or workforce team of the relationship and it will be handled in line with section 11 below.

Failure to inform the appropriate person/department of a close personal relationship in accordance with the requirements of this policy, may result in action being taken, in line with the Disciplinary Policy. Employees should also be aware that where a close personal relationship develops with a patient there may be serious consequences with the employee's Professional Code of Conduct guidelines (see section 14)

Employees who are involved in a close personal relationship with a work colleague, even outside the immediate team/department, must be aware at all times of their behaviour towards each other in the work environment and must ensure that they behave appropriately at all times. Inappropriate behaviour may result in disciplinary action.

9. Existing Relationships between Employees

Close personal relationships, between team members, within the line management chain at the first or second tier or with an Executive Officer or a Divisional Director, that already existed before the introduction of the policy must be notified to the appropriate person/department¹. Where such a close personal relationship is notified of, the appropriate manager must undertake a review and risk assessment and make any adjustments as described above, in discussion with the individuals involved seeking advice from the Workforce Team as appropriate.

Employees, who are uncertain about whether they should inform of/report a close personal relationship that they are themselves involved in or where they are aware that such a relationship exists between colleagues, should seek advice in confidence from their relevant Workforce & OD team or trade union representative.

10. Pre-Employment, Recruitment and Appointment

Job applicants, including internal applicants, are required to identify on their

¹ (NWSSP employees, Close personal relationships between team members, within the line management chain at the first or second tier or with a Shared Services Committee member, member of the Senior Management Team or a Service Director that already existed before the introduction of the policy must be declared.

NWIS employees, close personal relationships between team members, within the line management chain at the first or second tier or with a Director, Head of Department or senior manager, that already existed before the introduction of the policy must be declared.)

application form whether they are related to any existing Trust (or hosted organisation) employees, including Executives, and Independent Members.

If an employee is involved in a recruitment and selection process and realises that one of the applications received is from someone with whom they have or have had a relationship as defined in section 4 above, they must inform their line manager, department manager or workforce team and withdraw from the process.

An employee who has a close personal relationship with another must not act as a referee for that person for either internal or external positions.

10.1 Line Management Chain

Where a close personal relationship develops or exists (and it comes to light) and it results in a direct management /supervisory relationship between the two individuals at either immediate line manager or next tier manager level, this situation will not be permitted to continue. In determining the most appropriate course of action a risk assessment should be undertaken to include the equality and social economic impact on the decisions or proposed changes in the working environment to ensure no disadvantage to either party.

In very exceptional circumstances, in particularly specialised or hard to recruit areas, and where the individual is the most suitable/only candidate for the role, an appointment can be made only;

- where all potential issues of concerns and or risks can be mitigated;
- this mitigation can be evidenced; and
- the appointment has been expressly agreed with the relevant Divisional Director (or where the Divisional Director is involved, with the express agreement of the Trust's Chief Executive Officer / NWSSP's Managing Director/ NWIS Director of Informatics Service.)

10.2 Team Members

Where the candidate is applying for a post in the same team / department as someone with whom they have, or have previously had a close personal relationship, the implications of such an appointment must be considered and discussed during the selection process, taking care to ensure matters considered are free from bias and would not result in discrimination, either direct or indirect. This is to ensure that if they are the most suitable candidate for the post, the appointment would be appropriate taking into account:

- Operational issues e.g. shift patterns, annual leave allocation etc.;
- any issues relating to financial regulations in terms of separation of duties;
- potential conflict of interest, confidentiality issues; and
- The impact on the rest of the team.

Where the candidate is subsequently appointed a formal risk assessment (**Appendix 1**) must be completed and held on the personal file of both parties for as long as required with a periodic review to ensure it is still relevant.

11. During Employment

When a manager is informed or becomes aware of a close personal relationship that has developed either:

- involving the direct line manager, or the manager above, and a member of their team;
- **or** between co-workers in the same team / department;
- **or** involving a Trust Executive Officer, Very Senior Managers, Independent Member, or a Divisional Director, / for NWSSP employees, involving a NWSSP Shared Services Committee Member, Senior Management Team Member or a Service Director / for NWIS employees involving a NWIS Director, Head of Department or Senior Management Team Member.

The appropriate senior manager within the team/service/department will, in consultation with their relevant Workforce Advisor, discuss with the employees involved the potential risks posed by and the implications of such a relationship taking into account the equality and social economic impact on the decisions or proposed changes in the working environment to ensure no disadvantage to either party.

11.1 Line Management Chain

Where a close personal relationship develops involving an employee and the direct line or next tier manager, the appropriate senior manager within the team/service/department will, in consultation with their relevant Workforce Advisor:

- Undertake a risk assessment to consider any operational issues that may occur and how these should be managed, and assess any impact on service users and the general public including issues relating to trust and confidence and the public image of the organisation;
- Make immediate alternative supervision / line management arrangements for employee where there is a potential conflict of interest. These include matters related to pay, promotion, job opportunities, appraisals and disciplinary action /capability matters. In these situations this will require the subordinate employee to be supervised for these purposes by another manager with immediate effect. The day to day management of their work will remain unchanged until such time as suitable alternative arrangements can be made and this may include the transfer of one or other of the parties to another team / department, which take into account the equality and social economic impact and in line with section 12 below;
- Where it is necessary for one of the employees to be moved into a different team / department this may result in a change of base or working arrangements. The decision about which employee will be moved will be based on service needs in conjunction with a discussion with the employees concerned taking into account the equality and social economic impact. The

agreed arrangements will be communicated to other colleagues in the team/department only as deemed absolutely necessary.

11.2 Team Members

Close personal relationships that develop between team members must be identified to the manager, department manager or workforce team whether or not the employees themselves feel that it results in any impact on their work. Such relationships have the potential to have an adverse effect on their own and /or their colleagues work. Therefore, any associated risks must be mitigated at the earliest opportunity.

The line manager must undertake a risk assessment and discuss the relevant issues with the individuals concerned, including:

- Any general operational issues relating to shift or working patterns, annual leave requirements etc., which may affect cover arrangements;
- Any potential conflict of interest or confidentiality issues, including the impact on employee relations within the team;
- Any impact on patients, donors, service users or the general public, including issues relating to trust and confidence and the public image of the Trust;
- Equality and social economic impact.

11.3 Executives and Very Senior Officers of the Trust

Where an employee has a close personal relationship with an Executive Officer of the Board, a Very Senior Manager, Independent Member or with a Divisional Director, NWSSP Shared Services Committee, Senior Management Team or Service Director, whether or not they work within the same Division, both parties must inform their immediate manager or workforce advisor, of the relationship, who are required to report it to the Director of OD and Workforce. Where the Director of OD & Workforce is involved, the matter must be reported to the Trust's Chief Executive Officer / NWSSP's Managing Director, as appropriate. For NWIS, where an employee has a close personal relationship with a Director, Head of Department or Senior Manager, whether or not they work within the same Directorate, both parties must inform their immediate manager or workforce advisor of this relationship, who must in turn report it to the Head of Workforce & OD.

The relevant Workforce & OD Department will maintain a central register of all such relationships.

11.4 Conduct and Behaviour

Employees are expected to conduct themselves in a professional manner and to deal sensitively with any confidential information, which one or both individuals may possess or have access to.

Employees are encouraged to bring to the attention of their manager, department manager or workforce team any difficulties they may be experiencing in relation to their working arrangements that the manager may not

be aware of.

12. Transfer of Employees

Where a close personal relationship exists and a risk assessment highlights issues that cannot be managed effectively by allowing the employee to remain working in the same team / department, there will be a need to explore, in discussion with both individuals, alternative arrangements, taking into account the equality and social economic impact, which may include the transfer of one of the parties to another work team / area.

A transfer of one of the employee in the close personal relationship may come about for the following reasons:

- Where a relationship develops or exists between employees in a line management relationship at first or second tier;
- Where the employees are working within the same team or department and the risk assessment indicates that it is not possible to mitigate the potential risks to the individuals, the service, the Trust or to the trust and confidence of the public.

This must be managed by discussion with the employees concerned. The employees are expected to work with their manager, department manager or workforce team to identify suitable alternative working arrangements, to ensure that their close personal relationship does not interfere with or compromise their position or employment within the Trust.

When considering a move to a different team, department or location, there must be no assumptions made on gender, seniority, hours worked etc. when identifying which employee required to move. Any decision will be made based on the needs of the service. Care must be taken to avoid discrimination and ensure that the views of both employees involved are taken into account, alongside the equality and social economic impact and balancing this with the needs of the service and the issues that present or have the potential to present themselves.

Where, during the discussions, an employee suggests a solution in terms of a potential transfer to another department / location this should be given favourable consideration, if it is possible to do so within the existing structures. The matter must be resolved in a timely manner and progress in relation to the resolution of the matter will be monitored by the relevant Workforce Advisor.

13. Relationship Break Down

There may be occasions when a close personal relationship breaks down and the employees remain in the same team, department or work area. Both parties are expected to conduct themselves appropriately, to avoid any impact on their working relationship, team relationships and service delivery. Inappropriate conduct at work will be managed under the appropriate Trust policy e.g. Dignity at Work Procedure or / and the Disciplinary Policy. Inappropriate behavior may result in the transfer of one or other of the employees, care must be taken to avoid discrimination and a decision to transfer employees will be in line with section 12

14. Relationships between a Patient, Donor, Service User and an Employee

Employees should not enter into a close personal relationship (including via social media) with a current patient / donor / service user attending their immediate place of work.

Where a relationship of this nature develops or already exists, including family members, the employee must immediately inform their line or departmental manager. The employee must not provide care or treatment to the patient / donor. This may require temporary redeployment of staff member e.g. to a different clinical setting if patient is an inpatient.

N.B. Relationships between an employee and a patient may have serious consequences with the employee's Professional Code of Conduct guidelines and possibly result in disqualification from practice.

15. Links with Grievance Policy and Dignity at Work Procedure

If an employee feels that they are being victimised and / or unfairly treated they have recourse to the Grievance Policy and Procedure and Dignity at Work Process.

16. Monitoring and Review

This policy will be monitored on a regular basis and will be reviewed as required but initially no later than 6 months after implementation. Managers will be required to maintain a record of personal relationships that they have been informed of and the declaration form and details of the risk assessment must be maintained on the individuals' personal files for as long as it is required and reviewed periodically to ensure it is still relevant.

17. Associated Policies

- Annual Declaration of Interest;
- Dignity at Work Procedure;
- Disciplinary Policy;
- Capability Policy;
- Grievance Policy;
- Information Security Policy;
- Social Media Policy;
- Standards of Behaviour Framework Policy;
- Standards of Business Conduct for Employees.

18. Equality

The Trust recognises and values the diversity of our workforce. The Trust aims to provide a healthy and safe environment for our staff, where they are all treated fairly, consistently and with dignity and respect. The Trust recognises that the promotion of

equality and human rights is central to its work both as a provider of healthcare and related services and as an employer.

18.1 Equality Impact Assessment Statement

This policy has been screened for relevance to equality. Potential negative impact of the policy has been recognised in relation to equality and social economic impacts and potential disclosure of sensitive personal information. To address and mitigate this, options have been included in the policy to protect individuals' right to maintain privacy.

The application of this policy will be monitored and reviewed to ensure that any actions taken in line with the Policy have not resulted in and potential unfair treatment and/or discrimination, either direct or indirect.

Appendix 1 - Close Personal Relationship Risk Assessment Form

CONFIDENTIAL

Complete a separate form for each employee

Description of Risk	Presence/ Significance of Risk	Options available to control risk	Action agreed
Line Management e.g. PADR, discipline, capability etc.			
Team working e.g. Allocation of duties / annual leave / rostering / job sharing / overtime, flexible			
Patient /Donor care, service user contact (If appropriate).			
Financial Governance E.g. Sign off of expenditure.			
Other To be specified (e.g. relationship with Executive Officer, VSM etc.)			

A copy of the completed form must be signed by the employee
and line manager and retained on the employee's personal file

Signed (employee)..... Signed (manager).....

Print name (employee).....Print name (manager).....

Date.....

Appendix 2 - Close Personal Relationships in the Workplace Declaration Form

In accordance with the Trust's Close Personal Relationships in the Workplace Policy employees are required to inform the appropriate person/department of any close personal relationships in the workplace with their line manager, department manager or workforce team as appropriate to the situation and individual circumstances.

In the context of this document, a close personal relationship is defined as;

- Current spouses, civil partners, those who are involved in a romantic, emotional or physical relationship and or in a co-habiting arrangement, which previously existed outside of work, or where it has developed in work;
- Immediate family members, including step parents, e.g. parent, child, sibling, grandparent;
- Extended family members such as aunts, uncles, cousins, in laws (where the individual is aware of them being employed by the Trust).

You will need to inform the most appropriate person/department where any of those described above:

- work with you in the same team or department (i.e. where you are both reporting to the same line manager); or
- where you and the individual are in the same line reporting chain at either first or second tier; or
- are Executives, Very Senior Managers, or a Divisional Director, even if you don't work in the same Division / hosted organisation.

Name:		ESR Number:	
Post:			
Department:			
Division / Hosted Organisation Unit:			
Name of Line Manager:			

Name of person with whom you have a close personal relationship outside of work as detailed above.

Name:	
Post:	
Department:	
Nature of Relationship:	

Sign and date the section applicable:

Is the person named above in the same line management chain as you at either first or second tier?

Yes ☐ No ☐

I understand that where a close personal relationship exists between me and another employee in the same line management chain, at first or second tier second tier that alternative line management arrangements must be made and this may result in one or other of us being moved to a different team / department or location, following discussion and based on service requirements.

Signed:

Dated:

Do you and the person named above work in the same team/department (i.e. report to the same line manager)?

Yes ☐ No ☐

I understand that where I work in the same team or department as someone with whom I have a close personal relationship outside of work, a risk assessment must be undertaken to mitigate any possible risk to myself, my colleagues and the service. I understand that if it is not possible to mitigate the risk, it may be necessary to consider the transfer of one or other of us to another team / department or location following discussion.

Signed:

Dated:

Is the person named above an Executive, Very Senior Manager or a Divisional Director (even if you don't work in the same Division / hosted organisation) Or

a NWSSP Shared Services Committee Member or Senior Management Team Member or a Service Director Or

a NWIS Director, Head of Department or Senior Manager.

Yes ☐ No ☐

I understand that where I have a close personal relationship outside of work, with an Executive, Very Senior Manager or a Divisional Director (even if you don't work in the same Division / hosted organisation) **Or**

a NWSSP Shared Services Committee Member or Senior Management Team Member or a Service Director **Or**

a NWIS Director, Head of Department or Senior Manager.

This must be advised of as appropriate and a register of this relationship will be maintained by the relevant Workforce & OD Department.

Signed:

Dated

This section to be completed by the line manager (or more senior manager in the case of section b above)

Line Manager:

Risk Assessment to be undertaken by:

Date:.....



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

WELSH LANGUAGE ANNUAL REPORT

DATE OF MEETING	24 th August 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Jo Williams Welsh language Manager
--------------------	------------------------------------

PRESENTED BY	Sarah Morley, Executive Director of OD & Workforce
---------------------	--

EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce
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REPORT PURPOSE	For Approval
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	21/7/2020	NOTED
Executive Management Board	04/08/20	ENDORSED FOR APPROVAL

ACRONYMS

WLC	Welsh language Commissioner
WLS	Welsh language Standards
WLO	Welsh language officer

1. SITUATION/BACKGROUND

The Trust received its Welsh Language Compliance notice in November 2018 with the organisation currently working towards compliance of 128 standards.

Standard 120 requires the Trust to provide an annual report which deals with the way in which we comply with each of the Standards with the format of the report being suggested by the Commissioner.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

This is the Trust's first annual report and it demonstrates a proactive approach to the development of work that moves us towards compliance with the Standards. The focus in the first year has been to assess development against priorities set by the compliance notice, providing a foundation for future work.

The organisation has challenged a number of Standards but these challenges have been rejected by the Commissioner. This has been the picture across Wales and the Trust's ability to comply with the Standards is mostly in line with other Local Health Boards and Trusts.

There are a number of areas however that we need to focus on in the coming year, especially areas such as Patient appointment letters and staff training and development needs.

This is being looked at in line with a new Welsh language framework. Details of this framework and work associated with it will be further developed with engagement of Board members in September / October 2020.

Following initial discussion at the Executive Management Board on the 21st July an updated report including improved visuals and updated data was endorsed by EMB on the 4th August for Board approval.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The aim of the standards are to give patients and donors an equivalent service in Welsh and English. The Trust is required to not treat the Welsh language less favorably than the English language. Noncompliance with this standard means that patients and donors could be treated less favorably

	should the trust not be able to communicate with them in Welsh.
RELATED HEALTHCARE STANDARD	Staff and Resources
	Safe care Timely care Staff and resources Dignified care Effective care
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	An EQIA was completed on the Welsh language policy/standards in April 2019
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Noncompliance with this standard could result in complaints. These complaints have the potential to lead to an investigation and financial penalty, up to £5,000 per complaint upheld
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As stated above.

4. RECOMMENDATION

The Board is asked to **APPROVE** the Annual report for 2019/20.

WELSH LANGUAGE ANNUAL REPORT 2019/20



Forward

Velindre University NHS Trust welcomed the introduction of the Welsh language standards as an opportunity to take account of its current Welsh language provision for Patients and Donors and support new ways of recognising the needs of Welsh speakers.

Delivery of the Standards and the supporting framework 'More than Just Words...' is currently a challenge for the Trust and we have put in place mechanisms in which we can monitor our ability to move forward with each of the four areas recognising that any change is a positive one in order to strengthen our services.

Developing the skills of the workforce and increasing our staffing ability to provide an 'Active offer' is the way in which we will ultimately succeed and yet this is our greatest barrier as it is for all Trust's and Local Health Boards. Having the necessary skills to provide a Welsh language service is not easy and it takes planning and perseverance in order to succeed.

Over the last year we have recognised that there needs to be a shift in perspective in order to succeed and therefore the second year of the standards will be supported by a Welsh language cultural framework currently being developed in order to focus the Trust further on what it can achieve, being proactively positive about staff skills and creating a learning environment able to support and grow any level of Welsh language ability across the divisions.

Training opportunities will be crucial but this will be against a changing environment and will need to recognise the different approaches to training via on line methods etc. Again, it is a challenge but one we are fully committed to and that will support the developments underway with the new Cancer services and Blood collection programmes.



Steve Ham
Chief Executive

WELSH LANGUAGE STANDARDS COMPLIANCE ANNUAL REPORTING REQUIREMENTS

Introduction

The Welsh language standards compliance notices were issued to the NHS in November 2018 with most of the NHS receiving compliance dates of either May 2019 or November 2019 on their specific and individual standards.

Most of the standards have been aligned nationally, but a number of caveats or specific differences have been given to certain Health Boards or Trusts giving them standards more relevant to their areas and numbers of Welsh speakers or exceptions to timescales.

Overall responsibility for this agenda lies with the Trust board of course and we have a Welsh language Manager and a Translator supporting the development and delivery of Welsh language services.

Compliance Development

Velindre University NHS Trust has responded to the Welsh language standards by positively changing the way it provides a platform for the work in order to further disseminate the importance of bilingual provision for patients and donors.

Since the introduction of the standards the focus sits as part of the Workforce and Organisational Development department which includes responsibility for training and education. Providing this focus has meant that all initiatives for the workforce which ultimately provides support for patients and donors, takes into account the needs of Welsh speakers.

A number of work streams have been identified and we have developed:

- A new Equality Impact assessment process that specifically highlights the relevant Welsh language standards and encourages discussion around the promotion of the language and the protection of individual's rights to use the language whilst working for the Trust. vacant posts prior to the recruitment process
- Translation of workforce policies relevant to staff to ensure staff have access to Welsh language internal development and support
- In house translation requests have increased significantly over the last year as demonstrated by the word count collected for the previous year and this reporting year:

- 2018/19 - 169,760
- 2019/20 - 379,202

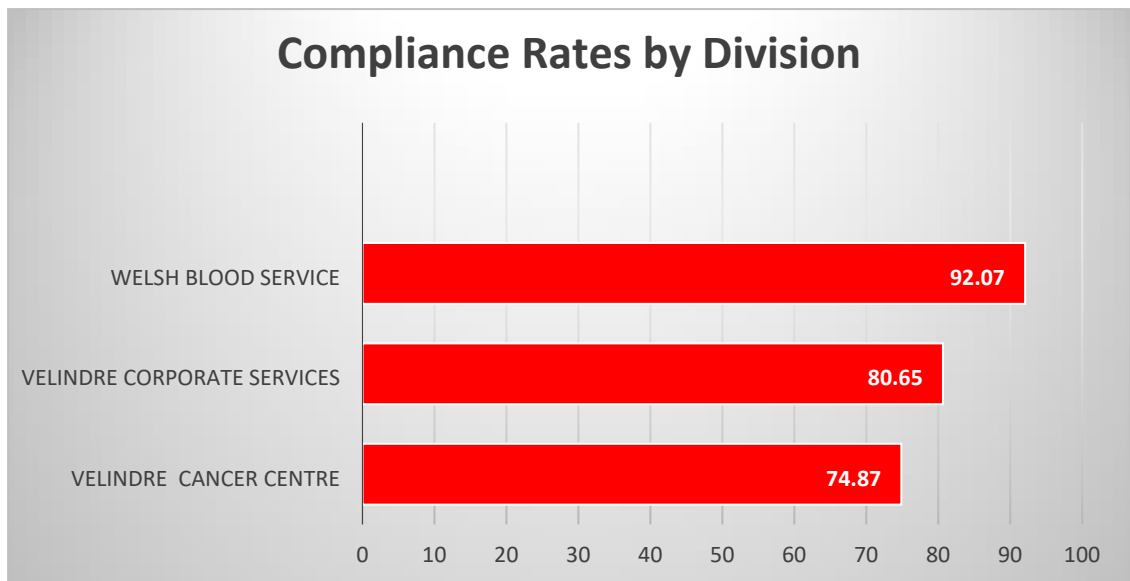


The Trust has its own translation resource but in order to address the increased demand since the introduction of the Standards it has been necessary to outsource as well as utilise the internal resource.

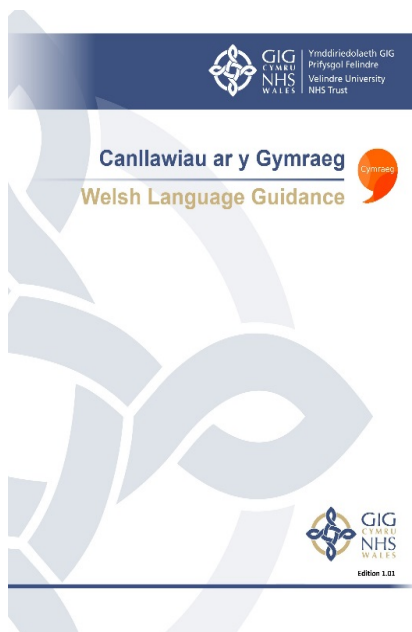
Since the introduction of the Standards you can clearly see the rise in demand and as such the need to outsource. Outsourcing has meant a strengthened relationship with Shared Services and their pool of translators. This will continue into 2020 and beyond as we enter into a Service level agreement with them in order to meet the increased demand for translation services.

- An in-patient plan to enable the Trust to monitor its ability to provide in-patients with access to bilingual staff was drafted and is being monitored and delivered by the Velindre Cancer Centre's senior management team.
- Welsh language awareness training continues as part of the statutory and mandatory training requirements.

To date, and within this reporting time frame, the following compliance % has been achieved:



- Guidance documents aimed at the promotion and dissemination of bilingual processes across the Trust and to act as a 'one stop shop' for all process changes in relation to the standards. It specifically looks at practical ways of answering the phone, how to request translation services, internal and external meeting expectations etc.



- Specific Welsh language Intranet pages relevant to staff in order to give them full access to workforce issues and Welsh language procedures

- Opportunities offered to staff to receive specific relevant internal training through the medium of Welsh including statutory and mandatory training. The offer is included in the sign up process and an explanation given as to how this will work practically.

- Staff are able to assess their requirements using this additional information as they plan their training needs analysis.

- A new internal process ensuring global emails to all staff are fully bilingual with relevant messages to incoming emails regarding the need to identify a language preference for future correspondence
- Changes made to corporate identity relating to emails and opportunities for external correspondence to identify language preference in order for the Trust to plan future correspondence

- A partnership approach to working with other Local Health Boards was investigated and a workshop took place in order to look at plans to discuss and establish best practice across Wales. All Local Health Boards attended and it resulted in a positive sharing of best practice across the NHS and an opportunity to assess current compliance methods. This method of sharing best practice will be monitored and as the Trust initiated this we will be assessing the need for another opportunity in the future.
- Alongside this the Welsh language officers have come together to establish a workforce and Welsh language group. The group is well embedded and has been very useful for sharing best practice, knowledge and developments relating to both the Standards and the 'More than just Words...' framework. The group has a portal on the Academi Wales site which it holds relevant documents available to promote and deliver the Standards. This group continues to meet regularly.
- Increased bilingual social media presence across all platforms has meant that all divisions now have both English and Welsh platforms. Increasing the use of these will now be our priority for us.
- Training continued to be provided via the online courses and the Welsh Blood service was specifically active in encouraging their staff to complete these courses resulting in an internal staff award for their commitment and drive.
- A new Welsh language Policy was developed and is available for staff to view on the Intranet, giving further guidance and support in relation to providing Welsh language services
- NWSSP have actively encouraged a partnership approach to the translation of job descriptions with the Heads of Workforce across Wales. This process has identified the need to rationalise Job descriptions and attempt to provide a data base that could be accessed across Wales. This work continues
- NWIS are working on a system that will enable the NHS to collect and record the language choice of individuals. This national system is in order to adhere to standards 4 and 5 and not primarily for recording language preferences of patients in the first instance.

Complaints or Concerns

A new specific section relating to the Welsh language standards has been developed in order to highlight the importance of collecting concerns relating to this agenda:

When dealing with concerns Velindre University NHS Trust will take account of its statutory duties in relation to the provision of services in Welsh as laid down by the Welsh language Standards (No 7) regulations 2018.

Velindre University NHS Trust is committed to providing bilingual services through the delivery of its Welsh Language Standards to promote or facilitate the use of the Welsh Language and to ensure that the Welsh Language is treated no less favourably than the English language.

We will ensure effective decision making to achieve positive effects or opportunities for the Welsh Language and in ensuring that individuals and third parties are not disadvantaged nor adversely affected.

Velindre University NHS Trust welcomes concerns or alternatively, concerns can be raised direct with the Welsh Language Commissioner.

<http://www.comisiynyddygygymraeg.cymru/English/Commissioner/Pages/Complaints-about-the-Welsh-Language-Commissioner.aspx>

For Welsh language concerns please email the following addresses:

For Velindre Cancer Centre and Velindre University NHS Trust:

Pryderonconcerns.felindre@wales.nhs.uk

For The Welsh Blood Service: Pryderonconcerns.gwasanaethgwaedcymru@wales.nhs.uk

For further information and to view the Trust's Compliance notice visit:

<http://www.velindre-tr.wales.nhs.uk/welsh-language>

From May 2019 to March 2020 Velindre University NHS Trust received three complaints.

Complaints related to:

1. A monolingual patient form – NWSSP
2. A registration process in English only –WBS
3. A donor was given monolingual information only whilst giving blood – WBS
4. A monolingual SMS message - WBS

None of these complaints were taken to the official investigation stage as they were dealt with internally and processes agreed to ensure future compliance.

TRUST WELSH LANGUAGE SKILLS

From May 2019 to March 2020 85.5% of staff had recorded their level of Welsh Language skill within its Electronic Staff Record system. The Trust, as part of its annual staff performance review cycle reminds staff to record their competency levels and also informs them of any Welsh language training opportunities. This has enabled the Trust to monitor the percentage of compliance recording and prompt managers to engage further with staff on their Welsh language needs.

It is important to note that a high proportion of these roles are situated in non-patient/donor facing roles and as such would not be available to directly communicate with the public.

Staff on reception areas are given lists of Welsh speakers in order for them to contact an individual with the relevant skills should this be required by a patient or to assist with donor requests. However, the current skill capacity does not meet the required need of the service and as such the Trust is aware that providing the 'active offer' will take further investment in this area.

The number of employees who have Welsh language skills at the end of the year in question on the basis of the records and in accordance with standard 116:

Number of Staff in Velindre including hosted organisations: 4,510

Recruitment

	Number of employees in the organisation on 7 Apr 2020	Higher Level recorded in ESR 3-5	Lower Level recorded in ESR 0-2	Number of employees whose Welsh language skills have been recorded in ESR by 7th April 2020	Number Not recorded in ESR	Percentage of employees Welsh language skills have been Recorded in ESR by 7 Apr 2020
120 Cancer Research Wales Division	3		1	1	2	33.33
120 Corporate Division	125	9	102	111	14	88.80
120 Health Technology Wales Division	17	1	15	16	1	94.12
120 NHS Wales Informatics Service Division	743	41	661	702	41	94.48
120 NHS Wales Shared Services Partnership Division	2292	192	1735	1927	365	84.08
120 Research, Development and Innovation Division	52	1	46	47	5	90.38
120 Transforming Cancer Services Division	17	1	15	16	1	94.12
120 Velindre Cancer Centre	809	48	609	657	152	81.21
120 Welsh Blood Service	452	33	345	378	74	83.63
Grand Total	4510	326	3529	3855	655	85.48

In 2019/20 recruitment procedures were tightened and a new process was developed to ensure managers were given the support they needed to assess vacant posts for Welsh language skills.

This is an additional element to the current process, strengthening the approach to language assessing posts.

The number (in accordance with standard 117) of new and vacant posts that the Trust advertised during the year which were categorised as posts where

- (i) Welsh language skills were essential;
- (ii) Welsh language skills needed to be learnt when appointed to the post;
- (iii) Welsh language skills were desirable; or
- (iv) Welsh language skills were not necessary

	Total	Essential	Desirable	Skills needed to be learnt
Velindre Cancer Centre	255	1	254	0
Velindre Corporate Services	54	0	54	0
Welsh Blood Service	101	0	101	0
NWSSP	450	7	443	0
NWIS	246	4	242	0
Health Technology Wales	2	0	2	0



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

NHS WALES INFORMATICS SERVICE – VELINDRE EXIT

DATE OF MEETING	24/09/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	CLAIRE OSMUNDSEN LITTLE	
PRESENTED BY	Mark Osland, Executive Director of Finance	
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance	
REPORT PURPOSE	FOR APPROVAL	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
	(DD/MM/YYYY)	Choose an item.
ACRONYMS		
NWIS	NHS Wales Informatics Service	

1. SITUATION/BACKGROUND

On 30th September 2019, Vaughan Gething AM, Cabinet Secretary for Health and Social Services announced that the NHS Wales Informatics Service (NWIS) would transition from its current structure, as part of Velindre Trust, to a new Special Health Authority (SHA).

The announcement read:

“The NHS Wales Informatics Service (NWIS) will transition from its current structure, as part of Velindre Trust, to a new Special Health Authority. Establishing our national digital services organisation as a dedicated organisation reflects the importance of digital technology as a key enabler of change, as set out in A Healthier Wales. This change will strengthen governance and accountability, both in terms of relationships with other NHS Wales organisations and through stronger leadership and oversight, through an independent chair and board members, with experience and understanding of digital change.

A key task of the Transition Finance work stream is the establishment of financial systems to ensure the new organisation is able to receive income, make payments and account for their assets and financial flows.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

All NHS Wales organisations use the ‘Oracle’ Financial System to process their financial transactions. Currently all NWIS financial transactions are recorded on the Trust’s system but the SHA will need to set up its own system prior to establishment.

Maintenance of the Oracle Financial system is done on an All Wales basis and the existing version will be upgraded centrally in 2021. To enable preliminary work to be completed in advance of this upgrade, a change freeze will be put in place at the end of 2020 which will prevent any changes being made or new ledgers being built from that date until the upgrade has been completed. It is therefore important that the SHA are able to work with the All Wales team to ensure their ledger has been built prior to this change freeze and a deadline of 8th December 2020 has been set.

In order for the SHA to implement and roll out a working Oracle Financial system, it is essential for the new organisation to be established with the correct financial registrations, accounts and accounting processes in place. One of the key elements of this is to ensure that the SHA has a bank account set up in time for the creation of the new ledger system for configuration and testing purposes. Due to timing of the release of the establishment

order it may not be possible to create a bank account in the SHA's name by the build deadline of 8th December 2020.

If the deadline is missed then the organisation would be unable to complete the implementation of the financial system until October 2021 at the earliest due to the Oracle upgrade change freeze. This would mean that the organisation would not have a financial system, and could result in a request for its transactions to be processed via the Trust's financial system. Such an arrangement would cause reporting difficulties for both the Trust and SHA Finance teams.

To ensure that the ledger is available it is proposed that a bank account be set up under the auspices of Velindre UNHS Trust for the purposes of ledger configuration, testing and readiness. The bank account will transfer to the new organisation once established and become its responsibility.

The Trust Board are asked at their meeting on 24th September 2020 to approve the opening of an account in order to facilitate timely implementation of the new organisation's Oracle Financial System. If approved, the Executive Director of Finance and the Chief Executive will be asked to sign the bank form to apply for the account, use of the 'Bankline' internet banking service and accept the Bankline terms on behalf of the organisation until such a time as the necessary systems and governance are established for the bank account to be novated to the new organisation.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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 are asked to approve the opening of the bank account as outlined in this paper and give approval for the Executive Director of Finance and the Chief Executive to sign up to the NatWest business account terms.

5. APPENDIX

Communication for information:

Letter from Ifan Evans Director – Technology, Digital & Transformation Welsh Government



Letter to Velindre -
SHA Bank Account - 1

Response from Steve Ham - Chief Executive Velindre University NHS Trust



Letter to Ifan Evans
01 09 2020.pdf



Steve Ham
Chief Executive
Velindre Health Trust

(by email)

17th Aug 2020

Dear Steve,

As you will be aware Welsh Government is currently leading a programme of work to transition the NHS Wales Informatics Service into a new Special Health Authority (Digital Health & Care Wales) on 1st April 2021.

In order to achieve a successful transition, it is essential for the new organisation to be established with the correct financial and accounting processes in place. One of the key elements of this is to ensure that the SHA has a bank account set up in time for the creation of the new ledger system. Ordinarily, this would be undertaken once an Establishment Order is made, however, due to an upcoming change-freeze in the all-Wales Oracle system this needs to be completed by 8th December 2020 at the latest..

Welsh Government is committed to finalising the Establishment Order for the SHA as soon as possible, however, given the timescales for the set-up of bank accounts for new organisations, there is a real risk that a delay to the Establishment Order beyond September 2020 could push the obtaining of bank account information beyond the 8th December deadline.

Welsh Government has identified, in partnership with the Government Banking Service, that the bank account for the new organisation can be opened up prior to establishment in the name of a holding organisation. As Velindre NHS Trust already acts as the host organisation for NHS Wales Informatics Service it seems like the most logical candidate to set up an account on behalf of the new SHA and we would therefore appreciate your support in doing so.

Given the urgency of timescales for this action, I would be grateful if you could indicate your agreement to proceed with an application for a bank account on behalf of the SHA no later than the 1st September 2020.

I would be happy to respond to any queries that you may have in order to provide assurances around the proposed course of action.

Yn gywir / Your Faithfully

A handwritten signature in black ink, appearing to read 'Ifan Evans'.

Ifan Evans

**Cyfarwyddwr –Technoleg a Thrawsnewid
Director – Technology, Digital & Transformation**

**Llywodraeth Cymru - Grwp Iechyd a Gofal Cymdeithasol
Welsh Government - Health & Social Services Group**



GIG
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NHS
WALES

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Prifysgol Felindre
Velindre University
NHS Trust



Pencadlys Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University NHS Trust Headquarters

2 Cwrt Charnwood
Heol Billingsley
Parc Nantgarw
Caerdydd/Cardiff
CF15 7QZ

Ffôn/Phone : (029) 20196161
www.velindre-tr.wales.nhs.uk

Mr Ifan Evans
Director – Technology, Digital & Transformation
Welsh Government
Health & Social Services Group

1 September 2020

To be sent by email

Dear Ifan

Further to your letter dated 17 August 2020, I am writing to confirm our agreement to proceed with an application for a bank account on behalf of the SHA.

Preparatory work has already started, but we will need to get approval at the next Trust Board and Audit Committee to enable us to formally sign the documentation.

Yours faithfully

Steve Ham
Chief Executive
Velindre University NHS Trust

Mae'r Ymddiriedolaeth yn croesawu gohebiaeth yn y Gymraeg
This Trust welcomes correspondence in Welsh





GIG
CYMRU
NHS
WALES

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Velindre University
NHS Trust

TRUST BOARD

Trust 2019/2020 Annual Quality Statement

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Anna Harries, Senior Nurse Professional Standards & Digital & Amy Mumford, Deputy Head of Nursing Velindre Cancer Centre
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Scientists
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, AHP & Health Scientists

REPORT PURPOSE	FOR APPROVAL
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	N/A	Approved
Q&S Committee	N/A	Approved

ACRONYMS	
AQS NHS	Annual Quality Statement National Health Service

1. SITUATION

This paper is provided for the Trust Board to **APPROVE** the Trust's 2019/2020 Annual Quality Statement prior to publication.

2. BACKGROUND

2.1 Annual Quality Statement requirements

The Annual Quality Statement provides an opportunity for organisations to 'tell the story' of good practice and initiatives being taken forward, as well as confirming what went well and what not so well and the actions being taken as a result. All NHS organisations are required to publish an AQS, as part of the annual reporting process.

NHS organisations need to be mindful that the Health and Social Care (Quality & Engagement) (Wales) Bill includes a new, broader duty of quality which requires NHS bodies in Wales to exercise their functions with a view to securing improvement in the quality of health services. In the interim, annual quality statements will continue very much as in previous years but with an eye on the future requirements under the Bill. This Welsh Health Circular therefore provides guidance on the content and structure of the statement for 2019-20. In developing its Annual Quality Statement the Trust should:

- provide an assessment of how well they are doing across all services, across the patient pathway, including social care and the third sector;
- promote good practice to share and spread more widely;
- confirm any areas which need improvement;
- build on the previous year's AQS, report on progress, year on year;
- account to its public and other stakeholders on the quality of its services; and
- Engage the public on the quality of services received from their health board / NHS Trust to help inform the AQS content.

There is clear guidance regarding what should be contained within an Annual Quality Statement. This includes the need to combine an element of looking back at what has been achieved with a forward look using data and information available for the reporting year. In looking back, we are required to seek to answer the following questions:

- are we meeting standards and delivery requirements and are we improving outcomes, across the whole patient pathway?
- are we genuinely seeking to understand the patient/user experience and is it improving?

- are we meeting or exceeding our improvement goals?
- are we being open and learning from errors and concerns?

2.2 Publishing the Annual Quality Statement

As the Annual Quality Statement is a public document it should be presented in a way which is accessible to all, bilingually and published electronically on the Trusts website, and make hard copies available on request. The Trust is required to take into account the needs of their local populations and consider making the statement available in other formats or languages where there is a need to do so, considering going beyond meeting the legal requirements in such matters.

Initial timescale was to publish the Annual Quality Statement bilingually no later than the **29th May 2020**, however due to the COVID-19 pandemic this was extended to the **30th September 2020**.

This year's Velindre University NHS Trust statement will be the first to be published in Welsh and this has impacted on time scales for publication. However, meeting the 30th September publication date is possible with NWSSP support.

2.3 Assuring the Annual Quality Statement

The Board is accountable for the Trusts Annual Quality Statement and must therefore assure itself, through its internal assurance mechanisms, including internal audit, that the information published is both an accurate and representative picture of the quality of services it provides and the improvements it is committing to.

Internal audit have reviewed and reported reasonable assurance based on Version 3. Version 6 is now the final draft. All Internal Audit recommendations relating to content have been incorporated within the final draft.

The Community Health Council and Patient Liaison Group have both reviewed and provided comments as feedback to the Statement.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Final Draft Annual Quality Statement

The final draft Annual Quality Statement is attached in **Appendix 1**. Due to the impact of the pandemic some minor changes were required following consideration

at the Quality and Safety Committee. The Committee endorsed the version received and provided authority for Chairpersons action to approve the final draft.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	All aspects of quality and safety with Velindre to outlined within the statement
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	All aspects of healthcare standards cover section by section but must be balanced and represented across Trust
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	Many aspects considered and when finalized must be available in Welsh
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	For internal audit approval and with new Health and Social Care Bill, the Act has a legal requirement
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Many services within the statement have a great deal of resource associated and must be reviewed at various stages to ensure effective working.

5. RECOMMENDATION

The Trust Board is asked to **APPROVE** the 2019/2020 Trust Annual Quality Statement prior to publication.



VELINDRE UNIVERSITY NHS TRUST

ANNUAL QUALITY STATEMENT 2019/2020

This is our eighth Annual Quality Statement, through which we would like to share some of our successes and challenges with you. This year as you will see has been a very busy year for all areas of Velindre and this could not have been achieved without the amazing support of our patients, donors, staff and partners.

Velindre University NHS Trust is one of the leading providers of specialist cancer, and blood and transplantation services within the UK, bringing together expert staff, high quality cancer care, donor and transplantation services, together with excellence in research, development and innovation. We have built and continue to advance with a strong reputation across the United Kingdom, Europe and internationally for the services we provide.

We place a high value on ensuring we always keep our patients and donors at the heart of everything we do, and we are grateful for the continued levels of assistance, encouragement and positive feedback we get from our patients, donors, staff, partners and supporters.

We hope you find our Annual Quality Statement interesting and informative, and as always, we very much welcome your feedback on how we are doing and what you would like to see from us in the future. For more information on how to contact us please see page 41.



Professor Donna Mead OBE
Chair



Mr. Steve Ham
Chief Executive

CONTENTS

Introduction	Page 2
Our Challenges	Page 5
Looking Back	Page 7
<u>Staying healthy</u>	Page 8
<u>Safe care</u>	Page 12
<u>Effective care</u>	Page 16
<u>Dignified care</u>	Page 21
<u>Timely care</u>	Page 25
<u>Individual care</u>	Page 27
<u>Our staff</u>	Page 31
Looking Forward	Page 38
Endorsement & Feedback	Page 39

Introduction

The Trust was established in 1994 and provides a wide range of specialist services at local, regional and all Wales levels. We provide two core delivery services:



Welsh Blood Service: providing blood, bone marrow, haematopoietic stem cell and transplant laboratory services, and immunogenetics services across Wales.



Velindre Cancer Centre: providing non-surgical tertiary oncology and palliative care services to the population of south-east Wales, and highly specialist cancer services for patients from other regions of Wales.

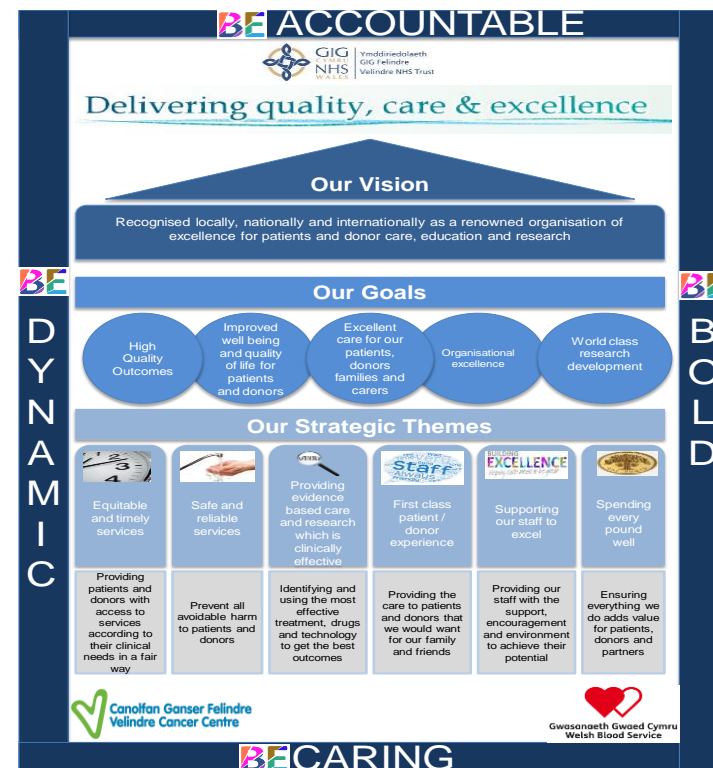


We host three organisations on behalf of NHS Wales, the NHS Wales Informatics Service, NHS Wales Shared Services Partnership, and Health Technology Wales.

We are a very ambitious organisation, striving to provide services which are recognised as excellent by the people who use them, the people who work in them, and peer organisations. Our vision is:

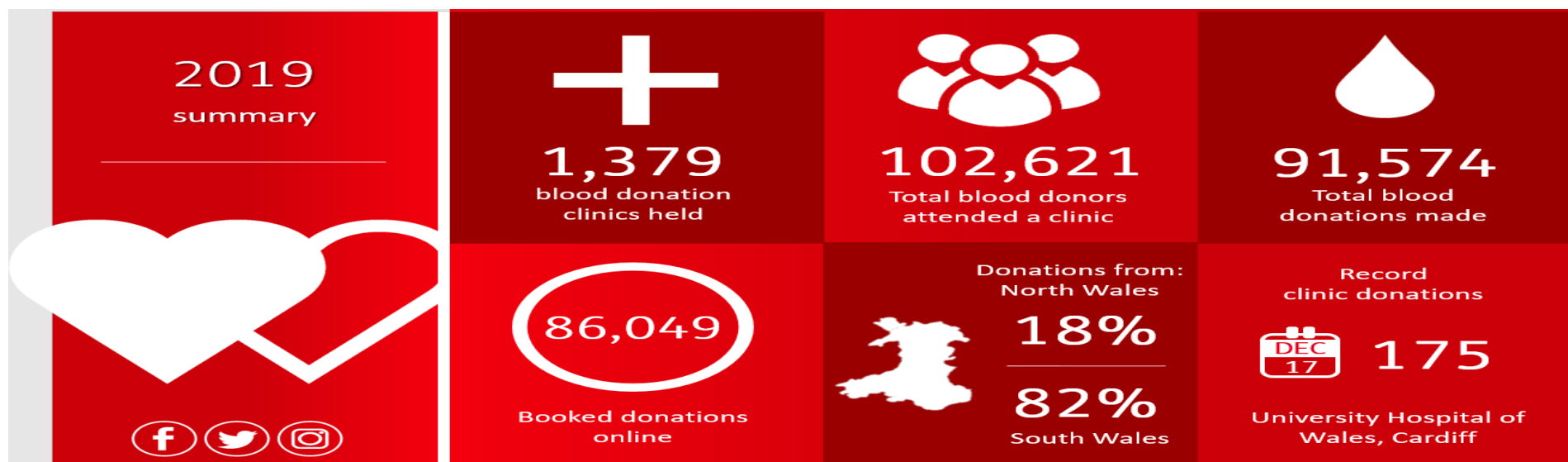
'To be recognised locally, nationally, and internationally as a renowned organisation of excellence for patient and donor care, education and research.'

We aim to continually improve the quality, safety, effectiveness and efficiency of our services, provide evidenced based care and research, and spend every pound well.



We apply the four principles of prudent healthcare to all we do.





Canolfan Ganser Felindre Velindre Cancer Centre

twitter.com/VelindreCC

facebook.com/velindrecc

instagram.com/velindrecc

Year in, year out

Velindre Cancer Centre provides specialist cancer services to **1.5 million** people living in South East Wales.

More than **61,000** outpatients

2,000 Inpatients

24,000 SACT Day cases

Providing cancer treatments for over **63 years**
Velindre Cancer Centre was established in 1956.

Although Velindre Cancer Centre is the main focus for services, we provide outpatient clinics and chemotherapy services at **other hospitals** throughout South East Wales.



The Wales Cancer Patient experience survey 2016 revealed we:

93% Treated with dignity and respect while in hospital

84% Were told sensitively about cancer

78% Understood the explanation of what was wrong with them

89% Staff did everything they could to help manage their patients pain

Source: Macmillan Cancer Support and Quality Health



Cancer - the challenge

Wales Has one of the highest incidences of cancer

Wales has highest proportion of >65 year olds

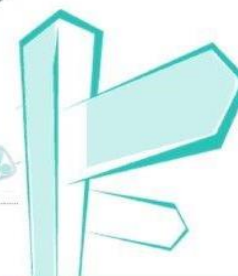
More than **1 in 3 people** Will develop cancer

Disease of old age and lifestyle

Every day **49 people** hear the devastating news they have cancer



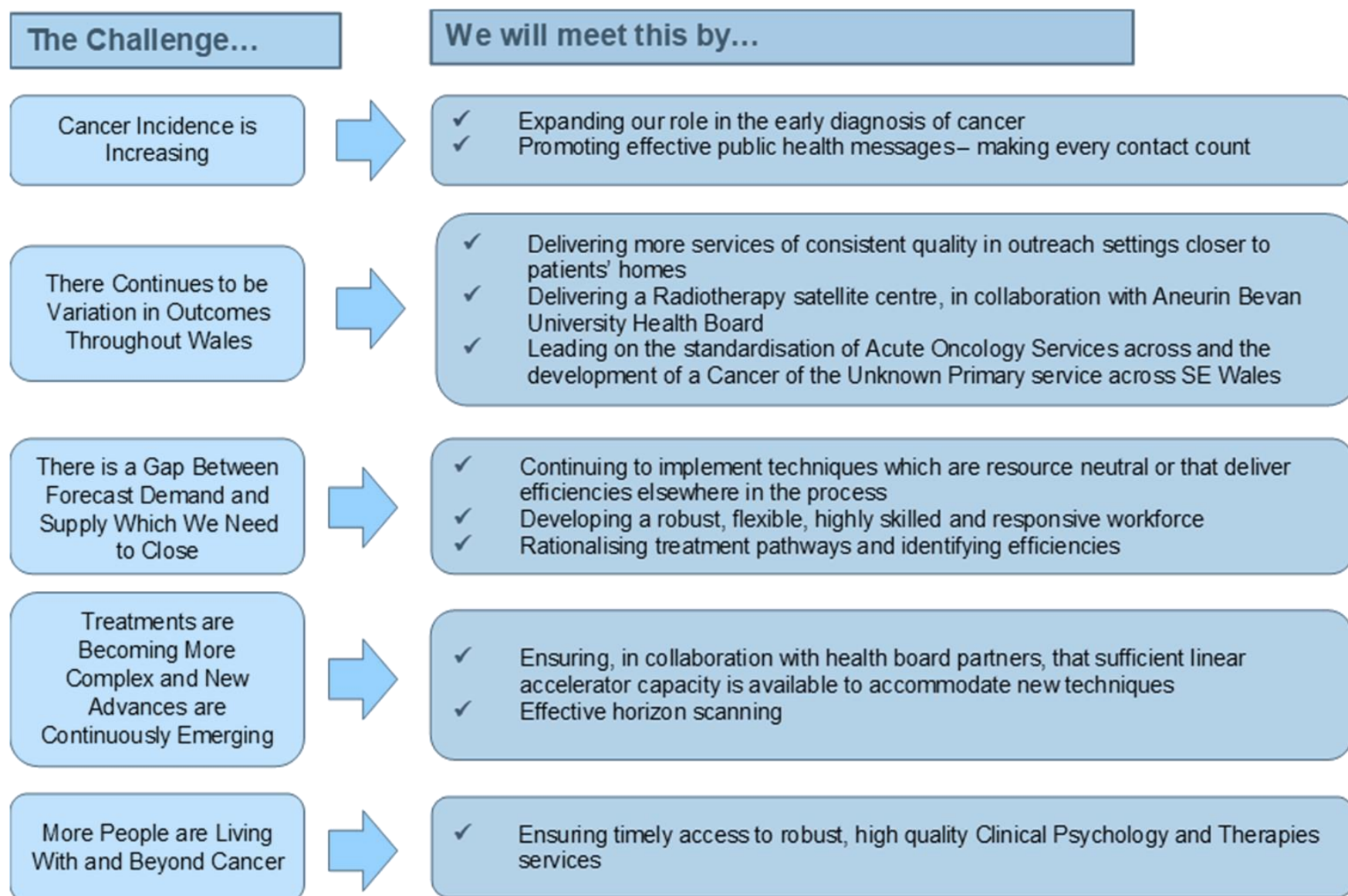
Every day **49 people** hear the devastating news they have cancer

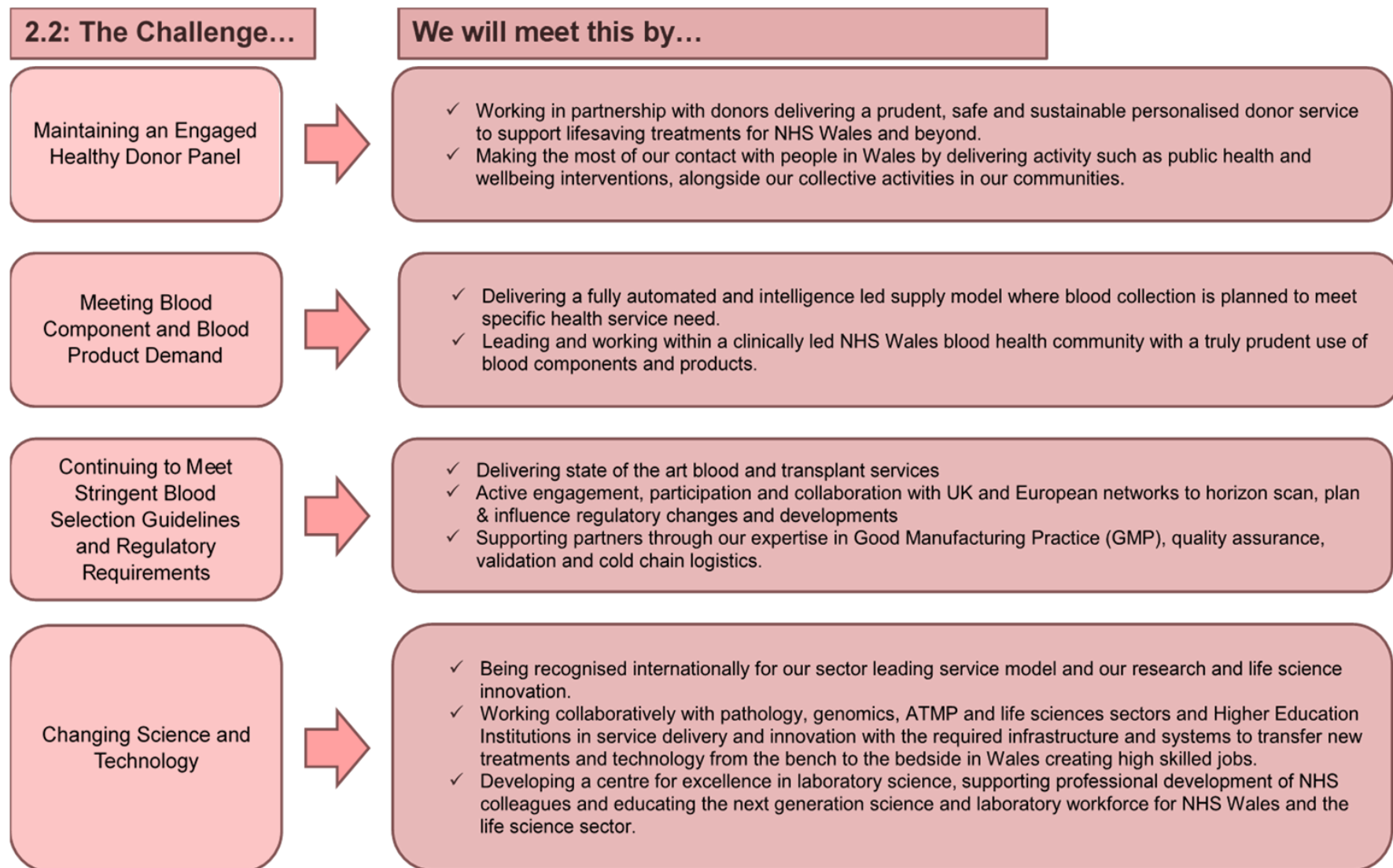


Increase of **80%** people living with cancer between 2010 and 2030

Rapid increase of new cancer drugs - how to use most effectively







Looking Back

Over the course of 2019, we have continued to build upon the excellent work undertaken by Velindre University NHS Trust, working with our many partners to develop a set of ambitious priorities which will result in people who use our services receiving excellent care, service and support.

Towards the end of the financial year COVID-19 became a consideration and had a major impact on service delivery. Looking at this positively is difficult as it impacted personally and professionally on Velindre University NHS Trust patients and staff, however it vitally important to ensure a focus is maintained to drive forward with positive aspects of service changes.

Before we move into the body of this statement, COVID-19 the global pandemic must be highlighted. Many of the projects, achievements and challenges have been affected towards the end of the financial year 2019-2020. Some projects were paused, some escalated in order to meet patients' needs and this will shape the Trust in how it moves forward into the next financial year and beyond. Some challenges became heightened and some were overcome as a result of the pandemic.

Velindre Cancer Centre wants to lead in the delivery and development of compassionate, individualised and effective cancer care to achieve outcomes comparable with the best. We continue to plan for a new Cancer Centre that will serve generations of people across south-east Wales for decades to come. There have been significant steps towards this throughout 2019 and thankfully some of the infrastructure restraints evident through COVID can be considered moving forward as lessons learnt for 2020-2021.

Looking back over the past year we have achieved a number of key objectives including:

- ✓ Implementation of a range of new radiotherapy techniques.
- ✓ Robust infrastructure to support the delivery of immunotherapies
- ✓ Introduction of a new service model for Acute Oncology Services at Velindre Cancer Centre and across South-East Wales.
- ✓ Implementation of a new cancer of unknown primary/metastases of undefined primary origin pathway.
- ✓ Development of rehabilitation service and review of therapy provision.
- ✓ Implementation of Attend anywhere, linking patients with clinicians during COVID but also for future working. [Video link:](#)

<https://youtu.be/Z9k9q5awtB8>



- ✓ During 2018/2019 recruitment of consultants was a challenge which was successfully overcome with consultants and workforce collaborative approach to recruitment and future planning.

Welsh Blood Service We have continued to develop our Blood and Transplantation Services having introduced a truly pan-Wales service in 2016. Over the past year we have achieved several key objectives that include:

- ✓ A programme structure has been set up to undertake work around management of anaemia for pre-operative patients
- ✓ Developed successful partnerships with schools across Wales and with the Football Associate of Wales as their first community partner.
- ✓ Written and piloted a 'Before you donate' leaflet to fully inform donors of the risks associated with donation to enable a fully informed decision to be made.
- ✓ Continued to develop our web based customer portal to enable donors to book their own appointment to donate blood.
- ✓ Developed an award winning game to support education around correct selection of blood and importance of correct patient identification.
- ✓ Developed platelet conservation strategy to reduce waste of blood products
- ✓ Developed a cyber security strategy and plan to protect personal and often sensitive donor and patient data at WBS
- ✓ Introduced a new Donor survey to understand from donors their views on the service and donating.

We have also experienced a number of challenges including:

- Some issues remain and continue from the last statement with our Electronic Patient administration system (CANISC) this prevented Pilot of the electronic nursing care record, however we strive forward to resolve this into 2020.
- Many digital projects being implemented within the organisation, this challenged all members of staff and service delivery.
- COVID-19 was a challenge for all services but a challenge that was risen to and responded to with unity ensuring quality and safety maintained for both service users and staff. This included rapid set-up and training of a HCSW bank to ensure an uplift in workforce was possible if required but maintaining quality and safety for patients.

In the coming pages we provide information about work we have been doing in relation to seven themes; **staying healthy, safe care, effective care, dignified care, timely care, individual care, staff and resources.**

Staying healthy

The principle of staying healthy is to ensure that people are well informed to manage their own health and wellbeing. We recognise that through working with others, we can play our part in this important work. We are always trying to find ways of providing advice and support to help our patients, donors and staff to improve their health and wellbeing.



During 2019 and into 2020 we continued to focus on well-being as we work to embed the Sustainable Development Principle, as a normal part of everything that we do following the publication of our own set of well-being objectives based on the Well-being of future generations (Wales) Act 2015

<https://www.futuregenerations.wales/about-us/future-generations-act/>



Below are some of the well-being and sustainable development initiatives that we have been working on over the past year:

- ✓ 2 Occupational Therapists (OT's) have successfully completed their National Institute of disability Management and research qualification (NIDMAR) to deliver vocational rehabilitation – first NHS OT's in Wales to achieve this qualification
- ✓ The daily staff update provides links to well-being, very much a focus all year however really advanced during COVID and will remain a focus. Wellbeing rooms and space have been set up and provided vital escape and regeneration for staff.
- ✓ Menopause Cafés, have had to resign over COVID as online sessions were required. Use of Personal Protective equipment (PPE) created a whole new issue with heat exhaustion.
- ✓ *Retention of Gold Corporate Health Standard*
- ✓ *Mindfulness App and Education*
- ✓ Health and Wellbeing Channel, funded by Macmillan for a Multidisciplinary approach to wellbeing.

We aim to transform the way in which people are able to access information and the services that they require through the use of digital technology, making it simple, effective and adding value for people. Furthermore, we will use our skills and capabilities to develop our research, development and innovation activities to benefit the population of Wales in staying health and receiving cutting edge services and treatments when they are ill.

Staying healthy

last year we said we would:

- ***Revisit our well-being objectives.***
- ***Develop a sustainable development strategy and a framework for reporting progress against our well-being objectives.***

Each year, Velindre Cancer Charity organises an overseas challenge event to raise vital funds for Velindre Cancer Centre.

From climbing Kilimanjaro, cycling from San Francisco to LA and trekking across Patagonia to name a few – these events have raised in excess of £3million for cancer patients and their families in Wales.

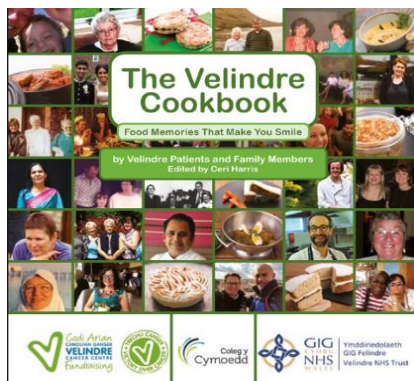


In 2019, 45 participants took part in the Helambu Trek in Nepal, led by Velindre Patron Rhod Gilbert, raising £256,000.

The 5-day trek was extremely tough. The group trekked an average of 9 hours a day over very challenging mountainous terrain, in blazing sunshine and even snow on one day, and camped each night in freezing temperatures.

But it was all worth it to witness some of the most stunning scenery in the world and to share some very special moments in this spiritual, beautiful place.

<http://www.velindrefundraising.com/events/nepal-trek-09-feb-2019>



The Velindre Cookbook: The cookbook remains on sale and continues to promote health and wellbeing.

While the cookbook won the award for the best cookbook in Wales and was shortlisted and put forward “best in the world” unfortunately this was not achieved during the event held in China on 3rd July 2019.

<https://youtu.be/H3bnzGdSOS8>

Moving forward into 2020, as an organisation we aim to promote keeping fit for the future. The Year of the Nurse and Midwife t-shirts incorporating our Welsh logo were purchased and will be distributed for the event. This is an event, if proves popular could continue within Velindre University NHS Trust.



<https://www.who.int/campaigns/year-of-the-nurse-and-the-midwife-2020>



Nurses and Midwives keeping fit for the future of our profession





Menopause Café and other link initiatives have gone from strength to strength: Velindre University NHS Trust became the first workplace organisation in Wales to introduce a Menopause Café for staff which Featured on ITV news-

<https://www.itv.com/news/wales/2018-11-28/first-workplace-menopause-cafe-launched-by-velindre-university-nhs-trust/> .

The café creates a supportive space for colleagues of all genders and ages to share experiences and ask questions about the menopause. We will continue to introduce a range of initiatives and schemes to support the Trust's goal of becoming a Menopause Aware and Supportive Employer.

The concept behind the Menopause Café is to remove some of the barriers that can often make the menopause an uncomfortable and off-limits subject for discussion for many women and their families.

The work won the HPMa Wales Award for Health at work and Shortlisted for the HPMa National Awards in June 2020 which did not proceed due to Covid-19 so we don't know the outcome.

Velindre have also rolled out Menopause Café Events for Velindre Cancer Patients which are hosted in Maggies on a quarterly basis. Due to COVID the team reacted quickly and continued this service virtually.



“What’s my type?” and Schools donation venue programme have continued with success through 2019 and 2020.

The schools donation venue programme has proactively engaged with schools to propose them becoming a donor venue. In the last 6 months of 2019, seven new school venues were added to the currently list and a further five schools have already expressed an interest in hosting sessions across Wales.

Together these schools have collected over 1,400 units of blood and added 206 students to the Welsh Bone Marrow Donor Registry.

<https://www.welsh-blood.org.uk/whitchurch-high-school-students-learn-a-lifesaving-lesson/>



The Blood Health Plan:

The Blood health team at WBS support the delivery of Welsh Government Blood Health Plan. The plan has three core aims, which include supporting individuals to manage their health and well-being, avoiding unnecessary intervention. It has done this through the development of several key works streams. In 2019, a work stream to look at pre-operative anaemia was established. The pre-operative anaemia plan for Wales will aim to treat iron deficiency anaemia in patients before they undergo major surgery. This will result in a decreased need for blood transfusion and shorter lengths of hospital stay for the patient

Football association for Wales Partnership: In 2019, WBS became the first official community partner for 2019/20 and 2020/21 season of the football association of Wales (FAW) Cymru leagues and Welsh Premier Women's League.

As community partners, the WBS will provide promotional materials to enable the football clubs to promote the importance of giving blood at their local clinic when appropriate.

Clubs will receive bespoke content packs, including the information needed to encourage their fans to donate.

The campaign is intended to be delivered at a local level through relationships between the donor engagement coordinators and the football clubs. The FAW has committed to strengthening these links.



Wrexham AFC captain gives blood during lockdown.

Staying healthy

Next year we will:

- *Implement Mental Health Awareness Training for staff*
- *Develop Travel Plan for Velindre Cancer Centre staff, patients and visitors*
- *Develop Plastic Reduction Key Performance Indicator and Strategy*
- *Develop Smoking Cessation Pathway for Patients*
- *Support the further development and implementation of an anaemia strategy for a healthier Wales.*
- *Extend the number of schools on the school donor venue programme*
- *Continue to work with FAW as their official community partner*

Safe care

The principle of safe care is to ensure that people are protected from harm and are supported to protect themselves from known harm.

Our patients, donors and their families should expect that we will make their safety our first priority and that we will keep them safe and protected from avoidable harm through appropriate care, treatment and support.

'Our Challenges'



Within Velindre University NHS Trust we are committed to continuous improvement that impacts positively on the care, treatment and outcomes for our patients and donors. Across Velindre Cancer Centre and the Welsh Blood Service staff continue to be actively engaged in quality and safety initiatives.

Below are examples of some of the areas we have been taking forward:

- All our laboratory and diagnostic services at WBS are successfully audited and accredited to international standards. Welsh Blood continues to host the UK accreditation scheme for Histocompatibility and Immuno-genetics)
- The Welsh Blood Service was inspected and re-approved by both the Medicines and Healthcare Products Regulatory Agency and the Human Tissue Authority for Transfusion and Transplantation services
- Positive Health Inspectorate Wales IRMER (Ionising Radiation Medical Exposure Regulations) Inspection. This is designed to protect people while undergoing examinations and treatment using ionising radiation.
- Continued Compliance against General Pharmaceutical Council Inspections
- Improved the way we identify patients at risk of developing pressure ulcers by with access to expert advice via Service Level Agreement with Tissue Viability Service
- Implementation of Pressure Ulcer Scrutiny Group to provide multidisciplinary led review of all pressure ulcers

Safe care

last year we said we would:

- *Work towards transforming the organisation into one synonymous with excellence in research development and innovation by redeveloping our RD&I strategy.*
- *Pilot nursing e-documentation assessment tools within inpatient services.*

- Implementation of Medicines Transcription and Discharge Advice Letters on inpatient areas providing electronic communications that feed into Welsh Clinical Portal that is accessed by NHS Wales
- Formal Service Level agreement (SLA) for Point of Care Testing (PoCT) advice, training and support
- Donations from women who have miscarried or undergone termination of pregnancy are referred to a physician for assessment.
- In June 2019, WBS enabled guest/public Wi-Fi across all its sites. Visitors can now securely connect to a local Wi-Fi network using a simple passcode.
- The Blood Health Team aims to avoid harm, placing safety and quality at the core of patient care. As part of their work in 2019, they have continued to develop the annual training programme for all final year medical students in Wales, which has four interactive stations including: decision to transfuse; adverse reaction; sampling competency and; 'play your card right'. 'Play your cards right' is a game developed to explain principles around correct selection of blood and the importance of correct patient identification.
- Work with Public Health Wales Antenatal Screening Programme to implement foetal D testing, which aims to prevent unnecessary administration of anti-D prophylaxis
- **Protection of personal and sensitive donor and patient data:** The protection of personal and often sensitive donor and patient data is important to WBS. In May 2019 a cyber security strategy and plan was agreed by the Trust. The strategy aims to implement a range of service to reduce the risk of security attacks and patient and donor data being accessed. The plan will also develop a range of learning and education tools designed to provide staff with a range of skills and knowledge on how to identify and combat cyber security both at home and in their personal lives

Throughout 2019 the Welsh Blood Service has continued to be engaged in the Public Protection and Domestic Violence agenda. In collaboration with the Trust safeguarding lead training, education and resources have been provided to staff in collection teams across Wales to ensure staff are aware and understand their role in public protection.

At WBS a Clinical Governance Operational Service Group (CSOSG) has been created to link patient facing care to the donor service and provide strategic oversight and operational delivery across the supply chain.

Membership includes the donor & patient facing directorates and the group works in close collaboration with the Regulatory Assurance and Governance group (RAGG) to ensure all aspects of governance are covered.

This structure provides visibility and management of clinical issues and ideas from operational areas to the senior management team and facilitates an important channel of information back to staff.

Safeguarding:



During National Safeguarding Week in Nov 2019 Velindre's Senior Safeguarding Nurse took the opportunity to launch the new Wales Safeguarding Procedures and raising awareness across the Trust.

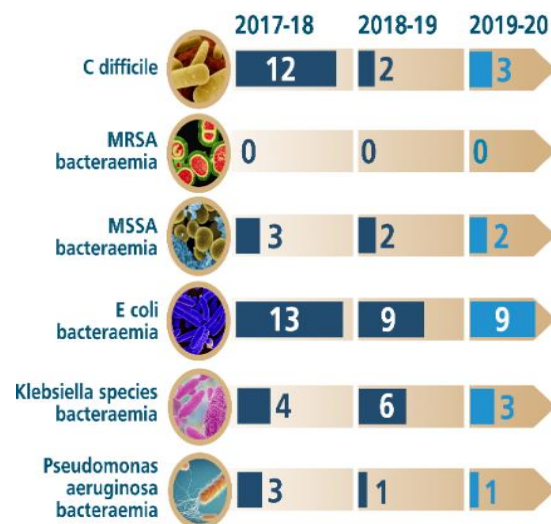
All identified Health & Care 2.7 standard actions for 2019/20 were achieved and were included in the work plan of the Safeguarding and Public Protection Management Group.

Pressure Ulcer scrutiny panel meets regularly to scrutinise each incident report and completed All Wales Pressure Ulcer Reporting Investigation Tool for accuracy, completeness, timeliness, and effectiveness.

A review of the safeguarding arrangements was completed in line with the trusts 2019/20 internal Audit plan, the audit result was that the board can take substantial assurance that arrangements to secure governance, risk management and internal control within safeguarding, are substantially designed and applied effectively.

Health Care Associated Infections (HCAIs): The Trust is committed to preventing infections and carefully monitor the number of infections monthly, quarterly and annually.

Our clinical teams take action to reduce healthcare associated infections (HCAIs) in the Cancer Centre, and there has been a 50% reduction in Klebsiella species bacteria, while maintaining last years reduction across the board for other HCAIs.



Gram-negative bacteria such as *Escherichia coli* (*E.coli*), *Klebsiella* and *Pseudomonas aeruginosa* are a leading cause of healthcare associated bloodstream infections and can be resistant to antibiotics.

As part of the HCAI/Antimicrobial Resistance (AMR) collaborative with 1000 Lives and Public Health Wales, we are driving quality improvement initiatives to support the reduction of HCAI and promote prudent antimicrobial prescribing throughout the Trust.

Now 6 years free of MRSA Blood Stream Infections: On 22nd November 2019 we achieved 6 years without an MRSA bacteraemia at Velindre Cancer Centre which is an exceptional achievement (Photo is from the 5 year celebration event)

There has been really good progress against our improvement goals set in May 2019 by Welsh Government in relation to healthcare associated infections and antimicrobial prescribing this year.

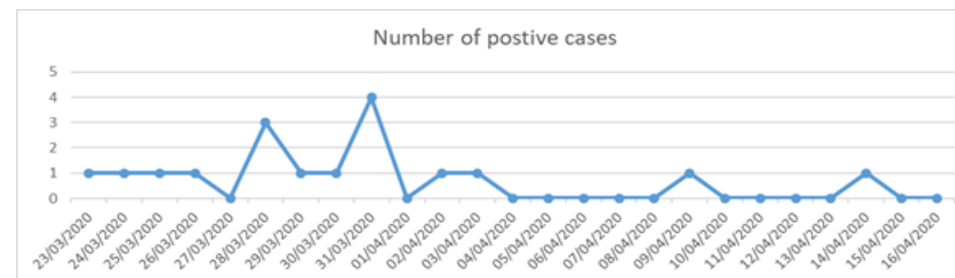
We have managed to reduce or sustain our numbers of infection with only a very slight increase in one case for *Clostridium difficile* (C).

Good progress has also been achieved in intravenous line management, staff influenza vaccination uptake.



Responding to the COVID-19 pandemic required intensive input from the Infection control and prevention team.

Frequent updates in Public Health guidance as the evidence and scientific understanding developed, proved very challenging at times but was again managed well for safety of both staff, patients and wider population. As expected lessons are continuing to be learnt and will be reviewed further into 2020/21.



The number of cases was contained as above and was cited as the team being visible in all areas and through videos posted on social media or within teams. The management and isolation of patients through a screening process allowed the number of cases to be low, protecting the vulnerable patient group within Velindre.

Safe care

Next year we will:

- Continue to deliver an annual training programme for final year medical students
- Continue to roll out cyber security strategy and plan across the Trust
- Review all safeguarding and public protection training package's for the trust
- Review the lessons learnt through COVID and epidemic management

Effective care

The principle of effective care is that people receive the right care and support as locally as possible, and are enabled to contribute to making that care successful.

Our patients and donors should expect to receive care and support based on best practice, and should have access to information in a format that enables them to be equal partners in decision making.

'Our Challenges'



Our aim is to ensure that the services we provide remain fit for purpose now and into the future, and to ensure that patients and donors receive the same quality of care wherever they are treated.

This will include providing care closer to patient's homes and in community settings whenever we can.

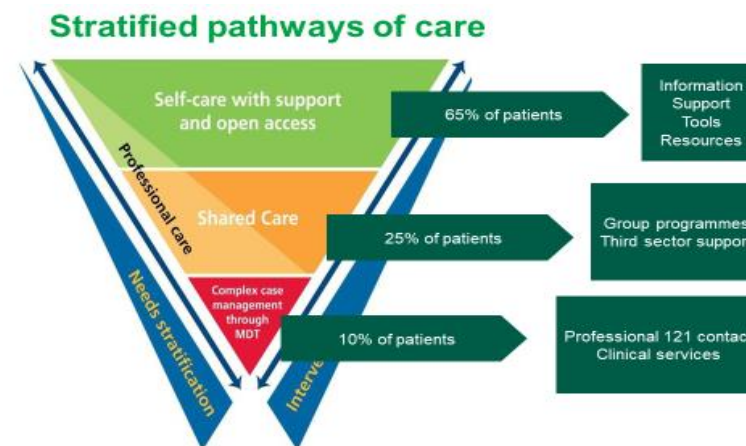
We already provide several services closer to our patient's and donors homes, and in recent years we have been actively working to establish outpatient services and Systemic Anti-Cancer Therapy (SACT) delivery units across south-east Wales.

Timely access to the most appropriate and effective evidence-based care is proven to improve outcomes. The prudent healthcare principles underpin the way in which treatment choices are made, ensuring that patients are equal partners in their care.

The following are examples of some of the areas we have been taking forward:

- Communication group for neuro patients launched at Maggie's – running every 6 weeks.

- Therapy/CNS led integrated neuro clinic (Speech and Language therapy and Occupational Therapy) weekly – introduced November 2019 to ensure patients meet the MDT as soon after diagnosis as possible to support them through treatment.
- Therapies have focused on supporting and empowering patients to self manage where appropriate so that patients who require 1-1 intervention have the resource available. This also promotes treatment within their home environment.



There has been investment into therapies over the last year:

0.8

0.8 Whole Time equivalent (WTE) band 7 advanced practitioner physio – 3 years charitably funded between friends of Velindre and VCC charitable funds. Post agreed 2019/2020 but not commenced until April 2020

0.5

0.5 WTE B6 dietitian for the patient support unit – charitable funds funded for 3 years.

0.6

0.6 WTE B5 SLT for the patient support unit – charitable funds funded for 3 years.

0.6

0.6 WTE B6 core funded SLT to support the ongoing secondment of a staff member to WPAS – this is a permanent post however.

- Commencement of a video fluoroscopy swallowing clinic – Speech and Language Therapy (SLT) and radiology combined specialist clinic.
- As part of Acute Oncology service (AOS) the Assessment unit physio continued specialist input throughout 2019-2020
- Continued Charitable funds investment for acupuncture/physical activity - 18 months. The Physical activity part will be in the form of a pilot with Newport Live: Collaborative working between Velindre and leisure services
- Initial work has taken place working with colleagues in Betsi Cadwaladr to look at a platelet conservation strategy and reduce platelet wastage within Health Boards. Platelets are a blood product, which are used in the treatment of medical and surgical patients across Wales. A platelet only has a seven day life span and therefore effective management is essential to prevent wastage.
- The VCC Macmillan Welfare rights service was externally audited and awarded the prestigious Advice Quality Standard (AQS). The AQS is the quality mark for organisations that provide advice to the public on social welfare issues. Organisations that hold the standard have demonstrated that they are easily accessible, effectively managed and employ staff with the skills and knowledge to meet the needs of clients.
- This includes a comprehensive quarterly performance record keeping covering the number of new enquiries, level of reach and amount achieved in financial gains for patients. The lead adviser role is required to complete file reviews and to oversee quality and to ensure the office Manual is being followed.



- Non-medical authorisation of blood transfusion programme has continued, with the aim to equip health care professionals other than medics with the skills and competencies to authorise blood transfusion. In Wales 70 practitioners have been successful in achieving this qualification. By supporting staff within each health board to complete this qualification, care is being delivered closer to the patient providing a patient focused service to improve outcomes.
- The Blood Supply Chain 2020 (BSC20) initiative has continued its programme of service improvements that will enable the Welsh Blood Service to remain fit for purpose now and to enable future service development and transformation projects. BSC20 established in 2017, set out a three-year roadmap of how WBS would support the realignment of the planning, collection, processing and distribution of blood components to hospitals in Wales, working with staff and other stakeholders, to enhance the service provision. The current programme of work is scheduled to be completed by December 2020.
- Improved the supply of specialised platelet components to neonates from Welsh donors by Informing HPA 1a negative platelet donors of their value and staggering appointments.

Effective care

Last year we said we would:

- Seek to accelerate the development of a range of innovative services including further developments in proton beam therapy and research.
- Seek to both lead and support a range of initiatives on the use of artificial intelligence, automation and cell and gene therapy.

Emergency Assessment Unit:



Since opening in September 2018, the Assessment unit (AU) is demonstrating that it provides a designated safe and coordinated assessment approach for patients requiring emergency unscheduled care as a result of an acute episode relating to their cancer or cancer treatments. The AU offers a unique approach by locating a therapies team within an acute oncology

Multi-Disciplinary Team (MDT). Which focuses on providing a dedicated dietetic, occupational therapy and physiotherapy service and early input from Specialist palliative care team.

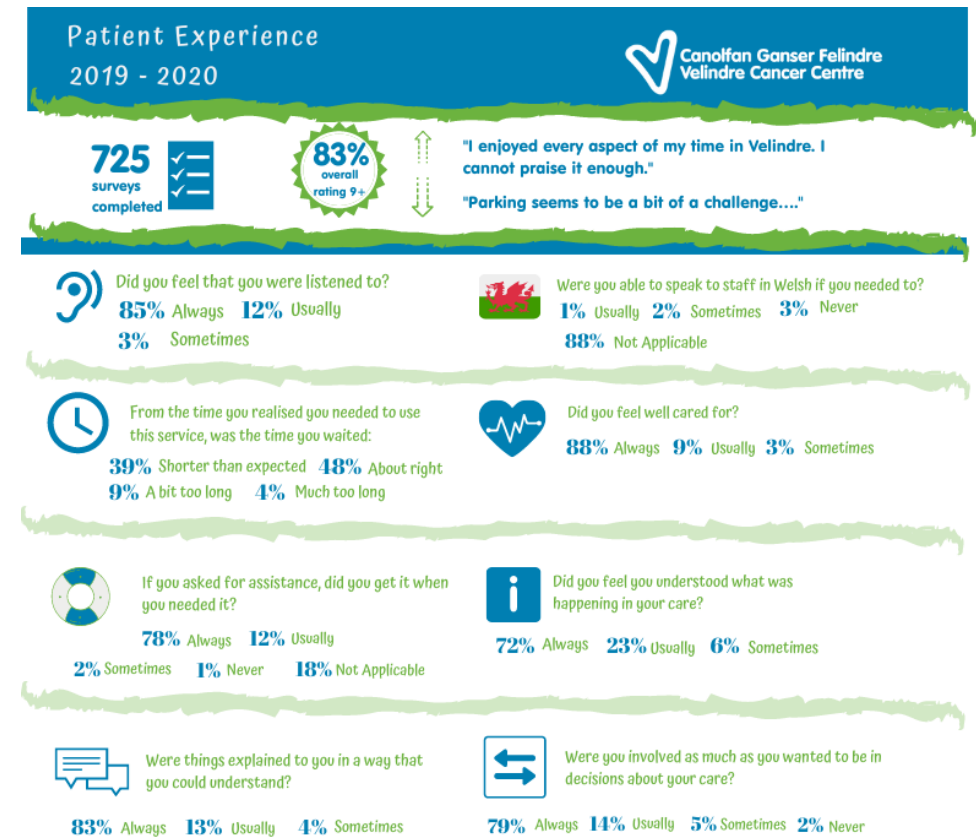
The assessment unit workforce model is proving successful and cost effective. Since opening there has been a considerable increase in emergency unscheduled admissions to the Cancer centre.

By providing one dedicated unit to deal exclusively with cancer emergencies, the process of assessing patients and providing rapid treatment has been streamlined meaning more patients can receive the treatment they need more quickly.

In the first year 1100 patient attended the unit and over half of these patients were able to be discharged back to their usual place of residence. For those patients who did require admission to the inpatient wards at VCC there has been a reduction in the average length of stay.

The AU team have been innovative in the development of new models of care and learning in collaboration with the LHB partners. An example of this is the ambulatory care pathway for MSCC utilising a shared document to improve communication.

Patient feedback has been very positive and has been captured using feedback forms and an online survey.



Launch of the acupuncture and Physical activity project:

The Physiotherapy team are now in a position to restart the acupuncture and physical activity project which is being funded by Velindre Charitable funds. This 18-month project will focus on providing the following services.

Patients who develop hot flushes as a consequence of their hormone therapy will be able to access a course of acupuncture treatment with aim of minimising and managing their hot flushes and its impact upon their quality of life.

Newport Live and Velindre Cancer Centre Physiotherapy team are working together to create a new cancer physical activity pathway. The pathway is designed to;

- Enhance the physical activity provision for adults with a cancer diagnosis in Newport and surrounding areas
- Increase physical activity levels of individuals in a safe and supporting environment
- Empower patients to be active in the long term, through local physical activity opportunities

Pre-Donation Haemoglobin screening

During 2018/19 pre-donation haemoglobin screening has been reviewed and a secondary numerical screening test 'Hemacue' introduced to reduce numbers of donors deferred from blood donation as a result of primary screening tests.

This practice implementation has been embedded across the organisation in 2019 and has resulted in a significant reduction in donors being deferred.

WBS Customer Relations Management System

In October 2019 there was a major upgrade to WBS computer system, which enables the future development of a bespoke customer relationship management system (known as eDRM). This will include a new hospital-based ordering application and a modern donor web portal and smart phone app.

New treatment researched in Wales doubles time Breast Cancer is controlled: In December 2019, Velindre University NHS Trust were awarded the Health and Social Care Research Partnership Award with Industry at the MediWales awards for its work on the breast cancer trial called FAKTION.

Consultant Oncologist, Dr Rob Jones co-led the trial that could benefit millions of patients with incurable breast cancer. The Welsh-led research also presented at the world leading cancer research conference in Chicago, the research shows that, by combining investigational therapy with a standard treatment, patients may expect that their cancer will be controlled for twice as long.

The study is now progressing to a phase three trial, where the investigational combination will be tested in a larger number of patients, before any recommendations can be made to take it up as a new standard of treatment on the NHS.

Velindre Cancer Centre helps worldwide understanding of tumour spread:

Velindre is taking a leading role in understanding the seriousness of cancer and the best treatment for individuals. The Tumor, Node, Metastasis (TNM) staging classification is an internationally agreed means of classifying the stage of a cancer – giving medical professionals a common language to describe the size and spread of cancers.



Classification using the TNM staging classification means treatment results can be accurately compared between research studies worldwide and guidelines for treatment standardisation between different hospitals and cancer centres.

Professor Mason is leading a scheme at Velindre Cancer Centre, who will now lead the TNM review process which gathers and evaluates all new scientific evidence, providing a unique opportunity in Velindre to design and shape the future of cancer staging with worldwide impact.

Cabinet Secretary for Health, Well-being and Sport Vaughan Gething said: “I’m delighted Velindre Cancer Centre is taking an international lead on the classification system for cancer, which is testament to its world-leading skills and reputation.”

Patient information leaflets for transfusion: The WBS Blood Health Team (BHT) is currently undertaking a Bevan exemplar project reviewing patient information leaflets (PILs) for transfusion. The Bevan commission agrees a proportion of innovative projects annually and approved the BHT application.

The BHT will engage with patients and clinical colleagues using the prudent healthcare principle of co-production to develop their patient information in an accessible and readily available format.

The revised PILs will ensure that all patients receive information that is relevant and timely in a format that meets their needs.

Further Clinical Trial success: We are pleased to announce our Radiotherapy Research Team have been the highest UK recruiters of 2019 for the RAPPER (Radiogenomics: Assessment of Polymorphisms for Predicting the Effects of Radiotherapy) clinical trial led by the University of Manchester, designed to identify the genetic variants that increase a cancer patient’s risk of radiotherapy toxicity.

65 UK hospitals have recruited over 10,500 patients to the study since 2005 and data is collected for nine different tumour types (Prostate, breast, bladder, brain, gynaecological, head & neck, rectal, and sarcoma). Professor John Staffurth & the Radiotherapy Research Team’s efforts in participation of the study meant

Velindre were the highest UK recruiters of 2019 with 57 patients, a remarkable achievement!

Effective care

Next year we will:

- Continue to work with health boards to reduce unnecessary variation and reduce wastage of blood and blood products
- Continue to develop the donor web portal and smartphone app in order to improve access and information for donors, communicate directly with donors and to support a more targeted approach to the collection of blood and blood products in line with meeting the demand from hospitals.
- Expansion of WBS collection activities to enable individuals who have recovered from COVID-19 to donate their plasma for the treatment of the infection in others Implementation of the blood transportation model (Ambient Overnight Hold). This means that even more donated blood can be used to manufacture platelets, improving the supply of this precious resource during the COVID-19 pandemic. Review all new projects/programmes implemented in 2019/20



dignified care

The principle of dignified care is that the people are treated with dignity and respect and treat others the same. Our patients and donors should expect that their rights to dignity, privacy and to make informed choices must be protected at all times. The care we provide must take account of an individual's needs, abilities and wishes.

'Our Challenges'



We continually strive to improve support for patients to help them live well through and beyond cancer. As cancer is now recognised as a chronic condition, our patients require longer term support, ongoing treatment and rehabilitation to ensure they are able to maximise their potential and enjoy the highest quality of life. We recognise that our patients require holistic support that meets their needs.

Below are some of the examples of work we have been taking forward over the past year:

- Learning Disabilities Pathway to allow co-ordination of patient care, sharing information and Staff Support Book. However, this requires further development in 2019/20
- Therapies Outpatient Drop-In Clinic established
- Secured funding for implementation of National Systems (WPAS/WCP) to allow the use of national systems allowing for shared communication and information across organisational boundaries

- Document Management Solution created for the storage of clinical correspondence
- The Research Team were involved in the MOHO focus Group representing Wales. In collaboration with Flinders University, South Australia – Model of human Occupation (MOHO) is a model of practice used by OT's in certain clinical settings. They're looking at its use in Oncology / Palliative care settings to establish whether it's appropriate.
- COVID-19 challenged the way supportive care services are delivered at the Cancer Centre, requiring new ways of working including:
 - Writing a new bereavement advice leaflet for guidance for families during Covid 19. This is available electronically so that it can be emailed to any family member unable to visit
 - Scoping the bereavement services still available during covid-19 and created a staff resource on the intranet to help direct bereaved families to local services. The internet version will go online once translated into welsh
 - Guidelines were written to support compassionate visiting when a dying patient has tested positive or suspected to be covid positive. Families have been given the opportunity to visit and say goodbye. We continue to offer children of deceased patient's memory boxes
 - Children' resources have been sent to parents with cancer by email or post and patients attending VCC are still able to speak to the supportive care lead nurse face to face. This includes information for children about covid-19
 - Children/grandchildren whose parents/grandparents have been inpatients have been sent "Forget-me-not" teddy bears and hearts with a card from the patient to help with separation.
 - iPad have been made available for any patient without their own device to connect with their family.

- Ordered 10 Blood Pressure recording machines for patients to take their blood pressure at home as requested by the urology team.
- Purchased new supplies of patients' pyjamas, toiletries, puzzle books, colouring in books particularly for people who were unable to bring items to the hospital due to shielding or quarantine restrictions or for patients without family.
- A new locker system for safe, secure storage of deceased patient property has been put in place. Any property of patients who die of suspected or confirmed covid, needs to be stored for 72 hours. This new system means that property is secure and safe.
- More listening devices have been ordered for patients experiencing hearing difficulties with staff wearing surgical masks.
- The "interpreter on wheels" and face to face interpreters have been used as and when appropriate.
- The supportive care team have increased the amount of money in the Samaritan's emergency payment fund and given two payments to people in financial hardship.
- The supportive care team have worked with Trussel Trust foodbanks to ensure we are still able to administer foodbank vouchers from VCC during Covid-19.
- The supportive care Macmillan welfare rights team have worked closely with the DWP to ensure that documentation and medical reports can be electronically sent to help minimise any delay in accessing benefits.
- Velindre staff including consultants, assessment unit, welfare rights lead, supportive care lead and clinical nurse specialist lead have all made social media clips to help reassure patients and families about the services that are still available to support at VCC during Covid-19.

dignified care

last year we said we would:

- *Review how we capture and use feedback from patients and donors*

Patient Experience Velindre Cancer Centre: In line with the National Framework for Assuring Service User Experience, we use a range of methods to capture feedback which helps us to listen to, learn from and involve patients in our work. We use the validated core questions at the spine of our survey work and our online snapshot survey (for those who prefer to share feedback in a faster way) Having various options, as recommended in the framework, makes giving feedback easier and faster.

During this period, we collected **725** surveys (*increase of 485 responses on previous year*) with an overall rating of **83%** scoring their experience as excellent (*9 or above*).

Social Media is another valuable tool to engage with our online community and our podcast Someone Else's Shoes enables us to listen and learn from patient stories. The feedback we receive is shared and discussed with staff in a variety of forums including our Listening and Learning Group and directly with department leads. Themes and ideas identified will inform improvement action plans and celebrations of good practice. We look forward to the implementation of a new national patient feedback system which will allow us to improve triangulation of this important feedback with other data captured across the organisation, to give a rich and full picture of patient experience in NHS Wales.

Improved patient interpretation services to be rolled out at Velindre Cancer Centre:

A new service is being rolled out at Velindre Cancer Centre to improve the availability of interpretation and to reduce delays in accessing it. The Interpreter on Wheels service provides audio interpretation 24 hours a

day, seven days a week. It includes an iPad on a stand which can be wheeled anywhere in the building.

Using the Cloud WIFI, it accesses audio and video relay interpretation. A simple touch screen means that you can get support in up to 240 languages.

The new Interpreter on Wheels service will minimise delays and provide additional services, especially for in patient care where an interpreter is unable to provide 24/7 communication support.

The service aims to meet the gaps in provision and save the Trust money in missed appointments and extended interpreter costs.

Responding to Service User feedback: Velindre Cancer Centre and the Welsh Blood Service follow the National Framework for assuring service user experience which centres on the three key domains which determine a “good” experience.

Having the option to provide feedback using different routes makes giving feedback easier and faster and developing these options has increased the amount of overall feedback captured. Some examples of you said and we did...:



It is important that we minimise waiting times for patients wherever possible.



A new and simplified process was developed and a nurse led clinic was introduced for patients receiving urology hormone injections in outpatients.



The wait for patients receiving urology hormone injections in outpatients has decreased. Patients are happier with patient feedback saying the following:

*"Great to see the same nurses every time I attend for my injection".
"Never wait long anymore".
"Can't fault the service".*





The decor of the Chemotherapy Day Unit was clinical and unwelcoming for patients.



A social media poll was launched asking patients and their families what they would like to see on the walls. Beach images won the poll and we requested all of our followers to send us their beach photos which would be considered for display.



The questionnaire received a huge response and we were inundated with imagery from patients and their families. Patients who spend time on the ward have commented on what a positive difference this made and how much more welcoming the ward feels.



The Maggie's Centre has got off to a great start – welcoming patients and their families from across south east Wales.

Since opening its doors for the first time in May 2019, the centre, which aims to provide practical, emotional, and social support, has welcomed many people with cancer together with their families.

Dignified care

Next year we will:

- To utilise digital technology for patient and staff feedback
- Further expand on Quality and engagement with the Health and social care Bill publication.

All free of charge, as well as individual support, organised group sessions at the centre have included yoga, art therapy, tai chi and relaxation. Since COVID disrupted access to the centre, the centre has been an invaluable support for staff and often coordinating donations to both staff and inpatients.



Further information on Maggie's Cardiff is available on their website:
<https://www.maggiescentres.org/our-centres/maggies-cardiff/>



Timely care

The principle of timely care is that people have timely access to services based on clinical need and are actively involved in decisions about their care. Our patients and donors should expect that their conditions should be diagnosed promptly and treated according to clinical need.

'Our Challenges'



We know that we have an ageing population and more people are living longer with and beyond cancer. We need to enable our patients and donors to achieve the best possible quality of life and experience they can.

There is growing demand for services and we must ensure that we have the ability to treat and care for patients. It is a challenge for us to ensure that we are able to

meet the increasing demand for the services we provide through Velindre Cancer Centre and the Welsh Blood Service.

The prudent and making choices together principles underpin the way in which treatment choices are made. Patients need to be equal partners in their care and receive minimum intervention for the maximum benefit.

We know that timely access to the most appropriate and effective evidence based care is proven to improve outcomes.

- Achievement of Systemic Anti-Cancer Therapies (SACT) waiting time targets despite unprecedented demand
- Opening of Assessment and Probert Head and Neck Units that has provided dedicated triage and supportive care reducing inpatient length of stay
- The donor concerns process has been revised to provide timely responses to donor complaints. This has improved the donor experience and reduced the number, which reach formal status.

The following are some examples of work we have been taking forward over the past year:

- The transformation of cancer services is being clinically and professionally led across the organisation and is focused on the implementation of new models of care that are fit for the future.
- Speech and language therapy funded role to support patients on the PSU
- Charitable funds/friends of Velindre monies approved for 3 years Advanced Practitioner in gynaecological physiotherapy 2020- 2023
- Achievement of Systemic Anti-Cancer Therapies (SACT) waiting time targets despite unprecedented demand
- Opening of Assessment and Probert Head and Neck Units that has provided dedicated triage and supportive care reducing inpatient length of stay
- The donor concerns process has been revised to provide timely responses to donor complaints. This has improved the donor experience and reduced the number, which reach formal status.

Timely care

last year we said we would:

- We will explore opportunities to expand our role in the early diagnosis of cancer.
- We will review demand and capacity to deliver timely access to cancer services

New service relieves side-effects of treating head and neck cancer: Around three hundred people with head and neck cancer are referred to Velindre Cancer Centre every year, they are treated with radiotherapy and chemotherapy which can often lead to pain in the mouth and throat, which can make swallowing extremely difficult. In June 2019, the patient support unit, which is the first service of its kind in Wales, will relieve the side effects of treating head and neck cancer.

The service has been funded by a donation from Andrew Probert, whose wife Jean was treated at Velindre Cancer Centre for throat cancer. Due to the innovative thinking of Velindre staff and the generosity of our donors, this new service will improve the care we offer patients.

As well as supporting patients being treated with radiotherapy, the service will also support palliative patients. Velindre hope to reduce the number of head and neck cancer patient admissions by 20 per cent over three years.



Patients with head and neck cancer are found that their well being can be maintained longer if patients feel empowered to self-care.



The Patient Support Unit opened which provides patient centered and pro-active care.



Between June - October 2019, 234 attendances have been received from 74 patients on the Patient Support Unit with 113 attendances using the ward for feeding and nutritional purposes.



Green light to procure new radiotherapy equipment: The next steps to upgrade Velindre's radiotherapy equipment have now been approved by the Minister for Health and Social Services. Vaughan Gething AM, has endorsed the Trust's programme business case and agreed to give Velindre £1.11m to support the procurement process which will run through 2020.

The process will replace and extend the cancer centre's current linear accelerators and associated software systems with a single solution. As a result, Velindre will be able to treat more patients and improve service quality by meeting staff and patient needs.

The plan will see the first of the new linear accelerators in place in the Velindre Cancer Centre in 2021. The contract will cover equipment for the new cancer centre as well as the proposed satellite unit.

The procurement of a leading edge radiotherapy solution will play a key role in supporting us to achieve our ambition to be a leader in research, development and innovation and to drive clinical quality and patient outcomes.

Timely care

Next year we will:

- *Review new methods of service delivery implemented during Covid 19 and consider implementing long term, for example virtual consultations*
- *Review and improve our Acute Oncology Model of delivery across South East Wales, so that patients have timely access to specialist support*

Individual care

The principle of individual care is that people are treated as individuals, reflecting their own needs and responsibilities. Our patients and donors should expect that the care we provide will respect their rights, and will be tailored to meet their individual needs and wishes.

As a Trust we are striving to anticipate patient and donor needs, and to better translate the feedback we receive to influence the services we provide today and our plans for the future.

We have well established ways of getting feedback from our patients and donors about their experiences of our services, and in the coming year we will be looking at new and innovative ways of capturing the patient and donor voice.

Our approach will continue to involve face- to-face discussions with patients and donors but will further embrace the use of technology and social media platforms.

Below are some examples of work we have been taking forward over the past year:

- Physiotherapy weekend service restarted November 2019
- Macmillan Support grant approval for the development of a patient's health and wellbeing channel to support patient self-management in the ward environment.
- Fatigue & Coping strategies session @ Maggie's now being delivered monthly.
- Regular nutrition workshop at Maggie's implemented and delivered
- In partnership with Bridgend Council the Supportive care team are able to recommend that a Blue Badge is awarded rather than patients having to go to their local civic centre which means less travel, time and expense at a time when patients least need this.
- BAPS app development and promotion
- OT weekly drop in clinic – initially for pressure, posture and seating – now for all tumour sites / anyone experiencing difficulties carrying out their occupations/Activities of daily living.



Increased bilingual social media presence across all platforms has meant that all divisions now have both English and Welsh platforms. Increasing the use of these will now be our priority for us.

'Our Challenges'



- The multi-faith prayer room has been updated with leaflets to support patients and families with the addition of a "Prayer Box" for requests for prayer or support which has received positive feedback. The multi-faith prayer room has been updated with leaflets to support patients and families with the addition of a "Prayer Box" for requests for prayer or support which has received positive feedback.
- In terms of Coproduction, the supportive care Macmillan welfare rights service has developed excellent links with the local Department of Works and Pensions (DWP) and now use their influence to prioritize those in need – a poor prognosis, extreme financial hardship or in the case of a cancer patient with learning difficulties who could cope well with the

required face-to-face assessment, arranging an alternative assessment. The DWP were invited by the team to attend the clinical nurse specialist nurses meeting at VCC. The aim was to build good working relationships and help allay nurses concerns about completing special rules forms to ensure timely, efficient and effect pathways for VCC patients needing to access benefits.

- **Donor** Award ceremonies are held across Wales for milestone donors who have given at least 50 donations. Each year around 12 award evenings are hosted where senior management sit amongst donors and gather feedback.
- Each donor session attendee is invited to complete a digital surgery based on their experience at the session.
- The VCC Supportive Care Team have contacted all Trussell Trust Foodbanks in the geographical area, we have successfully visited and completed training with five food banks. The team hope to visit and complete further training in the near future to enable us to provide comprehensive food bank vouchers for all patients and their families at their most vulnerable time. The first food bank voucher was issued on the 04.12.19 providing the patient and their family with food for at least three days, the food provided has been evaluated by a dietician to ensure it is of good nutritional value.
- In 2019, the supportive care lead nurse celebrated 10 years of partnership working with City Hospice running the children's bereavement group and 20 years since the opening of the Lion's den family room at VCC



Development of 'Before you Donate' donor information leaflet

To ensure that donors are provided with the relevant information required to provide consent to blood donation the 'Before you donate' leaflet has been written to fully inform donors of the risks associated with donation to enable a fully informed decision to be made in line with the Montgomery Principles.

This has been piloted with donors attending a donation clinic and information was collected on the effect the document had on an individual's decision to continue with the donation having read about the risks associated with donating blood. A total of eight clinics were involved in the pilots.

Four clinic sessions used the existing information leaflet and four clinic used the new leaflet. There was minimal impact on clinic flow on clinics using the new Before You Donate booklet as well as some constructive feedback. The revised booklet will be implemented in 20/21.

Involvement in MDT late effects

Working in collaboration with the Dietetic team a Specialist Physiotherapist will be present during the Gynaecological late effects of pelvic radiotherapy clinic.

This service aims to identify those patients that are experiencing late side effects of pelvic radiotherapy, such as urinary incontinence, sexual dysfunction and pelvic pain and be able to provide appropriate assessment and management for such issues.

Individual care

last year we said we would:

- *We will commence work to develop a more tailored individual experience for blood donors based on their preferences and lifestyle*
- *We will improve timely access to Clinical Psychology and Therapy services.*

The clinic offers 1:1 sessions but also will be offering information and provision of first-line advice at an information session held every 6 weeks. We are taking positive steps to comply with the new Welsh Language Standards.

Donor/ Service User Feedback

During 2019 the Welsh Blood Service have worked hard to improve systems and processes relating to concerns management to ensure that donor and service user feedback is consistently managed in a timely and effective manner whilst ensuring lessons are learnt and identified service improvements are introduced.

In 2019, a new donor survey was introduced. The donor survey aims to provide WBS with information on the service it provides from the view of the Donor.

Between September and December 2019, 16,701 email surveys were sent across Wales and 3,445 response were received. Respondents were between the age of 17 and 81. There was an over 95% satisfaction rate.



WBS patient
satisfaction Apr 19 -

[Link to full report](#)

For the Assessment of Individualised Risk- 'FAIR' Study

Traditionally blood establishments have introduced donation acceptability criteria based upon a population risk, however, in recent years this has been reviewed and it is considered more favourable to be able to base acceptability criteria upon an individual donor risk assessment. To further investigate the feasibility of individualised donor risk assessments, WBS are collaborating in a UK wide study called 'FAIR- For the Assessment of Individualised Risk Study.

Launch of new 'Medicines@Home' Immunotherapy service:

On Monday the 3rd of June 2019, a new 'Medicines@home' immunotherapy service was launched at Nantgarw by leading members of the Tenovus, Lloyds Pharmacy and Velindre staff.

The Service aims to benefit patients by providing them with access to treatment in a more convenient setting.

Velindre Cancer Centre staff supporting the worry monsters

Since 2018, through a concept introduced by the supportive care lead nurse, we have been providing families with the opportunity to use worry monsters.

These colourful and huggable worry monsters are funded by Velindre Charitable funds and are available free of charge at Velindre Cancer Centre for children who have a parent or grandparent with cancer.



The monsters have a really important job which is to hold a child's anxieties and worries.

The idea behind the worry monster is that children write down or draw a picture of what's worrying them and put it into the monster's mouth, which is then zipped shut — holding on to their worries. It then gives parents the chance to look at the written or drawn worries and gain an insight into their child's concerns. It provides a valuable opportunity to sit down together and talk about things.

Non- Medical Authorisation of Blood Transfusion (NABT) Programme Delivery of the Non- Medical Authorisation of Blood Transfusion (NABT) programme has been a cornerstone of the WBS Blood Health Team's (BHT) education strategy. The qualification is accredited by Swansea Bay University and is delivered by members of the BHT. It allows Advanced Nurse Practitioners (ANPs), Critical care

Practitioners (CCPs), pharmacists and other relevant staff to authorise the transfusion of blood and/or blood components without the need for medical staff.

The intensive course provides these staff with the skill and competence to understand the transfusion process and when a blood transfusion is necessary. This allows care to be more personalised and nearer the patient as it can be run by ANPs in day unit settings with familiar staff undertaking the decisions. The NABT course has also supported the EMRTS air ambulance to provide life saving transfusions at the scene of an incident.



The demand for Dietetic services currently outweighs the resources available within the department.



New accessible options have been implemented including a drop-in clinic and Skype/telephone clinic.



More people have been seen and 87.5% of patients surveyed stated that they would change at least one aspect of their diet as a result of seeing a dietitian.



BAPS App: The breast axilla postoperative support (BAPS) application designed in partnership with Cardiff and the Vale University Health Board has been shortlisted for the 'best new mobile app', at the best mobile app awards. The BAPS breast app developed **by oncology physiotherapists and breast surgeons aims to take post-operative patients** through exercises and includes feedback on progress.

The app sends notifications to remind the user to do their exercises and prompts the patient to contact their key worker if the exercises aren't

progressing as well as expected, to access early intervention and prevent delays in treatment, which could be affected due to restricted movement.

The app aims to encourage self-management, to decrease the users anxiety and to give a sense of achievement and improved well-being. The app was launched in January 2019 and is now available to all breast patients.

Mindfulness App: Mindfulness is the act of noticing what's going on in the present moment. Our minds often get caught up in thinking about events from the past or an uncertain future, rather than focussing on what's going on for us in the present moment.

Mindfulness can be used as a grounding tool so that we can take a step back and think about the here and now.

The app was developed by the Department of Clinical Psychology and Counselling at Velindre Cancer Centre to mirror the mindfulness patient groups delivered by the department on a monthly basis. Patients expressed a desire to continue to practice mindfulness after attending the groups but found the use of guided exercises key to this. As a result, the idea of an app to make the exercises easily accessible was developed.

Although the app was created as a result of the patient group feedback, it is non-cancer specific and can be used as a standalone tool to help patients, carers, family members and staff alike to use mindfulness to help better manage difficult thoughts, feelings and emotions and thereby improve wellbeing.



of

- Patient Leadership Programme that has led to improvements in patient engagement
- BAPs App that encourages self-management for breast cancer patients.

- Improvements in collaboration, communication and engagement with Teenage Cancer Unit
- Continued development of Patient Stories *Someone Else's Shoes* podcast stories that are shared both within the Trust and with other NHS Wales organisations.

Individual care

Next Year we will:

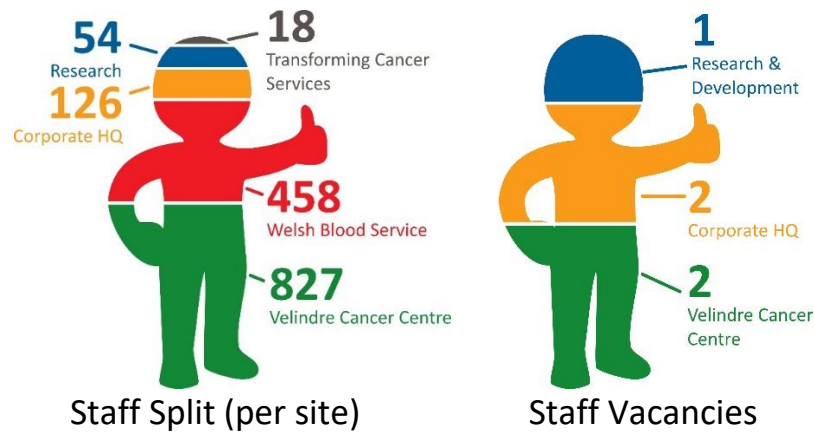
- Continue to undertake our donor survey
- Roll out implementation of the 'Before you Donate' information leaflet
- Continue to work towards a more individualised donor risk assessments as part of the FAIR study
- Full implementation of an individual focused donor programme, which will use digital to communicate with donors.
- Continue to work on availability of Bilingual Patient information, consultations and communication.



Our staff

The principle is that information about how the NHS is resourced to ensure careful use. Our workforce is integral to the delivery of high quality, person centred and safe services.

We recognise that individual members of our workforce must be skilled and competent, and the workforce as a whole must be planned configured and managed.



Our staff recognise that being the best for our patients and donors underpins everything that we do across the Trust and we know how lucky we are to have a committed and highly talented workforce, who make a difference on a daily basis.

The Trust faces the same workforce challenges and opportunities as other NHS organisations; Increasing demand for services from an ageing population, new treatments, technology and skills shortages across the healthcare workforce.

Over the coming years we need to develop a resilient, efficient and appropriately skilled workforce to meet these challenges.

The patient information and support services manager Leigh-Anne Porter won a UK NHS Unsung hero award 2020. The annual “Unsung Hero Awards” shine a light onto the hard work that non-medical / non-clinical staff and volunteers of the NHS strive towards providing on a daily basis. The VCC Macmillan welfare rights team were also finalists in the UK NHS Unsung hero awards 2020.

Unsung Hero awards 2020



The VCC Macmillan welfare rights team won the VUNHST Employee Excellence award 2020 for partnership working category and accessing over £4million in benefits and grants for VCC patients in 2019-20.

The supportive care lead nurse Michele Pengelly won the VUNHST Employee excellence award Patient’s choice category

Kate Baker Clinical Lead Physiotherapist in VUNHST Awards Won the Leadership category recognising her work with the BAPS app.



Safeguarding Recognition Awards Ceremony

The Safeguarding Recognition Awards Ceremony was held during national safeguarding week.

Velindre staff recognised for their contribution to safeguarding include Michele Pengelly, Helen Way, Zoe Gibson and Sian Lewis.

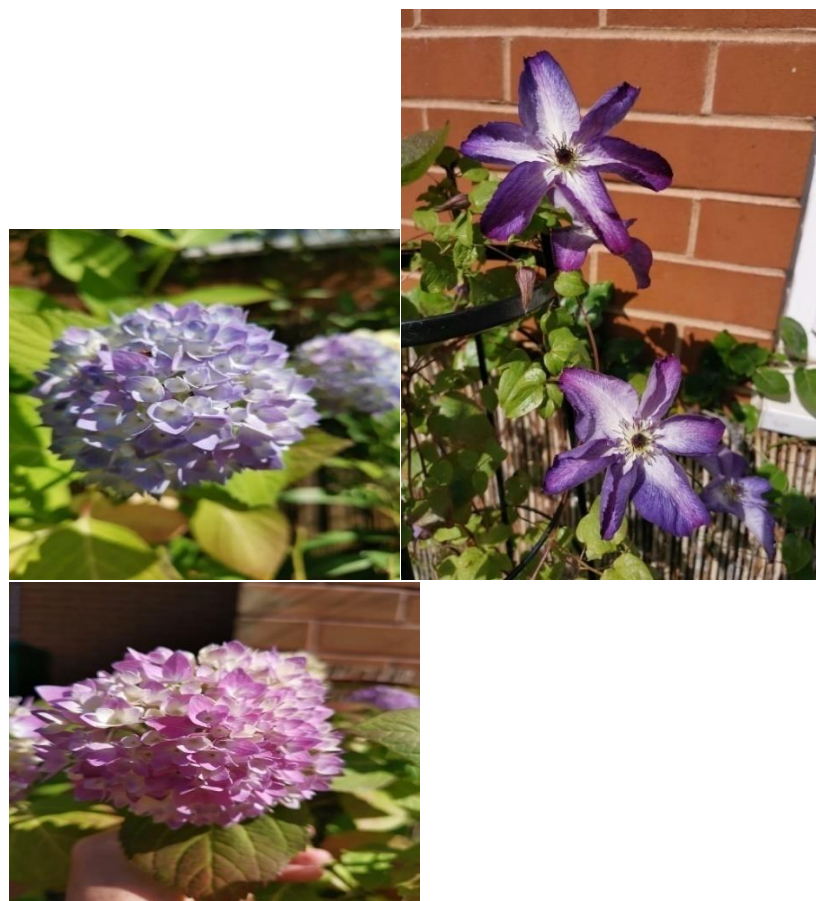
The ceremony was a fantastic opportunity to celebrate an array of outstanding contributions to safeguarding in a multi-agency context and to also recognise all the hard work of staff who have made a real impact on people's lives.



Carol Lowe the wonderful VCC volunteer gardener has been unable to attend the hospital to care for the CIU garden due to current Covid restrictions.

She was really worried about plants dying and the garden becoming over grown when so many plants had been donated in memory of people who had died. Hospital switchboard operator Tristan Fareel and Dr Sheena One-Sim Lam have been watering and tending the garden (along with some nursing staff) every day and even bought plants to bring more colour to the garden.

Not only did Tristan and Sheena do this they also set up a social media group with Carol so that she can see photos of the garden, give advice on what to plant and stay connected with something she has worked so passionately on for so many years.



As we move forward with our transformational service changes set out in the [Welsh Blood Service Supply Chain 2020](#) and [Transforming Cancer Services](#), our responsibility to our workforce is to enable them to continue to give their best. Over the past year:

- ITV Wales broadcast from Velindre Cancer Centre highlighting the incredible work of our staff who care and treat cancer patients in south east Wales.
- We received positive NHS Wales Staff Survey results with over 90% of staff happy with the standard of care provided by the Trust.
- We have demonstrated our continued commitment to a healthy and engaged workforce through retention of the Platinum Corporate Health Standard award.
- The Trust has undertaken the Mindful Employer 'On the Way' Commitment Review Process and as a result has been given Charter Status from 2019-2024.
- We launched a Change Toolkit.
- Launched a workforce planning guidance for staff.
- The Education & Training strategy was approved and will support talent management and succession planning.
- Our leadership and management programme was re-shaped to focus on compassionate leadership.
- We continue to take steps to attract Consultants and other specialist staff to ensure our services are fit for the future.

Our staff

last year we said we would:

- *We will evaluate the Clinical Leadership Programme*
- *We will develop our workforce planning models in collaboration with others to identify ways to fill current and predicted skills gaps and shortages.*

Clinical leadership Programme:

The Welsh Blood Service in collaboration with Velindre Cancer Centre and the RCN developed and delivered a multidisciplinary clinical leadership programme.

Launched in late February 2019, the Clinical Leadership Programme was the first of its kind for Wales, and sought to provide frontline clinical staff at all levels with the skills, knowledge and confidence to advance their leadership abilities.

Although offering this approach was initially considered bold it has proved to be incredibly successful enabling an enhanced learning opportunity for all.

The Clinical Leadership Programme was designed to drive high standards of clinical care through effective, efficient and evidence-based continuous improvement across the organisation.

The initial cohort consisted of 12 staff from Welsh Blood Service collection teams and Nursing Staff from VCC. Programme ran over 9 months and all 12 individuals successfully completed the programme and delivered 12 excellent service improvement projects.

- Although offering this approach was initially considered bold it has proved to be incredibly successful enabling an enhanced learning opportunity for all. R&D active
 - DT support for ***eat-CIT trial*** - An investigation of eating problems in people with stage I-III colorectal cancer receiving Systemic Anti-Cancer Therapy (SACT): the potential for nutritional care to potentiate cancer treatment
 - Leading on ***EDMONd*** trial - EDMONd - A feasibility study of the elemental diet as an alternative to parenteral nutrition for ovarian cancer patients with inoperable malignant bowel obstruction
 - ***Be Treatment Ready (BeTR)***: research to evaluate proactive preparation to cope with side-effects of radical head and neck cancer treatment, compared to reactive in-treatment care

- Growing research profile, Rachel Evans completion of MSc in palliative care, oral presentations at national neuro conference and various poster presentations at research conferences including NCRI in Glasgow. Collaborative working with Tenovus grant looking at MDT therapy working.
- Involvement in research trials, PEARL (PET-BASED ADAPTIVE RADIOTHERAPY CLINICAL TRIAL)
- Dietetic assistant has commenced her Agored Cymru HCSW level 3 qualification.

Velindre Trust wins Silver Award for supporting the armed forces community:

In November 2019 Velindre University NHS Trust was awarded a Defence Employer Recognition Scheme, Silver Award. The award is afforded to organisations that pledge, demonstrate or advocate support to defence and the armed forces community.

The Trust was awarded a Bronze award in spring 2019 recognising that it was improving its offer and support for the number of service leavers employed from both the Reservists and Armed Forces. A memorial placed in the Velindre grounds has drawn many positive comments.



Macmillan Professionals Excellence Award: Acute oncology services (AOS) provide care for patients with unscheduled cancer related emergencies. This includes disease-related and treatment-related complications, as well as previously undiagnosed cancer. The Macmillan funded AOS quality assurance and service development project was a two year project, in collaboration with the Cancer Network; to develop services across Wales.

Driven by a commitment to improve the patient experience and a passion for educating staff, Rosie Roberts, Chemotherapy Specialist Nurse at Velindre Cancer Centre and Macmillan Clinical Lead Nurse for Acute Oncology and Systemic Anti-Cancer Treatment (SACT) has worked tirelessly to contribute to the development of AOS services.

Palliative care Team:

Nikki Pease Palliative Care Consultant Won the Welsh Ambulance Service Trust Commendation Award for end-of-life-care training for paramedics 2019

Mark Taubert Palliative Care Consultant was entitled [2019 Researcher of the Year Winner - European Association Palliative Care](#) in the 16th EAPC World Congress Berlin



Follow the link for the full article.

Palliative Care Team/TalkCPR project on Do Not Attempt CPR conversations: [Winner RCP Excellence in Patient Care Awards 2019 - Royal College of Physicians, London](#)

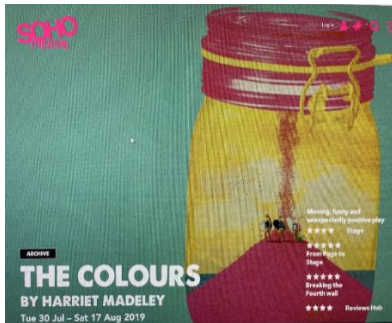
“The impact of these videos on patients, nurses and doctors was measured through pre- and post-video surveys and a focus group session. Results showed a significant increase in the confidence of staff with regards to openly discussing DNACPR after watching the videos”

Dr Mark Taubert, clinical director/consultant in palliative medicine, #TalkCPR team

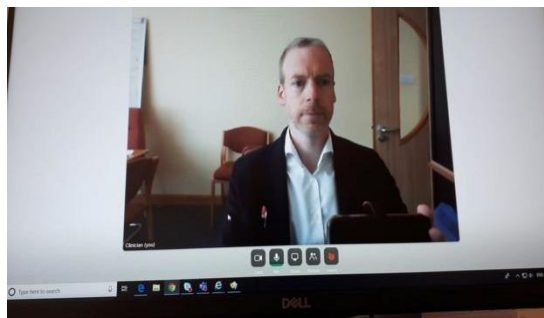
Palliative Care 'Op-Ed' [article in the Washington Post](#) voted a 'top-pic' by the US newspaper for 2019

"what's the last song you would want to hear before you die?"

'The Colours' theatre production ran in London's Westend and featured the work of Velindre palliative care and its patients <https://sohotheatre.com/shows/the-colours/>



BBC authored article by Mark Taubert Coronavirus: Helping the bereaved with 'emotional PPE' <https://www.bbc.co.uk/news/uk-wales-52833504>



BBC Listening Project 2019: Interviewed with a Palliative Care Registrar at Velindre for the BBC Listening Project.

<https://www.bbc.co.uk/programmes/m000b0ry>



WBS clinical workforce: workforce changes to strengthen the clinical directorate have included: the appointment of a consultant with expertise in donor medicine and the appointment of a consultant in transfusion medicine with specific responsibility for the transfusion laboratory and Welsh Boone Marrow Donor Registry.

WBS clinical staff have routinely provided advice and support to Welsh Government.

Within the UK/Internationally members of the clinical services staff have:
Championed and facilitated WBS staff to become members of – the Joint Professional Advisory Committee (JPAC) Specialist Advisory Committees, the Safety of Blood Tissues & Organs (SABTO), the Serious Hazards of Transfusion (SHOT) working group, the NHS Blood & Transplant National Comparative Audit committee and the UK Blood Stocks Management Steering group. This allows influence over decisions, learning, and implementation of best practice.

Blood Health Team: As part of their role in transfusion education and promoting best practice the WBS Blood Health Team (BHT) submitted six posters to the British Blood Transfusion Society (BBTS) Annual Scientific Meeting (ASM).

One of the posters reviewed a novel and innovative approach to training 5th year medical students by developing an immersive board game which puts the medic at the centre of transfusion giving them a unique perspective on transfusion requesting. The poster won first prize in the education category at the ASM.

Acute Oncology Service (AOS): Through Rosie's leadership, hard work and enthusiasm, AOS services in Wales have developed from a few pockets of good practice in 2013 to established services within every acute hospital/health board by 2018 and strengthening going into 2020.

A key strength is standardisation of systems and processes for patients receiving SACT across Wales and Rosie has led this work from a nursing perspective.

Beyond this project, Rosie continues to lead on AOS in the UK, provide expertise to SACT projects, and lead the treatment helpline at Velindre Cancer Centre.

Rosie also achieve a PhD in March 2020, so many congratulations to Dr Rosie Roberts.

Clinical Oncology Registrars: Training plan wins double award for Sam Cox in July 2019.

Newly-qualified doctors can now give better quality care to cancer patients thanks to a double award-winning initiative by a Velindre junior doctor.

It has transformed their training to guarantee they gain experience of a wide variety of cancer emergencies. They also spend time shadowing consultants in their outpatient clinics and multidisciplinary teams. And senior medics hope that as well as benefiting patients it will encourage more young doctors to specialise in oncology.

The enhanced training is being provided at the South West Wales Cancer Centre at Singleton Hospital, Swansea.

It was devised by clinical oncology registrars Emma Christopher and Sam Cox, who now works at Velindre. They realised that with just a one-week placement in

the oncology department during their four-year training programme, the experience gained by Swansea University medical students could be hit and miss.

To complete their placement successfully, students have to learn how to manage four different emergencies that cancer patients might experience. These include an overwhelming infection known as neutropenic sepsis and malignant spinal cord compression, when a tumour presses on the spinal cord and nerves.

But unless patients were admitted with these conditions during their placement they would not gain the experience.

So Sam wrote a one-hour tutorial based on four real but anonymised patient cases and a step-by-step guide for the students. This ensured they were guaranteed the required training in these cases and was delivered on a weekly basis by the oncology registrars.

She also arranged for several consultants to host the students in their outpatient clinics so their experience was not limited to the ward. All of this, together with a new timetabled and structured approach to the week and a glossary of oncology terms she produced, won her glowing feedback from the students.

They reported feeling better prepared to care for cancer patients as they entered clinical practice. The initiative won Sam the Swansea University Medical School Clinical Teacher of the Year award and the Undergraduate Education, Innovation and Excellence Prize from the Royal College of Radiologists.

Sam said: "This simple yet rewarding project has not only improved medical student training but also enabled the registrar doctors to gain teaching and leadership experience. "I hope it has demonstrated that involvement in medical student teaching has real benefits, not only to our patients but also the department and the next generation of junior doctors."

Caption: Dr Sam Cox receives the Swansea University Medical School Clinical Teacher of the Year award

Looking Forward

Some of our priorities and aims for 2020/21 are set out below and we will provide an update of how we have progressed in next year's Annual Quality statement.

Staying healthy

- Support the development and implementation of an anaemia strategy for a healthier Wales.
- Extend the number of schools on the school donor venue programme
- Continue to work with FAW as their official community partner
- Development of bone marrow donor strategy
- Work with Public Health Wales Antenatal Screening Programme to implement foetal D testing, which aims to prevent unnecessary administration of anti-D prophylaxis

Safe care

- Continue to deliver an annual training programme in relation to blood transfusion for final year medical students
- Continue to roll out cyber security strategy and plan across the Trust
- Review all safeguarding and public protection training package's for the trust
- Review the lessons learnt through COVID and epidemic management

Effective care

- Continue to work with health boards to reduce unnecessary variation and reduce wastage of blood components
- Continue to develop the donor web portal and smartphone app in order to improve access and information for donors and

to support a more targeted approach to the collection of blood and blood products in line with meeting the demand from hospitals.

- Blood Supply Chain 2020 (BSC20) to conclude its programme of service improvement.

Dignified care

- *To utilise digital technology for patient and staff feedback*
- *Further expand on Quality and engagement with the Health and social care Bill publication.*

Timely care

- *Review effectiveness of new services implemented in 2019/20*

Individual care

- Full implementation of an individual focused donor programme, which will use digital to communicate with donors.
- Continue to develop an understanding of views of donors through the donor survey.
- Continue to work towards a more individualised donor risk assessments as part of the FAIR study
- Implement the Electronic Donor Relationship Management (eDRM) system, to support the introduction of a personalised communications approach for our donors.
- Roll out implementation of the 'Before you Donate' information leaflet across Wales

Our staff

- Implement Mental Health Awareness Training for staff

- Develop Travel Plan for Velindre Cancer Centre staff, patients and visitors
- Staff achievement recognition awards to continue and to celebrate and highlight these achievements widely locally and nationally.

Endorsement & Feedback

This year as last year, Shared Decision Making has been the focus of some very interesting and worthwhile meetings that have taken place with clinicians, members of the PLG and Patient Leaders.

PLG Report 2019-20

Patient Liaison Group meetings for 2019-20 provided members with an excellent overview of the work being carried out throughout the Trust. We are very grateful to all the speakers who came to our meetings each month to tell us about their work and the projects they are involved in.

As patient and carer representatives we are also pleased to hear about the work being carried out in the hospital which will benefit patients directly. The changes proposed for Outpatients and patient appointments will be of particular interest to the group.

We also had an interesting meeting with health care professionals from the Welsh Blood Service who were planning to set up a patient and carer group. They were interested in the work we do and requested our help in reviewing their patient information. We look forward to hearing from them.

Last November we were asked if PLG members would like to be involved in a project with Cardiff University who were planning to produce a self-management book for people affected by cancer. We were making some progress on this work and hope we will have the opportunity to complete it in the coming months.

PLG members have always taken a particular interest in the plans for the new hospital, some time ago we attended a number of meetings held in the community, took part in discussions and presentations. We were always impressed by the way the consultations were carried out and the opportunities we were given to comment on the location of the new hospital as well as the design and environmental issues. We continue to support the project and look forward to hearing that work will go ahead as planned.

This July the PLG were able to hold their first (Zoom) meeting following lockdown in March. We have a great deal to catch up on. Throughout these difficult and worrying times patients have continued to receive excellent care from the amazing and dedicated staff who work at Velindre hospital. On behalf of PLG members our sincere and grateful thanks for all you do.

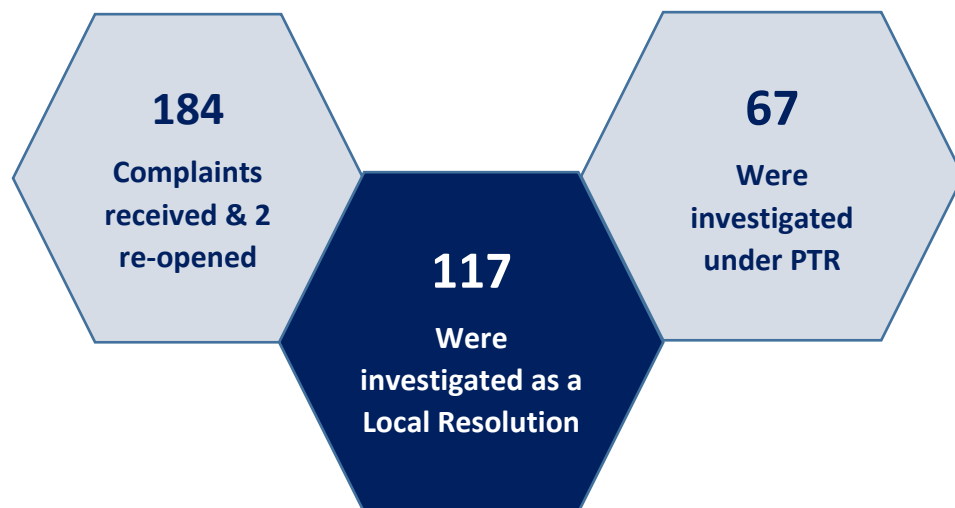
Welsh Blood Service: In 2019, a new donor survey was introduced. The donor survey aims to provide WBS with information on the service it provides from the view of the Donor.

Velindre Cancer Centre: In line with the National Framework for Assuring Service User Experience, we use a range of methods to capture feedback which helps us to listen to, learn from and involve patients in our work. The feedback we receive is shared and discussed with staff in a variety of forums including our Listening and Learning Group and directly with department leads. Themes and ideas identified will inform improvement action plans and celebrations of good practice. We look forward to the implementation of a new national patient feedback system which will allow us to improve triangulation of this important feedback with other data captured across the organisation, to give a rich and full picture of patient experience in NHS Wales.

During the past year we have undertaken the following activity relating to the Velindre NHS Trust and listening to Patients', Service Users and Carers who use their services.

Putting things Right Annual report 2019-2020.

Complaints received between the 1st April 2019 – 31st March 2020



PTR annual report
2020 ver 8.docx

Follow link for full report

Peer Review of Systemic Anti-Cancer Therapy (SACT) services – Velindre NHS Trust

This was completed on Monday 3Rd February 2020 by the Wales Cancer Network, This identified no immediate risks and no serious concerns.

Good Practice was identified and listed as:

- Excellent education package for the nurses.

- Demonstrates a collaborative approach to working with primary care.
- Allocated resource for scheduling is having a positive impact.
- Good quality validated data for performance.
- Achieved targets for implementing new drugs.
- A good team that are passionate about what they do and work well collaboratively.
- All the nurses do an outstanding job, are a very supportive and flexible team that put the patients' needs at the centre.
- A dedicated patient experience manager, an active patient liaison group and cohort of patient leaders.
- A dedicated complaints manager who in conjunction with the Director of Operations monitors the formal complaints/concerns.

<http://www.walescanet.wales.nhs.uk/home>

Community Health Council



The Independent Patients NHS 'Watchdog'

During the past year we have undertaken the following activity relating to the Velindre NHS Trust and listening to Patients', Service Users and Carers who use their services.

Independent Advocacy – Velindre NHS Trust

The CHC uses the information provided by the users of the Advocacy Service, alongside that obtained from Continuous Engagement and other forums, to focus its Scrutiny Visiting to NHS services.

Scrutiny Visits

Visits are undertaken by CHC volunteer members to listen to the views of patients, carers, and the public on their experiences of using services.

In 2019/20, we undertook a wayfinding visit, to look at signage from a patient perspective especially for someone visiting for the first time we plotted our journeys by car, train, bus and walking we made a number of recommendations

which resulted in a commitment by the Trust to take action. We are aware the Trust is working through these and we will undertake a follow up visit 2020/21.

Continuous Engagement & Service Change

The South Glamorgan CHC Officers & Members have continued to provide support and advice in relation to the 'Transforming Cancer Services' Programme, specifically on engagement processes, on behalf of the CHC's in Wales.

Additionally, the CHC have been invited as regular attendees of the Trust Quality & Safety Committee, where we are able to observe the Trust's arrangements for improving the quality and safety of patient and service user centred healthcare.

Summary

The CHC has provided input into this year's Velindre NHS Trust Annual Quality Statement and are confident the information provided is an honest appraisal of the specialist services it provides its local and regional population. The CHC has endorsed this Annual Quality Statement for 2019 – 2020.



Malcolm Latham
Chair



Stephen Allen
Chief Officer

Write to:

AQS Development Manager
Velindre NHS Trust
Corporate HQ
Unit 2 Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ

Email:

Corporate.Services2@wales.nhs.uk

Further Information and Giving Feedback

If you require further information about anything contained in this Annual Quality Statement, please contact by:



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Cydweithrediad
Iechyd GIG Cymru
NHS Wales Health
Collaborative

NHS Wales Collaborative Leadership Forum

Minutes of Meeting held on 15 January 2020

Author: Mark Dickinson**Version:** 1 (Approved)**Members
present**

Ann Lloyd (Chair), Chair, Aneurin Bevan UHB (AL)
 Maria Battle, Chair, Hywel Dda UHB (MB) (part of meeting)
 Tracey Cooper, Chief Executive, Public Health Wales (TC) (part of meeting)
 Sharon Hopkins, Interim Chief Executive, Cwm Taf Morgannwg UHB (SHo)
 Charles Janczewski, Interim Chair, Cardiff and Vale UHB (CJ) (CJa)
 Chris Jones, Chair, Health Education and Improvement Wales (CJo)
 Gary Doherty, Chief Executive, Betsi Cadwaladr UHB (GD)
 Vivienne Harpwood, Chair, Powys tHB (VH)
 Sian Harrop-Griffiths, Director of Planning, Swansea Bay UHB (for Tracy Myhill)
 Donna Mead, Chair, Velindre NHS Trust (DM) (part of meeting)
 Judith Paget, Chief Executive, Aneurin Bevan UHB (JP)
 Martin Woodford, Chair, Welsh Ambulance Service NHS Trust (MW)

**In
attendance**

Mark Dickinson, NHS Wales Health Collaborative (MD)
 Rosemary Fletcher, Director, NHS Wales Health Collaborative (RF)

Apologies	Steve Ham, Chief Executive, Velindre NHS Trust Alex Howells, Chief Executive, Health Education & Improvement Wales Jason Killens, Chief Executive, Welsh Ambulance Service NHS Trust Marcus Longley, Chair, Cwm Taf Morgannwg UHB Tracy Myhill, Chief Executive, Swansea Bay UHB Steve Moore, Chief Executive, Hywel Dda UHB Mark Polin, Chair, Betsi Cadwaladr UHB Len Richards, Chief Executive, Cardiff & Vale UHB Carol Shillabeer, Chief Executive, Powys tHB Jan Williams, Chair, Public Health Wales Emma Woollett, Interim Chair, Swansea Bay UHB	
Welcome and introduction		Action
AL welcomed colleagues to the meeting and noted apologies for absence.		
Approval of minutes of previous meeting (LF-2001-01)		Action
The minutes of the meeting held on 17 September 2019 were approved as a correct record.		
The minutes will be forwarded to the board secretaries of the 11 NHS Wales organisations for noting at board meetings.		MD
Action log (LF-2001-02)		Action
The action log was reviewed. RF reported that all actions agreed to have been completed at the previous meeting had been removed from the action log and that: <ul style="list-style-type: none">• action LF/A/114 (circulation of minutes) had been completed• actions LF/A/116 to LF/A/119 (major trauma) would be addressed later in the meeting under the relevant agenda item• action LF/A/120 (peer review) remained open pending reviewing the Act in its final form• action LF/A/122 (risk register) will be addressed through the development of the Collaborative Work Plan for 2020/21		
Matters arising from minutes (LF-2001-01)		Action
<i>River House</i> The previous minutes record that “the letter [from WG] confirms that River House is to be the main hub of the Executive and that the ground floor is being acquired”.		

<ul style="list-style-type: none"> • The importance of ensuring appropriate and responsive rehabilitation • The need for assurance around operational readiness • Ongoing concerns about value for money continue to be expressed • The budget allocation (section 3 of the report) does not include specific figures but the wording confirms that funding will be provided for specified aspects • As part of the move to the implementation phase, a final meeting of the existing network board will be held in late January, prior to the transition to the new network implementation board. The new board will be leaner, made up of executive leads, who will, in turn, lead local implementation groups • All organisations have been asked for information about readiness for 'go live', including appropriate mitigations where required. This feedback will be collated with the results of readiness assessment visits to health boards and WAST, and reported to the implementation board. The implementation board will make recommendations to inform a formal decision by WHSSC Joint Committee on when to 'go live' • Independent support to Cardiff and Vale, in preparation for 'go live' is being provided by Chris Moran, National Clinical Director for Trauma, for NHS England • A desk top exercise on repatriation will be held at the end of February, with operational input from health boards and WAST. This will also inform the 'go live' readiness assessment • Work is ongoing on the development of the Memorandum of Understanding for the Operational Delivery Network (ODN) • A further briefing will be provided for Boards in March • Swansea Bay UHB need to identify the SRO for the ODN <p>[TC and MB joined the meeting during the above summary]</p> <p>CJa extended an invitation to other organisations to attend the Cardiff and Vale readiness assessment meeting for the Major Trauma Centre.</p> <p>CJo commented on the importance of transport and suggested that the desktop exercise needs to simulate repatriation, transport timescales and communications challenges in times of escalation. It was agreed that this</p>	<p>RF</p>
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should be considered in the design of the exercise. SH-G highlighted the need for medical director involvement in the desk top exercise.

CJ asked if there is clarity about 'go/no go' parameters for a 'go live' decision. RF responded that this is informed by the standards and which needs to be supported by clinical engagement via medical directors informed by readiness assessment visits.

AL asked how WG is scrutinising the request for central funding. RF replied that WG had reviewed the programme business case and had come back for some clarifications, which had been provided. There are also regular monthly trauma policy meetings, chaired by the Deputy CMO, and involving WG policy and capital leads, and other key interests.

RF reported that the next Gateway review is expected in March 2021 after the network is fully operational, as both Gateway 3 and 4 requirements had been assessed as having been met at the time of the last review in October 2019.

Single Cancer Pathway (SCP) Update (LF-2001-04)

Action

TC introduced the report and highlighted the following points:

- An SCP Strategic Leadership Group had been established, with LR, SM and AH involved and with links to diagnostic programmes and other key stakeholders.
- Work is continuing on a 'case for investment' in improving cancer outcomes in Wales. The £3m allocated in support of the implementation of the SCP is only a starting point and is not considered sufficient to transform cancer outcomes in Wales
- The emerging evaluation, by Swansea University, of the pilot Rapid Diagnostic Centres (RDCs) had attracted significant media interest and consideration of scaling up this service would be considered by the Cancer Implementation Group
- Issues with the high threshold for referral from primary care in Wales for cancer diagnostics
- The need for further consideration of the contribution that AI could make to cancer diagnostics and the role the Life Sciences Hub could play in this

[DM joined the meeting during the above summary]

SH noted the unbalanced communications regarding the Swansea Bay RDC in comparison with the equivalent in Cwm Taf Morgannwg and suggested there is a need for better join up. SH-G responded that the media interest had been instigated by the local lead clinician, a GP. DM queried whether the RDCs had generated the significant increase in referrals to Velindre. TC responded that this was the result of a range of factors that were driving up referrals across the country.

The fact that Wales has only one PET scanner at the moment was noted by CJo. TC commented that the number of PET and CT scanners per head of population in Wales is amongst the lowest in Europe.

SH noted the recent seminar on AI held at the Imaging Academy.

RF noted that the development of a robust 'case for investment' is challenging, including as a result of issues with data availability and robustness. The work on demand and capacity in endoscopy was noted.

Informatics Projects Update (LF-2001-05)

Action

RF introduced the update report on three projects.

LINC (Pathology)

RF reported that the LINC Outline Business Case had been considered by individual Boards about a year ago. Progress had been delayed by discussions over the appropriate length of contract that should be entered into. WG had proposed '3+2' years and a revised position of '7+2' years has been agreed as a basis on which to test the market. The programme board has agreed to proceed to procurement on this basis.

It was **noted** that health boards have agreed to support the achievement of 90% electronic test requesting by 2022

RISP (Radiology)

RF reported that this was a new project, which incorporates a new PACS system as a part of a wider 'end to end' informatics solution for radiology. Work was behind schedule, with a Strategic Outline Case currently under development, informed by experience in the LINC project.

<p>CJo queried whether there was the potential to combine the radiology and pathology systems. RF agreed to seek advice on this.</p> <p><i>CC-CIS (Critical Care)</i></p> <p>MD provided an update on post-procurement attempts to agree a funding package, using revenue and capital, that is affordable and compatible with accounting regulations and the terms of the procurement.</p> <p>CJo comment on the need to ensure staff education in the use of a new critical care system. MD responded that the implementation will be managed as a change management programme, facilitated by an informatics solution, rather than as an informatics implementation project.</p>	RF
New work commissioned from the Collaborative Team (LF-2001-06)	Action
<p>RF introduced a discussion of new work that the Collaborative is being asked to undertake. RF noted that some requests are clearly in keeping with the overall role and remit of the Collaborative and can often be incorporated within existing programmes of work. Other requests are clearly in addition to existing responsibilities and need additional resources. New functions and roles have led to a significant expansion in staffing and additional corporate support and management is also needed. Constant ad hoc and incremental expansion is not helpful and it would be better if the development of the Collaborative could be planned and implemented in a more strategic way.</p> <p>In relation to the specific requests being reported on, RF noted that work on Inflammatory Bowel Disease and childhood surgery did not require major resource, but that some additional clinical capacity was required.</p> <p>The Collaborative role suggested in relation to Allied Health Professionals would represent a more significant change. WG want to put a team into the Collaborative, with a senior programme lead and a budget of approximately £0.5m per annum. It was agreed that there was a need for further discussion with WG as to whether this was the best approach.</p> <p>AL noted the need to assess whether new areas of work are in line with collective NHS Wales priorities. CJo observed that</p>	RF

	Paper Ref: LF-2007-01
NHS Wales Health Collaborative Leadership Forum	Minutes 15/01/20

<p>many emerging technological developments will require staff under the broad category of AHPs and there is a need to join up the key themes, including how innovative new roles will be regulated.</p> <p>It was noted that the direct commissioning of Collaborative work by WG is incompatible with the current governance arrangements for the Collaborative, with accountability to the Collaborative Executive Group and Collaborative Leadership Forum. It was agreed that the Collaborative Executive Group should discuss this matter further.</p> <p>It was noted that there had been no significant recent developments relating to the planned establishment of the NHS Wales Executive function.</p>	JP/RF
Recording language preference of members	Action
Members of the Forum were reminded of the need to inform the Collaborative of their language preference, Welsh or English, for Forum related papers and correspondence.	All
Date of next meeting	
It was noted that the Forum is scheduled to meet next on Tuesday 14 April 2020 from 9am to 12 noon.	



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TRUST BOARD

GUIDANCE TOWARDS DEVELOPING A SUSTAINABLE WORKFORCE

DATE OF MEETING	24/09/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	Susan Thomas, Asst Director of Organisational Development	
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce	
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	4/8/20	Approved
ACRONYMS		

1. SITUATION/BACKGROUND

- 1.1 In June 2020 Velindre University NHS Trust received an Internal Audit report in relation to workforce planning arrangements. The finding of the Audit was Limited Assurance with a key recommendation in the report for formal ratification of the Trusts workforce planning guidance and for the guidance to be re-launched.

The guidance was originally developed in March 2019 following a recommendation of the Velindre Workforce Planning Think Tank to adopt the Skills for Health “6 Step Workforce Planning Model”, however, it was noted in the Audit Report “that that there was little awareness and use of this document other than by those who attended the 2017 HEIW workshop and that this guidance could be used as a valuable tool for future workforce planning IMTP submissions”.

- 1.2 There were three actions identified to address this finding:-

ACTION: Review the current guidance on Workforce Planning and prepare revised documentation. By 11th August 2020

ACTION: Present the revised guidance and plans for re-launch to EMB for approval and dissemination across Velindre NHS Trust. By 25th August 2020

ACTION: A communications and dissemination plan will be developed to aid visibility of the Trust approach to workforce planning. By 30th September 2020

2. ASSESSMENT

- 2.1 The Guidance towards Developing a Sustainable Workforce has subsequently been reviewed and updated to reflect current practice in workforce planning and has been further developed into a toolkit for managers to assist in undertaking both short and medium-long term workforce planning to support the Trusts IMTP and Strategic Planning processes.

- 2.2 Following approval at EMB in August 2020, a communications and dissemination plan has been developed to aid visibility of the Trust approach to workforce planning.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

- 4.1 The Trust Board is asked to **NOTE** the Guidance towards Developing a Sustainable Workforce.



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Version 1
July 2020

Velindre University NHS Trust Guidance towards Developing a Planned and Sustained Workforce

This Toolkit has been developed in line with a key recommendation of the Velindre University NHS Trust Think Tank in Workforce Planning to support workforce planning across Velindre University NHS Trust and provides managers with a structured and integrated approach to developing a planned and sustainable workforce. Use this toolkit to help develop a short term plan or use in conjunction with the Velindre

Our App
to Plan

1. Define
Plan

2. Map
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6. Implement -
Action Plan

Velindre University NHS Trust - Framework towards Developing a Planned Sustainable Workforce

"Having the right people, in the right place, at the right time to deliver a safe, effective and efficient service for our patients and donors, in an environment that supports proactive planning and innovation to continuously improve service delivery" Definition of Workforce Planning Excellence for Velindre University NHS Trust from the Workforce Planning Think Tank

Velindre University NHS Trust recognises that in order to continue to provide the very best care for our patients and donors we need to ensure that the workforce is planned and sustainable in the longer term. The vision for developing a planned and sustainable workforce is to have in place clinically agreed short and long term multidisciplinary workforce plans fully integrated with IMTP and longer term strategic plans.

This Guidance has been developed in line with a key recommendation of the Velindre University NHS Trust Think Tank to adopt the Skills for health Six Step Methodology to Workforce Planning to support Velindre University NHS Trust in achieving this vision

[Click to go to the SfH 6 Step Model](#)

The six step model fits within the Velindre (NHS Wales) Planning Framework and can support development of Operational Plans in the short, medium and longer term.



Short Term - up to 12 months ahead
Could also be described as establishment monitoring, typically includes headcount, budget management and is usually reactive to immediate service demand

Medium Term - up to 3 years

Likely to be linked to IMTP planning, focusses on workforce required to meet IMTP aims and objectives. Typically includes planned recruitment, succession planning, and organisation change plans (OCP)

Long Term - up to 10 years

Usually developed to meet longer term strategies. Typically includes scenario planning for future service models, longer term projects, predictions in availability of future workforce, increasing demand for services aligned to population changes



[Back to Main Menu](#)

Clarify the rationale and scope of your plan. Be clear on why a workforce plan is required, what the scope of your plan is and what it will be used for.

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

Potential Outputs at this stage:-

Project Initiation Document (PID)
Stakeholder Map
PEST Analysis
SWOT Analysis
Impact Assessments
Risk Assessment
Strategic Workforce Plan

You may want to think about using:-

SWOT Analysis

IMTP

Strategy Documents (e.g. Healthier Wales; NHS Wales Workforce Strategy, Organisation Strategy)

Reviews (e.g. Audit; Peer Review; Inspections)

Relevant Policies

Stakeholder Mapping

Impact Assessments

Project Documents (PID, Project Plan)

Horizon Scanning

Velindre NHS Trust Strategic Workforce Plan Template

**Click to go to useful
links and documents
page**

Some things to consider:

Define Your Plan

Plan Purpose	What are the goals/aims/objectives of the plan? Why are you doing it? What is the Driver? What will the plan enable you to do? What is your case for change? Who will the plan impact upon?	
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[Back to Main Menu](#)

This is about the service redesign in response to donor/patient need and/or changes in service delivery. Be clear about costs and outcomes and identify the intended benefits from service change.

This is the first of three inter-related steps. This is the process of service redesign in response to patient need, changes in models of care, advances in technology or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clarity about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

Potential Outputs at this stage:-
Project Initiation Document (PID)
Options Appraisal

You may want to think about using:-

SWOT/PEST Analysis
IMTP
Relevant Policies
Options Appraisal
Government Policy

Impact Assessments
Finance/Budget
Performance Measures
Field Research/Literature Review
Organisation Change Policy (OCP)

**Click to go to useful
links and documents
page**

Some things to consider:

Map the Service Change(s)

[Back to Main Menu](#)

This step involves identifying the workforce needed to deliver the reconfigured services. What skills are needed the type of workforce and numbers of staff required.

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

Potential Outputs at this stage:-

Skill Mix Analysis
Process Maps
ESR BI Reports
Equality Impact Assessments
Literature Review
Job Descriptions

You may want to think about using:-

Skill Mix Analysis	Impact Assessments
Skills Mapping/Process Mapping	Job Descriptions
Competency Based Assessments	Process Mapping
ESR BI Reports	Career Pathways
Stakeholder Mapping	All Wales Delegation Guidance
Literature Review/Research	

**Click to go to useful
links and documents
page**

Some things to consider:

Define the Workforce Required

[Back to Main Menu](#)

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any re-training, redeployment and/or recruitment activities that could increase or change workforce supply.

Potential Outputs at this stage:-

Staff Profile
Benchmarking

You may want to think about using:-

Professional Guidance
ESR BI Reports - Staff Profiles
Literature Review/Research
IMTP - Education Commissioning
Trust Education Strategy
Audit Reports

Skill Mix
Trainees in the pipeline
Shortage Occupation List/Difficult to recruit to posts
Career Pathways
All Wales Delegation Guidance
Performance Reports
Benchmarking

**Click to go to useful
links and documents
page**

Some things to consider:

Understand the Workforce Supply

[Back to Main Menu](#)

Your plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales.

This step involves reflecting on the previous 3 steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build momentum for change, including clinical engagement.

Potential Outputs at this stage:-

Gap Analysis
Action Plan
Strategic Workforce Plan

You may want to think about using:-

Project Plan Resources
Velindre NHS Trust Strategic Workforce Plan Template
Organisation Change Policy (OCP)

**Click to go to useful
links and documents
page**

Some things to consider:

Define the Actions Required

[Back to Main Menu](#)

our plan must be delivered effectively and will need periodic review and adjustment.

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

You may want to think about using:-

Project Plan Resources
IMTP
Education Strategy
Organisation Strategy

[Click to go to useful
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[Back to Main Menu](#)

Find your staff profile charts and staff lists downloaded from ESR - find ESR Guides

[Click to go to the top of the page](#)

Useful Links

Key Organisation Documents

[Velindre Workforce Planning Guidance](#)

[Velindre University NHS Trust IMTP](#)

[VCC Strategy Documents](#)

[WBS Strategy Documents](#)

[Velindre University NHS Trust Education Strategy](#)

1. Define your Plan

[A Healthier Wales](#)

[Office for National Statistics](#)

[Stats Wales](#)

[Wellbeing of Future Generations Act](#)

[SWOT Analysis](#)

[PEST Analysis](#)

[Equality Impact Assessment](#)

[Quality Impact Assessment](#)

[Privacy Impact Assessment](#)

[Example completed stakeholder mapping](#)

[Five questions to identify key stakeholders \(HBR\)](#)

[Risk Assessments](#)

[Topol Review](#)

2. Map the Service Change

[Project Initiation Document \(PID\)](#)

[Options Appraisal](#)

3. Define the Workforce

[Skill Mix Analysis](#)

[Process Maps](#)

[ESR BI Reports](#)

[Job Description Template](#)

4. Workforce Supply

[Office for National Statistics](#)

[Workforce supply challenges \(NHS Providers\)](#)

[Shortage occupations \(NHS Employers\)](#)

[ESR BI Reports](#)

[Stats Wales](#)

5. Define Actions Required

[Action Plan](#)

[Strategic Workforce Plan Template](#)

[Change Toolkit - Project Planning Tools](#)



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Velindre University NHS Trust Strategic Workforce Plan Template

"Having the right people, in the right place, at the right time to deliver a safe, effective and efficient service for our patients and donors, in an environment that supports proactive planning and innovation to continuously improve service delivery"

Department/Division:	
Author(s)/Owner(s)	
Date	

Contents

1. Introduction	3
2. Service Model	3
3. Workforce Required	4
5. Action Plan.....	5
6. Implementation, Monitoring and Review.....	5

1. Introduction

Define your Plan - Hints & tips for this section

Consider the context, be clear on the **purpose** of your plan. Describe what the issues/problems are that you are trying to solve through developing your plan. Clarify what is in **scope** and what is out of scope and identify who **owns** the plan as you build your case for change.

Consider your plan scope carefully, you will probably be looking at finding new ways to meet the challenges being faced. One way to address those challenges maybe through modernisation of your workforce in developing an integrated workforce model that encompasses all staff groups across a service or pathway. Take a look at [competence based approach](#) to workforce planning, this approach can help to create a more flexible and sustainable workforce that is competent across a wider role people with the right skills and competencies in the right place at the right time.

2. Service Model

Map the Service Change - Hints & tips for this section

Include the current position in this section, what is the current demand for services? What is the **service model/new models of care**? What is your service strategy/vision? What are your **goals**, describe what the **benefits** will be and to whom.

Including a process map or a pathway can help to demonstrate those tasks that require expert knowledge and those tasks which can be undertaken by other appropriately competent individuals.

Include your current **baseline**, this usually includes current performance and workforce (age, pay band, use of overtime/agency staff and vacancies) you should also include any critical workforce points, e.g.do you have any posts where only 1 or a small number of people are competent? Do you have an ageing workforce? Are there any benchmarks, regulatory guidelines on staffing numbers you can include?

3. Workforce Required

Define your Workforce - Hints & tips for this section

Describe the workforce that is required to deliver the service, think about the competences that the workforce will need, is there a move towards a different model of care and what skills will staff need?. In this section consider which types of staff should best carry out particular **activities** in order to reduce costs and improve the patient/donor experience does this lead to new roles **and new ways of working** and **how many do you need?**

Development of new skill sets and competences could see blurring of traditional professional boundaries, extension to practice of all grades of scientific/technical and support staff can enable medical staff to focus on the highly skilled, complex elements of their job roles. The dissolution of boundaries between staff groups and the development of novel methods of work, extending practice will ultimately enable service delivery to be undertaken more cost effectively and provide more opportunities for staff to develop their skills creating a more sustainable workforce.

4. Workforce Supply

Workforce Supply - Hints & tips for this section

Describe your existing workforce including its existing skills and deployment, bring through any critical workforce points you identified from 2 section. **Is there a shortage of staff in this area**, can the existing workforce be developed to gain new skills/competences? **What are your options?** What would that cost? how long would it take?

Important - now you have looked at workforce availability/workforce supply, you may need to revisit the realism or achievability of your proposed new service model.

5. Action Plan

Action Plan - Hints & Tips for this section

Reflect back on the previous 3 steps **what are your gaps?** how can they be filled and what will this mean for staff and for the service. **Determine the most effective way** of ensuring the availability of staff to deliver services, **what are your priorities.** Do you need a training/development plan or a recruitment plan?

Is there any barriers that cannot be overcome without external support e.g. HEIW? Does there need to be further service redesign outside of the scope of your plan?

Your plan needs to be developed with milestones and timescales, take a look at the **project management tools available** in the [Trusts Change Toolkit](#). You should also include in your plan an assessment of anticipated problems and how you will build momentum for change, including stakeholder engagement and collaborative/multi-disciplinary working

6. Implementation, Monitoring and Review

Implement, Monitor & Review - Hints & tips

After the plan begins to be delivered, it will need periodic review. Include in your plan how it's going to be **monitored, reviewed and what will happen in the event something changes.**

How will success be **measured?** Do you need a benefits realization plan, do you need to provide feedback to any particular stakeholders (e.g. for funded elements in your plan?)

How are lessons learned, captured and cascaded to your organisation? Is this part of a wider service transformation/improvement/cost saving plan?



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Guidance to Support the Development of a Sustainable Workforce

The guidance provides managers with a structured and integrated approach towards developing a planned and sustainable workforce.

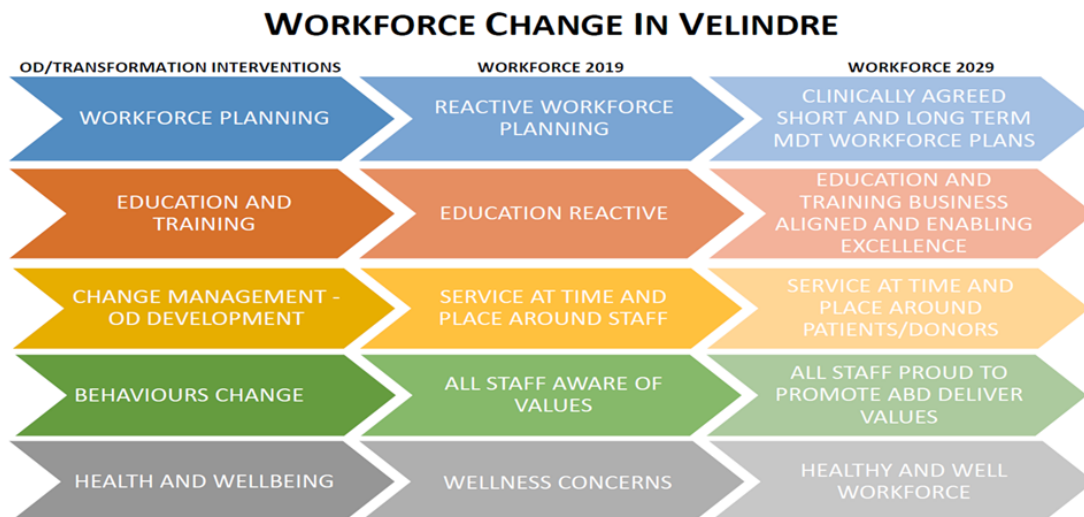
Version Control

Version 2
July 2020

“Having the right people, in the right place, at the right time to deliver a safe, effective and efficient service for our patients and donors, in an environment that supports proactive planning and innovation to continuously improve service delivery”

Definition of Excellence in Workforce Planning for Velindre University NHS Trust from the Workforce Planning Think Tank

Velindre University NHS Trust recognises that in order to continue to provide the very best care for our patients and donors we need to ensure that the workforce is planned and sustainable in the longer term. The vision for developing a planned and sustainable workforce is to have in place clinically agreed short and long term multidisciplinary workforce plans fully integrated with IMTP and longer term strategic plans.



This Guidance has been developed in line with a key recommendation of the Velindre University NHS Trust Think Tank in Workforce Planning to support The Trust in achieving this vision.

A key recommendation of the Velindre University NHS Trust (VUNHST) Think Tank was to mandate the use of the Skills for Health “6 Step Workforce Planning Model” framework. The Skills for Health Six Steps Methodology to Integrated Workforce Planning, is a framework that provides a practical approach to planning that ensures the organisation has a workforce of the right size with the right skills and competences.

The Six Steps Methodology provides a framework that offers VUNHST:

- a systematic practical approach that supports the delivery of quality donor and patient care, productivity and efficiency
- assurance that workforce planning decisions taken are sustainable and realistic
- a flexible scalable approach, from small team plans to large Divisional plans.

The Trust also recognises that there are a number of ways and different approaches that can be applied when it comes to workforce planning within the framework and has developed a toolkit which managers may find helpful in developing their sustainable workforce plan and choosing the right approach for their needs.

The Think Tank recommendations included a range of suggested questions to support and assist Managers in utilising the 6 step model within the Trust. The questions form an integral part of this document alongside other useful practical guidance and suggested resources as well as a Strategic Workforce Plan Template for longer term planning.



Two key resources that you may also find helpful to support your workforce planning

Trust Change Toolkit



NHS Wales Workforce Planning Guidance and Practical Tools for different approaches to planning a sustainable workforce available on the HEIW site



The Six Step Model

Step 1

Define your Plan

Clarify the rationale and scope of your plan. Be clear on why a workforce plan is required, what the scope of your plan is and what it will be used for

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning.

Links into the Strategic Workforce Plan Template:-

- Purpose
- Scope
- Ownership

Some things to consider:

Plan Purpose	What are the goals/aims/objectives of the plan? Why are you doing it? What is the Driver? What will the plan enable you to do? What is your case for change? Who will the plan impact upon?
Plan Scope	Are you able to define the plan? What area/team/department/service is covered by the plan? Who are your stakeholders (internal and external) and how will they be affected? How will your stakeholders (internal and external) be involved?
Ownership	Who owns the Workforce Plan? What are the key roles? Who needs to be involved both internally and externally? How will you engage with the stakeholders?

Step 1 Checklist - Before moving to Step 2 it is important to have the following information in place.

PURPOSE

- What is the problem you are trying to solve?
- What will a good plan enable you to do?
- Who initiated the plan and why?
- Who will the plan impact upon?

SCOPE

- What geographical area is covered by the plan?
- What services and organisations does it cover?
- What types of staff are covered?
- What patient/donor groups does the plan cover?
- Is this a short term or long term problem and solution?

OWNERSHIP

- Who owns the workforce plan?
- Who needs to be influenced if the plan is to be successful?
- Do stakeholders understand their part/contribution to the delivery of the plan?
- Is everyone involved signed up to achieving the plan?
- Do you need a Project Initiation Document (PID)?

Step 2

Mapping Service Change

This is about the service redesign in response to donor/patient choice and/or changes in service delivery. Be clear about costs and outcomes and identify the intended benefits from service change

This is the first of three inter-related steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints

Links into the Strategic Workforce Plan Template:-

- Goals/benefits of change
- Current baseline
- Drivers/ constraints
- Option appraisal
- Service models

Some things to consider:

Goals/Benefits of Change	What are the benefits to this change? Is there a positive outcome? What are the options? Patient Centred/Donor Needs
Current Baseline/ Summary	What are the current costs and outcomes under the current model? What is the basis of the current service model that you will be building on? Is there any research that can support you in this mapping? Is there any National policies and strategies that could assist you? Has another organisation already made similar changes?
Future Model Design, the Drivers and Constraints	Challenge the driver(s) and ensure there are benefits to proceeding Think about the risks Does this service change support the Future Generations Act wellbeing goals? Does it need to be clinically agreed? What are the Patient/Donor Needs?

Step 2 Checklist - Before moving to Step 3 it is important to have the following information in place.

GOALS AND BENEFITS OF CHANGE

- What are the drivers behind the service change?
- What are the costs and outcomes under current models?
- What are the intended benefits from the service change?
- How will the change be effectively monitored?

DRIVERS/CONSTRAINTS

- What are the forces that support the service change?
- What the forces that hamper the change?

OPTION APPRAISAL

- What different scenarios for service change have been considered

WORKING MODELS

- Does the preferred model deliver the described benefits more effectively than other models?
- Or is the model simply more likely to be achievable given the anticipated constraints?
- Is there a clear shared understanding of the future service configuration based on the patient experience, patient outcomes and financial realities?
- Is it clinically agreed?
- Does it meet patient/donor needs

Step 3

Define the Workforce

This step involves identifying the workforce needed to deliver the reconfigured services

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

Links into the Strategic Workforce Plan Template:-

- Activity analysis
- Types/numbers
- New ways of working

Some things to consider:

Activity Analysis	<p>What are the key tasks within the new service delivery model?</p> <p>Have the activities been broken down into skills, competences and knowledge e.g. against a patient pathway?</p> <p>Do I know my workforce profile, age, gender?</p> <p>Do I have the right skills to undertake this stage?</p>
Type and Numbers of Staff Required	<p>Have the teams through which the service is delivered been identified (consider including other organisations' contributions in the pathway)?</p> <p>What is the expected case load and case mix for individual teams?</p> <p>What is the size and composition of the teams needed to deliver the service?</p> <p>What new roles will you introduce into the team? What will the effect of these roles be on other staff?</p> <p>Do I need support at this stage from workforce planning experts?</p> <p>Is there evidence/research base that can support me in defining the requirements?</p> <p>Will this affect other teams or individuals? What will be the impact?</p>
The New Way of Working	<p>Have productivity implications been considered based on technology, patterns of working, service models, skills mix and/or redistribution of tasks and training requirements?</p> <p>Has staff wellbeing been taken into account?</p> <p>Are there any process/system developments that I need to take into account, new technology, non-staffing considerations e.g. estates/equipment</p> <p>Have I considered the here and now as well as the long term future generations e.g. sustainability and resilience</p> <p>What are the timeframes to consider</p>

Step 3 Checklist - Before moving to Step 4 it is important to have the following information in place.

ACTIVITY ANALYSIS

- What are the key tasks within the new service delivery model?
- Have the activities been broken down into skills, time, individual or team?
- Has the standard required been identified including links with other activities?
- How are roles constructed including duties and responsibilities?
- Have new roles been identified?

TYPES/NUMBERS

- Has the activity through which the service is delivered been identified?
- Has an assessment of the size and composition of the team needed to deliver the service been identified?

PRODUCTIVITY AND NEW WAYS OF WORKING

- Have productivity implications been considered based on technology, therapeutic advances, patterns of working, service models and redistribution of tasks?
- Have different blends of skill mix been measured?
- If new ways of working have been identified have the fundamental principles been applied?

Step 4
Workforce Supply

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any re-training, redeployment and/or recruitment activities that could increase or change workforce supply.

Links into the Strategic Workforce Plan Template:-

- Describing/understanding the current workforce
- Workforce forecasting/shortages
- Supply options

Some things to consider:

Current Workforce	What are the characteristics of the current workforce? Describe the current workforce in terms of numbers of certain types of: staff, skills, services? – do I know my current workforce? Are we working effectively now? What current vacancies are there within the service area? What impact are these having? Do they represent a significant recruitment issue?
Workforce Forecasting	Do I know what skills, training and qualifications I require from the workforce? What turnover/attrition is expected? What numbers are in the commissioning pipeline? What influences on supply are there even with no service change (e.g. shorter working hours and the Working Time Directive) What is the anticipated competition for skills with other employers in the local/national labour market? What is the internal workforce supply forecast? Do I know the wider environment and the supply? Will this help me have the right people, in the right place with the right skills? Am I clear on the requirements for my workforce?
What are the Options	What do I need to ensure resilience and sustainability? What options for retention, retraining, recruitment, redeployment etc. can be realistically developed? Have the options for working differently been analysed and costed?

Step 4 Checklist - Before moving to Step 5 it is important to have the following information in place.

CURRENT WORKFORCE

- What are the characteristics of the current workforce?
- Has this been described in terms of numbers or certain types of staff, skills or service unit?
- What staff feedback have you had (e.g. stress/ wellbeing/ engagement)

WORKFORCE FORECASTING

- What turnover/attrition is expected and what numbers are in the commissioning pipeline?
- What influences on supply are there even with no service change (e.g. shorter working hours and the Working Time Directive)?
- What is the local labour market?
- What is the internal workforce supply?
- What is the anticipated competition for skills?

OPTIONS

- What models for retention can be developed to increase supply e.g. redeployment, retaining, and recruitment?
- Have options been analysed and costed to increase workforce availability?
- Have the options for working differently been analysed and costed?

NEXT STEP

Now you have looked at workforce availability/workforce supply, you may need to revisit the realism or achievability of your proposed new service model.

Step 5

Action Planning

Your plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescale

This step involves reflecting on the previous 3 steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build momentum for change, including clinical engagement and collaborative/multi-disciplinary working.

Links into the Strategic Workforce Plan Template:-

- Gap analysis
- Priority planning
- Action planning
- Managing the change

Some things to consider:

Priority Planning	<p>What are the most significant areas for change (to reduce the gap in Supply & Demand)?</p> <p>What is the cost?</p> <p>What are the least significant areas for change (to reduce the gap in Supply & Demand)?</p> <p>Is there a Cost Improvement Plan in place</p> <p>Have I considered National Issues – national shortages?</p>
Gap Analysis	<p>Has a gap analysis been undertaken of each scenario? What changes are needed to the current workforce? (Gaps between supply and demand)</p> <p>Has the gap analysis identified any new skills, knowledge and competences required for the current and future workforce?</p> <p>Do I know my target audience? How do I make the role(s) attractive?</p> <p>How can I avoid it being perceived as NHS exclusive?</p> <p>Do I know how best to develop to develop job descriptions? Decide on the advertising routes and how best to recruit, can I opt for a less traditional route (e.g. apprenticeships) do I know how to access these options?</p> <p>Have I considered all the equality aspects?</p> <p>Does the Job Description accurately reflect what is required of the role?</p>
Action Planning	<p>What is the action plan based on; your 'best' option?</p> <p>How does education and other strategies support this plan?</p>
Managing Change	<p>Has momentum been built in for change? (Mandated from top management?)</p> <p>Ownership from key Stakeholders? OD? Planners? Financial resources?</p> <p>How will momentum for change be sustained?</p>

Step 5 Checklist - Before moving to Step 6 it is important to have the following information in place.

GAP ANALYSIS

- Have you undertaken a gap analysis of each scenario?
- What changes are needed to the current workforce?

PRIORITY PLANNING

- What are the key hotspots that need the most significant change?
- What cold spots need the least change?

ACTION PLANNING

- What is the plan based on your 'best' option?
- How do education and other strategies support the plan?

MANAGING CHANGE

- How do you build momentum for change?
- How do you sustain the momentum for change?

Step 6
Implement

Your plan must be delivered effectively and will need periodic review and adjustment

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

Links into the Strategic Workforce Plan Template:-

- Implementation
- Measuring progress
- Revisiting Six Steps

Some things to consider:

Implementation	What are the key milestones of your plan? Progress against the plan is to be monitored? What are the lines of responsibility? What would be the appropriate stage to review the outcome?
Measuring Progress	How can I measure success, what impact has it had? How are the outcomes and unintended consequences going to be measured?
Refresh your Plan and Actions	What is the process for revisiting your plan and refreshing any requirements? Have I learnt any lessons that could help me next time and how can this inform the review
Continuous Improvement	How will you ensure your plan and actions are fed into the strategic aims and objectives of the organisation? How will you ensure the plans are integrated across organisational systems and processes for the delivery by the services? What system and processes will be used by and across the organisation to ensure there is clarity of responsibility and roles for monitoring, taking action, and reviewing progress?

Step 6 Checklist

HOW TO ENSURE YOUR PLAN IS DELIVERED

- What are the key milestones of your plan?
- How are the outcomes and unintended consequences going to be measured?
- What is the process for revisiting your plan and refreshing any requirements?



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TRUST BOARD

ADVANCED THERAPIES (CELL & GENE) STATUS UPDATE: ADVANCED THERAPIES WALES MIDLAND-WALES ADVANCED THERAPIES TREATMENT CENTRE PRECISION MEDICINE SERVICE

DATE OF MEETING	24/09/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report	
PREPARED BY	Mark Briggs, Head of Cell and Gene Therapy	
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer	
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
VUNHST Executive Management Board	14/09/2020	NOTED
ACRONYMS		
ATW	Advanced Therapies Wales	

MW-ATTC	Midland-Wales Advanced Therapies Treatment Centre
VUNHST	Velindre University NHS Trust
ATMP	Advanced Therapy Medicinal Product
IUK	Innovate UK
UKRI	UK Research and innovation
BEIS	Department for Business, Energy and Industrial Strategy
AWMGS	All Wales Medical Genetics Service
nVCC	New Velindre Cancer Centre
PM	Precision Medicine
CMO	Chief Medical Officer
WG	Welsh Government
COO	Chief Operating Officer

1. SITUATION/BACKGROUND

- 1.1 Velindre University NHS Trust (VUNHST) formally hosts and provides secretariat programme resource for e of two aligned, but complementary, externally fully funded programmes focused on accelerating patient access and maximising the overall benefits of Advanced Therapy Medicinal Products (ATMPs; cell and gene therapies) in Wales/UK namely Advanced Therapies Wales (ATW) and the Midlands-Wales Advanced Therapies Treatment Centre (MW-ATTC). (See appendix).

1. **Advanced Therapies Wales** – funded exclusively by Welsh Government (up to ~0.5Mpa with annual review/renewal. Technically commenced April 2019 - key staff in post January 2020 and formal 'launch' 04 August 2020).

2. Midland-Wales Advanced Therapies Treatment Centre; part of a larger UK ATMP initiative – primarily funded by Innovate UK (IUK; Part of UK Research and Innovation (UKRI)) (original programme March 2018 – February 2021 (up to ~£1.5M to Wales) with additional COVID-19 related funds March 2020-June 2021 from the Department for Business, Energy and Industrial Strategy (BEIS) (to June 2021) and COVID-19 ‘extension’ funding (IUK) to March 2022 (total up to ~£0.5M to Wales).

- 1.2 Due to their reliance upon activities and contributions conducted by external organisations (clinical, academic and commercial) both programmes’ progress has been severely impacted by COVID-19 with a minority of activities continuing as per original plans, many paused but now restarted with review/revision of deliverable timelines in progress.
- 1.2.1 **(Supra) Regional Precision Medicine Service:** The Minister for Health & Social Care announced, in a written statement in April 2019, a vision for Precision Medicine (PM) in Wales comprising two elements, integrated diagnostics and advanced targeted therapeutics (see Appendix). As part of this initiative, a proposal is being developed (chaired by the Life Sciences Hub Wales) to explore the opportunity to develop a Cardiff (supra) region focussed PM offering that would include NHS, academic and commercial partners. The proposal is currently in the formative stage and will build upon plans to expand and relocate the All Wales Medical Genetics Service (AWMGS) from the current location on the University Hospital Wales site to one in North Cardiff. The ATW programme and outputs will link into this proposal with potential additional linkage and significant benefits for the planned new Velindre Cancer Centre in respect to the type and range of resources available locally and services that may be offered to patients.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 From a VUNHST perspective, for both the ATW and MW-ATTC programmes, the Trust primarily hosts staff that provide programme and facilitation support with 100% cost reimbursed (including overheads) by the funding bodies.
- 2.2 A majority of deliverable activity and tasks are reliant upon external clinical (NHS), academic and commercial organisations. COVID-19 has severely impacted these activities with many paused since March 2020, or unable to progress to plan, due to resource availability. Both programmes are now in a ‘Review, Refresh, Restart’ phase with a move back to a formal operational rhythm and re-establishment/continuation of active governance processes and oversight.

For the period March-August 2020 a majority of the VUNHST ATW and MW-ATTC staff were either redeployed or in recruitment phase. From September 2020 the teams are at planned levels and have returned to their primary posts for a majority of their time.

- 2.3 External resources are now becoming available again (Aug 2020) to allow a phased resumption against original deliverables. However, there is still a lack of confirmation/clarity as to the extent, timing and reliability of the continued availability, critical input and contributions required from external organisations, especially NHS Wales. As such, plans are under constant review and amendment until a period of suitable stability can be achieved (anticipated 4Q20).
- 2.4 Both ATW and MW-ATTC programmes have a significant requirement to deliver ATMP-based clinical trials to support understanding and robust delivery pathway development. COVID-19 resulted in the pausing of established and planned trials (UK CMO requirement) in this space. This had a significant 'knock on' impact on all timelines due to programme interdependencies and related deliverables. Where possible these activities have been restarted although a majority remain in the planning/approval and feasibility phases.
- 2.5 The MW-ATTC programme is funded by IUK and was due to run to February 2021. In recognition of the disruption and impact of COVID-19 upon the overall UK ATTC programme 'extension' funding has been secured (announced 10 September 2020). This will extend the programme to end March 2022 (aligning with close of the fiscal year). The potential funds available to VUNHST, up to ~£0.5M, consist of 'COVID impact' (~£322K to June 2021; sourced from BEIS) and new 'runway' projects (~£170K to March 2022; sourced from IUK) (Runway projects are exploratory activities that will inform an anticipated ATTC 'Phase 2' grant competition; details not yet available). Note: That full details of the extension funding is yet to be received.
- 2.6 The Welsh Government (WG) funded ATW programme is subject to annual confirmation of financial support and it is the intention to apply for further support for FY21/22 as part of the annual budget cycle.
- 2.7 All ATW staff contracts and financial commitments currently only run to March 2021. MW-ATTC will now run to March 2022.
- 2.8 Precision Medicine: There are early stage conceptual, formative plans and proposals to develop (supra) regional Precision Medicine capability and Centre of Excellence in the Cardiff area. This would be a collaborative programme between NHS Wales, academia (min. Cardiff University) and commercial organisations (TBC). This centre would primarily

serve the Cardiff/SE Wales region but align with national services and would link and benefit the planned nVCC. 'Advanced Therapies' will be a key element of any PM offering and the ATW programme has been involved with and input since early-stage discussions in this area were initiated. To date progress has been limited due to external resource availability and COVID-19 impact.

- 2.9 The Life Science Hubs Wales is chairing the working group that has been formed to develop the programme (current secretariat provided by the NHS Wales National Pathology Network; anticipated 12-18 month activity) and to maintain progress. VUNHST is currently represented by the VUNHST COO/Welsh Blood Service Head of Cell and Gene Therapy and (indirectly) the ATW programme. A request to extend invite of membership to the Transforming Cancer Services programme leadership/nVCC Project Director has been made and supported.
- 2.10 North Cardiff has been identified as a potential location for elements of the physical presence of the PM centre with proposals for the All Wales Medical Genetics Service plans to relocate there in the first instance.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	All VUNHST costs are 100% reimbursed.

4. RECOMMENDATION

4.1 To note the current status of the Advanced Therapies Wales and Midland-Wales Advanced Therapies Treatment Centre programmes, the impact of COVID-19 and the ongoing activities to continue to either deliver to original or revised plans, as appropriate.

4.2 To note the extension in funding secured from IUK and BEIS to enable the continuation of the MW-ATTC programme from February 2021 to March 2022.

4.3 To note the intention to apply for further funding, beyond March 2022, for the MW-ATTC if IUK/UKRI announce further grant competition details – ‘ATTC Phase 2’.

4.4 To note the intention to apply to Welsh Government for continuation funding for the ATW programme for FY2021/22.

4.5 To note the opportunity for inclusion of the ATW programme (and nVCC) within a wider Precision Medicine programme proposed for the Cardiff supra-region.

APPENDICES

1. Advanced Therapies Wales Statement of Intent – high-level outline of scope and deliverables



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Advanced Therapies !

2. Midland-Wales Advanced Therapies Treatment Centre – see www.theattcnetwork.co.uk (accessed 17 Sept 2020)

3. Precision Medicine – written statement by the Minister for Health & Social Care, see <https://gov.wales/written-statement-precision-medicine> (accessed 17 Sept 2020) and included as a an embedded file for convenience



Written Statement_
Precision Medicine _

Advanced Therapies Statement of Intent

This Statement of Intent provides a compelling vision for a strategic approach to harness the benefits from emerging and transformative therapies called Advanced Therapy Medicinal Products (ATMPs). The intention is to create a sustainable platform to enable NHS Wales to provide patients with equitable access to emerging ATMPs, explore how this sector can contribute to the objectives of the Welsh Government's *A Healthier Wales: Our Plan for Health and Social Care in Wales* and deliver our full potential in the international and UK development of ATMPs. Multiple expert groups and the UK Government's Life Sciences Industrial Strategy suggest development of the ATMP sector will provide key opportunities for investment and economic growth for the UK. ATMPs are set to transform current care pathways by potentially offering durable and curative outcomes where acute unmet medical need exists. Healthcare services are not currently configured to commission and provide these therapies as mainstream treatment. It is vital to translate the hope and potential of advanced therapeutics, with an immediate focus on cell and gene therapy, into reality to improve outcomes for the people of Wales. This framework will also support and foster strategic partnerships and collaboration between NHS Wales and our academic and industry partners. By working together we will harness the potential of ATMPs to improve health, well-being and prosperity for the people of Wales.

An ATMP can be either a:

- Gene therapy (i.e. the transfer of genetic material into the cells of a patient's body to treat the cause or symptoms of a specific disease).
- Cell therapy (i.e. the transfer of intact, live cells into a patient to help lessen or cure a disease). The cells may originate from the patient or a donor.
- Tissue engineered product (i.e. a regenerative medicine that replaces or regenerates human cells, tissues or organs to restore or establish normal function).

ATMPs offer significant promise for the long-term management and even cure of disease, especially in areas of high unmet medical need. The current clinical treatment approaches to cancer, heart disease, diabetes, stroke and other conditions will be changed by ATMPs. These therapies will impact many treatment pathways by exploiting techniques and methods to repair, replace, regenerate and re-engineer human genes, cells, tissues or organs in order to restore or establish normal function. Future plans will need to consider other advanced therapies and parallel healthcare innovations that will affect strategic implementation.

There will be major challenges to enabling the broad adoption of new ATMPs, especially around the production, transportation, and application of these products. Developing pathways to identify patients for treatment, aftercare and follow-up, will require consideration as will education, workforce, estates, quality and safety, research and innovation, informatics, commissioning, overall cost and partnerships.

ATMPs have the potential to alter patient outcomes radically for previously incurable diseases. The cost of these products will initially be high but their overall value will be higher due to the life-changing impact for patients compared to existing treatments. As these therapies move from clinical

trial to become available treatments the NHS will need to define, capture and quantify the cumulative value that they offer to inform commissioning decisions. NHS Wales needs to be able to deliver equitable and timely access to emerging ATMPs for all patients.

This area is rapidly developing with significant growth potential for the ATMP sector in Wales. Countries such as the USA, Canada, Japan, China and Australia have already taken a proactive strategic approach to capitalise on opportunities in this sector.

Alongside clinical adoption and aligned with wider Welsh Government ambitions, there is an opportunity to create a thriving and dynamic environment for ATMPs through strategic partnerships with industry and academia to increase prosperity alongside improving health and well-being for the people of Wales. To achieve this Wales will need to continue to be open to partnership and collaboration, at a national, European and international level, and play a significant role in this sector. This will require effective working with existing organisations (e.g. the Life Sciences Hub Wales, Health Technology Wales, Health and Care Research Wales, Welsh Health Specialised Services Committee, Health Education and Improvement Wales) national programmes (e.g. Value-based Healthcare, Genomics for Precision Medicine), academic and commercial partners, and the third sector. There will be unique opportunities to drive a “Once for Wales” approach to adoption and innovation at local, regional and national level meeting the aims of *A Healthier Wales: Our Plan for Health and Social Care*, and aspirations of the *Well-being of Future Generations (Wales) Act 2015*, within the philosophy of Prudent Healthcare. The Life Sciences sector, of which ATMPs form a part, is without doubt an industry of the future and the *Economic Action Plan for Wales* is a firm commitment to accelerating innovation and enhancing cross-cutting collaboration between the NHS, academia and industry.

This Statement of Intent outlines the challenges, opportunities and actions necessary to develop a sustainable strategic approach to developing the ATMP sector in Wales.

Key Priorities

1. Public Involvement and Engagement

The public are central to healthcare in Wales and will be at the heart of the development of systems and services to enable broad adoption of these treatments. Meaningful public involvement and engagement will allow the public and patients to contribute as equal partners to co-producing services for Wales that make a real difference. This will promote value-based medicines and approaches which prioritise achieving the outcomes that matter most to the people of Wales, rather than being over-focused on the service delivery process.

It will be necessary to continue to engage with and educate the public and patients around life-style related disorders, and their origin and management. Consequently there is a need to provide up-to-date accurate information, in an appropriate form and engage people in the debate around these potentially transformative therapies. It is essential that we enhance public understanding of the balance between cost, value and potential benefits that both experimental and developed ATMPs will have on patient outcomes and society as a whole.

ACTION

- NHS Wales will develop effective, targeted communication methods and maximise opportunities to work with the public to facilitate co-production of services and provide patients and the public with information to enable them to engage with decisions around commissioning, and the adoption or non-adoption of these treatments.

2. Clinical Pathways

Supply chains and treatment pathways are well-established for traditional small molecule medicines, but ATMPs require new systems to be designed, developed and implemented. These will include the treatments themselves, as well as manufacturing facilities, IT systems, logistics solutions, support services and companion diagnostics. There is close interconnectivity between ATMP pathways and developments in other specialties, such as genomics, pathology and imaging.

Ongoing programmes with industry, academia and service providers will supply an initial pathfinder approach for the development of clinical pathways and systems. This work will inform an understanding of the challenges of developing new ATMP pathways and potential solutions. This new knowledge will need to be shared across NHS Wales, and beyond. The requirements for ATMP delivery will include: estates, infrastructure and equipment; workforce and training; quality management and regulatory compliance; IT; and patient experience. ATMP pathways are complex in terms of production and patient administration, often requiring input from several medical teams. From patient identification, through treatment, and to short- and long-term follow-up, the existing clinical systems and processes within the health and care setting will require reconsideration. For cell-based ATMPs the nearest current clinical pathway is stem cell transplantation, and the expertise and standards required to deliver these treatments has been recognised as the basis for developing ATMP-related pathways in the NHS.

The patient care pathways for ATMPs will require a range of complementary services: timely access to diagnostics, preparatory treatments along with access to operating theatres and intensive care facilities. These pathways will span secondary and tertiary care, across active treatment and patient follow-up.

ACTION

- NHS Wales will establish a mechanism for coordinating and collaborating on a local, regional and national basis, including how to identify, map and share best practices for pathways.

3. Regulatory Compliance, Quality and Safety

There is a wide range of regulatory and quality standards for ATMPs that spans manufacturing, storage, transport, clinical facilities, quality management, policies, procedures, patient and product data, research activity, and patient care. For existing cellular therapies accreditation to FACT-JACIE (Foundation for the Accreditation of Cellular Therapy - Joint Accreditation Committee of the International Society for Cellular and Gene Therapies (Europe)-European Society for Blood and Marrow Transplantation) is standard and is typically mandated for the entire clinical pathway.

Whilst there are FACT-JACIE accredited facilities for cell-based therapies in Wales, there is a need to ensure the accreditation scope covers the future ATMPs that will be delivered through those centres. Furthermore, there is additional need to evaluate the specific requirements for other ATMPs that will be delivered through new centres in Wales. Regulations and quality standards are rapidly evolving and keeping pace with the rate of change and advancement in this sector. As such, it will be necessary to monitor, prepare for and dynamically react to these changes, along with those changes mandated by the *European Union (Withdrawal) Act 2018*. It is important to anticipate and prepare for all these new requirements to maintain compliance, and the expertise and systems to support these requirements.

ACTIONS

- NHS Wales' delivery and commissioning groups will review FACT-JACIE accreditation requirements anticipating short, medium, and long-term needs for [cell-based] ATMPs.
- NHS Wales will review broader regulatory and quality standards requirements (e.g. Human Tissue Authority, Human Medicines and Healthcare Products Regulatory Agency) for existing and future ATMPs.
- NHS Wales will develop a sustainable mechanism to support national adoption and compliance with emerging regulations and mandated standards and best practice.

4. Workforce Development

The initial adoption of ATMPs, and subsequent sustainable delivery and growth, will require new knowledge, skills, and competencies for each pathway, profession and partner. New workforce models will need to reflect the entire ATMP pathway, including the required phasing, scalability, cross-profession and multi-partner working. Professional bodies, academic centres, and staff in clinical practice will play a significant role in informing and developing new training and educational pathways. For the NHS in Wales, Health Education and Improvement Wales (HEIW) will lead on strategic workforce planning, education and continuing professional development. It will be important to ensure a close working relationship with NHS staff, professional bodies, commercial, trade and non-commercial/third-sector organisations to ensure training and education provision matches the evolving needs of this sector.

Many ATMPs are in an experimental phase and manufacturing processes are largely underdeveloped and niche. As a result, the skills and knowledge requirements associated with ATMPs are highly specialised (often post-doctoral). Until the industry matures, we will become increasingly reliant on highly trained professionals whilst processes are automated, mainstreamed and technician-controlled.

The commercial sector has identified proposals to increase the capability and capacity of the UK science talent pool to meet needs over the next decade. These include strengthening the link from academia to industry, STEM outreach, and promoting vocational and experiential training opportunities. The availability of skilled technical staff will be essential in the transition from small to large-scale production. Developing a detailed workforce and education strategy in Wales for advanced therapies will be a vital component of a future work programme.

ACTIONS

- NHS Wales will work with HEIW and partners and will develop a workforce plan for ATMPs that reflects the evolution and emergence of new treatments.
- NHS Wales will work with HEIW, and other professional bodies, to review relevant undergraduate and postgraduate curricula as well as CPD provision for current and future workforce requirements to establish if they are fit for purpose.
- NHS Wales will work with Welsh Government to ensure the funding models will allow the delivery of a national approach to workforce training that reflects the evolving needs of ATMPs.
- NHS Wales and Welsh Government will work with industry, academia and other partners to support the growth, skills, competence and expertise of the workforce in Wales.

5. Estates

The adoption of ATMPs, including the establishment of clinical pathways, service specifications, and meeting regulatory requirements, will require timely access to the appropriate facilities. This includes the collection of components, materials and tissue from patient or donor, through to preparation, administration and post-treatment care. Near patient manipulation, storage and transport will need consideration, some approaches to which will be outputs from current programmes of work. In the short-term, there will be a need to adapt and upgrade existing facilities. In the medium to longer-term, further strategic planning that includes academia and industry will be required to inform investment decisions. Where possible, flexibility and future-proofing of infrastructure should be ensured to maximise value from capital-intensive investments, coupled with a phased implementation approach to ensure adequate capability and capacity at all times.

ACTIONS

- NHS Wales will review current infrastructure, resources and facilities necessary for the delivery of ATMPs in Wales such as clinical trials delivery, general wards, and laboratory and pharmacy services.
- NHS Wales will facilitate the development of a coordinated approach to identify, evaluate, and prioritise infrastructure needs based upon emerging ATMPs.
- NHS Wales will ensure that regional utilisation, workforce consideration, and facilities are considered in business cases and procurement decisions.
- NHS Wales and Welsh Government will work with industry and academic partners to develop a long-term strategic infrastructure plan, and bring consideration of ATMPs to wider NHS development planning.

6. Informatics and Information Governance

Developing a high quality and robust informatics ecosystem will be critical for delivering a world-leading, sustainable, effective and efficient ATMP service in Wales. *Informed Health and Care - A Digital Health and Care Strategy for Wales (2015)* and *A Healthier Wales: Our Plan for Health and Social Care in Wales (2018)* outline the vision for improving access to information and introducing new ways of delivering care with digital technologies. Effective planning and resource allocation will

be needed to support the development of the requisite connected IT environment for ATMP delivery.

A coherent vein-to-vein informatics network will be necessary to enable seamless sharing of necessary information between care setting and product supplier, to allow effective management of care pathways and follow-up, and for ensuring chain of custody and identity of the ATMPs.

An adaptive informatics infrastructure will be required to allow multiple NHS IT platforms to interface with ATMP supplier systems in order to maintain a reliable and seamless linkage through cell harvest, transport, manipulation and therapeutic delivery. A safe and effective product supply chain will require efficient exchange of information between the health provider and supplier, allowing appropriate patient data to be accessed and shared in a safe and secure manner that complies with the best standard of information governance.

An informatics ecosystem will need to enable improved understanding of patient demand, provide validated data for service modelling and benchmarking, and so inform demand management. Relevant and real-time key performance indicators will need to be developed to ensure the future ATMP service meets demand.

Healthcare informatics stakeholders (e.g. NHS Wales Informatics Service, Secure Anonymised Information Linkage Database, industrial partners, academia) will need to collaborate to develop an approach to compliantly access patient data and records for research purposes (e.g. meta-data analysis and clinical trials), identification of potential treatment cohorts, and to inform service planning and commissioning decisions. There is ongoing UK work to develop potential solutions to these needs. Consequently, all activities in Wales will need to be cognisant of such initiatives and where necessary aligned with UK outputs and international best practice.

ACTIONS

- NHS Wales will develop a plan for informatics, information governance, and business intelligence, and explore this with commercial partners.
- NHS Wales working with Welsh Government will ensure ATMP informatics requirements are included in strategic plans.
- NHS Wales will establish a sustainable mechanism that ensures relevant national and international informatics and information governance requirements are met.

7. Research and Innovation

7.1 Trial Delivery

Evidence indicates that patients treated in research-active environments have significantly improved outcomes. Due to this and the beneficial potential of ATMP treatments it is important that we ensure Wales maintains an active, credible and relevant clinical trials portfolio and platform.

Consideration will need to be given to physical infrastructure, collaborative and joint-working agreements, and in developing the necessary engaged, empowered and educated workforce. These are critical elements that will enable the sector to grow and develop and in turn will improve health, well-being and prosperity for the people of Wales.

Simplification of study set-up, contract management, and trial delivery will be important to attract and retain trial sponsors. Work is ongoing in Wales to streamline study set-up in alignment with wider UK processes, and to develop an all-Wales coordinated approach to contracting and costing of research. Additionally, opportunities exist to assist the identification and recruitment of patients for studies and subsequent trial delivery by learning from proven initiatives, such as the Bloodwise UK Trials Acceleration Programme.

Similarly, an opportunity exists to review financial considerations, such as adequacy of excess treatment and service support costs provided by Welsh Government for delivering non-commercial ATMP trials. The local support and delivery funding model supported centrally needs to be considered due to the complexity of ATMP clinical trials.

For the commercial ATMP sector to grow in Wales a single point of entry will be necessary. A national collaborative framework of organisations (e.g. The NHS in Wales, the Life Sciences Hub Wales, MediWales, Industry, UK and international partners, Health and Care Research Wales) could facilitate this.

7.2 Academic and NHS collaboration.

University status within the NHS in Wales provides an excellent environment and base for the development of expertise and new treatment approaches, products, services and clinical pathways. However, it is recognised that there are opportunities to improve and optimise the effectiveness of working partnerships. Translation of outputs and progression of ideas from academic and pre-clinical researchers, particularly to Phase I clinical trial, could be facilitated by identifying and connecting with relevant clinical counterparts. Differing priorities between NHS bodies and universities can result in a disconnect between service delivery and academic study that may be further impacted by factors such as the lack of access to procedural knowledge, accessible specialist equipment or funding to allow the translation of research into service provision.

Wales has a number of internationally recognised academic and clinical research clusters which undertake world class research and possess expertise in a number of fields. An opportunity exists to build upon this established academic and translational science base by further developing existing capabilities and capacities, retaining and attracting world-leading researchers and academics for Wales and developing Centres of Excellence.

Innovative funding solutions will be required to support the delivery of the above initiatives, the final approach to which will draw upon experience from both established centrally-funded and pathfinder models, such as the Life Sciences Bridging Fund. Regardless of the final route(s) to support that is adopted it is vital that Wales fully exploits the potential of our academic expertise.

Closer working and collaboration between academia, NHS Wales and other commercial and non-profit organisations will expedite bringing new products and innovations into a clinical setting. It is anticipated that this will lead to opportunities to generate and secure valuable, new intellectual

property (IP) in its various forms. Due to the complexity of the associated technologies (ATMPs and their production, deployment and adoption systems) careful oversight and management will be required to ensure that all opportunities are maximally exploited. Consequently, Research Offices

and Technology Transfer teams in NHS Wales and Universities may require additional speciality expertise and legal input that could be facilitated by organisations such as AgorIP

7.3 Horizon Scanning

Due to the fast pace of development of ATMPs and demands of associated clinical trials, horizon scanning will be essential to ensure that stakeholders are aware of new developments and opportunities in a timely manner. It is essential that the commissioning bodies, service providers, and professional directorates continue to assess new products and innovations promptly to improve planning, initiation and phasing of programmes. There is an opportunity to develop further the co-ordinated horizon scanning approach for this sector, bringing together intelligence and expertise, from additional interested organisations and stakeholders. These would include, the All Wales Medicines Strategy Group (AWMSG), Welsh Health Specialised Services Committee (WHSSC), NHS Directorates and Health Technology Wales; along with their UK counterparts and (trade) associations such as the ABPI.

ACTIONS

- NHS Wales, Welsh Government and Health and Care Research Wales will work to further support clinical trials of ATMPs in the short term.
- NHS Wales and Welsh Government will work with stakeholders to develop a strategic plan to ensure that research and innovation opportunities and current challenges for ATMPs are addressed (e.g. clinical trials, finance, strategic partnerships, Centres of Excellence) in order to improve health, well-being and prosperity for the population of Wales. This will include the link to adoption and commissioning.
- NHS Wales will work with stakeholders in order to develop an effective horizon scanning service for emerging ATMPs and related innovations to support strategic planning.
- NHS Wales and Welsh Government will work with stakeholders to develop a national network that will provide a strategic framework for ATMPs in Wales, which could include signposting and supporting academic and commercial research opportunities.
- NHS Wales will review funding for translational research in the advanced therapies sector to identify current opportunities and gaps, and explore new opportunities that build on successful models in other sectors.
- Health and Care Research Wales will actively consider the research, development and innovation of ATMPs in the development of its systems and processes for Wales, including its infrastructure support role.
- Welsh Government will work with NHS Wales to explore sector opportunities with higher education institutions in Wales.

8. Hosting and Commissioning.

The rapid emergence of new ATMPs, with high associated expenses and curative potential, will require the NHS in Wales to consider the suitability of its service planning and commissioning activities to enable the delivery of these therapies in Wales. Responsibility for a majority of the commissioning for ATMPs will reside with WHSSC, which is responsible for the joint planning of specialised and tertiary services on behalf of Local Health Boards (LHBs) in Wales. However, initially a national approach will be taken and WHSSC will commission all ATMPs delivered in Wales.

Consequently, ATMP developers will require clarity of the role and methods of co-ordination amongst stakeholders, service providers, commissioning and advisory bodies such as: Local Trusts and Health Board planning functions; AWMSG; Health Technology Wales; and WHSSC.

Conventional NHS therapy appraisal and reimbursement models are being challenged as they may not support commissioning decisions for ATMPs. Currently these treatments can be expensive per patient and are supported by a limited evidence base, but as they potentially offer substantial or transformative health gains and wider societal impacts they are worthy of careful consideration. Whether or not the current appraisal processes are the most suitable warrants further review as the sector matures and more ATMPs and relevant data become available. To find innovative solutions to these issues there is potential to engage with product suppliers, through collaborative working and co-production, and that builds on existing projects.

Given the differences between ATMP pathways, consideration will need to be given to how and where services are provided in Wales. Location, infrastructure, clinical delivery capability and capacity, and clinical governance will require significant consideration in order to support forward facing commissioning plans

ACTIONS

- WHSSC will work with NHS Wales, Welsh Government and relevant stakeholders to review the commissioning strategy to consider the emerging challenges related to ATMPs (e.g. costs and benefits, service providers).
- WHSSC, NHS Wales and Welsh Government will consider approaches to partnership working to develop new models of commissioning.

9. Strategic Partnerships

Due to the potential economic promise and healthcare benefits of ATMPs there is an aspiration for the UK to be a global leader in the development, delivery and commercialisation of ATMPs to attract a breadth of commercial organisations to the UK, stimulating sector growth. Welsh Government has an opportunity to ensure alignment of ambitions with those of the UK by building a stronger strategic agenda for science and innovation to support the economy with an effective translation through innovation to more high quality jobs. This approach recognises the links between the research and science-skills base and the processes that transform scientific outputs into economic advantage, improve health and well-being and benefit the Welsh population and economy.

Wales boasts clusters of genuine excellence from research to manufacturing and is well placed to exploit and develop opportunities in terms of scale, integration and access to markets. There is a growing ATMP sector, with an increasing number of commercial companies who benefit from close ties and strong support from the Welsh Government, NHS Wales and academia. These organisations address all aspects of the overall therapeutic supply chain including delivery, administration and follow-up pathways. This encompasses the design, implementation and support services for clinical trials; information technology systems; cold chain transport and logistics; storage and distribution solutions; as well as those developing therapies in a range of clinical areas (e.g. heart disease, tissue injury, blindness, and cancer).

Within the context of the global environment and supply chain, the UK-wide focus in this and the wider Life Sciences sector, Wales needs to create a strategic approach to cementing a position as a global player in ATMPs. In creating a strategic approach for Wales in this sector our specific potential, as well as the needs of healthcare systems and of our population must be recognised. There should be a focus on areas of strength where we can provide solutions and skills to support the development, delivery, equitable access and adoption of these transformative therapies and not seek to be world class at every element from conception to patient delivery. It is clearly recognised that benefits to the Welsh economy must be won in an international market. Wales' ability to work collaboratively to embrace and encourage innovation will drive new business investment and job creation in Wales.

Wales is well placed to deliver on these developments. The Life Sciences Hub Wales is positioned to be a key partner to accelerate economic development activity within the life sciences sector. Adoption of an open participation model, based on co-design and engagement between healthcare, industry and academia, will aid the identification of solutions which will meet health needs. Access to facilities and a well trained workforce are crucial elements in enabling partnership working.

Aligned to the above strategic commitments UK Government funding plays a key role in supporting development in the sector, including aspects of the research, translation, production, adoption and deployment of ATMPs. For example, in March 2018 competitive grant funding was secured to establish the Midland Wales-Advanced Therapy Treatment Centre. This consortium will explore a number of the challenges outlined above, and the outputs of this programme will be used to direct and inform subsequent strategic implementation plans.

ACTIONS

- Welsh Government will work with national, UK and international partners to provide strategic leadership for ATMPs in Wales.
- NHS Wales and Welsh Government will work with partners (e.g. Life Sciences Hub Wales) to develop a plan for strategic partnership working that increases new opportunities for ATMPs in Wales.

10. Next steps

A national Advanced Therapies programme and associated board will be formed to develop an implementation plan. A Programme team (currently hosted by the Welsh Blood Service) will support delivery of the plan and continue to act as a resource centre providing sector expertise and domain knowledge. The programme will engage with the public and other stakeholders and will report back to ministers in summer 2019. The implementation plan will be delivered in partnership together with and led by NHS Wales.



CABINET STATEMENT

Written Statement: Precision Medicine

Vaughan Gething, Minister for Health & Social Care

We are living in an era of rapid technological innovation, which is permeating every area of our lives. Increasingly this will include the management of our health and care. This technological revolution is opening up new areas in our understanding, detection and treatment of disease. Through these innovations we are entering into a new era of healthcare called 'precision medicine' which holds the promise of more personalised health and care. Advances in DNA analysis for the diagnosis and targeted treatment of diseases, such as cancer; point of care testing for infection control and the use of Artificial Intelligence to support clinical decision making together with digitally connected health records are just a few examples of how technology will support the provision of personalised care.

In Wales, our journey towards precision medicine is well underway and I am confident that we can be a front runner in the global race to harness the potential of precision medicine. It is vital that we have a connected and collaborative approach towards precision medicine and that our story is heard both in and outside Wales as an example of good practice and of working together towards a common set of goals.

NHS Wales is on the cusp of realising the significant benefits that can be delivered from providing the right test or treatment to the right patient at the right time. The continuing evolution of precision medicine will help us to mitigate the escalating costs we face from providing excellent healthcare to an ageing population whilst providing more care closer to home. Our long term plan "A Healthier Wales" recognises the importance of moving towards earlier detection and intervention which is designed to prevent illness and prolong independence.

The integration of diagnostics and personalised therapies with big data (e.g. machine learning) are the vital components for expanding precision medicine and the enhanced delivery of high value care. We already have strong foundations in place to widen the options for prevention, diagnosis and more effective treatment.

My vision for precision medicine has two elements, which are integrated diagnostics and advanced targeted therapeutics. For both elements we have a clear national vision that sets out how we will transform our services to create sustainable, high quality, future-facing care pathways that have space for increased research, innovation and strategic partnerships.

In the NHS, diagnostics must be firmly positioned at the forefront of patient care. If we can know earlier what the diagnosis is, we can be more effective with our decisions and provision of care and support. Accurate and appropriate diagnosis provides the bridge for decision making between the clinician and the patient that will lead to better patient outcomes and experiences. We must strive to improve the prediction and prevention of disease. There are already a wide range of advanced technologies that can yield higher quality laboratory and imaging results than were previously available only a few years ago. For hundreds of years the examination of tissue sections and blood samples has been carried out using a microscope and glass slides. Since 2019, we have had digital microscopy for pathology tissue samples in all University Health Boards (UHBs). Building on the successful work in Betsi Cadwaladr UHB, the digitalisation of pathology workflows will be a vital first step to harness the potential for computational approaches for pathology image analysis. Here, I want to be clear that we are transforming accepted clinical practice that has been in place well before the creation of the NHS and embracing new technologies for the betterment of patient care and our service.

Today, I have published a Statement of Intent setting out plans for a national programme to transform pathology services, like digital pathology, across Wales. This provides the strategic framework for working with NHS Wales and partners to develop an implementation plan that will be presented for my consideration later in the year.

Last year, I published a strategic framework setting out a national vision for transforming imaging services across NHS Wales. An early priority was to establish the National Imaging Academy (Pencoed), which I opened last month. We are also working with NHS Wales on plans for an all-Wales approach to investment in positron emission tomography scanners that provide highly accurate images of disease and guide subsequent treatment decisions. Last year, through Welsh Health Specialised Services, we commissioned a wider range of PET scans in Wales and this year we are broadening the number of conditions that we scan to meet the emerging evidence base. These are just two examples of us doing what we say, more will follow and will include new ways of multi-professional working, improved image sharing across Wales and the analysis and accurate detection of disease through artificial intelligence.

Human and pathogen genomics are important components of the personalised medicine journey and will refine the diagnosis, treatment and prevention of disease

in Wales. Building on the Genomics for Precision Medicine Strategy that I published in July 2017, Genomics Partnership Wales will provide the foundation for the infrastructure needed to develop world class genomic services for the people of Wales. The pace of change in the field of genomics is startling. I am committed to making sure that people have access to the latest genomic tests and pleased to say that £5.9m has been allocated in 2019-20 to continue to take forward the Strategy and this includes an additional £2.3m to support the delivery of new genetic tests. We will continue to work with our UK colleagues to make sure people have access to the right test when needed and ensure there is mutual benefit from UK research and innovation funding for genomics.

On an almost weekly basis, we hear of new disease treatments through cell and gene therapies. Our understanding of disease and our ability to manipulate human tissue is ushering a new era of advanced therapeutics. Regenerative medicine (stem cell therapies, gene editing and gene therapies) are treatments which seek to replace, repair or regenerate the body's cells, tissues and organs. A number of the emerging regenerative medicine treatments offer potentially curative or long-term treatments for chronic diseases, as well as new opportunities for personalised cancer therapeutics using the patient's own immune cells. Given the need to ensure health system readiness for implementing these therapies as their number and range expand over the coming years, I have also today published our Statement of Intent for Advanced Therapeutic Medicinal Products. This sets out our intention to develop and deliver a national approach for precision therapeutics in Wales. We will build upon the successful UK Industrial Strategy Challenge Fund bid to support an Advanced Therapies Treatment Centre, to work with NHS Wales, industry and academic partners to prepare an implementation plan that will report back to me later this year.

In keeping with precision therapies, I visited today the Rutherford Cancer Centre in Newport where they will provide proton beam therapy for some adult cancer cases. Proton Beam Therapy is a highly targeted radiotherapy technique which will support the treatment of patients with otherwise difficult to treat cancers. The relationship with the Centre is new and illustrates how we are working collaboratively for the betterment of patients in Wales so that they can access this treatment locally.

There are huge opportunities to support patient care by the use of digital data and our ability to interpret the information in a meaningful and valuable way. The quantity, quality and relevance of patient information being collected today, with the promise of more tomorrow, will be critical to improving precision in medical diagnoses and treatment. We already safely and securely collect, collate and care for significant amounts of patient data through the electronic patient record and Welsh Government supported Secure Anonymised Information Linkage Databank (SAIL). We will also be able to capture and store large amounts of quantitative data from high-resolution medical images and there are big strides to be made by analysing the results of the

visual images using diagnostic algorithms which will help to reduce variability in diagnosis. Over time, the application of deep learning and artificial intelligence techniques to anonymised clinical data sets will give clinicians and medical researchers the ability to establish connections and patterns that would not be apparent if data sets were smaller and involved human interpretation alone.

One of the most pressing cross-cutting requirements is the need for improved informatics infrastructure to be able to collect, store, share, integrate and analyse the vast amounts of patient data. Without the underpinning investment in informatics platforms and software solutions progress towards greater personalisation will stall. In a fast evolving era of data and machine learning it will be crucial that our health system's informatics solutions are sufficiently agile and flexible to respond to the evolving capabilities of these new biomedical and digital health technologies. Welsh Government are supporting this drive through our digital strategy and investing in the development of the National Data Resource.

Unlocking the real opportunities from precision medicine and artificial intelligence will require even greater collaboration with innovators from industry and academia, as well as meaningful engagement with both the patient and public, to support joint decision making and patient empowerment. With everyone committing to this journey, we can foster a culture of trust that will permeate healthcare and ensure that new technologies are integrated swiftly for the benefit of patients.

We are fortunate that we already have a strong cluster of life science companies and the Life Sciences Hub who can help to support our journey into the precision medicine era. We have strength, depth and close working relationships with our academic partners in Wales, many of which already have both national and international reputations in precision medicine. I am keen that we should build on our strong foundation and international reputation of excellence in clinical research and industry activity and look to further strengthen our national and international position in precision medicine.

We will fully explore opportunities like the Cardiff City Region Deal and those emerging from the UK Government through the Industrial Strategy and Life Sciences Sector deal to benefit businesses in our life sciences sector as well as the people of Wales. We will use 'national collaboration' and a 'system-level approach' to create an axis of precision medicine progress, encouraging and creating opportunities for others to work with us on this journey so that we can play our part in this global revolution.

My ambition to expand precision medicine and to put diagnostics at the forefront of care will lead to higher value patient care. Our ability to capture and harness the significant benefits from future advances in diagnostics and personalised therapies, together with powerful artificial intelligence, are vital if we are to improve patient

outcomes and help to mitigate the significant financial pressures our health system faces on a daily basis. Collaboration between all our partners involved in these initiatives is vital to ensure that precision medicine will create the foundations for a learning health system that will drive ongoing improvement, research and innovation in healthcare practice.

This statement is being issued during recess in order to keep members informed. Should members wish me to make a further statement or to answer questions on this when the Assembly returns I would be happy to do so.

Documents

[Advanced Therapies Statement of Intent](/sites/default/files/inline-documents/2019-04/190409%20-%20VG%20-%20Advanced%20Therapies%20Statement%20of%20Intent%20-%20English.pdf) (/sites/default/files/inline-documents/2019-04/190409%20-%20VG%20-%20Advanced%20Therapies%20Statement%20of%20Intent%20-%20English.pdf)

301 KB

[Pathology statement of intent](/sites/default/files/inline-documents/2019-04/pathology-statement-of-intent.pdf) (/sites/default/files/inline-documents/2019-04/pathology-statement-of-intent.pdf)

362 KB

First published

9 April 2019

Last updated

9 April 2019

TRUST BOARD

CONVALESCENT PLASMA PROJECT UPDATE

DATE OF MEETING	24 th September 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Huw Lovett, Portfolio Project Manager
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PRESENTED BY	Alan Prosser, Interim Director of Welsh Blood
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EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer
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REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
EMB	14/09/2020	NOTED

ACRONYMS

BECS	Blood Establishment Computer System
CCP	COVID-19 Convalescent Plasma
NHSBT	NHS Blood and Transplant
PHE	Public Health England
WBS	Welsh Blood Service
WG	Welsh Government

1. SITUATION/BACKGROUND

- 1.1 COVID-19 convalescent plasma (CCP), antibody-rich plasma donated by recovered COVID-19 patients, is a promising treatment option for COVID-19. Treatment involves transfusing CCP to sick patients to boost their immunity and ability to fight the virus.
- 1.2 The Welsh Blood Service (WBS) has been commissioned by the Welsh Government (WG) to collect CCP for use in a number of clinical trials looking at Covid-19 therapies, and has approved funding to support this work.
- 1.3 A project was set up in March 2020 to begin collecting CCP taken from whole blood donations and the first donations were taken in April 2020. As the plasma is derived from a whole blood donation the donor is unable to donate again for at least 12 weeks. By this time the antibody level within their blood is likely to be so low that their next donation will not be suitable for use as a CCP unit.
- 1.4 A second phase of the project is now underway to set up a pilot plasma collection service utilising plasmapheresis technology.
- 1.5 Plasmapheresis technology enables WBS to collect only the plasma component of a donor's blood. Because only the plasma is being taken WBS can potentially collect several plasma units from one donor in a single donation. In addition the donor can be bled more frequently (potentially every 2 weeks). This means that a donor can be bled repeatedly over a period of time when their antibody levels are more likely to be at their highest, thereby enabling WBS to build its stock of CCP at a quicker rate than by whole blood collection alone.
- 1.6 WBS has committed to being in a position to begin collecting CCP by plasmapheresis by 31st October 2020.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The WG funding has enabled WBS to purchase 10 plasmapheresis machines. These machines will be split across north, south and west Wales in new fixed plasmapheresis donation venues at the following locations:
 - Welsh Wound Innovation Centre, Talbot Green
 - WBS west Wales team base, Dafen
 - Pembroke House, Wrexham (WBS north east Wales base)

- 2.2 Validation of the new machines is progressing on schedule and configuration changes are being made to the ePROGESA Blood Establishment Computer System (BECS) to enable plasmapheresis donations to take place.
- 2.3 Antibody testing has been brought in-house, having previously been outsourced to Public Health England (PHE). A Contingency Agreement has been put place with NHS Blood and Transplant (NHSBT) to provide antibody testing as a business continuity measure.
- 2.4 Additional staff have been recruited to allow existing blood collection staff to be released to attend training to deliver plasmapheresis clinics.
- 2.5 As part of project governance arrangements a Project Group has been established to oversee and direct the project within WBS. The Project Group meets on a weekly basis and receives regular Highlight Reports from the Project Management Team on project progress.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The activity will support WBS in expanding its provision of safe components for treatment of Covid-19.
RELATED HEALTHCARE STANDARD	Staff and Resources
	Staying Healthy, Timely Care, Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	The activity will support WBS in providing plasma collection services more equitably across Wales.
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.



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FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Welsh Government capital and revenue funding has been provided for an initial period of 12 months (April 2020 – March 2021). Ongoing funding will be required to continue to deliver the service beyond this period and WBS are actively discussing this with WG.

4. RECOMMENDATION

4.1 Board are asked to note the contents of this report.



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TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING

24/09/2020

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

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;

- Board Briefings on 27th August and 10th September
- Integrated Governance Group on 21st September
- Annual General Meeting on 22nd October
- Recent Work on Committee Structure, Risk Appetite and Board Champion Roles
- Birthday Honours 2021 Nominations
- Independent Member Update

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Board Briefings on 27th August and 10th September

2.1.1 The Chair would like to summarise matters discussed at the recent Board Briefing sessions.

2.1.2 During the session on 27th August the Board had a discussion regarding the background to some of the latest developments in radiotherapy capacity modelling and the alignment with wider service improvement programme in the Velindre Cancer Centre. There was then an update on the planning permission process for the building of the new Velindre Cancer Centre. Finally the Board discussed some of the latest stakeholder feedback on the development of the regional cancer service model.

2.1.3 During the session on 10th September the Board were provided some development time on risk appetite which was facilitated by external experts from Ernst & Young. The Board were then provided with an update on the context for the latest performance with respect to systematic anti-cancer therapy (SACT). The latest data is indicating an expected impact on performance following the Covid-19 pandemic and this would be presented to the Trust Board in today's meeting. The Board then discussed the latest developments in engagement with stakeholders on the regional cancer service model.

2.2 Integrated Governance Group on 21st September

- 2.2.1 The Chair would like to note that there will be a meeting of the Integrated Governance Group on 21st September and an update from that meeting will be noted in the Trust Board.

2.3 Annual General Meeting on 22nd October

- 2.3.1 The Chair would like to note an update to the date of the Annual General Meeting which is now 22nd October. The corporate governance team is exploring various options for how to best facilitate an engaging meeting and showcase event which will be accessible to all our stakeholders.

2.4 Recent Work on Committee Structure, Risk Appetite and Board Champion Roles

- 2.4.1 The Chair would like to thank the Independent Members for their work over the past few months on the committee structure, risk appetite and Board Champion roles. These are all important pieces of work to support the on-going development of the organisation and the approach has been collaborative, with significant input provided by all Members, resulting in co-produced and high quality output.

2.5 Birthday Honours 2021 Nominations

- 2.5.1 The Chair would like to draw the attention of the Board to the invitation for nominations from the Head of Public Appointments and Honours for the Birthday 2021 honours round. The Chair would welcome views from Board Members on possible nominations they may like to make that this is indicated to the Director Corporate Governance within the next two weeks.

2.6 Independent Member Update

- 2.6.1 The Chair is delighted to confirm that the Minister for Health and Social Services has agreed to extend the appointment of Mrs Jan Pickles as Independent Member (Quality) of Velindre University NHS Trust until 30 September 2021.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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	24/9/2020	
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	Steve Ham, Chief Executive	
REPORT PURPOSE	FOR NOTING	
COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
N/A		Choose an item.

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;

- Further development of in the management of the clinical model and the Nuffield Trust appointed to provide independent advice
- Consideration of service delivery over the next period

- Update on preparing for the next phase as an organisation

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Further development in the management of the clinical model and the Nuffield Trust appointed to provide independent advice

The model of care for cancer will continue to develop over time with changes in clinical practices, advances in treatments, changes in technology and evolving expectations and choices from patients and their families about how they would like to be cared for. Understanding and adapting to these changes is at the core of what we do as clinicians, support and management teams.

The Transforming Cancer Services Programme has facilitated further development of the model over the past few years, with extensive input from stakeholders in agreeing key themes including: care closer to home; more integrated care; better use of technology; a holistic and partnership approach; and improved facilities. This service model has been at the heart of driving the plans to build a Radiotherapy Satellite Centre in Abergavenny, a new Velindre Cancer Centre in Whitchurch and significant investment in radiotherapy equipment.

For the next phase the arrangements are evolving, so that the responsibilities for driving the design for service model in the future, as well as continuing with the responsibilities of leading changes required today, will be led directly from the clinicians and management team within the Velindre Cancer Centre. This work will be called Velindre Futures. The Transforming Cancer Services Programme will then deliver the infrastructure in order to deliver this service model as well as provide the platform and mechanism for the regional engagement and development of integrated services across the region with our partners.

The CEO would also like to update the Trust Board that the Nuffield Trust have been appointed to provide independent advice on the regionally integrated networked clinical model for tertiary cancer services across South East Wales. This work will conclude by end October and the Trust Board will be kept apprised of its progress and will formally and transparently receive the conclusions when available.

2.2. Consideration of service delivery over the next period

There are a number of ways in which the Board will be updated during the course of this meeting on the current service performance and the context for the next phase. The CEO would like to reflect on the significance of the challenge ahead and to thank all the staff in

the Trust for the tremendous work they have already done and to consider what they will be delivering over the next period for our patients and donors.

The service reports for the collection of blood as well as the care for cancer patients are starting to significantly reflect the impact of the Covid-19 pandemic. We were aware there would be a lag impact on our services. In the Welsh Blood Service due to the continued pressure of lockdown and changing lockdown rules impacting venues, staff and behavior of donors. For cancer services, as the risk based decisions by patients and their clinicians change further as the pandemic started to recede in July, this started to cause an inevitable spike in demand. Work to increase our capacity, in anticipation of this since April, has provided a clear means of tracking and managing the situation, nevertheless the impact on the service and the staff delivering the service continues to be significant. Layered now onto this situation is the developing picture of Covid-19 across Wales and its potential on service delivery.

The CEO would, therefore, like to provide this initial context to a number of updates that will be provided to the Trust Board today. More importantly the CEO would like to reflect on the tremendous effort and work that all staff across the Trust have provided to date in 2020 for the good of all our donors and patients. Then to also collectively not underestimate what will be required of them for the coming months also - and to underline the support, faith and gratitude of the whole Board and Executive team in them continuing to surpass expectations in delivering our service for our donors and patients.

2.3. Update on preparing for the next phase as an organisation

During the last CEO update in July, a number of themes and work packages were highlighted which the Executive team had identified in order to continue to develop the organisation into the connected, agile and engaging organisation that we want it to be. In today's Board agenda the progress against two of these significant developments is being presented for approval for the Trust Board – a new Committee Structure and a developed Risk and Assurance Strategy and Framework. This represents the first significant formal milestones for the Board in the development of these pieces of work which will now continue to embed and evolve over the months and years to come. The Board will continue to oversee the delivery of these developments as well as the changes to the organisation's culture as a result.

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
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RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	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.

2 RECOMMENDATION

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



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TRUST BOARD

HIGHLIGHT FROM THE QUALITY & SAFETY COMMITTEE

DATE OF MEETING	24/09/2020
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, & Health Scientists
PRESENTED BY	Janet Pickles, Independent Member
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Nursing, Allied Health Professionals, & Health 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 meeting held on the 27th August 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, following which the proposed revised Board Committees may come into place. 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.

3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the Quality & Safety Committee meeting held on the 27th August 2020.

ALERT / ESCALATE	No issues were identified for alerting or escalating to the Board.
ADVISE	<p><i>Welsh Blood Service accepting donations from all patients with haemochromatosis</i></p> <p>The Committee were verbally advised during the presentation of the Welsh Blood Service Quality & Safety Report of a change in for patients with haemochromatosis (a medical condition that causes people to absorb too much iron from their diet) who require therapeutic venipuncture (regular removal of blood to remove excess iron and maintain low normal body iron stores in patients). This procedure has, until recently required patients to attend hospital on a frequent basis to have blood removed (for some patients this could be as often as every</p>

	<p>2 weeks). Welsh Blood Service have not accepted patients having therapeutic venipuncture as blood donors.</p> <p>Following repeat risk assessments with hematologists since April 2020 the Welsh Blood Service is now undertaking the therapeutic venipuncture at the frequency prescribed by their hematologist instead of patients having to go to hospital. This blood is also used. This has resulted in an enhanced service for such patients, they feel as if they are helping the wider NHS as their blood is now being used, rather than being wasted and has increased donors by 85. This resulted in an additional 109 units of blood donated between April and July 2020.</p>
ASSURE	<ul style="list-style-type: none"> Quality of VCC Divisional Quality & Safety Report The Committee highlighted the significant positive improvement in the quality of information and depth of cover and reporting within the Velindre Cancer Centre Divisional report. In particular, the Committee commended the 'so what'/'You said....We did...' approach providing assurance detailing how the Cancer Centre is learning from complaints and patient feedback. Listening & Learning Sub-Committee The highlight report from the Listening & Learning Sub-Committee was discussed. The Committee in particular noted the speed at which the Sub-Committee matured and the professional approach taken by all involved in reflecting back on what could be learnt and how learning could be disseminated across the Trust. The Committee were advised that this work would now become subsumed into the Quality and Safety Committee itself moving forward. Trust Annual Quality Statement (AQS) The Committee endorsed the 2019-2020 Trust Annual Quality Statement. The AQS required some minor final changes to be made following feedback from Internal Audit. The Committee noted that a reasonable assurance rating had been provided by Internal audit and provided authority for the Chair to approve the final version on behalf of the Committee prior to publication (required by 30th September 2020). Quality & Safety Annual Report and Effectiveness Survey The Committee received its Annual Report and the results of its effectiveness survey, which are attached in appendix 1 for the Trust Board's information.

	<ul style="list-style-type: none"> Information Governance Incidents The Committee noted when reviewing the Trust Quarter 1 Incident Report a trend in relation to Information Governance incidents. As the Information Governance and Information Management & Technology Committee had been paused during the COVID-19 pandemic assurance was requested regarding more detail and understanding of these incidents, their route cause, and that appropriate remedial action has been taken. The Committee requested a detailed report from the Trusts Information Governance Manager outlining this detail to be provided at the next meeting. Workforce Report: The Committee noted from the Workforce Report the plans in development in relation to implementing a new 'Work in Confidence Platform'. The platform would allow staff to raise any issues / concerns either named or anonymously. It was discussed that the benefit of the new platform was that it allowed dialogue with anonymous contacts and allow the Trust to respond directly, whilst the individual still remained anonymous. In addition, the report provided information on the development of a Fire Safety Training Plan to increase compliance with fire training through the provision of both face-to-face, Teams and e-learning to optimize training opportunities.
INFORM	<p><i>Need for a Cover/Shelter for Front Entrance of Velindre Cancer Centre</i></p> <p>The Committee were made aware that, given the new COVID patient triaging, the need to reduce the numbers of patients within waiting area of the Cancer Centre Outpatients and that there is no available shelter when patients are being dropped off outside the entrance in adverse weather the need for a large shelter over the entrance area of the outpatient department has been identified.</p> <p>Lisa Miller assured the Committee that she has commissioned this work, and a Contractor assessment has been undertaken.</p>
APPENDICES	<p>Quality & Safety Committee Annual Report and Effectiveness Survey- attached in <i>Appendix 1</i></p>

4. RECOMMENDATION

The Board is asked to **NOTE** the report and the Quality & Safety Committee Annual Report and Effectiveness Survey.

TRUST BOARD

DEVELOPMENT OF THE RISK AND ASSURANCE STRATEGY AND FRAMEWORK

DATE OF MEETING	24/9/2020	
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	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
Board Briefing Session on Risk Appetite	10/9/2020	IN SUPPORT
Executive Management Board	2/6/2020 30/6/2020 7/9/2020	ENDORSED FOR APPROVAL

1. SITUATION/BACKGROUND

- 1.1 In January the Trust Board confirmed their sponsorship for a significant review of the organisation's risk and assurance framework. This included:

- i. Complete review and refresh of the Trust Risk Management Strategy, last updated in 2015
 - ii. Complete review and refresh of the Trust's Risk Management Framework, last updated in 2016
 - iii. Creation of a Trust Assurance Framework, which has been accepted good practice for NHS organisations in Wales for many years and the Trust has had an Audit Wales Structured Assessment action to develop such a framework since 2018
 - iv. Refresh of the Trust Risk Appetite levels, which had last been assessed in 2017 and feedback from Board members was that it did not reflect the strategic direction or priorities of the organisation. Also the creation of a Risk Appetite Strategy for the first time in order to agree how as a Organisation risk appetite was to be operationalised in our approach to strategy and risk management
 - v. Creation of a new Datix Risk Module, to create one consistent module for the Trust which will reflect all of the development above. Then agreement for and management of the migration between existing module to new
 - vi. Complete review and refresh all off the procedures and user guides for different stakeholders in the organisation for their role in risk and assurance – from the Board, Executives, Senior Management Teams, Heads of Department, Line managers and all staff
 - vii. Risk culture and training for key stakeholder groups and for all staff to develop risk culture “why is it important and what is my role”.
- 1.2. This update provides an update on this work and provides the Board with an opportunity to approve some of the key framework documents which will underpin the continued development and embedding of the various aspects.

2. SUMMARY OF MATTERS FOR CONSIDERATION

The Board is being asked to approve:

- i. Risk Management Framework – Appendix 1
- ii. Risk Management Process – Appendix 2
- iii. Risk Appetite Strategy – Appendix 3

- iv. Updated Risk Appetite levels set by the Board – As set out in the Risk Appetite Strategy
 - v. Trust Assurance Framework – Appendix 4
- 2.2. In addition, the Board is being asked to note the progress that has been made to create and refresh the content that will inform the Trust Assurance Framework, when approved, and also inform the newly formed Trust Risk Register.
- 2.3 The Board is also asked to note the important changes to the way in which risk will be managed in the organisation, which will drive a different risk culture going forwards in support of the sort of accountable, bold, caring and dynamic organisation that we want to be.
- 2.4 To illustrate points 2.2 and 2.3 above, the following section considers the changes from the perspective of different stakeholders as a result of these developments:

To note that all these comments are illustrative only, and a synthesis of the extensive engagement with many stakeholders on risk and assurance over the past few months.

i. Board Member



What did I used to see,
feel and was asked to
do?

- “I would see the risk register presented at Board each time and the relevant parts of it in the Committees on which I sat on. This was well managed and updated and I could see that the Executive team were actively considering what new risks may need to be escalated and de-escalate to it.

- However, the register was quite static in terms of the overall shape and in terms of the respective risks and it was not very easy to provide effective oversight and assurance as to how risk was being managed in the organisation.
- In addition, we agreed risk appetite levels in 2017 but I am not confident that this now reflects the type of organisation we want to be and also how effective we are as a Board in effectively apply our understanding of our risk appetite to driving the strategy of the organisation.”

What will change as a result of this development?

“We now receive two distinct reports in Board each time:

- The first is the Trust Assurance Framework. This is the articulation of the threats that we think there are to achieving our strategic objectives. We then receive a clear view from the Executive team of the controls, actions and decisions against these risks. Key is also that we can see a comprehensive range of assurances against these risks, what insight this is providing to us and also a clear view of where the Executive think there are gaps in assurance against a particular strategic risk and the action that they are taking to fill this gap.
- Secondly we receive the Trust Risk Register – but this is quite different to the one we used to receive. The Trust Risk Register is a report produced from Datix of all the risks that are recorded in the organisation that meet the criteria that we have set as a Board. This criteria is based primarily on the appetite to risk that we have set as a Board. I understand that further cuts of the risks in Datix are considered in the Executive Management Board, Senior Team Meetings of the Divisional and Functional Meetings in the organisation, depending on the levels and view of scope agreed to.
 - This now means that I have a view of all risks in the organisation, can see how the controls are operating against these and the progress of the actions that the organisation is taking to reach the target risk scores. As a result I am confident about how actively and dynamically risk is being managed at all levels of the organisation.
 - It is worth noting that to get to this point was a journey for the organisation for us and as a Board. What we used to receive in the Trust Risk Register was manually pulled together template. Whereas in now receiving a cut of

the base data in Datix, for a number of months there were data quality challenges, as staff and management teams were supported in improving the quality of the data that was being input to the system and how this was then being actively managed and tracked. However I am confident it was the right thing to do as it drives the culture we want as an organisation where risks are identified, prioritised and managed in a clear, effective and transparent way for all our staff and wider stakeholders.

- In addition to these regular reports I am confident that as a Board we understand our risk appetite and are continually developing and adapting the way in which we drive the strategy and culture of the organisation as a result”

ii. Staff Member



What did I used to see,
feel and was asked to
do?

- “As a member of staff working in a clinical setting, in a highly regulated setting or as a member of staff supporting these colleagues to provide services to our patients and donors, then I intuitively understand risk. I make risk based decisions every day for the good of our patients, donors and to work towards what the organisation wants to achieve.
- However I am not really clear about how I am meant to interact with a process called “risk” and how it can help me and my colleagues in providing the best service that we can.”

What will change as a result of this development?

- I received some training which I found really interesting and engaging as it provided me with the confidence of how I do in fact understand risk, as I'm making good risk-based decisions all the time and thinking about and acting on how to best control risks. However it also helped me to understand what the organisation has been doing to help us all manage risk in an even better way which will lead to improvements in service for our donors and patients.
- Going forwards I will have access to a new risk section of Datix and I am able to clearly and simply record if I think that there is a threat to me or my team being able to deliver what we have been asked to in the best way now or in the future.
- When I recorded a risk, I then had a conversation with the person in my section of the business responsible for that type of risk and together we agreed on the score, what controls we currently have in place and what actions we think there need to be to address the risk. This was then discussed at a governance meeting and I received feedback on what was being done about this risk. I am still involved in helping to implement the actions we agreed to take to manage the risk and this is all being recorded clearly on Datix.
- Regarding one particular risk I identified, it turned out that a similar type of risk was being raised by lots of staff across the organisation which did not have a significant impact on each occasion but that the collective impact was potentially significant. It has been fed-back to me that this has therefore been considered by the Executive Team and the Board and Organisational-wide action has been taken as a result.
- I feel empowered, listened to, accountable and even prouder of the service my colleagues and I provide to our patients and donors."

3. NEXT STEPS

If these baseline documents and frameworks are approved today, the next steps are:

i. **Updating the Trust Assurance Framework**

Progress to date:

- There have been nine workshops held which have created the draft content for the newly established Trust Assurance Framework:
 - Strategy
 - Transforming Cancer Services
 - Velindre Cancer Centre
 - Welsh Blood Service
 - Charity
 - Medical
 - Nursing
 - Finance
 - Workforce
- These workshops have been led by the Executive lead for these areas supported by some of their senior team.

Next steps:

- The initial outline of the newly articulated risks will be brought to the October Audit Committee and also the October Strategic Development Committee (if Committee structure approved). These Committees will then provide the Board with the assurance that from both a perspective respectively of the appropriateness according to the organisation's risk and assurance framework and also effective alignment with the organisation's strategic objectives.
- The Board will then start having reporting on this basis from the November meeting onwards.
- The on-going development, maturity and embedding will continue to be reported to the Board of this framework and its effectiveness.

ii. Updating the Trust Risk Register

Progress to date:

- New module has been created in Datix to reflect the newly established risk management framework and process
- The output from the risk workshops referred to above will form the basis for the refreshed articulation of risks that will be input into the new module.
- Agreed with all parts of the organisation, including divisions and change programmes, a common scoring and management approach for risk going forwards – as described in the Risk Process document.

Next steps:

- The refreshed risks will be formally assessed and articulated, including controls, target scores, actions etc – and input into the new Datix risk module.
- In addition, there will be a migration of all other risks from the previous module of Datix, as well as the manual processes (excel) running in some parts of the business, where it is agreed that these risks are required in addition to those agreed to as part of the refresh exercise.
- The initial meetings of each of the Committees in the newly established Committee structure, if approved, will then consider their particular view of the refreshed risk register.
- The Board will then have reporting from the November meeting onwards on this basis.

iii. Further development of risk culture

- All staff in the organisation to have access to new Datix module and associated training by end March 2021.
- Prior to this the mapping of risk reviewer roles through Datix to be developed and agreed and the associated management and governance routes through the organisation. In-depth engagement, training and on-going development provided to all such specific role holders.
- To also note that publically accessible versions of all of this material is being developed for the website and to share and engage with our wider stakeholders. This includes a summary of the Risk Appetite strategy, which will be ready for publication along with the longer formal document which is being asked for approval today.

4. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required



LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Board is asked to **APPROVE**:

- Risk Management Framework – Appendix 1
- Risk Management Process – Appendix 2
- Risk Appetite Strategy – Appendix 3
- Updated Risk Appetite levels set by the Board – as set out in the Risk Appetite Strategy
- Trust Assurance Framework – Appendix 4

The Board is asked to **NOTE** the on-going development of the risk and assurance control frameworks and to **SUPPORT** the next steps as articulated in this paper.

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Velindre University NHS Trust Risk Management Framework

v. Final Draft 2020

Contents

1. Statement of Commitment	2
2. Background.....	4
3. Aims & objectives	9
4. Risk strategy	11
5. Risk governance	16
6. Key accountabilities, roles and responsibilities.....	19
7. Risk domains / categories.....	24
8. Risk and control interdependencies.....	26
9. Risk documentation	28
10. Risk Reporting	33
11. Risk management process	36
12. Implementation, training and support	38
Appendix 1: Bibliography	39

1. Statement of Commitment

Velindre University NHS Trust (VUNHST) has built a strong reputation for safe, high quality care since its establishment in 1994. We are one of the leading providers of specialist cancer, blood and transplantation services together with the provision of first-class research, development and innovation that has local, national and global impact.

Made up of our **Corporate Services** (including our Workforce & Organisational Development; Finance; Quality & Safety; Governance & Communications; Planning, Performance & Estates; and Research & Innovation departments); **Velindre Cancer Centre** and the **Welsh Blood Service**; and a number of **Hosted Units**, including NHS Wales Informatics Service (NWIS), Health Technology Wales, and NHS Wales Shared Services Partnerships (NWSSP). We also work with other organisations and partners across health, local authorities, emergency services and the voluntary/charity sector; including Macmillan; Cancer Research Wales; Tenovus; and Maggie's Centre. Together we are bound by moral and legal obligations to improve the safety, quality and experience of our services for patients and donors. We are also obliged to protect our employees, volunteers and visitors/members of the public; as well as to protect our material assets and minimise any losses and liabilities as good stewards of public money.

We will not be able to meet the ambitions set out in our Five Strategic Pillars, including our Integrated Medium-Term Plan (IMTP) if we do not take risks. It is only by being innovative that we will meet the challenges for the future, and by continually looking for new and innovative ways of working, in the full knowledge of the potential risks involved.

As such, VUNHST acknowledge that some inherent risk will always exist, and that residual risk will never be fully eliminated. We are therefore committed to adopting best practice in the identification, evaluation and cost-effective control of risks to ensure that they are reduced to an acceptable level or eliminated where reasonably practicable; and that all opportunities to achieve our objectives, are maximised.

Risk management within VUNHST is a long-term commitment and an inherent part of good management and governance practices. To succeed, our strategy for risk must have the **full support of Board members** and be supported by the **active participation of the Trust Executive** and senior management, thereby improving our ability to deliver our priorities and improve outcomes.

With this in mind **all employees** must understand the nature of the risks they face and accept responsibility for risks associated within their area of work. In doing this they will receive the necessary support, assistance and commitment from senior management and Board Members.



Chief Executive Officer
Mr Steve Ham



Chair
Professor. Donna Mead. OBE

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2. Background

2.1 Purpose and context

The provision of healthcare is by its nature, a high-risk activity and the process of risk management is an essential control mechanism. To ensure that the care provided at VUNHST is safe, effective, caring, responsive to patient and donor needs and well-led, the VUNHST Board must be founded on and supported by a strong governance structure. Effective risk management processes are central to providing the Board with assurance on potential risk exposure and the appropriateness of governance arrangements. Failure to implement effective risk management processes could severely impact VUNHST's ability to deliver its objectives, affecting its reputation, resulting in serious consequences – both financial and non-financial.

VUNHST aim to make risk management integral to our culture. This Risk Management Framework (RMF) describes how we plan to do that and forms part of our internal control and governance arrangements. It defines the strategy, principles and mandatory requirements for how risks are consistently managed and embedded at all levels 'from Ward to Board', highlights key aspects of the risk management process, and identifies the main reporting and escalation procedures.

The underlying risk principles applied throughout this framework are consistent with the overarching principles of *HM Treasury's Orange Book 'Management of Risk – Principles and Concepts', 2020*; and *ISO 31000: 2018 'Risk Management – Guidelines'*. The framework also supports the UK Corporate Governance Code 2018 and the Financial Reporting Council's '*Guidance on Risk Management, Internal Control and Related Financial and Business Reporting*'.

This document should be read in conjunction with our Risk Appetite Strategy, Trust Assurance Framework (TAF), Risk Management Process (Procedures Manual) and other associated risk management guidance.

2.2 Definitions

Risk can be defined as the "effect of uncertainty on objectives". This definition recognises that we operate in an uncertain world and that potential threats, actions or events may occur (internally or externally) which could adversely or beneficially affect our ability to deliver our strategic priorities, legislative responsibilities, major programmes and business plan objectives.

To ensure consistency of understanding across our Corporate service teams, Divisions and Hosted Units, we have compiled a comprehensive list of risk management terms and definitions.

These are intended as key references for those involved in risk management and are largely based on the definitions in the Risk Management Dictionary to ISO 31000: 2018, *Risk Management – Guidelines*.

Key definitions are highlighted below:

Term	Definition
Risk	‘effect of uncertainty on objectives’
Risk management	‘co-ordinated activities to direct and control an organisation with regard to risk’
Risk management framework	‘set of activities / arrangements for designing, implementing, monitoring, reviewing and continually improving risk management’
Key Control (also referred to as ‘internal controls’ or mitigating actions’)	‘measure that maintains and/or modifies risk’ / measure, currently in place, that maintains and/or modifies a risk’s likelihood and/or impact’
Impact (also referred to as ‘consequence’)	‘outcome of an event affecting objectives’ i.e., the effect (i.e., on the organisations finances, infrastructure, and/or reputation etc.) when a risk materialises.
Likelihood (also referred to as ‘probability’ or ‘frequency’)	‘chance of something happening’ i.e., valuation or judgement regarding the chances of a risk materialising.
Risk Register / Trust Risk Register (TRR)	‘a log of all the risks that may threaten the success of the Trust in achieving its declared aims and objectives’. It will operate at both a local (Department/Division) and organisational (Trust) level and will include Board Assurance Framework managed risks. The TRR is the principle tool that the Trust will use for managing its risk assessment systems and processes.
Trust Assurance Framework (TAF)	‘a high level management assessment process and record of the principal risks relating to the delivery of strategic objectives and the strength of internal control to prevent risks occurring. It identifies sources of control and assurance and evaluates them for suitability. By receiving and reviewing actual assurances and using findings, the adequacy of internal control can be confirmed or modified.’
Issue	‘an event which has happened and is currently having a negative impact. Issues require immediate attention and action in real-time and may be a result of risks identified or they may have come from an unseen area.’

Inherent risk (also known as the gross risk)	'exposure arising from a specific risk before any action has been taken to manage it (or the risk that would crystallise if controls failed in their entirety).' Note: inherent risk rating does not take account of any mitigating actions VUNHST may wish to or plan to implement to further reduce the level of severity for that particular risk.
Residual risk (sometimes referred to as net risk, managed risk or current risk)	'existing level of risk taking into account the current controls in place.'
Actions	'planned / future controls not yet implemented.'
Target risk	ultimate level of risk that is desired by executive and within resource envelope when planned additional actions and controls have been implemented' i.e., the position taking into account successful delivery of all mitigating actions and controls.

2.3 Scope

VUNHST's risk management framework is a corporate document and represent compulsory minimum standards. Activities and functions in and out of scope are outlined below.

In scope

All members of staff from 'Ward to Board'

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

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

All activities of VUNHST are in scope of the RMF. This includes assessing risks attached to our key dependencies, core processes, stakeholder expectations, and/or risks to the achievement of our Mission, Vision and Goals as set out within our Five Strategic Pillars/Goals **To Note – these are draft and not yet formally approved:*

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

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

Hosted Units

VUNHST is 'Host' to a number of external organisations:

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

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

All domains/categories and levels of risk (STOC)

VUNHST view risk as the effect of uncertainty on objectives, measured through a combination of the likelihood of an event happening and the impact of its consequences should it occur. We face numerous levels of risk in delivering on objectives; these can relate to strategic challenges, our tactics/programmes, clinical and operational issues, compliance with laws, statutory duties and reporting obligations. This is often summarised as **STOC** (Strategy, Tactics, Operations and Compliance).

In addition, VUNHST categorise risks across nine key domains. The nine domains are: quality, safety, compliance, research and development, reputation, performance and service sustainability, financial sustainability, workforce, and partnerships. All types of risk are in scope.

Outside, Downside and Upside Risks

Actions or events leading to risk may be internally or externally driven (**outside risks**) and may relate to negative threats (**downside risks**) requiring mitigation or positive opportunities (**upside risks**) to be exploited. Risks may be fully, partially or outside the direct control or influence of VUNHST. All such risks should be considered by VUNHST.

Out of scope

Issue management, Incident Reporting and Investigations

To avoid duplication of the same 'concern' as both an issue and a risk, issues will be managed and reported on separately. This will either be through programme/project management reporting, or through existing local management reporting. This ensures that the risk management process is focused and is not overwhelmed by the demands of issue management.

Incidents are considered out of scope and should be escalated and actioned immediately. The aim is to learn lessons from our experiences and ensure that practice is immediately altered to improve the way services are delivered and the environment in which they are provided. For complete details of the incident reporting and investigation process, please refer to VUNHST's Incident Reporting and Investigation Policy (including Serious Incidents) and any supplementary guidance in this area.

N.B., Materialised risks (i.e., pre-identified risks that later become issues) will continue be tracked via the risk reporting process to ensure adequate visibility and provide assurance that they are being controlled, however they may be managed separately. Note: issues that may impact existing risks should be considered when undertaking risk review exercises.

3. Aims & objectives

The primary objectives of this framework are to identify and manage the risks that may prevent the achievement of the Trust's objectives. The RMF aims to deliver a pragmatic and effective multidisciplinary approach to risk management which is underpinned by a clear accountability structure from Board to Ward. It recognises the need for robust systems and processes to support the continuous and ever-changing nature of risk. The RMF enables individuals throughout VUNHST to embed risk management in the day to day activities and support better decision making through a deeper understanding and insight into risks and their impact.

The RMF is a key component in VUNHST's risk management strategy. As such it:

- promotes consistency and transparency by articulating a single methodology for managing risk, establishing a common risk language across VUNHST;
- provides a governance model for the execution of risk management, establishing authorities for governance committees and defining risk management roles and responsibilities for individuals and teams within VUNHST;
- promotes an 'enterprise-wide' approach by integrating risk management processes with strategy/business planning, programme/project management, and operational process and decision-making, ensuring that risk management processes support and align with the overarching corporate vision and strategy for VUNHST;
- recognises that timely and accurate monitoring, review, communication and reporting of risk are critical to providing:
 - early warning mechanisms for the effective management of risk occurrences
 - assurance to management, the Boards and our partners/stakeholders
 - a sound platform for organisational resilience
- enables the design and implementation of controls that:
 - are structured to promote effective realisation of objectives
 - provide appropriate assurance
 - are cost effective.
- supports decision-making through risk based information;
- helps develop a culture where risk management is integrated into all Trust business;
- Create a system which is user-friendly and allows for the prompt assessment and mitigation of risk;
- Clearly describe the risk appetite of the organisation;
- Reduce risks to patients, carers, staff, members of the public, visitors, etc., to an acceptable level; maximise resources available for patient services and care; and minimise financial liability;

Effective risk management supports better planning and enables the Trust and its senior managers to take risks with increasing confidence. With the result that:

- Adverse (damaging) events are less likely;
- Capital and resources are utilised more efficiently and adverse (damaging) events are less likely;
- Costly re-work and firefighting is reduced;
- Achievement of objectives is more likely;
- Quality of service is improved;
- Compliance with statutory legislation;
- All sources and consequences of risk are identified;
- Risks are assessed and either eliminated or minimised;
- Information concerning risk is shared with staff across VUNHST;
- Lessons are learnt from incidents, complaints and claims in order to share best practice and prevent reoccurrence.

VUNHST will ensure that all employees have the necessary support and assistance to undertake effective risk management. Where appropriate this will tie in with induction/training provided. Our organisation will also be dynamic, iterative and responsive in its approach to change.

4. Risk strategy

The management of risk is a key factor in the provision of high-quality care to our patients, donors and service users. Of equal importance is the legal duty of the Trust to control any potential risk to staff and the general public, as well as safeguarding the assets of the Trust. It is the responsibility of all staff to be involved in the identification and reduction of risks.

VUNHST's risk management strategy does not focus on total risk avoidance but on identifying and managing an acceptable level of risk. We do not want to adopt unnecessary internal controls and management procedures, or introduce bureaucratic processes, but to use risk management to evaluate the impact on our objectives of decisions, actions or uncertainties.

The Board recognise that effective risk management is a key component of corporate and clinical governance and is integral to the delivery of our objectives. VUNHST's risk strategy therefore focuses on deploying a holistic approach to risk management which embraces financial, clinical and non-clinical risks across all parts of the organisation. It seeks to ensure that risks, untoward incidents and mistakes are identified quickly and acted upon in a positive and constructive manner so that any lessons learnt can be shared. This will ensure the continued improvement in the quality of care and the achievement of strategic objectives. The commitment of the Board is therefore to:

- minimise harm to patients, colleagues or visitors to a level as low as reasonably practicable;
- protect organisational value (such as high standards of patient care, reputation, community relations, assets and resources);
- maximise opportunity by adapting and remaining resilient to changing circumstances or events;
- assist with managing and prioritising activities through using risk information to underpin strategy, decision-making and the allocation of resources; and
- to ensure that there is no unlawful or undesirable discrimination, whether direct, indirect or by way of victimisation, against its service users, carers, visitors, existing employees, contractors and partners or those wishing to seek employment, or other association with the organisation.

The rest of this framework details our approach to risk management / sets out the arrangements for managing risk at all levels within the organisation; however, a summary of key risk management obligations is highlighted below:

Risk management obligation	Description
A risk management framework (RMF) in place, endorsed by the Board and communicated to all staff	<p>We have created a risk management framework (this document), which is annually endorsed by the Board and made readily available to all staff. We use it alongside other management tools, such as performance and quality dashboards and financial reports, to give the Board a comprehensive picture of the Trust risk profile and internal control environment. It is formally reviewed every year, or upon significant change. Any changes require approval from the Audit Committee and Board.</p> <p><i>Outlined in this document</i></p>
Clear roles, responsibilities and accountabilities for risk management established	<p>We have assigned risk management roles, responsibilities and accountabilities across the organisation, and appointed business leads for risk in each department / division and hosted unit.</p> <p><i>Outlined in this document</i></p>
Established Risk governance arrangements	<p>Our organisational structure helps us manage risk effectively. A ‘three lines of defence’ model ensures clear accountability and expectation for risk management. This gives departments / divisions and hosted units autonomy for identifying, managing and reporting risk (this is the first line of defence), with our central functions i.e. governance, IT, HR and Legal etc. providing oversight (this forms the second line of defence) and internal/external audit providing independent assurance (the third line of defence). The following is also in place:</p> <ul style="list-style-type: none"> • Committee structures and terms of references • internal risk reporting requirements, specifically the reporting and escalation of key risk information through the governance structure on a monthly basis • procedures for responding to urgent incidents and external events • external reporting, disclosures and certification <p><i>Outlined in this document</i></p>
Risk management embedded within daily operation and decision-making processes	<p>Risk management is ongoing and embedded in VUNHST’s daily operations and decision-making processes, from strategy setting and business planning, through to programme/project management, business-as-usual processes and activities, and partnership working arrangements.</p>

	<ul style="list-style-type: none"> • The Board systematically discusses the risks to achieving its Vision, Mission and strategic priorities as part of the IMTP planning process. • Assessing risk compared to acceptable levels is not a one-off, quarterly or annual activity but an integral part of everyday decision-making: <ul style="list-style-type: none"> – New risks (and altered existing risks) identified through decision-making processes and forums, including the Board, Quality & Safety Committee, Information Governance & IM&T Committee, Workforce & Organisational Development Committee, and Planning & Performance Committee etc. are considered for inclusion in the relevant risk register / TAF and reported through the organisation alongside changes to existing risks according to risk governance and urgent escalation arrangements. – Risks and key controls/mitigations will also be assessed and documented by departments/divisions and hosted units as part of the business planning and performance monitoring processes, and during their regular leadership meetings/regional support groups. <p><i>Outlined in this document</i></p>
<p>High level risk appetite statements and risk tolerance limits should be in place for principal risk categories/types.</p> <p>VUNHST manages risk in accordance with those statements and limits</p>	<p>We have a clear approach to risk taking and innovation, outlined within our risk appetite strategy, and we encourage staff to read it.</p> <ul style="list-style-type: none"> • Risk appetite statements align with the organisation's strategic priorities/objectives, and we communicate them according to high level categories of risk/principal risk types. • Where possible, we will use early warning indicators to alert our executive and the Board that the risk of planned outcomes/objectives not being met is increasing. • We use our risk quantification matrix / heatmap criteria as a guide for setting risk tolerance levels and where they exist, we will use pre-existing key performance indicators, limits or thresholds as key indicators of risk. • Risk appetite considerations are also an intrinsic part of the standing financial instructions (SFIs) / delegation of authority arrangements within VUNHST; and risk/reward trade-offs are included within impact assessments. <p><i>See separate Risk Appetite Strategy</i></p>
<p>A detailed risk management process</p>	<p>A risk management process / procedures manual is in place for use by all teams to identify, analyse, manage, monitor and report on risks threatening their objectives.</p>

available to guide staff in identifying, assessing, treating, reporting and communicating risks	<p>This includes guidance on using our risk quantification matrix, which assess the likelihood of risk occurring and its impact if it is not well managed. It also includes details of risk assessment tools and techniques.</p> <p><i>See separate risk management process / procedures manual for details.</i></p>
Risk registers established at strategic and operational levels	<p><u>Top down</u>: TRR and TAF principal risks as they relate to the delivery of commitments, and/or which threaten the viability of our organisation.</p> <p><u>Bottom up</u>: Our departments / divisions and hosted units are each accountable for managing their risks (and opportunities) and maintain a local register of these as they relate to their objectives. Major programmes and/or projects will also have risk registers where necessary.</p> <p><i>Outlined in this document</i></p>
Trust Assurance Framework : Regular evaluation of the nature and extent of principal risks that we are exposed to, the adequacy of key controls, sources of assurance and commentary against any gaps in control or assurance are provided	<p>Our internal controls are designed to provide reasonable assurance that risks to our objectives are at acceptable levels. Departments/divisions and hosted units regularly consider their effectiveness, and our committees and the Board formally examine them monthly and report on them (externally) annually. Where risk management is judged to be weak or limited in effect, we will enhance controls.</p> <p><i>See separate TAF Guidance Document and template</i></p>
Opportunities for training and shared learning on risk management provided	<p>A variety of risk training materials/course(s) tailored to the audience is available.</p> <p>An annual risk review session for a senior audience and ad hoc risk leads forum are also undertaken.</p> <p><i>See separate risk management training material</i></p>
Risk and control interdependencies	<p>When assessing risks, our departments/divisions, hosted units and programmes/projects identify where multiple risks could compound each other, ensuring that they are not considered in isolation.</p>

	<p>External risk interdependencies i.e. the identification and evaluation of risks associated with partners, contractors and partner organisations, is also undertaken as standard.</p> <p><i>Outlined in this document</i></p>
<p>We will ensure that robust business continuity arrangements are in place</p>	<p>Specific contingency plans for external events/uncertainties may also be developed and maintained e.g. EU Exit contingency planning, COVID-19 recovery and response planning.</p> <p><i>See separate business continuity planning (BCP) procedures.</i></p>

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5. Risk governance

Risk governance and the internal control system

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

The British Standard BS 13500 defines governance as a: 'system by which the whole organisation is directed, controlled and held accountable to achieve its core purpose over the long term'. Similarly, the UK Corporate Governance Code states that 'good governance should facilitate efficient, effective and entrepreneurial management that can deliver the long-term success of the company'.

Good risk governance should therefore:

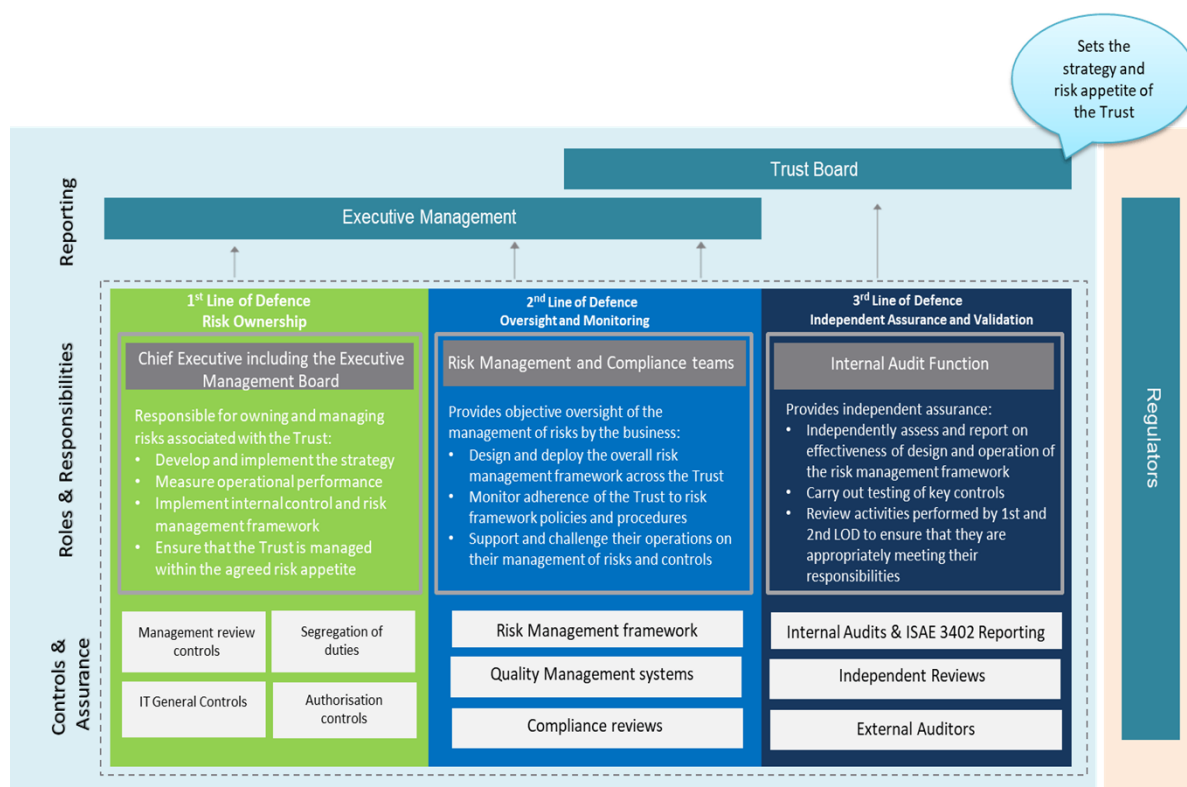
- put in place a structure of risk responsibility throughout the organisation so that everybody is aware of their own risk responsibilities and accountabilities and those of others with whom they work
- establish clear and effective lines of communication up and down the organisation and a culture in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

Three lines of defence risk governance model

VUNHST operates the three lines of defence model - a leading practice in risk governance - that help ensures segregation between direct accountability for risk decisions, oversight and assurance. This allows us to assure ourselves and those to whom we are accountable that we are managing the organisation well. It gives departments, divisions and hosted units autonomy for identifying, managing and reporting risk; with our specialist functions such as the governance, IT, and legal teams providing oversight; and internal/external audit providing independent assurance. We manage risks and report and escalate key risk information through this governance structure.

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

Figure 2: VUNHST's three lines of defence model



The first line of defence

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

The second line of defence

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

The Corporate Governance Team play a crucial role in the provision of support: facilitating identification and evaluation of risks, coaching management in responding to risks, co-ordinating risk management activities, consolidated reporting on risks, maintaining and developing this framework, championing establishment of risk management, and developing the risk management strategy for committee and Board approval. The team

monitors and facilitates the implementation of effective risk management practices by departments and divisions and assists risk owners in reporting adequate risk-related information throughout the organisation. Assurance is provided through monthly monitoring and reporting of risk and control activities through our various committees, Audit Committee and Board.

The third line of defence

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

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

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6. Key accountabilities, roles and responsibilities

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

Board

The Board has overall responsibility for risk management and will ensure our risk management approach is sufficient by considering whether the Trust Risk Register (TRR) and TAF identifies principal areas of risk against strategic objective and that adequate risk mitigation strategies have been designed and implemented to manage all identified principal risks (bi-monthly) and by endorsing and reviewing the framework's effectiveness (annually) as assured by the Audit Committee. It sets the 'tone at the top' for risk management by setting risk appetite and explicitly considering risk when developing or updating the strategy and business plan, or when considering performance and/or major programmes of change.

Note: in discharging its risk-related responsibility, the Board operates through several key governance forums/committees and will be supported in the discharge of its responsibilities by the Audit Committee.

Audit Committee

The Audit Committee is accountable for overseeing risk management and will support the Board by reviewing the effectiveness of the internal controls system by reviewing the comprehensiveness and reliability of assurances on risk management. Specifically, the Audit Committee monitors that strategic objectives are being achieved and it receives regular reports on risks to the strategic objectives and the processes in place to manage them. It also needs to ensure that:

- the TRR is reviewed, updated and monitored regularly; and
- it is satisfied with the controls in place and progress is being made in completing mitigating actions.

The Audit Committee independently reviews the adequacy and effectiveness of risk management across the Trust. Through a programme of work, it will review and approve compliance monitoring, internal and external audit plans and monitor risk reporting. The Audit Committee plays a key part in supporting the Board in discharging its responsibilities regarding risk management by advising the Board of the outcomes of its work at regular stages throughout the year.

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

Directors

Directors will support and promote risk management. They must ensure that risk management is integrated into all activities (i.e. that risk management is not just a checklist feature but embedded), and should demonstrate leadership and commitment by ensuring:

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

Note: Where principal risks have increased, or risks are outside agreed appetite/tolerance, owning executive directors may be called on to attend the Audit Committee to discuss mitigations.

Executive Lead / Senior Accountable Officer (SRO) for Risk

The Director of Corporate Governance will act as the Senior Responsible Officer (SRO) for risk within VUNHST. The SRO will own this risk management framework and any associated procedures and is accountable for the strategic development and implementation of organisational risk management. Including arrangements for:

- Maintaining and updating appropriate risk management Policies and procedures;
- Ensuring there is a clear and dynamic link between the Board Assurance Framework and Corporate Risk Register;
- Ensuring the Trust has a comprehensive and dynamic Risk Register and working with divisional management teams to ensure that they understand their accountability and responsibilities for managing risks in their areas;

The SRO will also ensure that the overall risk to VUNHST is presented to, and challenged at, the appropriate level in our governance structure.

Risk owners

A risk owner is the person who will be accountable if the risk occurs. They are responsible for monitoring their risks and executing risk responses when appropriate. Risk owners often aid in defining the risk response/treatment plans and in performing qualitative risk analysis and the quantitative risk analysis for their risks. When identifying a suitable risk owner, you should consider if that person has the authority to manage the risk; if they are the person who best understands the causes of the risk, and the impact; if they are willing to monitor the risk and ensure it is mitigated. Note: Members of the Executive Team act as risk owners for corporate-level risks.

Executive Management Team

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

Departmental/Divisional Risk leads

Risk leads are embedded personnel who act as the liaison point for risk management in their department or division. They support directors in implementing this framework. This includes developing and maintaining a local risk register and reporting and escalating risks through the governance structure every month, on behalf of their directors. Note: Risk leads will be appointed by their director and it is recommended that as a minimum they operate in a clinical or business manager or equivalent role to ensure consistency of application and adequate focus. They should also be regular attendees at their local management/leadership meetings, have the authority to challenge their peers on risk, and enough capacity to dedicate to managing the risk process on behalf of their areas. Risk leads may be supported by local risk co-ordinators.

Specialist functions, and other executive committees

Specialist functions (including but not limited to: legal, workforce & organisational development, finance, IT, performance, procurement, and business continuity) and other executive committees (including Planning and Performance Committee etc.) in the organisation will be called on to manage, own and/or advise on specific risk exposures as they relate to their sphere of influence.

Corporate Governance Team

The Corporate Governance team are responsible for the maintenance and development of DATIX the Trusts risk management system, maintaining the Trust risk register, supporting the Trust to produce ad-hoc reports outside of those produced routinely by the relevant manager. It will also act as a risk 'think tank' and independent review mechanism for risks and opportunities escalated by teams and programmes/projects.

Service Directors

Service Directors are accountable for ensuring that risk is managed in line with this framework within their service and wider areas of responsibility. They are required to:

- maintain a suitable local forum for the discussion of risks arising, at which the local risk register is reviewed at least monthly;
- ensure that risks raised by staff are fully considered, captured on local risk registers, kept up to date, re-assessed, and re-graded as necessary;
- develop and implement action plans to ensure risks identified are appropriately treated;
- ensure that appropriate and effective risk management processes are in place within their designated area and scope of responsibility and that all staff are made aware of the risks within their work environment and of their personal responsibilities to minimise risk; and
- monitor any risk management control measures implemented within their designated area and scope of responsibility, ensuring that they are appropriate and adequate.

All Managers and Staff

All managers are responsible for the local implementation of this framework and associated policy documents in their departments, wards and/or other clinical and non-clinical areas.

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

All staff should:

- take action to protect themselves and others from risks;
- Identify and report risks to their line manager;
- Ensure incidents and complaints are reported using the appropriate procedures;
- Attend mandatory and statutory training as determined by their Line Manager; and
- Be aware of and comply with Trust's risk management framework

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7. Risk domains / categories

Categorising risk for effective risk management

Identifying the cause of risk by type (or root cause) is a useful method for exploring potential risk and risk appetite. Grouping risks this way helps VUNHST understand where the largest risk exposure originates and the effectiveness of its internal controls. In consultation with Executive, Audit Committee and the Board, the following principles were used to guide the selection of key risk types. In summary, risk types should:

- be important to achieving VUNHST's long term strategy and IMTP objectives (as well as to addressing key dependencies on our organisation, and the delivery of our core processes);
- be subject to measurement in a simple, transparent and objective way (where data is relatively frequent, available and complete). Note: This is especially important, so that the Board can see how Trust-wide risks are evolving and moving towards target levels over time;
- allow for risk appetite to be applied and should provide useful direction for management in making trade-off and resource allocation decisions and the primary purpose of setting risk appetite; and
- can be at least partially mitigated by VUNHST and our partners (there is limited value to setting risk appetite if the risk cannot be mitigated and therefore must be accepted)

Using the above principles and with agreement of the relevant Board Committees, nine key risk types / domains were selected. The nine domains are:

1. Quality
2. Safety
3. Compliance
4. Research and development
5. Reputation
6. Performance and service sustainability
7. Financial sustainability
8. Workforce
9. Partnerships.

Interaction between risk categories and types

There may be a degree of overlap between categories. Please see the Risk Appetite Strategy, which is updated from time to time, for final guidance on determining these interactions and how to approach trade-offs between risk categories.

Using risk types to structure risk appetite

VUNHST Board structures its risk appetite around the nine domains or principal risk types. Please see the separate risk appetite strategy document for further details of our risk appetite statements and tolerance limits.

Note: The list of selected risk types is expected to be dynamic and may be changed in consultation with the Committees. If that happens a revised risk appetite proposal will be presented to the Board for approval.

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8. Risk and control interdependencies

VUNHST's approach to risk helps us to manage risk opportunities as we work closer with other health and social care providers to find new ways of improving services. It will also enable an integrated approach to risk management as we fulfil our statutory obligations and protect the health and well-being of the people who access our services.

Partnership working / third party risk management / external interdependencies

Risk interdependencies between VUNHST, our Hosted Units and other organisations and partners must be identified, assessed, monitored and tracked. For risk exposure to be understood and managed holistically, it is important for VUNHST to understand where it could cause risk to a partner organisation; where it operates controls that mitigate risk to a partner; where it depends on another body to operate controls on its behalf; or where it is exposed to risk as a result of another organisation.

Our business planning process identifies organisations likely to influence the success of our objectives. Departments/Divisions, programmes/projects identify, and hosted units, assess and communicate risk interdependencies with partner organisations, logging them on their risk register and communicating and escalating them to VUNHST committees and the Boards as required – in accordance with escalations set out in this document.

We jointly identify and assess risks that cut across boundaries or relate to partnership working / shared programmes of work, with responsibility for managing them clearly assigned and understood by all those involved in joint working or partnerships. Such risks are escalated within programme governance structures as well as via arrangements described in this framework. The impact of partnership working / third party risk management on our risk profile forms part of our monthly risk-reporting cycle.

Internal interdependencies

It is important for departments/divisions and hosted units *within* VUNHST to understand where they could cause risk to another part of the Trust; where they operate controls that mitigate risk to another part of the organisation; where they depend on another team to operate controls on their behalf; or where they are exposed to risk because of another part of VUNHST. Such risk should be identified, shared and managed together and raised at relevant committees/Board.

Risk assessment considerations – horizon scanning and emerging risks

VUNHST endeavour to identify risks of the broader risk environment, and periodically undertake horizon scanning of future risk areas to assess emerging areas of risk. Emerging risks are reported through the governance structure alongside other risks.

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9. Risk documentation

The purpose of risk management in VUNHST is to challenge the assumptions of management decisions in the areas of strategy setting/business planning, budgeting and performance management. It is therefore an enabling tool for our management teams and staff to respond to opportunities and threats that affect the achievement of objectives, making them aware of the pitfalls of intended actions and providing the ability to change course if necessary.

Good documentation is a prerequisite in the successful implementation of risk management, as it acts both as a delivery and message mechanism. Risk management documentation is used to deliver a consistent message, to speak a common language and to provide clear (risk management) objectives linked to organisational objectives. It is constantly reviewed and evaluated. Documenting VUNHST risk control efforts also provide evidence of our evolution in risk management, may be used for audit purposes to demonstrate that risk management has taken place, and acts to safeguard the organisation against any potential claims.

Risk management document inventory

VUNHST risk management document inventory, which together outlines the Trust's current exposure, commitment and attitude towards risk, includes the following:

- risk management framework (this document)
- risk appetite strategy (available separately)
- risk management process, and other risk management procedures and methodologies (available separately)
- the risk register (found on Datix)
- Board Assurance Framework (available separately)
- risk reports (available separately)
- risk escalation process (included in this framework)
- risk training material/course(s) (available separately).

Risk registers

A risk register is a live document maintained to monitor potential risks. It also tracks the actions taken to minimise risks and provides contingency plans that should be invoked if a risk does occur.

To ensure consistency, VUNHST provide a standard risk register template (available separately), which allows our departments / divisions to capture all the information needed to manage risk appropriately and determine whether any risks should be escalated through our governance structure. Each area should maintain their own

risk register and it should be kept up to date and reviewed regularly. New risks should be added as they are discovered.

Trust Risk Register (TRR)

On the Boards' behalf, the Corporate Governance Team maintains a Trust Risk Register (TRR) of all significant risks that may affect VUNHST's ability to achieve its objectives (and the control measures for dealing with them). They also maintain the TAF.

Trust Assurance Framework (TAF)

The TAF provides a mechanism for managing strategic (principal) risks. It sets out strategic objectives, identifies risks in relation to each strategic objective and maps out both the key controls that should be in place to manage those objectives and the sources of assurance (evidence) that these controls are operating effectively. The TAF confirms that agreed actions are in place to address identified gaps in control or assurance. Additionally, the TAF is cross-referenced with operational risks. The TAF should drive the board agenda.

The Executive Team has responsibility to discuss the TAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks prior to the TAF being submitted to the Board for approval. This will include:

- Review the updates to the existing principal risks since it was last approved by the Board.
- Consider de-escalation of any principal risks to operational risk registers and make this recommendation to the Board.
- Agree the submission of any new principal risks to the Board for approval.

Although each strategic objective has a lead Director, it is in the interests of the Executive Team to work collectively to manage these principal risks to ensure that the strategic objectives delivered within the agreed timescale, thus increasing the VUNHST's probability of success and reducing likelihood of failure.

Please refer to the separate TAF Guidance document for full details and TAF template.

Local risk registers

Departments / divisions will maintain their own risk registers and escalate risk as appropriate. Major programmes and/or projects will also have risk registers where necessary. Please refer to the VUNHST risk management process / procedures manual for additional risk register guidance.

Risk register

The Corporate Governance Team provides a standard risk register template that should be used to capture risks at strategic and operational level. This will be managed through DATIX.

The standard risk register template allows departments/divisions to capture all information needed to manage risk appropriately and determine whether any risks need to be escalated through our governance structure. This will capture:

Description of risk	A simple phrase that describes the risk: "There is a risk that <risk event> as a result of <cause> which may lead to <impact>." Departments/Divisions may find it useful to have a shorter 'risk title' for use in reports, with a longer and more complete description.
Cause(s) consequence(s) impact	and Causes (also referred to as risk drivers or influencing factors), both internal and external, /should be explained. Consequences (also referred to as effects, impact or outcomes) should also be explained.
Link to business priorities	objectives/Where possible, risks should be linked to our strategic priorities, legislative duties, major plan programmes/projects, business plan objectives or business-as-usual activities.
Triggers	Where identified, early warning triggers or indicators should be identified and tracked to signal whether the risk is becoming an issue or has reached a point that requires action.
Existing controls	To aid risk assessment and action planning, the current measures to control the risk – and whether they are considered adequate – are recorded.
Assessment of and control	of risk Risk ranking (impact and likelihood): to assist with prioritisation, risks are scored/given a ranking using VUNHST's impact and likelihood matrix; this enables the 'most significant' risks to be identified. Inherent, residual and target risk scores are assigned.
Risk and owner(s)	control Owner (lead person): you need to assign risks and controls to a lead person responsible for ensuring they are adequately controlled and monitored.
Action(s)/treatment plans	Where a plan of action or treatments to address the risk have been agreed, they should form part of the register. Alternatively, include a link to a separate action plan.
Dates	As the register is a 'living' document, it is important to record the date that risks are added or modified. If the register includes an action plan, you should provide target and

completion dates for actions. To ensure all open risks are reviewed at least annually, you must provide a review date.

Comments / updates Where separate update/summary reports are not produced, risk registers should include a comments column to allow for useful updates, such as meetings to discuss the risk.

The risk treatment / action plan

Where a risk is outside agreed appetite levels, where controls are deemed inadequate, or where controls are missing, a risk treatment action plan should be in place to document the management controls to be adopted; it should include the following information:

- who has responsibility for the implementation of the plan
- what resources are to be utilised;
- timetable for implementation;
- details of the mechanism and frequency of review.

Please refer to the risk management process and procedures manual for additional guidance on controls/treatment options.

Risk embedded into terms of references

VUNHST's risk governance structure has been designed to help provide effective stewardship to anticipate and combat threats and to take appropriate opportunities to improve. Risk governance is a fundamental part of corporate governance, and therefore our committee and Board terms of references have a built in risk component / risk discussed as a standing agenda item.

Risk communications, assurance statements and disclosures

The Board has overall responsibility for ensuring that risks are managed. One of the key requirements of the Board is to gain assurance that risk management processes are working effectively and that key risks are being managed to an acceptable level. The starting point and most foundational step in this assurance are the existing documents listed within the risk management document inventory; specifically, live risk registers and regular risk reports.

In addition to these, twice a year all Directors are asked to provide supplementary assurance by certifying that identified risks are being managed and that internal controls are working effectively. These assurances will inform the Annual Governance Statement, which is signed off by the internal audit team and the Chief Executive. All external disclosures are handled by the legal and governance team and any disclosures related to risk management are discussed with the Corporate Governance Team before disclosure. For example, any freedom

of information requests in relation to risk management documentation are discussed with the relevant committee and Audit Committee before information is released to the requester.

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10. Risk Reporting

Monthly risk reporting cycle

Bottom up: local risk reporting for departments and divisions

Departments/Divisions regularly monitor and report risks affecting their activities – and the effectiveness of control measures for managing them – to senior managers or directors during routine management meetings, committees, groups or panels. Note: each department/division is responsible for defining an internal risk review and reporting process, proportionate to its local needs, however risk registers are formally submitted to the Corporate Governance Team every month for upward reporting; alongside a covering paper articulating changes to risk profile and any risks requiring escalation.

The following considerations for escalating a risk should be followed:

- sufficient capability is not held at the current risk reporting level to manage risk successfully
- risk rating has significantly worsened
- risk is significantly outside appetite
- risk is related to cross-cutting / operational issues and/or has a wider impact than just one department/division.

Top down: corporate risk reporting at Trust Level

The Corporate Governance Team coordinate risk reporting through our governance structure monthly. In addition to managing monthly reporting, they will on a periodic basis (and at least annually) review and challenge risk management procedures and their implementation defined by departments/divisions and programmes in compliance with the risk management framework.

This may take the form of initial self-assessments of risk management activity, subsequent further analysis of these assessments with key risk responsible personnel, monitoring of risk registers/Datix activity by respective areas and/or programmes, and review of escalation processes to ensure:

- sufficient capability is held at the current risk reporting level to manage risks successfully
- risk ratings if worsened are escalated
- risks outside appetite are escalated
- if risks are related to cross-cutting issues and/or has a wider impact than just one department/division they are escalated.

Urgent risk escalation / out of cycle escalations

Risks can be raised at any meeting and at any level in our organisation. Staff must immediately escalate newly emerging, high impact, highly likely risks; risks breaching risk appetite or with a significant or rapid change in severity resulting in a RAG rating of red or amber/red, to their director and business lead for risk, and not wait for the monthly reporting cycle. The Corporate Governance Team should be informed at the same time.

The director affected must decide whether the risk needs to be escalated to the wider executive immediately or at its next available meeting, for consideration and action. Otherwise the risk will form part of the monthly report to the Audit Committee and the Board.

Summary of risk reporting and escalation routes:

- Risks can be raised at any meeting and at any level in VUNHST e.g. any member of staff; local management/team meetings; Executive Committees, or any other specialist/technical committees; at the Board; or from our partners.
- Risks scored **>=15**, and any risks where the impact is scored as 5 regardless of likelihood require confirmed review by the relevant Executive Committee and confirmed review by the Board. It should be escalated according to the RMF and considered for inclusion on the TRR and TAF, monthly.
- Risks scored **>=12**, and any risks where the impact is scored as 5 regardless of likelihood, will require confirmed review by the relevant Executive Committee, depending on source.
- Risks outside Board-specified tolerance ranges: As outlined in the Risk Appetite Strategy, the VUNHST Board has developed indicative tolerance ranges against 9 principal risk categories (or risk domains). In addition to the above-mentioned escalation criteria, any risks outside these ranges will require confirmed review by the relevant Executive Committee i.e., any material Quality, Safety and Reputational risks above a Low rating; any Compliance, Performance and Service Sustainability, or Financial Sustainability risks above a Moderate rating; or any Research and Development, Workforce, or Partnership risks above a High rating should be escalated for discussion.
- Example below (to note exact scoring levels to be finalised when modelling on refreshed risk register is completed):

Risk Levels	Appetite	Escalation level to Trust Board if at risk score at or above:

0 – Avoid	9
1 – Minimal	12
2 – Cautious	12
3 - Open	12
4 - Seek	15
5 - Mature	15

- Urgent risks: Staff must immediately escalate newly emerging, high impact/highly likely risks; risks breaching VUNHST's risk appetite (see Risk Appetite Strategy) or with a significant or rapid change in severity rating, to their owning Director, and not wait for the reporting cycle above. The director affected must decide whether the risk needs to be escalated to the wider executive immediately or at its next available meeting, for consideration and action. Otherwise the risk will form part of the above reporting to the relevant Executive Committee and/or the Board monthly.
- The Head of Corporate Governance will compile a Trust Assurance Framework (TAF), for the Board, consisting of the top strategic risks to VUNHST's objectives, including those that meet the above-mentioned escalation criteria and those the Board have requested sight of regardless of score.

What should risk reports contain?

Departments/divisions, and major programmes/projects should submit updated risk registers to the Corporate Governance Team monthly; and should include an overview of significant changes to their risk register since last reporting. This may include:

- new or emerging risks;
- risks breaching the escalation threshold;
- risks outside acceptable appetite / tolerance levels;
- progress on completing action plans for risks;
- Gaps in control / assurance;
- status of performance indicators for risk (where they exist);

- significant incidents or near misses;
- risks requiring upward escalation/central treatment; and
- progress on embedding risk management into the business-as-usual activities of their directorate/region or programme/project.

Corporate risk reporting at a Trust-wide level should provide an aggregate picture of VUNHST's exposure to risk. It will focus on updates to the Trust Risk Register (including any escalated local and/or programme/project risks) since the last reporting cycle. This may include:

- new or emerging strategic or high level operational risks;
- strategic or high level operational risks over the agreed TRR / TAF escalation threshold;
- risks where there is a substantial gap between current and target risk rating or where it is outside agreed appetite/tolerance levels;
- key control gaps / gaps in assurance;
- significant incidents or near misses affecting the strategic risk profile; and
- progress on embedding risk management across VUNHST.

11. Risk management process

The VUNHST risk management process provides the framework against which all categories of risk can be identified and assessed, so that risk-handling activities may be planned and invoked as needed.

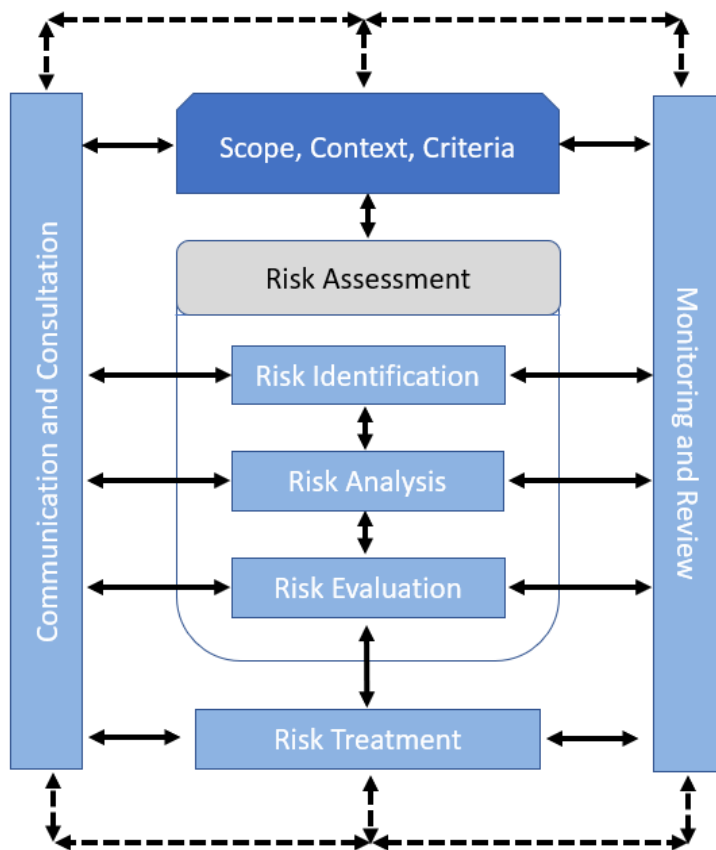
To ensure consistency across the organisation, we have adopted an iterative process for managing risk based on the ISO 31000 Risk Management - Guidelines. It consists of the following activities:

- establish the scope, context and criteria
- risk assessment (risk identification, risk analysis and risk evaluation)
- risk treatment
- recording and reporting
- monitoring and review
- communication and consultation

This process provides a logical and systematic method of identifying, analysing, evaluating, mitigating and monitoring risks in a way that will allow VUNHST to make effective decisions and allow for a timely response to risks and opportunities as they arise.

Figure 1 below demonstrates a high-level view of the risk management process influenced by the ISO 31000 (2018) Risk Management Guidelines. The diagrammatic representation is an update from the previous ISO 31000 (2009) depiction and now includes the additional elements of scope, context, criteria as well as recording and reporting. The aim of this is to build a more holistic, well rounded and interconnected approach to risk management, whereas previously it was more focused on the risk assessment piece itself. Please refer to our Risk Management Process / Procedures manual for full details.

Figure 3: VUNHST Risk Management Process



Please refer to the VUNHST risk management process and procedures manual (available separately) for further details of this process.

12. Implementation, training and support

The policy will be implemented across VUNHST and will be disseminated through the Directors portfolios.

To help implement the framework, an 'Introduction to risk management' eLearning module will be available to all staff through the intranet.

A tailored overview of the risk management process and accountabilities will also be built into induction/onboarding packs for staff at all levels, up to and including new directors and Independent Members.

To operationalise risk management, plans are in place to use Datix to log risks, controls and mitigating actions. Datix training will be available and should be taken up wherever possible when new users start to access the system; this can be tailored to the experience of the user(s), and their role in the system.

There will be annual facilitated risk review sessions and/or a stand-alone in-house training exercise for a senior audience (e.g. in the form of an executive or board risk workshop) to ensure risk is treated as a core discipline at senior/executive level.

The Corporate Governance Team will make further guidance and support available on the intranet as required and bespoke risk management training will also be available to departments/divisions, tailored to their specific needs on request. This could include advice and guidance on identifying and managing risk, the co-ordination of peer reviews and/or help with developing risk registers.

Appendix 1: Bibliography

VUNHST's approach to risk management considers HM Treasury guidance on managing risk (The Orange Book), with reference to good practice from the National Audit Office (Managing Risks in Government) and other risk management standards as appropriate. Other reference material used to inform our approach includes:

- Welsh NHS Confederation (2009) The Pocket Guide to Governance in NHS Wales. Good Governance Institute
- Your Risk & Assurance Framework: A structured approach – (Welsh Government, December 2009)
- Risk Essentials – A Risk Management Framework (Welsh Government, Version 2, October 2006)
- Committee of Sponsoring Organizations of the Treadway Commission (COSO) Enterprise Risk Management – Integrated Framework, 2017.
- “Fundamentals of Risk Management” by Paul Hopkin
- HM Treasury (2012) Assurance frameworks
- HM Treasury (2005) Principles of managing risks to the public
- HM Treasury (2020) The orange book: management of risk – principles and concepts
- IRM/Alarm/AIRMIC (2002) A risk management standard
- ISO 31000: 2018, Risk management – Guidelines
- “Managing Risks: A New Framework” by Robert S. Kaplan and Anette Mikes
- National Audit Office (2011) Managing risks in government
- OCEG ‘Red Book’ 2.0 (2009) A governance, risk and compliance capability model
- UK Corporate Governance Code

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Velindre University
NHS Trust

Risk Management Process

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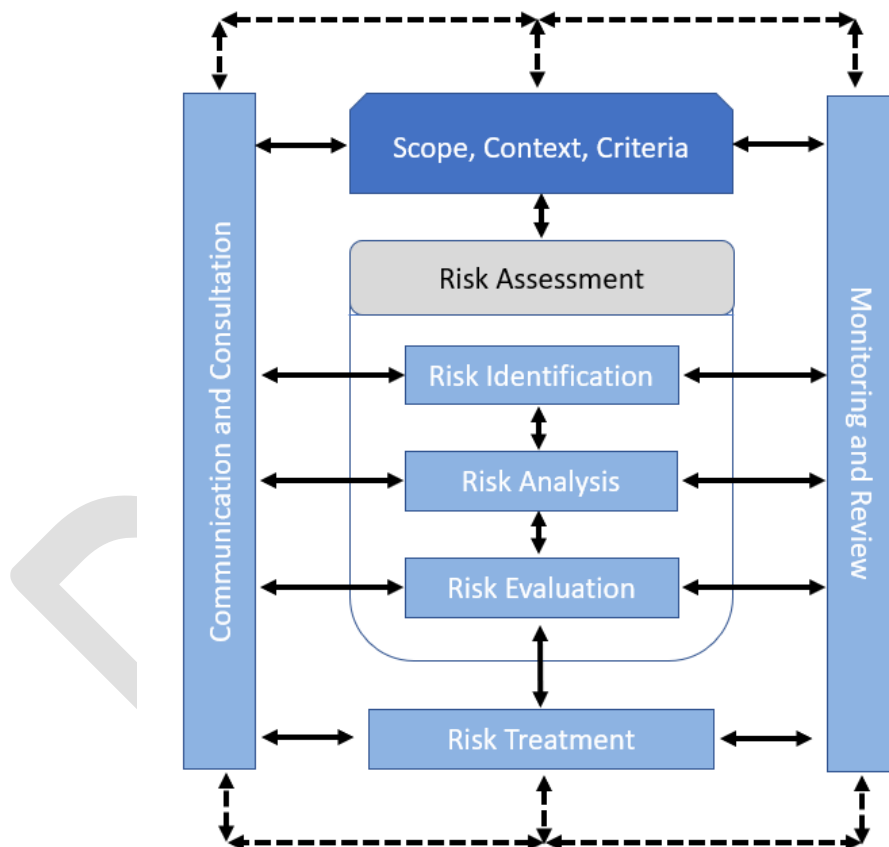
Table of contents

1.	Introduction.....	3
1.1	Scope, Context & Criteria	3
1.2	Defining the Scope.....	4
1.3	Defining the Internal and External Context.....	4
2.	Risk Assessment.....	5
2.1	Risk Identification	5
2.2	Risk Analysis.....	7
2.3	Risk Evaluation.....	7
3.	Risk Treatment and Response	8
3.1	4 T's Model.....	9
3.2	Preparing and Implementing Risk Treatment/ Action Plans	10
4.	Risk Recording and Reporting	11
4.1	Risk Register.....	11
4.2	Risk Reporting	11
5.	Risk Monitoring and Review	12
5.1	Review of Effectiveness	13
6.	Communication and Consultation.....	14
	Appendix A: Risk Assessment Techniques	16
	Appendix B: Risk Control Techniques / guidance on key controls.....	17
	Appendix C: Risk Quantification Matrix	20

1. Introduction

To ensure consistency across the organisation, an iterative process for managing risk has been adopted based on the ISO 31000 (2018) Risk Management - Guidelines. This process provides a logical and systematic method of identifying, analysing, evaluating, mitigating and monitoring risks in a way that will allow Velindre University NHS Trust (VUNHST) to make effective decisions and allow for a timely response to risks and opportunities as they arise. Figure 1 below demonstrates a high-level view of the risk management process influenced by the ISO 31000 (2018) Risk Management Guidelines. The diagrammatic representation is an update from the previous ISO 31000 (2009) and includes the additional elements of scope, context, criteria as well as recording and reporting. The aim of this is to build a more holistic, well rounded and interconnected approach to risk management, whereas previously it was more focused on the risk assessment piece itself. Section 7 aims to expand on the process depicted below and use it as the base of the risk management process at VUNHST.

Figure 1: ISO 31000 (2018) Influenced Risk Management Process

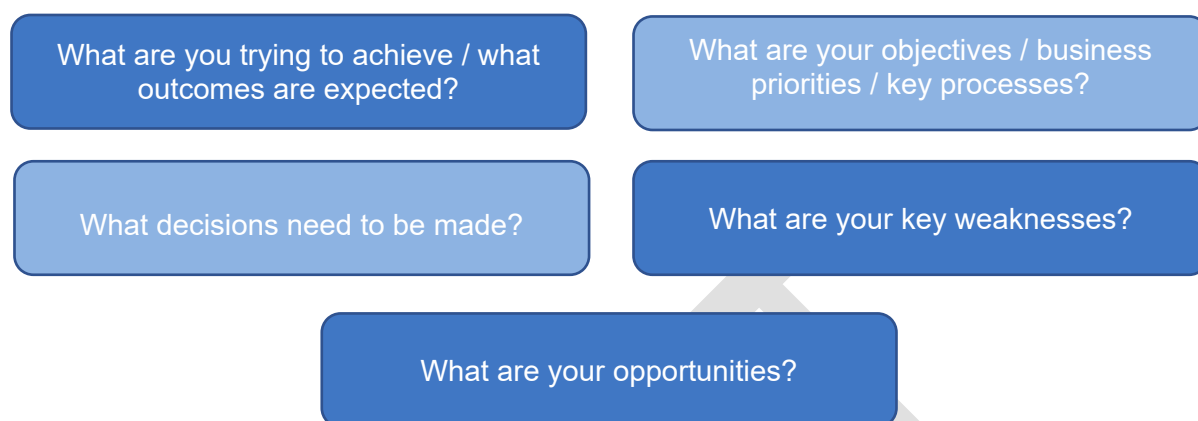


1.1 Scope, Context and Criteria

The purpose of establishing the scope, context and criteria is to make the risk management process work for you, enabling effective risk assessment and appropriate risk treatment. It involves defining the scope, the internal and external context, and the risk criteria (such as risk appetite/tolerance and scoring criteria to be used).

1.2 Defining the Scope

As the risk management process may be applied at different levels (i.e. strategic, operational, programme, project or other activities) it is important to be clear about the scope under consideration, the relevant objectives to be considered and their alignment with wider corporate commitments. Considerations include:



Determining the scope of your risk review enables you to focus on identifying the correct risks. For example, are you looking at strategic risks to your organisational objectives? Do you want to identify cross-cutting operational risks that may affect achievement of local objectives or business as usual tasks (e.g. Clinical and non-clinical)? Or do you want to ascertain the potential delivery risks associated with a particular project?

1.3 Defining the Internal and External Context

The internal and external environment in which Velindre University NHS Trust seek to define and achieve their objectives should be considered as it can be a source of risk.

Considerations for examining VUNHST's external context may include, but is not limited to:

- The social, cultural, political, legal, regulatory, financial, technological, economic and environmental factors, whether international, national, regional or local
- Key drivers and trends affecting the organisations' objectives
- Patients and other external stakeholders' relationships, perceptions, values, needs and expectations
- Contractual relationships and commitments
- The complexity of networks and dependencies.

Examining VUNHST's internal context may include, but is not limited to:

- Vision, mission and values
- Governance, organisational structure, roles and accountabilities
- Strategy, objectives and policies
- Culture
- Standards, guidelines and models adopted by the organisation
- Capabilities, understood in terms of resources and knowledge (such as capital, time, people, intellectual property, processes, systems and technologies)
- Data, information systems and information flows
- Availability of adequate funds to fulfil corporate commitments and meet/address anticipated liabilities
- Business continuity plans in place to ensure continuity of activities following disruption

- Relationships with internal stakeholders, taking into account their perceptions and values
- Contractual relationships and commitments
- Interdependencies and interconnections.

2. Risk Assessment



Risk assessment is made up of three processes: risk identification, risk analysis and risk evaluation.

Risk assessment is an iterative and collaborative process which draws on the knowledge and view of stakeholders. It should use the best available information, supplemented by further enquiry as necessary and attempt to answer the following questions:

- What may help or prevent us from achieving our organisational objectives?
- Which of those things are most significant and therefore require the most focus?

Note: When assessing risk, consideration should be given to the category of risk as per the risk management framework. We identify risks by considering the key dependencies of the organisation, the corporate objectives, stakeholder expectations, as well as by analysis of our core processes (which may be strategic, tactical, operational or compliance related). Emphasis should therefore be placed on risks that fall within our full and/or partial control.

2.1 Risk Identification

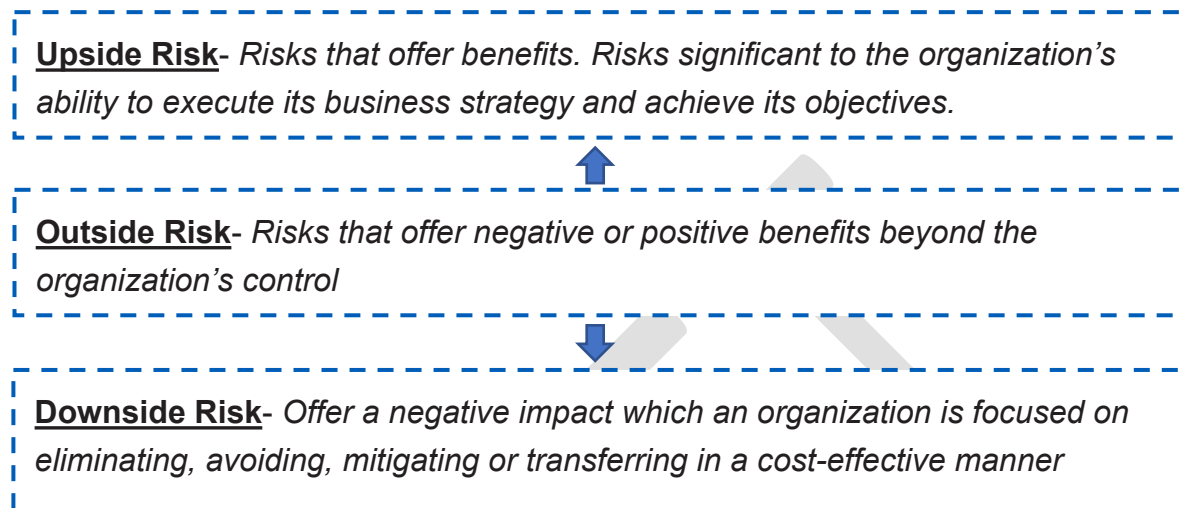
Risk identification involves identifying the whole range of possible risks and the likelihood of losses occurring as a result of these risks. It finds possible sources of risk as well as events and circumstances that could affect the achievement of the organisation's objectives. The process also involves identifying possible causes and potential consequences such that it allows an entire picture to be formed with regards to any given risk. This can be helped by answering the following questions:

- Causation - what has to happen for the risk to occur?
- Outcome - what are the consequences and the impact on objectives should the risk materialise.

When it comes to an organisations risk portfolio, a balanced approach must be taken, and 3 key questions need to be considered:

- What could go wrong?
- What must go right?
- What may surprise you?

Disruption brings new challenges and an added level of complexity which many organisations have never experienced. In order to deliver value, leadership must focus on understanding the risk portfolio and seize disruption with confidence. The process of risk management is no longer solely focused on risk avoidance and mitigation but has now moved forward into embracing disruption in order to achieve ever greater business outcomes through embracing upside opportunities:



There are a variety of techniques for identifying uncertainties that may affect one or more objectives, each of which has strengths and weaknesses, so more than one approach should be used to identify risks. Appendix A provides an overview of common risk assessment techniques. Drawing on experience, examining core assumptions and biases and considering changes in the internal and external environment are all relevant factors to consider when identifying risk. Others are:

- 'Tangible' sources of risk (e.g., schedule slippages, personnel unavailability and budget shortfalls)
- 'Intangible' sources of risk (something which cannot be reasonably predicted or quantified, e.g., reputational harm caused by a tweet or computer hack, or damage or theft resulting from a cyberattack)
- Threats (i.e., chemical, biological, ergonomic, physiological, materials, equipment, environment and people)
- Opportunities
- vulnerabilities and capabilities
- indicators of emerging risks
- the nature and value of assets and resources
- limitations of knowledge and reliability of information
- time-related factors (i.e., risk proximity).

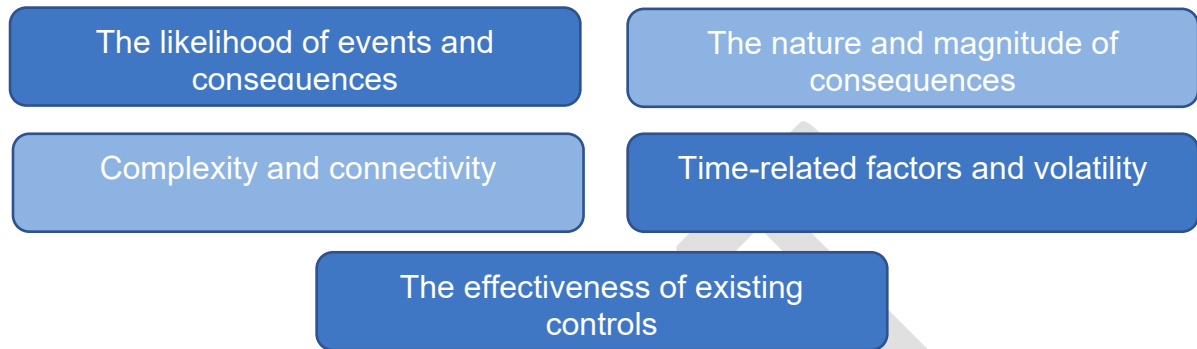
The overarching key point, however, is to ensure that risks relate to an objective or set of objectives. A specific risk owner should be identified for each risk. Ideally the risk owner will also own the related objective or significantly influence its achievement. Ownership of a risk usually results in a greater understanding of said risk, greater emphasis in monitoring the risk, and the implementation of appropriate/ effective controls.

Once identified, the risk needs to be described clearly to ensure that there is a common understanding by stakeholders of the risk. It is important that risks are described in a succinct and

clear way.

2.2 Risk Analysis

Risk analysis determines a risk's significance by considering its potential likelihood in occurring and quantifies the resultant impact if it were to occur and therefore yields the gross risk value. Risks should be assessed in an objective and consistent manner if they are to be managed robustly; risk analysis should therefore consider factors such as:



Assessing likelihood and impact together produces a gross risk rating, known as a RAG (red-amber-green) rating. Appendix B provides VUNHST's risk heatmap criterion which is used to rate risks.

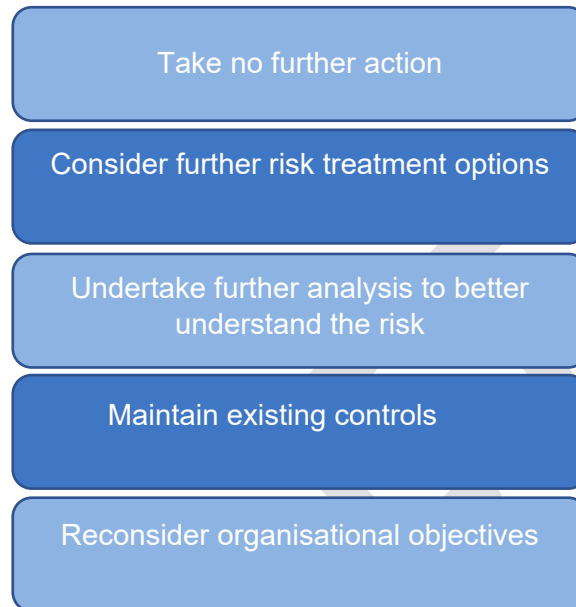
Each risk event on our risk registers has an inherent score (i.e. the exposure before any action has been taken to manage it or if existing controls failed entirely); a residual score (i.e. the threat that remains after all existing controls have been applied); and where risks are outside acceptable levels of tolerance, a target risk score should be agreed (i.e. the level that future mitigation should aim to achieve or better; this will vary over time and should be set and revised by the executive director). All scores should be recorded in the relevant risk register.

Human and cultural factors (risk perception and the social amplification of risk)

Human behavior and culture significantly influence all aspects of risk management at each stage. One of the most perplexing problems in risk analysis is why some relatively minor risks or risk events often elicit strong public concerns and result in substantially higher impacts than anticipated, or higher than our technical risk assessment predicts. This is because risks interact with psychological, sociological, and cultural perceptions and what constitutes 'risky' behavior, which can amplify public responses to the risk or risk event.

2.3 Risk Evaluation

Not all risks are equally important, so we need to filter and prioritise them to find the most potent threats (and the greatest opportunities). The purpose of risk evaluation is to support decisions. The process involves comparing the results of the risk analysis with the established risk criteria to prioritise significant risks and identify where additional action is required. This can lead to a decision to:



Decisions should take account of the wider context and the actual and perceived consequences to external and internal stakeholders.

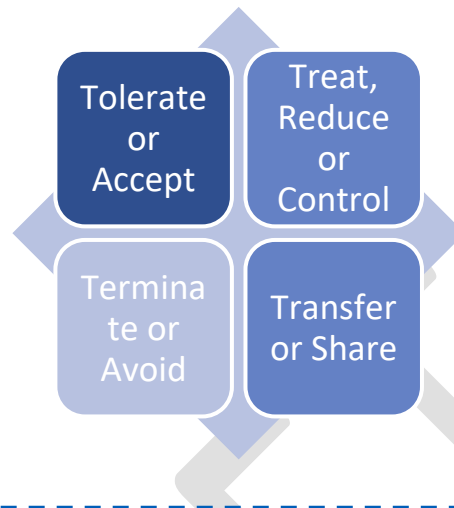
3. Risk Treatment and Response

Once a risk has been recorded, the risk owner needs to consider how each risk will be treated. In this step existing controls are improved, or new controls are developed and implemented. A risk action plan (also referred to as a risk treatment plan) should be put in place, which involves selecting and implementing one or more treatment options. Note: Once a treatment has been implemented, it becomes a control, or it modifies existing controls.

There are many treatment options. You can avoid the risk, you can reduce the risk, you can remove the source of the risk, you can modify the consequences, you can change the probabilities, you can share the risk with others, you can simply retain or accept the risk, you can insure against the residual risk (though this only mitigates financial impact) or you can even increase the risk to pursue an opportunity. The level and type of treatment will vary depending on the level of residual risk that has been determined and the tolerance for managing risk to within its risk appetite.

3.1 4 T's Model

To help guide response, the 4 T's Model (which depicts the 4 primary responses to hazard risk) of risk mitigation (illustrated below) will be utilised at Velindre University NHS Trust:



Terminate or Avoid- By deciding not to engage in an activity, that gives rise to a risk, the organisation will not be exposed to the risk itself and therefore the consequences. However, it will be very difficult to use this approach in the public sector.

Transfer or Share- By 'outsourcing' an activity to transfer the responsibility of the risk to another party, or through buying insurance. Again, it is rare that this option is available, and it is unlikely to remove reputational risks to a great extent.

Treat, Control or Reduce – By implementing action to constrain the risk to an acceptable level. This can include implementing controls to help ensure that the possible negative impact of a risk does not increase (managing threats) and can include actions to minimise any impact should the risk occur (such as identifying contingent actions). It can also be implementing actions to help ensure a risk does occur (managing opportunities).

Tolerate or Accept- By informed decision a risk owner may feel that:

- The level of risk is acceptable, and no further actions are required/ possible
- The risk is sufficiently low that treatment is not considered cost effective.
- A sufficient opportunity exists that outweighs the perceived level of threat

Additional considerations

It is not always possible to identify and then fully implement actions to eliminate or minimise a risk. Risk treatments might not produce the expected outcomes and/or could produce unintended consequences. Where this is the case, it is essential that the significance of the risk that remains is understood in the organisation and that, in accordance with risk management governance, the relevant committee confirms it is prepared to accept that level of risk.

Additionally, risks cannot be addressed in isolation from each other; the management of one risk may have an impact on another, or management actions which are effective in controlling more than one risk simultaneously may be achievable.

3.2 Preparing and Implementing Risk Treatment/ Action Plans

The purpose of risk treatment/action plans is to specify how the chosen treatment options will be implemented, so that arrangements are understood by those involved, and progress against the plan can be monitored. The risk owner must appoint an action owner, to be responsible for the day-to-day management and mitigation activity allocated to them. This must be a named individual who has the relevant authority and resources to undertake the task. There may be several action owners from more than one team or business area who will be responsible for managing and mitigating the risk.

When developing a risk action plan, you need to agree:

- 1** What actions or controls (future mitigating actions) are to be introduced?
- 2** Who will undertake the actions/implement the control?
- 3** When will the actions complete and controls be implemented?

Risk owners must also ensure that the actions/controls to be introduced offer value for money in relation to the risk, for example is the cost of mitigating the risk in proportion to the cost of the risk materializing?

4. Risk Recording and Reporting

The risk management process and its outcomes should be documented in a live risk register and reported through appropriate risk governance mechanisms. Recording and reporting aims to:

- Communicate risk management activities and outcomes across Velindre University NHS Trust
- Provide information for decision-making
- Improve risk management activities
- Assist interaction with stakeholders, including those with responsibility and accountability for risk management activities

4.1 Risk Register

A risk register is a live document maintained to monitor potential risks, it also tracks the actions taken to minimise risks and provides contingency plans that should be invoked if a risk does occur.

For Velindre University NHS Trust, once the risk has been identified and analysed the next stage is to ensure the risk is recorded in Datix Web Risk Register Module which will form the Unit's Risk Register. The register allows for corporate teams, departments and divisions throughout the Trust to capture all the information needed to manage risk appropriately and determine whether any risks should be escalated through our governance structure. The risk register should be kept up to date and reviewed regularly. New risks should be added as they are discovered.

The Corporate Governance Team provides a standard risk register template that should be used to capture risks at strategic and operational level. An exception would be if alternative, robust programme or project management arrangements were in place. Note: The Corporate Governance Team must agree all exceptions. NOTE: The intention is for all risk register to be transferred to the Datix system in 2020/21

4.2 Risk Reporting

To ensure Ward to Board connection / connectivity of the Trust Board to actual service delivery, each department maintains their own risk register which ultimately feeds the TAF to triangulate the messages contained in board papers with observations and interactions with patients, staff and stakeholders.

Departments/Divisions regularly monitor and report risks affecting their activities – and the effectiveness of control measures for managing them – to senior managers or executive directors during routine management meetings, committees, groups or panels. Note: each department/division is responsible for defining an internal risk review and reporting process, proportionate to its local needs, however risk registers are formally submitted to the Corporate Governance Team every month for upward reporting; alongside a covering paper articulating changes to risk profile and any risks requiring escalation).

The risk reporting and escalation routes are stated below

- ➔ Risks can be raised at any meeting and at any level in VUNHST e.g. any member of staff; local management/team meetings; Executive Committees, or any other specialist/technical committees; at the Board; or from our partners.

- Risks scored **>=15**, and any risks where the impact is scored as 5 regardless of likelihood (will require confirmed review by the relevant Executive Committee and confirmed review by the Board. It should be escalated according to the RMF and considered for inclusion on the TRR and TAF, monthly.
- Risks scored **>=12**, and any risks where the impact is scored as 5 regardless of likelihood, will require confirmed review by the relevant Executive Committee, depending on source.
- Risks outside Board-specified tolerance ranges: As outlined in the Risk Appetite Strategy, the VUNHST Board has developed indicative tolerance ranges against 9 principal risk categories (or risk domains). In addition to the above-mentioned escalation criteria, any risks outside these ranges will require confirmed review by the relevant Executive Committee i.e., any material Quality, Safety and Reputational risks above a Low rating; any Compliance, Performance and Service Sustainability, or Financial Sustainability risks above a Moderate rating; or any Research and Development, Workforce, or Partnership risks above a High rating should be escalated for discussion.
- Example below (to note exact scoring levels to be finalised when modelling on refreshed risk register is completed):

Risk Levels	Appetite	Escalation level to Trust Board if at risk score at or above:
0 – Avoid		9
1 – Minimal		12
2 – Cautious		12
3 - Open		12
4 - Seek		15
5 - Mature		15

- Urgent risks: Staff must immediately escalate newly emerging, high impact/highly likely risks; risks breaching VUNHST's risk appetite (see Risk Appetite Strategy) or with a significant or

rapid change in severity rating, to their owning Executive Director, and not wait for the reporting cycle above. The executive director affected must decide whether the risk needs to be escalated to the wider executive immediately or at its next available meeting, for consideration and action. Otherwise the risk will form part of the above reporting to the relevant Executive Committee and/or the Board monthly.

- The Head of Corporate Governance will compile a Trust Assurance Framework (TAF), for the Board, consisting of the top strategic risks to VUNHST's objectives, including those that meet the above-mentioned escalation criteria and those the Board have requested sight of regardless of score.

Additional guidance on risk reporting can be found in the VUNHST Risk Management Framework

5. Risk Monitoring and Review

The monitoring of risks forms an essential part of the risk management process. This is due to the ever-changing nature of risk profiles, and to ensure controls are still operating effectively. Risk owners should monitor their risks regularly to:

- Confirm that action plans to address risks are being undertaken and completed
- Report any change in assessment of the impact and likelihood of the risk
- Confirm the risks are still relevant in the changing environment
- Escalate if necessary, including if the risk cannot be managed at the current level.

The review process should fulfil the following requirements:

- Monitor whether controls remain aligned to risks in their area of responsibility
- Monitor whether key risks are being managed within the risk appetite in their area of responsibility
- Monitor the risk profile and key risks identified by the process and how they are changing over time
- Monitor the progress of actions to treat key risks and the operation of key controls
- Escalate risks
- Re-prioritise resources
- Make better informed decisions.

The regular review of risks should be built into the local management reporting and review cycle, supported by relevant risk leads and discussed at relevant management team meetings, programme or project meetings

6. Communication and Consultation

You must continually communicate with and consult internal and external stakeholders, where possible, to gain input and agree ownership of risk assessment results. It is also important to understand stakeholders' objectives, so you can plan their involvement and take their views into account in agreeing whether a specified risk level is acceptable or tolerable.

Discussions could be about the existence of risks, their nature, likelihood, impact and significance, as

well as whether risks are acceptable or should be treated, and what treatment options to consider.

As responsible professionals we should take advantage of our experience to learn lessons and benefit future ventures. This means that we should spend time thinking about what worked well and what needs improvement and recording our conclusions in a way that can be reused by ourselves and others.

Effective internal and external communication is important to ensure that those responsible for implementing risk management, and those with a vested interest understand the basis on which decisions are made and why particular actions are required.

Internal stakeholders can include any managers which the risk identified may impact on their service or staff. External stakeholders will vary depending on the type of risk and the divisional risk lead will need to consider which external stakeholders will need to be notified. All significant risks will be reported to the Welsh Government through the weekly brief from organisations and quarterly performance review meetings.

There will be occasions when a risk is shared with another Health organisation for example in the instance of Service Level agreements for the delivery of services across organisations. In this case VUNHST can share these risks with the relevant health organisations through the risk management database on the request from Units.

Appendix A: Risk Assessment Techniques

Risk assessment is an important step in the risk management process. If you don't identify a risk, you can't manage it. It's also important to scan the environment from time to time to identify new and emerging risks, as our exposure to risk is constantly changing.

Technique	Description	Advantages	Disadvantages
Questionnaires, checklists, surveys and interviews	Use of structured questionnaires and checklists to collect information that will assist with the recognition of the significant risks.	Consistent structure guarantees consistency Greater involvement than in a workshop	Rigid approach may result in some risks being missed Questions will be based on historical knowledge
Workshops and brainstorming To have a structured discussion at a risk assessment workshop, several brainstorming techniques can be used e.g. SWOT analysis (Strength, Weakness, Opportunity Threats); PESTLE analysis (Political, Economic, Sociological, Technological, Legal, Environmental); Hazard and Operability analysis (HAZOP); and Failure Modes Effects Analysis (FMEA).	Collection and sharing of ideas at workshops to discuss the events that could impact the objectives, core processes or key dependencies.	Consolidated opinions from all interested parties Greater interaction produces more ideas	Senior management tends to dominate Issues will be missed if incorrect people involved
Inspections and audits	Physical inspections of premises and activities and audits of compliance with established systems and procedures.	Physical evidence forms the basis of opinion Audit approach results in good structure Inspections are most suitable for hazard risks	Audit approach tends to focus on historical experience
Flow charts and dependency analysis	Analysis of the processes and operations within the organisation to identify critical components that are key to success.	Useful output that may be used elsewhere Analysis produces better understanding of processes	Difficult to use for strategic risks May be very detailed and time-consuming

Appendix B: Additional guidance on controls

Types of controls

There is a fundamental difference in how we respond to the upside and downside of risk. VUNHST naturally try and minimise hazard risks and the potential downside of opportunity risks, subject to it being commercially viable to do so. The upside of opportunity risks, however, is different and in this instance, we look to attach Key Risk Indicators to opportunity risks to monitor them and assess how best we might respond.

There are a range of controls that can be applied to hazard risks. The most convenient classification system is to describe these controls as preventive, corrective, directive and detective (PCDD). This is the risk classification system suggested in the Orange Book.

There is a relationship between these four types of controls and the dominant risk response described in the 4Ts of hazard response i.e., you would typically deploy Preventive controls for risks that you wish to terminate, Corrective controls for risks that you choose to treat, Directive controls for risks you wish to transfer, and Detective controls for those risks you agree to tolerate. Further information and examples of the types of hazard controls are provided below:

Control Type	Description	Examples
Preventive (terminate)	These controls are designed to limit the possibility of an undesirable outcome being realized. The more important it is to stop an undesirable outcome, then the more important it is to implement appropriate preventive controls.	<ul style="list-style-type: none">• Authorization limits of and separation of duties• Pre-employment screening of potential staff
Corrective (treat)	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realized. They may also provide a route of recourse to achieve some recovery against loss or damage.	<ul style="list-style-type: none">• Passwords or other access controls• Staff rotation and regular change of supervisors• Exposure reduction by limitation on hours worked
Directive (transfer)	These controls are designed to ensure that a particular outcome is achieved. They are based on giving directions to people on how to ensure that losses do not occur. They are important, but depend on people following established safe	<ul style="list-style-type: none">• Training and supervision to enforce procedures• Personal protective equipment and improved welfare facilities

	systems of work.	<ul style="list-style-type: none"> • Accessible, detailed, written systems and procedures • Training to ensure understanding of procedures
Detective (tolerate)	These controls are designed to identify occasions when undesirable outcomes have been realized. Their effect is, by definition, 'after the event' so they are only appropriate when it is possible to accept that the loss or damage has occurred.	<ul style="list-style-type: none"> • Health monitoring to enquire about potential symptoms • Reconciliation, audit and review by internal audit • Whistleblowing policy to report (alleged) fraud

Documenting and reviewing Key Controls

Controls are only good if they are relevant; therefore, departments/divisions need to ensure that they routinely review their controls to see if they are still effective. As things change, you need to think about making changes to your controls as your organisation evolves i.e., assessing whether controls are no longer valid and how new controls may help the organization implement changes.

When identifying / assessing key controls, the first steps are to determine:

- Do Key Controls exist?
- Are those controls working?
- Are those control activities documented and properly performed?
- What mechanisms are there to provide assurance (evidence) on the operation of controls?

Key versus Non-Key Controls

Only Key Controls should be documented within your risk register. A Key Control has the following characteristics:

- It is required to provide reasonable assurance that material errors will be prevented or timely detected
- It is the only or one of the only controls that covers a risk of material misstatement (it is indispensable to cover its control objective)
- If it fails, it is highly improbable that other controls could detect the control absence.
- It is a control that covers more than one risk or supports a whole process execution
- It needs to be tested by internal audit to provide assurance over financial assertions

A Non-Key Control has the following characteristics:

- It can fail without affecting a whole process
- It has an indirect effect on the risk of material misstatement
- It is generally not included within internal audit testing

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Appendix C: Risk Quantification Matrix

IMPACT Matrix

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

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

Likelihood – MATRIX

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

Risk Rating Matrix- Impact X Likelihood

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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

RISK APPETITE STRATEGY

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Review Date:

Version: Final draft

This document should be read in conjunction with Velindre University NHS Trust's **Risk Management Framework** and **Trust Assurance Framework (TAF)**

Table of contents

1.	Context.....	Error! Bookmark not defined.
2.	Aims and Objectives.....	4
3.	What is Risk Appetite and Risk Tolerance.....	5
4.	Operationalising Risk Appetite.....	7
5.	Velindre University NHS Trust Risk Appetite Strategy.....	10
6.	Risk Appetite Statement and Tolerance Ranges.....	11
7.	Appendix A: The Good Governance Institute Risk Appetite for NHS Organisations.....	14

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1. Context

- 1.1 The UK Corporate Governance Code states that **'the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives'**. This means that at least once a year, Velindre University NHS Trust Board should consider the types of risk they may wish to exploit and/or can tolerate in the pursuit of objectives. This helps demonstrate to our regulators, services users and other stakeholders that there are clear and effective processes for managing risks, issues and performance across the Trust.
- 1.2 Velindre University NHS Trust define risk appetite as **'the amount of risk that we are willing to seek or accept in the pursuit of long-term / strategic objectives.'** It is key to achieving effective risk management and should be considered before risks are addressed.
- 1.3 We recognise it is neither possible nor desirable to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory obligations, and that we may need to consider and/or accept a certain degree of risk where it is in our and ultimately our donors', patients' or staffs' best interests i.e., where taking managed risk (in keeping with our statements of risk appetite) may result in positive benefits for our patients, donors, service users, staff and visitors.
- 1.4 We carry out analysis, make judgements, take decisions, provide services and run projects every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We must therefore view risks holistically, assessing interdependencies to provide a more rounded assessment of risk, finding a better balance between the potential benefits of managed risk taking and avoidance of risk.
- 1.5 Risk management within Velindre University NHS Trust aims to achieve the optimum balance between quality of care, treatment and rehabilitation of patients, and the provision of services which are safe by optimising use of resources and identifying prioritised risk control action plans. Therefore, an approach to risk appetite which puts the quality of care and the safety of patients and staff at the centre but recognises the requirement for speed, especially in today's climate, has been considered to support clear decision making and accountability for our Trust.
- 1.6 In conclusion, risk appetite within Velindre University NHS Trust aims to prevent failure caused as a consequence of excessive risk-taking and ensure that Executive Management and the Board are taking the right risks for success (e.g., to maintain or enhance patient and donor safety and experience, to maintain performance within an appropriate use of resources, and to deliver improved outcomes for patients and deliver Value for Money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances across our Trust to help drive management action and facilitate informed decisions.
- 1.7 Risk appetite at Velindre University NHS Trust is:
 - a) set by the Board;
 - b) aligned with our strategy and corporate objectives and embedded into key business processes;
 - c) linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control;
 - d) not a single, fixed concept. There will be a range of appetites for different risks and these appetites may vary over time; in particular the Board will have freedom to vary the amount of risk which it is prepared to take as circumstances change, such as, periods of increased uncertainty or adverse changes in the operating environment (for example in response to COVID-19); and
 - e) reviewed once a year, or sooner if circumstances dictate.

2. Aims and Objectives

Why do we need Risk Appetite?

- 2.1 Increasing pressures, both internally and externally driven across the health and social care system, may mean that our staff may need to take decisions they may not have taken previously, or needed to have taken as quickly. The focus on maintaining the statutory duty of patient and donor safety and quality of care remains at the fore and our Board, Executive Team and management may have to make difficult decisions to balance quality, finance and operational performance.
- 2.2 The Velindre University NHS Trust Board is ultimately responsible for deciding the nature and extent of the risks it is prepared to take. The Trust's approach to risk appetite is a key element of the Board's strategic approach to risk management as it explicitly articulates their attitude to and boundaries of risk. When used effectively it is an aide to decision making and provides an audit trail in that it supports why a course of action was followed.
- 2.3 Risk appetite also provides clear expectations for staff and managers regarding the management of risk. It allows for controlled risk taking; evidencing preparedness to take risk appropriately.

Purpose / benefits / importance of Risk Appetite

- 2.4 A well-articulated risk appetite statement is a critical part of the Trust's overall risk governance process. The purpose of risk appetite is to articulate what risks the Board are willing or unwilling to take in order to achieve the Trust's strategic objectives. The purpose of stating risk appetite within the Trust is therefore to:
 - a) Create transparency and consistency for the type and level of risks that the Trust undertakes to achieve strategic and operational goals. Risk appetite provides awareness and an overall view of our risk profile, giving context to our risk position and exposure.
 - b) Help steer decision making across the organisation by providing a position against which potential decisions can be tested and challenged. Risk appetite provides freedom for prudent decision-making within agreed risk boundaries by:
 - i. Providing early warning where risks are outside of limits (yet still within risk capacity and well within legal requirements)
 - ii. Creating a "freedom" that promotes flexibility and accountability to management and operations
 - iii. Making sure a breach triggers internal actions designed to escalate and respond before it threatens the reputation and viability of the Trust
 - iv. Eliminates excessive risk aversion by articulating preference for risk taking
 - v. Defines thresholds for risk taking that optimise risk and reward
 - vi. Helps integrate risk taking and performance management
 - vii. Assists with the definition of risk metrics that support day-to-day business operations
 - viii. Defining escalation and reporting procedures related to pre-set levels
 - c) Drive risk behaviour and set the tone for the organisation's risk culture.

3. What is Risk Appetite and Risk Tolerance?

- 3.1 Risk Appetite and Risk Tolerance set boundaries of the level of risk Velindre University NHS Trust, and the underlying departments and divisions, are prepared to accept throughout the course of ongoing operations. Establishing these parameters should facilitate management's ability to set a proportional response to risk in the context of business objectives.
- 3.2 Having a defined risk appetite strategy helps management to consider how much risk is appropriate in the course of performing its activities and can be used to assess and prioritise the management of risks that are determined to be outside of the agreed appetite and tolerance set by the Trust Board.
- 3.3 This document creates a common language and understanding with regards to Velindre University NHS Trust's attitude to risk. Relevant definitions for Risk Appetite and Risk Tolerance, and other related terminologies, are defined in Figure 1 as follows:

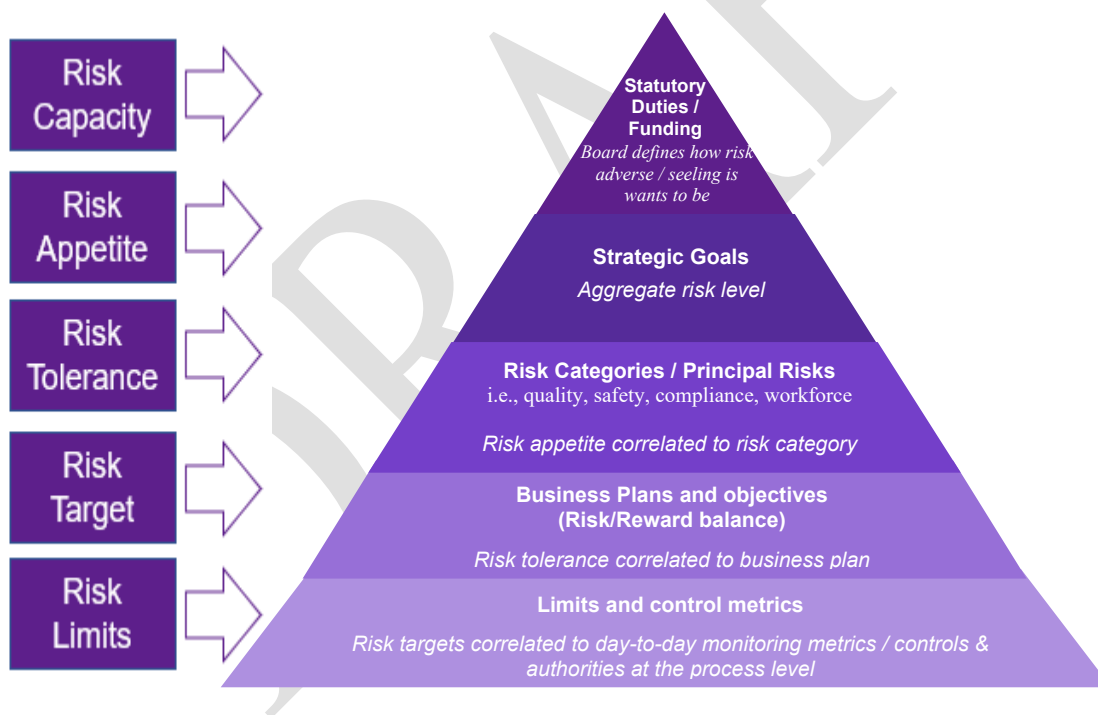
Figure 1: Risk Appetite Definitions

Key Term	Definition
Risk Capacity	The maximum amount and type of risk an organisation can assume / is <i>able</i> to support in pursuit of its objectives given its resources, operational environment and obligation.
Risk Appetite	<p>The amount and type of risk an organisation is willing to accept in the pursuit of objectives.</p> <p>Risk appetite is the aggregate level and types of risk that Velindre University NHS Trust executive management and Board is willing to assume <i>within its risk capacity</i> to achieve business objectives. Risk appetite is usually encompassed in practice through standard operating procedures, policy and guidelines.</p>
Risk Tolerance	<p>The acceptable level of deviation from a standard or objective delineated through the use of limits, policies, and delegation of authorities.</p> <p>Velindre University NHS Trust's tolerance for risk relates to the degree to which performance can deviate from expected outcome and still be considered within an acceptable range from a risk perspective. Risk tolerance determines the <u>maximum</u> risk Velindre University NHS Trust is willing to take for a particular activity / objective, or category of risk.</p> <p>Exceeding a risk tolerance will typically act as a trigger for corrective action at the executive level, immediate notification to the board, and a fulsome review of the underlying causes of the high-risk exposure or significant variation from expected performance.</p>
Risk targets	<p>The <u>optimal</u> level of risk that an organisation wants to take in pursuit of a specific business goal.</p> <p>This is usually based on the desired return or outcome, the risks implicit in trying to achieve the organisations' strategy and related returns and the ability to managing the related risks.</p>
Risk limits (or indicators)	The <u>thresholds</u> to monitor for the risk exposure or performance deviating from the target i.e., that actual risk exposure does not deviate too much from the risk target

	<p>and stays within Velindre University NHS Trust's defined risk appetite/tolerance.</p> <p>Exceeding a risk limit will typically act as a trigger for corrective action at the process level, immediate notification at management level, and reporting at a governance level.</p>
Principal Risks	<p>A principal risk is a significant risk or combination of risks that can threaten the delivery of our strategy / can affect the strategic performance, reputation, or prospects of the organisation. These include those risks that would threaten the business model, future performance or financial sustainability of Velindre University NHS Trust.</p> <p>Principal Risks are identified as part of the annual risk review exercise undertaken by the Board. These principal risks are identified through analysis and consolidation of risks reported by different functions and/or identified by key stakeholders (such as member of the Executive).</p> <p>By understanding its appetite, Velindre University NHS Trust will be able to activity manage its Principal risks to provide better services to its donors and patients.</p>

3.4 The pyramid from risk appetite to risk limit is visualised in the figure 2 below:

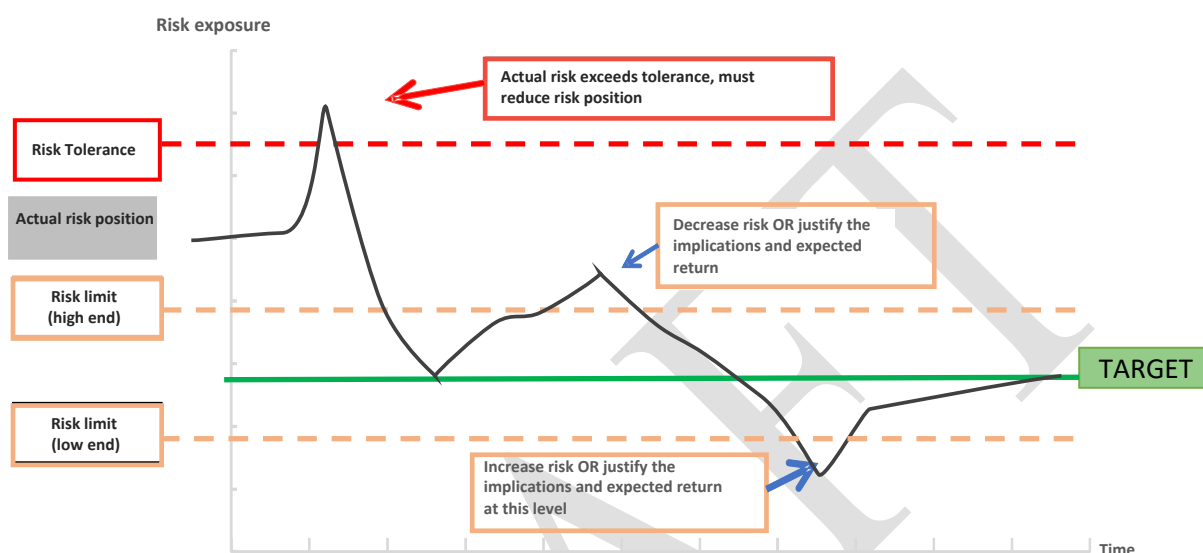
Figure 2: Risk Appetite Pyramid



4. Operationalising Risk Appetite

- 4.1 When risk appetite is defined rigidly it can impede innovation and make an organisation overly cautious. It can also fail to reflect the complexity and diversity of decision making required. The risk appetite concepts defined in Section 3, and how they work in practice, are best depicted in Figure 3 as follows:

Figure 3: Risk appetite in practice - understanding tolerance, limits and targets



Application and usage

- 4.2 Due to the nature of our organisation, and the duties we are mandated to perform, Velindre University NHS Trust acknowledges that a one-dimensional (overly adverse and heavily quantitative and directive) approach to risk appetite would not drive the right results. Therefore, in keeping with our culture to empower and trust decision makers, to drive consistency and enable staff to take well calculated risks and make accurate risk trade-off decisions to improve delivery when opportunities arise (and identify when a more cautious approach should be taken to mitigate a threat), the Velindre University NHS Trust Board has adopted a largely **qualitative approach** to risk appetite.
- 4.3 The aim is for risk appetite considerations to be an intrinsic part of both our risk management and business processes, not seen as something separate or extra. In many areas this is already happening:

Business processes:

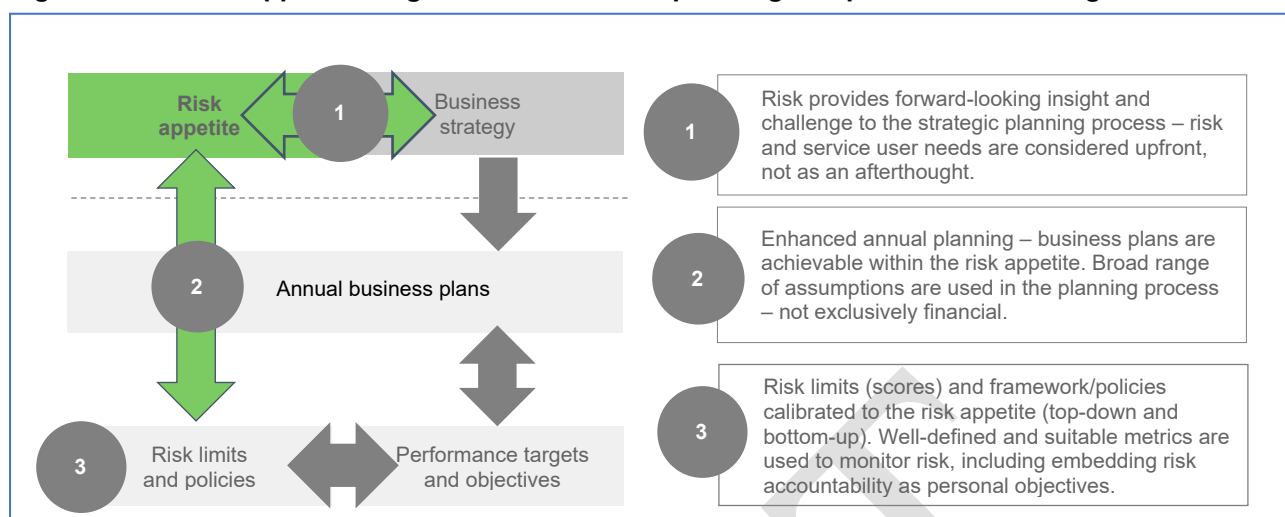
- 4.4 To ensure that the Trust's day-to-day activities are well managed and that decisions are well controlled within local circumstances, risk appetite considerations are an intrinsic part of how we do business; with the aim of improving organisational performance. Therefore, in some instances, for example from an operational perspective, risk appetite reflects the constraints that are *already* placed on staff in the organisation. For example, risk-reward trade-off discussions and/or appetite/tolerance limits are:
- Embedded within **operating limits**; delivery targets/KPIs; standing financial instructions (SFIs) / delegated financial limits and processes by which revenue and capital expenditure are committed to; and other delegation of authority arrangements i.e., delegated decision and oversight levels.

- b) An integral part of **strategic and financial planning**. For example, the annual budget prioritisation process is linked to our business planning cycle which allows an overview of financial and other types of risk.
- c) Built into **impact assessment processes**, and considered within any **Decision-Making Frameworks/Models**, and within **programmes and projects** (at the very outset of project conception, within the formal decision-making process and throughout delivery) actively guiding management to assess the level of risk beyond which programmes and projects would not be considered viable.

Risk processes:

- 4.5 A high-level qualitative **risk appetite statement** structured around the Trust's key risk categories/principal risk types (known as domains). N.B., Velindre University NHS Trust expresses its risk appetite using statements against nine key risk domains:
 - i. Quality
 - ii. Safety
 - iii. Compliance
 - iv. Research and development
 - v. Reputation
 - vi. Performance and service sustainability
 - vii. Financial sustainability
 - viii. Workforce
 - ix. Partnerships & innovation
- 4.6 In drafting the Trust's risk appetite across these nine domains, reference has been made to the Good Governance Institute's Risk Appetite for NHS Organisations Matrix (see Appendix 1).
- 4.7 As a guide for setting risk appetite/to find out if individual risks fall within an acceptable tolerance range, risk appetite is considered against the **Trust Risk Matrix** (see Appendix 2).
- 4.8 **Target risk levels** (i.e., the risk level that the affected risk owner, region or national directorate believe is best for meeting its objectives / the level of risk we would like to drive towards over time needed to achieve target level) are also assigned to each risk to ensure they are managed within set appetite.
- 4.9 The Executive will continue to monitor risks **top down** to ensure appetite is within tolerance range, that actions taken to reach target levels of risk are achievable and met, and/or that changes in one risk category do not unwittingly compound others.
- 4.10 The approach to risk appetite also provides a way of steering risk appetite/tolerance discussions **bottom up** and should ensure consistency of approach for the Trust as a whole, including in day-to-day service delivery and the delivery of programmes and projects. Departments and Divisions will continue to own, respond to, monitor and communicate risk management information bottom-up as articulated within the Trust Risk Management Framework.
- 4.11 Figure 4 below illustrates, at a high level, how risk appetite is embedded into the organisation from top to bottom.

Figure 4: How risk appetite integrates into business planning and performance management



4.12 Risk Appetite levels will be further linked to wider Risk Management Framework in two key ways – and the process underpinning these concepts is explained further in the corresponding process documentation:

1. Link of Risk Appetite level to target risk scores so that there is a clear calibration between the two
2. Alignment of Risk Appetite level to risk escalation level:

Draft example below:

Risk Appetite Levels	Escalation level to Trust Board if risk at level
	Score below – according to the 5x5 matrix
0 – Avoid	9
1 – Minimal	12
2 – Cautious	12
3 – Open	12
4 – Seek	15
5 – Mature	15

5. Velindre University NHS Trust's Risk Appetite Strategy

- 5.1 Velindre University NHS Trust believe that no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients, donors, staff and taxpayers.
- 5.2 Risk appetite is not a single fixed concept, and Velindre University NHS Trust recognise the complexity of decision-making in providing services and the inherent risks associated with those decisions.
- 5.3 The amount of risk the Trust is prepared to accept or be exposed to (its risk appetite) will vary according to the **perceived significance** of risks; **timing** (it may be more open to risks at different points in time); and **regulatory or legislative constraints**. As such they acknowledge that each case requires the exercise of judgement and that appetite levels may need to be reassessed and amended (i.e., increased or decreased) either temporarily or permanently to reflect new or changing circumstances.
- 5.4 Our approach to risk appetite is therefore based on the premise that trade-off conversations and a consideration of the counterfactual is undertaken when assessing risk on a case by case basis. This provides a flexible framework within which we can find an appropriate balance between risk and reward and make agile decisions and find a balance between boldness and caution in connection with risk. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour. In this sense, risk appetite should be used as a guide or a necessary 'check and challenge.'
- 5.5 When balancing risks, Velindre University NHS Trust will tolerate some more than others. For example: we will seek to minimise avoidable risks to patient safety in the delivery of quality care and have a very low appetite for risk in this area; whereas in the case of research and development we are prepared to take managed "moderate to high risk" on the proviso that the following 'check and challenge' has been undertaken:
- An assessment of what and where the current risks are;
 - That the potential future impact has been understood and agreed;
 - Rapid cycle monitoring is in place to enable swift corrective action should things go wrong;
 - Consideration of the Trust's ability to respond;
 - Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e., whether it will lead to an increase or reduction in other categories of risk);
 - Cost-benefit analysis and stated preference is undertaken;
 - Reliability and validity of data used to make the assessment has been considered;
 - Counterfactual risks have been considered to ensure management apply any learning before taking the risk;
 - We can demonstrate significant and measurable potential benefits (i.e., enhanced efficiency and/or value-for-money delivery).

6. Risk Appetite Statement and Tolerance Ranges

- 6.1 In addition to the strategy above and based upon the Good Governance Institute (GGI) Risk Appetite for NHS Organisations Matrix (Appendix 1), the Board has developed several risk appetite statements and indicative tolerance ranges. These risk appetite statements and indicative ranges are provided against 9 risk categories (or risk domains) and are reviewed annually by the Board:

Figure 5: High-level Statements and range of Risk Appetite Levels

	Domain / Risk Category	Risk Appetite (GGI Level)
1	Quality The provision of high-quality services is of the utmost importance for Velindre University NHS Trust. The Trust acknowledges that in order to achieve individual patient care, treatment and therapeutic goals there may be occasions when a low level of risk must be accepted. Where such occasions arise, we will support our staff to work in collaboration with those who use our services, to develop appropriate and safe care plans. We therefore have a 'LOW' appetite for risks which may compromise the quality of the care we deliver / could result in poor quality care, non-compliance with standards of clinical or professional practice or poor clinical interventions. Our service is underpinned by clinical and professional excellence and any risks which impact quality, could have catastrophic consequences for our patients.	2 - Cautious
2	Safety Velindre University NHS Trust hold patient, donor and staff safety in the highest regard. We have a 'NONE – LOW' appetite for risks which may compromise safety, however recognising that individual risk tolerance may on some occasions go above this if it is in the best interests of patients to accept some risk in order to achieve the best outcomes from individual patient care, treatment and therapeutic goals. We accept this and support our staff to work in collaboration with people who use our services to develop appropriate and safe care plans based on assessment of need and clinical risk. N.B., Key to keeping patients, donors and staff safe is the condition of the estate. We are committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and do not represent a health and safety risk.	1 - Minimal
3	Compliance	2 – Cautious

	<p>We are cautious when it comes to compliance and regulatory requirements. Where the laws, regulations and standards are about the delivery of safe, high quality care, or the health and safety of the staff and public, we will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them.</p>	
4	<p>Research and development</p> <p>We have a HIGH risk appetite for Clinical Innovation that does not compromise quality of care and patient safety / the Trust has a HIGH appetite for risks associated with innovation, research and development in order to take forward our vision in relation to the new treatments, developments of new models of care and improvements in clinical practice that support the delivery of our person centred values and approach. The Trust will only take risks when it has the capacity to manage them and is confident that there will be no adverse impact on the safety and quality of the services provided.</p>	3 - Open
5	<p>Reputation</p> <p>The Trust will maintain high standards of conduct, ethics and professionalism at all times. We have a LOW risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the organisation.</p>	2 – Cautious
6	<p>Performance and service sustainability</p> <p>We have a LOW- MODERATE risk appetite for risks which may affect our performance and service sustainability. And are prepared to accept managed risks to our portfolio of services if they are consistent with the achievement of patient/donor safety and quality improvements as long as patient/donor safety, quality care and effective outcomes are maintained. Whilst these will both be at the fore of our operations; we recognise there may be unprecedented challenges (such as Covid-19) which may result in lower performance levels and unsustainable service delivery for a short period of time.</p>	2 – Cautious
7	<p>Financial sustainability</p> <p>Velindre University NHS Trust is entrusted with public funds and must remain financially viable while safeguarding the public purse. The Trust has no appetite for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instruction. We strive to deliver our services within the budgets our financial plans and will only consider accepting or taking financial risks where this is required to mitigate risks to patient safety or quality of care according to a LOW-MODERATE risk appetite. We will ensure that all such financial responses deliver optimal value for money.</p>	2 – Cautious

8	<p>Workforce</p> <p>Velindre University NHS Trust is committed to recruit and retain staff that meet the high-quality standards of the organisation and will provide on-going development to ensure all staff reach their full potential. This key driver supports our values and objectives to maximize the potential of our staff to implement initiatives and procedures that seek to inspire staff and support transformational change whilst ensuring it remains a safe place to work.</p> <p>We have a MODERATE risk appetite for decisions taken in relation to workforce but given the recognised workforce shortages we may tolerate a HIGH level of risk on some occasions to support patients. N.B., We will not accept risks, nor any incidents or circumstances which may compromise the safety of any staff members and patients or contradict our Trust Values i.e., unprofessional conduct, underperformance, bullying or an individual's competence to perform roles or tasks safely nor any incident or circumstances which may compromise the safety of any staff members or group.</p>	<p>2-3 – (*TBC) – Cautious/Open?</p>
9	<p>Partnerships</p> <p>The Trust is committed to working with its stakeholder organisations to bring value and opportunity across current and future services through system-wide partnership. We are open to developing partnerships with organisations that are responsible and have the right set of values, maintaining the required level of compliance with our statutory duties. We therefore have a HIGH risk appetite for partnerships which may support and benefit the patients in our care. For example, the Trust has a high appetite for risks associated with innovation and partnership with industry and academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. However, the Trust will balance the opportunities with the capacity and capability to deliver such opportunities and is confident that there will be no adverse impact on the safety and quality of the services provided.</p>	<p>4 - Seek</p>

7. Appendix A: The Good Governance Institute (GGI) Risk Appetite for NHS Organisations- a matrix to support better risk sensitivity in decision making

To use the matrix, identify with a circle the level you believe your organisation has reached and then draw an arrow to the right of the level you intend to reach in the next 12 months:

Risk levels ►	0	1	2	3	4	5
Key elements ▼	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	Minimal (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Cautious Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Open Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VFM)	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
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VFM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VFM is the primary concern.	Prepared to accept possibility of some limited financial loss. VFM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.

DRAFT



Trust Assurance Framework (TAF)

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Approved by: X

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Table of contents

1.	Introduction.....	3
1.1	Background	3
1.2	TAF Definition	3
1.3	Purpose	3
1.4	Benefits of TAF	5
1.5	Barriers to an effective TAF.....	5
2.	Governance and Assurance	6
2.1	Good Governance Requirements.....	6
2.2	Levels of Assurance/ '3 Lines of Defence'	6
3.	Compiling the Trust Assurance Framework.....	7
3.1	Process of Compiling the TAF	7
3.2	Strategic Objectives.....	8
3.3	Content of the TAF.....	9
3.4	Assurance Ratings.....	9
3.5	Risk Quantification Matrix	9
4.	Operationalising the TAF	9
4.1	Summary, Scrutiny and Challenge of the TAF- including frequency	9
5.	Appendix A: TAF Summary	11
6.	Appendix B: TAF Dashboard report.....	12
7.	Appendix C: Risk Quantification Matrix	14

1. Introduction

1.1 Background

All Health Boards and Trusts are required to create and maintain a Board Assurance Framework (BAF). In doing so, the VUNHST Trust Board must be able to assure itself that the Trust is operating effectively and meeting its strategic objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

There are several ways in which the effectiveness of internal controls will be assessed and through which assurance will be provided to the public such as the Annual Governance Statement and the internal audit function providing an opinion as to whether the Board has identified its objectives, risks, controls and sources of assurance and accurately assessed the value of assurance obtained.

1.2 BAF Definition

To ensure consistent language and understanding, the following external definitions for 'BAF' are used:

Source	Definition
The Audit Committee Handbook	"the key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control".
The Institute of Chartered Secretaries and Administrators	"a structured approach for ensuring that boards get the right information which is accurate and relevant at the right time and with the level of assurance attributed to each source of data. It pulls together all data pertaining to organizations strategic goals and the risks it faces".

It was agreed to name this document and process Trust Assurance Framework (TAF) to firstly reflect the fact that the process should be of value for the whole Trust and secondly to reflect the ambition of this framework to, in time, effectively link with both the Quality & Safety and Performance frameworks.

1.3 Purpose of TAF

The TAF enables the Board to identify and understand principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks, and where improvements are needed suitable action plans are in place and being delivered; and to provide an assessment of the risk to achieving the related objective.

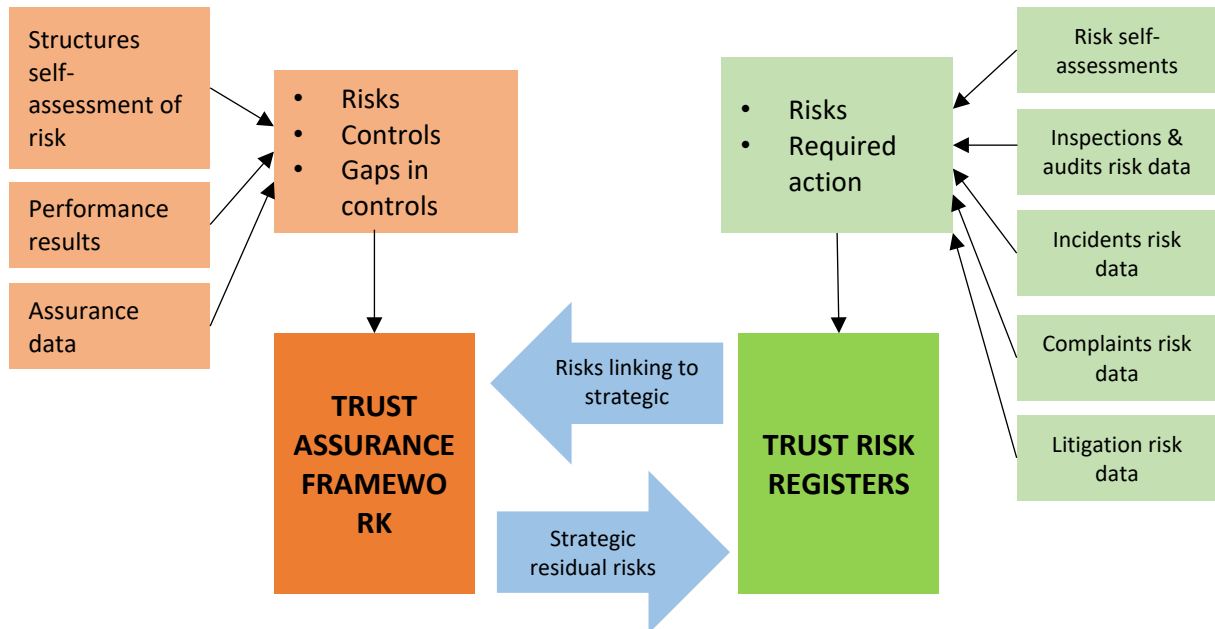
The TAF is used by the Trust to:

- To provide assurance to the Board that risks with the potential to impact on strategic objectives/vision, mission and purpose are being managed appropriately.
- As a key document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.
- As a systematic method to identify and understand the principal risks to achieving its strategic objectives, receive assurance that suitable controls are in place to manage these risks and where improvements are needed.
- Provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place.

- e) A method to provide aggregated board reporting, ensuring prioritised action plans are in place and are being delivered.

The TAF is the key source of information that links VUNHST's strategic objectives to risk and assurance, as demonstrated in figure 1 below:

Figure 1: Information flows between the risk register & the assurance framework



1.4 Benefits of the TAF

An effective assurance framework:

- a) Provides timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues.
- b) Facilitates escalation of risk and control issues requiring visibility and attention by senior management, by providing a cohesive and comprehensive view of assurance across the risk environment.
- c) Provides an opportunity to identify gaps in assurance needs that are vital to the Trust, and to plug them in a timely, efficient and effective manner.
- d) Can be used to raise organisational understanding of its risk profile and strengthen accountability and clarity of ownership of controls and assurance thereon, avoiding duplication or overlap.
- e) Provides critical supporting evidence for the production of the Annual Governance Statement.
- f) Facilitates better use of assurance skills and resources.

1.5 Barriers to an effective assurance framework

The goal is to ensure that the TAF is not seen as an add on, stand alone or tick box exercise but forms an integral part of the agendas and work of each sub-committee. If developed and used correctly, it is a tool for formulating and driving the agenda and ensuring that risk is managed accordingly. Potential barriers to keep in view when implementing and then operating are:

- a) Absence of clear, measurable, time limited strategic objectives and forward trajectories of performance against which risk can be identified and mitigated.
- b) Failure to provide adequate focus on the effectiveness of the controls and the strength of the assurance.
- c) Some risks held on the TAF are intangible, we know they exist, we have no tangible controls, but they have a potential for major impact on our organisation.
- d) No clear understanding of the purpose and benefit of a robust TAF.
- e) Infrequent review and TAF not seen as a live document i.e., risk owners / handlers only reviewing their risks when an update is due at Board.
- f) Lack of accountability/ownership i.e., little challenge or questions from the Boards not seeing themselves as owning it - more as another paper that comes their way for information.
- g) Over reliance on internal assurance, without an independent element of scrutiny.

2. Governance and Assurance

2.1 Good governance requirements

An efficient and effective assurance framework is a fundamental component of good governance and provides a tool for the Board to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to the Trust's success.

Additionally, the Chief Executive Officer must sign an Annual Governance Statement, as part of the organisations statutory accounts and annual report, which reinforces the need for the Board to be able to demonstrate that it has been properly informed about the organisational risk profile.

In order to be confident that the Trust's systems of internal control are robust, the Board needs to be able to provide evidence that it has identified its objectives and managed the principal risks to achieving them. The TAF will help the Board to undertake this duty.

2.2 Levels of Assurance / "Three Lines of Defence"

As outlined in the Risk Management Framework, the Trust applies the 'Three Lines of Defence' model to assure ourselves and those we are accountable to that we are managing our organisation well. Assurance information is provided as standard across the lines of defence as displayed below.

First Line of Defence (functions that own and manage risk)	Second Line of Defence (functions that oversee or specialise in risk management)	Third Line of Defence (functions that provide independent assurance)
Self-Assurance: <ul style="list-style-type: none"> Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation 	Internal oversight / specialist control teams, such as: <ul style="list-style-type: none"> Quality & Safety IT Governance (Corporate / Clinical) 	Internal Audit (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and external oversight , such as: <ul style="list-style-type: none"> External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance: <ul style="list-style-type: none"> Management Controls / Internal Control Measures Local management information / departmental management reporting Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services) Operational planning / Business Plans - Delivery Plans and Action Plans Governance statements / self-certification Local procedures Exceptions reporting Targets, Standards and KPIs Incident Reporting Staff Training Programmes 	Examples of assurance: <ul style="list-style-type: none"> Board, Committee and Management Structures which receive evidence from the 1st Line of Defence that risks are being managed effectively Finance reports KPI's and management information Quality, Safety and Risk reports Training records and statistics Performance reports BAF, VUNHS risk register Policies and Procedures including Risk Management Policy Compliance against Policies 	Examples of assurance: <ul style="list-style-type: none"> Recent internal audit reviews and levels of assurance External Audit coverage Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews Patient Feedback / Patient experience feedback Staff surveys / feedback Comparative data, statistics, benchmarking

3. Compiling the TAF

3.1 Process for compiling the TAF

The structured mapping of assurances is one of the fundamental steps in building an assurance framework. Understanding the sources of assurance and their scope means focus can be applied most effectively on the riskier areas.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers; these are supplemented by internal sources such as clinical audit, internal management representations, performance management and self-assessment reports.

Trust's 5 stage process for building the TAF is depicted in figure 2 below.

Figure 2: TAF development process



The key components of each of the 5 stages the assurance process are explained below;

Strategic Objectives - The first step in designing the assurance process is for the Board to identify its strategic objectives, e.g. clinical, financial, workforce, commercial and other objectives, focusing on those which are crucial to the achievement of its aims and values.



Strategic Risks - These are risks which threaten the achievement of the Trust's objectives. Strategic risks should be identified through Board meetings, workshops and/or seminars where the strategic objectives that these risks relate to are identified and debated. As part of the identification of strategic risks the level and type of risk the Trust is prepared to accept, or its appetite, should also be reviewed.



Key Controls - These are the management systems and processes the Trust has in place to manage its strategic risks. Controls will be scrutinized internally and externally e.g. by independent reviewers, which includes internal auditors, HIW and Audit Wales in conjunction with clinicians and other specialists where necessary. Key controls have been mapped to the principal / strategic risks. When assessments are made about the adequacy of key controls, consideration will be given not only to the design of the control itself but also their effectiveness in light of the governance and risk management framework within which they will operate.



Assurance on Controls - The Board must then gain assurance about the effectiveness of the controls in place to manage the principal risks. They not only need to ensure that controls are in place and effective, but to make use of the work of external reviewers and ensure that the control framework is proportionate to the associated risk. A gap in assurance is deemed to exist where it has not been possible to gain evidence that controls are effective. Any gaps in either controls or assurance will be identified in the TAF, along with agreed actions to be implemented, action owners and timescales for implementation. During the course of its business members of the Board should continually ask questions to assess the strength of the internal controls and assurances being presented.



Board Reports and Actions - The TAF provides a framework for identifying which of the Trust's objectives are at risk because of inadequacies in controls or where the Trust has insufficient assurance about those controls. At the same time, it provides structured assurances about risks which are being managed effectively and objectives that are on track to be delivered. This allows the Board to determine where to make best use of its resources and address the issues identified in the delivery of strategic objectives.

3.2 **Strategic Objectives**

The TAF serves to inform the Board of the principal risks threatening the achievement of strategic objectives and describes how the Trust is provided with assurances on the delivery of its:

- **Mission** to help improve the well-being of the people we work for and with;
- **Vision** by 2025 to have helped more people to live longer, better lives and be the organisation others come to learn from; and its
- **Five Strategic Pillars:**
 - Goal 1: Be recognised as pioneer in blood and transplantation services across Europe
 - Goal 2: Be a recognised leader in specialist cancer service in Europe
 - Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation
 - Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all
 - Goal 5: An exemplar of sustainability that supports global well-being and social value

3.3 **Content of the Board Assurance Framework**

The TAF template is provided in Appendix A and B. Each risk identified in the TAF will have the following minimum data set:

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • A sequential reference number (Risk ID) • A description of the risk • Link to strategic objective • Inherent risk rating • Current/residual risk rating • Target risk rating • Last and next review dates | <ul style="list-style-type: none"> • Executive Lead / Responsible Executive Director • Key Control(s) • Gap in Control • Actions required to bridge gaps in control / assurance • Trend / a way of demonstrating trajectory / the history of the risk rating throughout the reporting period | <ul style="list-style-type: none"> • Assuring Group / Scrutiny committee • Source / Form of Assurance (internal and/or external evidence to show that effective controls are in place) • Gaps in assurance • Assurance Rating / level of assurance (as per ratings below) |
|---|---|---|

3.4 *Assurance Ratings*

Executive Leads must provide an assessment of the level of assurance for each risk on the TAF. The following key is used by committees when assigning assurance ratings:

- **Positive assurance:** the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- **Inconclusive assurance:** the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
- **Negative assurance:** the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity

3.5 *Risk Quantification Matrix*

To score the risks identified VUNHST will use its Risk Quantification Matrix – see Appendix C.

4. Operationalising the TAF

4.1 *Summary / scrutiny and challenge of the TAF, including frequency*

The TAF aligns strategic risks, key controls, risk appetite, and assurance with strategic objectives. It sets out strategic objectives, identifies risks in relation to each strategic objective and maps out both the key controls that should be in place to manage those objectives and the sources of assurance (evidence) that these controls are operating effectively. Gaps are identified where key controls are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gap and improve outcomes.

The TAF supports the Annual Accountability Report, which includes the Annual Governance Statement (AGS). The TAF should drive the Board agenda and be a standing agenda item at Board, monthly.

The Board reviews a monitored, dynamic TAF. It is therefore important to note that the TAF must remain a live assurance tool. The Executive Team and Scrutiny Committees have responsibility to discuss the TAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks prior to the TAF being submitted to the Board for approval. This will include:

- Reviewing updates to the existing principal risks since it was last approved by the Board.
- Consider de-escalation of any principal risks to operational risk registers and make this recommendation to the Board.
- Agree the submission of any new principal risks to the Board for approval.

The Trust's Committees will oversee scrutiny and assurance on behalf of the Board for strategic risks captured on the TAF which are delegated to them for review. Committees will review their sections of the TAF on a monthly basis and draw to the attention of the Board any issues or concerns or the need for action plans.

4.2 *Risk reporting and escalation routes*

Full guidance on risk reporting and escalation can be found in the VUNHST Risk Management Framework (RMF) and Risk Management Process documents. In summary:

- The Head of Corporate Governance will compile a Board Assurance Framework (BAF) for the Board, consisting of the top strategic risks to VUNHST's objectives and any other risks the Board have requested sight of regardless of score. For example, the TAF is cross-referenced with the Trust Risk Register to ensure that any material operational risks that meet the escalation criteria below are included as appropriate to ensure completeness of coverage.
- Risks scored ≥ 15 , and any risks where the impact is scored as 5 regardless of likelihood will require confirmed review by the relevant Executive Committee and confirmed review by the Board. It should be escalated according to the RMF and considered for inclusion on the TRR and BAF, monthly.
- Risks outside Board-specified tolerance ranges: As outlined in the Risk Appetite Strategy, the Trust Board has developed indicative tolerance ranges against 9 principal risk categories (or risk domains). Any risks outside these ranges will require confirmed review by the relevant Executive Committee and considered for inclusion within the BAF

5. Appendix A: BAF Summary

[illegible]

6. Appendix B: BAF Dashboard Report

Risk ID:		<u>Principal Risk Description:</u>									
Datix Reference:											
Last Review:		<u>Related Strategic Objectives:</u>									
Next Review:		Risk Score									
		Inherent Risk				Current Risk			Target Risk		
		Likelihood	Impact	25	Likelihood	Impact	25	Likelihood	Impact	12	
		5	5		5	5		3	4		
Trend / Risk Timeline:	Responsibility								Level of Assurance		
	Executive Lead:										
	Assuring Group / Scrutiny Committee:										
GAPS IN CONTROLS						GAPS IN ASSURANCE					
1. XXXXXXXX 2. XXXXXXXX 3. XXXXXXXX						1. XXXXXXXX 2. XXXXXX 3. XXXXXXXX					
ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE											
<u>Action Plan</u>				<u>Owner</u>	<u>Progress Update</u>						<u>Due Date</u>
1.1											
1.2					.						

[illegible]

7. Appendix C: Risk Quantification Matrix

IMPACT Matrix

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

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

Likelihood – MATRIX

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

Risk Rating Matrix- Impact X Likelihood

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

Trust Board Part A

PROPOSED COMMITTEE STRUCTURE

DATE OF MEETING	24/09/2020	
PUBLIC OR PRIVATE REPORT	Public	
IF PRIVATE PLEASE INDICATE REASON	Not applicable – Public	
PREPARED BY	Rebecca Goode, Corporate Governance 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
Executive Management Board	07/07/2020 14/09/2020 (v2)	IN SUPPORT
Board Briefing Meeting	09/07/2020	IN SUPPORT

ACRONYMS

EMB	Executive Management Board
SO	Standing Orders
ToR	Terms of Reference
BAF	Board Assurance Framework
Q&S	Quality & Safety
OD	Organisational Development
IG	Information Governance
IM&T	Information Management & Technology
IMTP	Integrated Medium Term Plan
CHC	Community Health Councils
HIW	Health Inspectorate Wales
NWIS	NHS Wales Informatics Service
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

The Board has four main functions. These are set out in Standing Orders (SO) and are:

- Formulate the Organisation's strategic direction
- Establishing and upholding the organisation's governance and accountability framework, including its values and standards of behaviour
- Ensuring delivery of the organisation's aims/objectives through effective challenge and scrutiny of the Trust's performance across all areas of activity
- Shape the Culture of the Organisation

The Board will need to determine how it best discharges this responsibility which it can either be done directly or with the support of Board Committees. If further assurance is needed the Board can establish Committees to assist it in discharging this function.

The linking of assurance to Board objectives helps focus debate as it is not practical to seek or receive assurance on everything all of the time.

1.1 Establishing Board Committees

When considering the Committee structure that a Board decides appropriate to put in place, it is important to consider both the statutory requirements, and the areas requiring a greater level of scrutiny and assurance, that are linked to the objectives of the Board.

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

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

1.2 Board Objectives

As the Board and its Committees should seek assurance on the degree of achievement of Board objectives, it is important to see the need for Committees in this context.

The current Velindre University NHS Trust (from now on referred to as the “Trust”) vision is “to be recognised locally, nationally and internationally as a renowned organisation of excellence for patient and donor care, education and research.”

Its values are to be:

- **A**ccountable
- **B**old
- **C**aring
- **D**ynamic

The Boards strategic objectives as set out in the Integrated Medium Term Plan (IMTP) are:

- Delivering a transformation of tertiary cancer and blood and transplantation services;
- Developing system leadership roles and play a key role in system collaboration;
- Developing new and innovative services;
- Developing research, Development, Innovation and University status;
- Looking upstream – supporting the improvement of population health and the reduction in health inequalities;
- Being fit for the future;
- Working with partners to develop an enabling system that supports our transformation.

1.3 Statutory Requirements

The Board is required to have Committees that cover the following functions

- Audit
- Quality and Safety
- Remuneration and Terms of Service

- Charitable Funds
- Information Governance
- NHS Wales Shared Services Partnership

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

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

- A University Partnership Forum
- Local Partnership Forum

1.4 **Current arrangements**

Currently the Board has the following Committees:

- Appointments Advisory Consultant Committee (As Required)
- Audit Committee (every other month)
- Audit Committee for NWSPP (every other month)
- Quality and Safety (Quarterly)
- Remuneration and Terms of Service (every other month)
- Charitable Funds (Quarterly) and Investment Performance Review Committee (Sub Committee of Charitable Funds Committee meeting twice per year)
- Planning and Performance (every other month)
- Workforce and OD (Quarterly)
- Research, Development and Innovation (Quarterly)
- Digital and Information Governance (Quarterly)
- Transforming Cancer Services Programme Scrutiny Committee

The Board also has the following sub-committees:

- Investment Performance Review – Sub-Committee of the Charitable Funds Committee
- Advancing Radiotherapy Fund – Sub-Committee of the Charitable Funds Committee

In addition the Board holds:

- Integrated Governance Group (Quarterly)
- Academic (University) Partnership Board (Quarterly)
- Local Partnership Forum

2. Proposed Board & Committee Model

A review of our committees and a benchmarking exercise was undertaken earlier this year both against NHS Wales Health Boards (HBs)/Trusts and with Canterbury Health in New Zealand.

The proposed model for the Trust is to move to a five Committee Model as outlined below:-

- **Quality, Safety & Performance Committee**

Frequency: Bi-Monthly

Purpose: Assurance of how the organisation is performing against strategy and objectives, always primarily through a Quality and Safety lens and taking quality, safety, risk and assurance into account with escalation and reporting into Trust Board

Public transparency: Meeting held in public and a private agenda when required

Draft Terms of Reference: As outlined in Appendix 1

Draft Cycle of Business: As outlined in Appendix 2

- **Strategic Development Committee**

Frequency: Bi-Monthly

Purpose: Committee to have the time and space to discuss and then endorse aspects of strategic direction and development to the Trust Board for approval

Public transparency: Meeting held in public and a private agenda when required

Draft Terms of Reference: As outlined in Appendix 3

Draft Cycle of Business: As outlined in Appendix 4

- **Audit Committee** (Remains the same)

Frequency: Quarterly

Purpose: To assure that all governance systems, risk systems and processes including clinical are design and operating effectively.

Public transparency: Meeting held in public

Membership: *Remains the same with the addition of the Chief Operating Officer*

Draft Terms of Reference: *As outlined in Appendix 5*

- **Remuneration Committee and Terms of Service Committee** (Remains the same)

Frequency: Bi-Monthly

Purpose: *Will oversee appointments to the Board and Directors and primarily matters relating to remuneration and pay*

Public transparency: *Meeting held in private*

Draft Terms of Reference: *As outlined in Appendix 6*

- **Charitable Funds Committee** (Remains largely the same with strengthened links to Research, Development & Innovation Sub-Committee)

Frequency: Quarterly

Purpose: *To set and monitor against the strategic aims of the Charity, as a distinct organisation, ensure that assets are properly allocated, that its funds are spent effectively and its financial affairs are well managed*

Public transparency: *Meeting held in public*

Draft Terms of Reference/Membership: *As outlined in Appendix 7*

In addition it is proposed that there are the following Sub-Committees:-

- **Investment Performance Review Sub-committee** - Remains the same – as a Sub-Committee of Charitable Funds Committee
- **Advancing Radiotherapy Fund** - Remains the same – as a Sub-Committee of Charitable Funds Committee
- **Transforming Cancer Services Scrutiny Sub-Committee** – Proposed to be a sub-committee of both the Quality, Safety & Performance Committee and the Strategic Development Committee

It is important to note that this sub-committee retains the delegated authority granted to the current committee by Trust Board

Draft Terms of Reference: As outlined in Appendix 8

- **Research, Development & Innovation (RD&I) Sub-Committee** – This sub-committee will act as the “front door” for all RD&I business at Board level, with the right expertise around the table. It will be the point in the organisation where the quality of bids are assessed from a strategic alignment; science; ethics and value for money perspective. It will then feed into three Committees:
 - a. Quality, Safety & Performance Committee – for assurance of the performance of research and development
 - b. Strategic Development Committee – for innovation and RD&I strategy overall
 - c. Charitable Funds Committee – for alignment with strategy and funding of business cases

Draft Terms of Reference: As outlined in Appendix 9

The three partnership Forums and Advisory Groups:-

- Local Partnership Forum – remains operating as is
- Academic Partnership Board – continues to develop well following the inaugural meeting in August
- Advisory Consultants Appointment Committee – remains operating as is

Integrated Governance Group

Integrated Governance Group is on trial for a year and the purpose of the Group is to oversee and triangulate the information and assurances received at each of the Trust Committees of the Board to identify trends, ‘hot spots’ and areas of good practice across the work of the Committees and the delivery of safe, high quality, patient/donor-centred care.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

As indicated above there are a number of areas of work that the Board is required to have committees in place to cover. As a first step the Board should determine the areas where the Board would receive assurance directly and where additional assurance/scrutiny is required. In this context it is important to note that the Audit Committee is the prime governance Committee of the Board.

Additional Matters that has been considered:

- Independent Member/Officer time commitments – 4 days per month
- Committee Chair and Lead Officer per committee has been agreed

- Independent Member Champions has been agreed
- Agreed membership for the revised committees
- Committee support/secretariat has been identified
- Review of the Terms of Reference for each Committee is attached in the appendices
- Cycle of Business has been considered and outlined in appendices
- Hosted Organisations - Business Activity
- Involvement: CHC, HIW, Trade Unions has been considered
- Current Committee Model – is a formal closure required

Internal Guidance/Reference Documents (noting some of the below are in development):

- Velindre University NHS Trust Standing Orders and Financial Instructions
- Scheme of Delegation
- Integrated Medium Term Plan (IMTP)
- Velindre University NHS Trust Strategy
- Draft Trust Assurance Framework (TAF)
- Board & Committee Transparency Guide
- Quality & Safety Framework
- Performance and Assurance Framework
- Financial Management
- Internal and External Audit Programme (including Clinical Audit)
- Decision Making Framework
- Committee & Governance Manual
- Risk Management Strategy
- Policy Management
- Executive Team Portfolios (Roles & Responsibilities)
- Independent Member Champions (Roles & Responsibilities)

Please note the Committee/Board reporting template is also under development to ensure the cover report guides the reader to the key matters for consideration and how the matter is aligned with the objectives of the organisation and the Trust Assurance Framework.

External Guidance/Reference Documents

- Welsh Government Mature Board Guidance– 3 core elements:-
 - Leadership
 - Governance
 - Culture & Behaviours
- International Framework: Good Governance in the Public Sector (Achieving the intended outcomes while acting in the Public Interest at all times)
- UK Corporate Governance Code 2018
- The NHS Welsh Confederation Pocket Guide to Governance in NHS Wales

Values and principles

LHB and NHS Trusts' values should be built on the Welsh Assembly Government's Citizen Centred Governance principles and the core set of NHS values. All of these will provide a framework for good governance and embody the values and standards of behaviour expected to be seen at all levels of the service, locally and nationally. The extent to which the new organisations across the NHS are able to demonstrate their alignment with these principles will contribute to the Minister's annual review of NHS bodies' performance.

The Assembly Government's Citizen Centred Governance principles:

- **Putting the citizen first** - putting the citizen at the heart of everything and focusing on their needs and experiences; making the organisation's purpose the delivery of a high quality service.
- **Knowing who does what and why** - making sure that everyone involved in the delivery chain understands each other's roles and responsibilities and how together they can deliver the best possible outcomes.
- **Engaging with others** - working in constructive partnerships to deliver the best outcome for the citizen.
- **Living public sector values** - being a value-driven organisation, rooted in Nolan principles and high standards of public life and behaviour, including openness, customer service standards, diversity and engaged leadership.
- **Fostering innovative delivery** - being creative and innovative in the delivery of public services –working from evidence, and taking managed risks to achieve better outcomes.
- **Being a learning organisation** - always learning and always improving service delivery.
- **Achieving value for money** - looking after taxpayers' resources properly, and using them carefully to deliver high [quality, efficient services](#).

Corporate governance also encapsulates 'soft', more difficult to quantify, characteristics. These include Leadership, Culture and Ethical standards in public life (Nolan Principles).

4. ALIGNMENT TO PROPOSED STRATEGY / NEW WAYS OF WORKING

The proposed Board & Committee model should consider the following:-

- **Trust Strategy, Mission and Principles** - Completion and publication of Trust Mission and Vision and plans in place to develop underpinning Goals and Operational Strategies.
- **Development of Clear Structures, Roles & Ways of Working** - Clear Structures - Restructures of SMT at VCC, Digital, Estates, Communications and Engagement. Role Clarity for those in senior positions, with plans to move from interim to substantive appointments. Ways of Working – Learn from the Clinical Leadership Model and Lessons Learnt from COVID.

- **Improved Governance & Decision Making** - Implement new committee / meeting structures to support agile working. Embed clear, transparent evidence based decision making as near to the front line as possible, with authority for decision making transparent through organisation. Governance arrangements that can respond to the challenge set down in Team Wales, 'We don't know what the NHS will look like in 6 months' time' (Andrew Goodall, May 2020)
- **Enhanced Digital Connectivity** - For staff, patients and donors. This includes: Delivering a Digital Culture of innovation, development, learning and knowledge sharing. Enabling 'digital ready' employees – ensuring staff have the resources they need to deliver high quality services. Improving connectivity and access to support health and wellbeing. Enhancing inclusion and co-production – empowering patients and donors to use digital technologies to manage their own care. Reducing 'digital helplessness' via education and training.
- **Improved People Practices** - Including a bespoke Management and Leadership development offering, Developing Capability, Service and Workforce Planning, Embedding a Performance Management Framework. Development of People Strategy
- To also note **further planned developments** which will build on the foundations provided by this new structure:
 - Review of the mapping of the Trust's accountability for hosted organisations to the revised Committee Structure and associated oversight and assurance mechanisms. The conclusions of this work and any proposed changes to be worked through with the hosted organisations, the Chairs of the respective Committees and ultimately Trust Board.
 - The principles and practice of good governance and the value it can bring to be further embedded and supported across the corporate teams and divisional teams. This will include support and training on writing of papers.

5. BENEFITS

The proposed new Board & Committee Structure will deliver:

- Better delivery, planning and triangulation of business activity - less duplication
- Plans are considered and implemented in a local and partnership context
- Clear decision-making process on areas of accountability
- Enhanced collaborative working given the increasing agenda with local stakeholders
- Defined Governance and Assurance Structures.

6. TIMESCALES / COMMUNICATION

Planned engagement will be with the Chair at regular 1:1 meetings with the CEO and Interim Director of Corporate Governance and the wider engagement as follows:

Name/Title	Date Consulted
Executive Team Development Day	02/03/2020 ✓
Executive management Board (Run) - agree timescales / approach / leads	16/06/2020 ✓
Executive Management Board (shape) - review progress	07/07/2020 ✓
Board Briefing - present timescales / approach for initial discussion - CHC will be present to support the discussion of the Health & Social Care Bill	09/07/2020 ✓
1:1 Detail Cycle of Business Mapping and ToR Review Meetings with the Exec Leads and the IMs – <i>with governance team coordinating all materials, supporting the meeting and resulting actions</i>	July and August ✓ (Series of 1:1 Meetings).
1:1 Meetings with the Chair to discuss Champion Roles / Membership of Committees – <i>supported by Director Corporate Governance</i>	July and August ✓ (Series of 1:1 Meetings).
Executive Management - Final proposal to be approved by EMB for formal submission to September Board	14/09/2020 ✓
Trust Board Part A - Final Board & Committee Structure and final revised Schedule 3 for approval.	24/09/2020 – on track

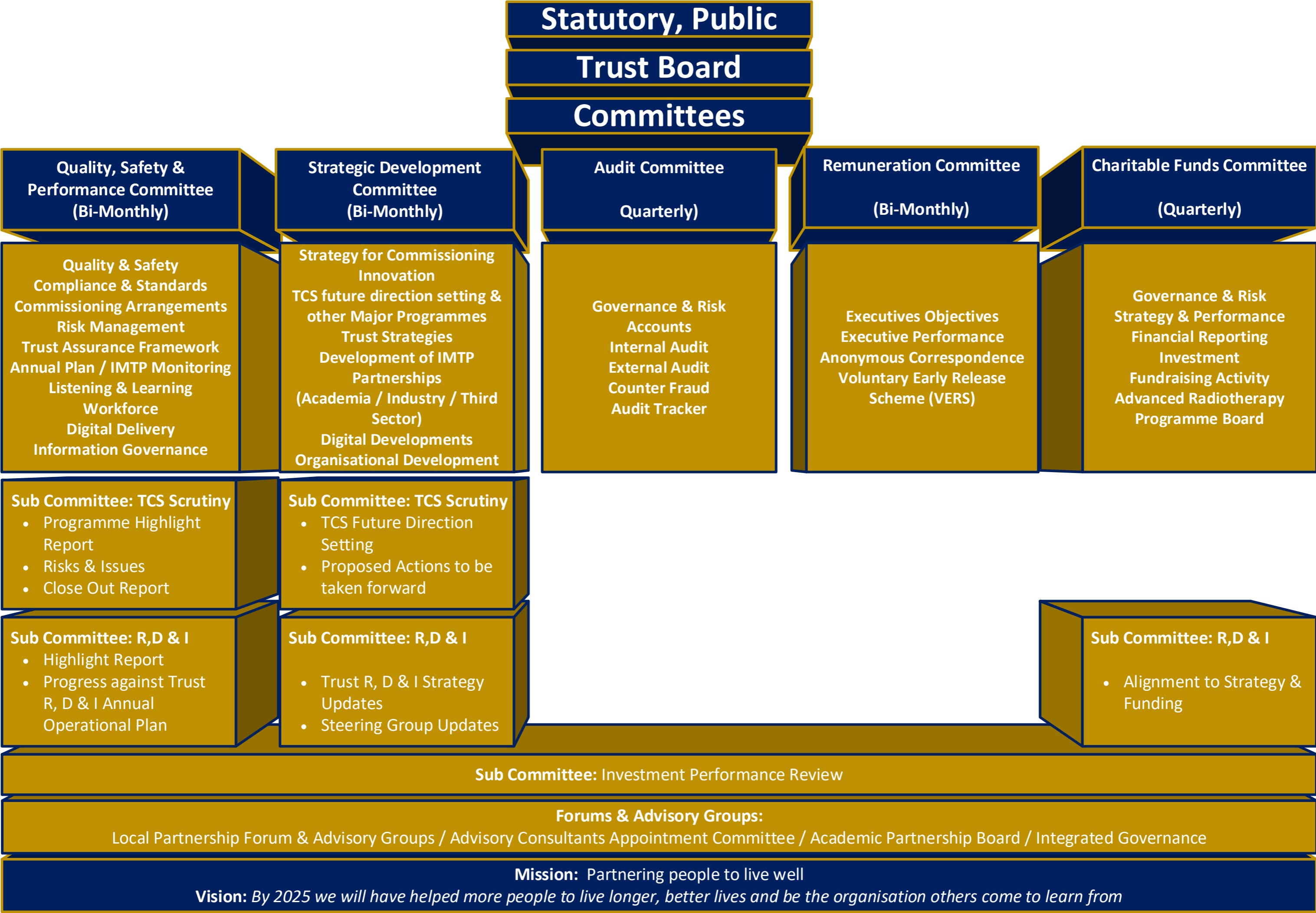
Audit Committee <ul style="list-style-type: none"> - Update on the Trust approach and changes to the Standing Orders will be shared with the Audit Committee for comment prior to September Trust Board. - Any further comments will be shared with the Board and a final paper received at Trust Board 24/09/2020 	08/10/2020 – on track
Implement new Structure if approved	01/10/2020 – on track

7. IMPACT ASSESSMENT (to be completed)

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)

8. RECOMMENDATION

- The Board is asked to **APPROVE** the new Committee structure.
- The Board is asked to **NOTE** the draft new and updated Terms of Reference and Cycles of Business to support this new Committee Structure if approved. The Board is asked to **SUPPORT** these documents to be finalised through the inaugural meetings of each of the Committees and Sub-Committees under this new structure, prior to being brought back to Board for approval. These changes will then also be reflected in the Trust's Standing Orders.



Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Developed:	September 2020
Approved:	
Next Review Due:	

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly 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".
- 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 **Quality, Safety and Performance Committee**. 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 Quality, Safety and Performance Committee "the Committee" is to provide:
- Evidence based and timely **advice** to the Board to assist it in discharging its functions and meeting its responsibilities with regard to the:
 - quality, safety and performance of healthcare;
 - all aspects of workforce;
 - digital delivery and information governance; and
 - **Assurance** to the Board in relation to the Trust's arrangements for safeguarding and improving the quality, safety and performance of patient and service user centred healthcare, workforce matters, digital delivery and information governance in accordance with its stated objectives, legislative responsibilities and the requirements and standards determined for the NHS in Wales.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** to the Board:

- Consider the implications for quality, safety, performance, workforce, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board.
- Consider the implications for the Trust's quality, safety, performance, workforce, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators.
- Monitor progress against the Trust's Integrated Medium Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board.
- Advise the Board on aligning service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.
- Monitor the Trust's sustainability activities and responsibilities.

- Monitor progress against cost improvement programmes.
 - Ensure that appropriate systems are in place to develop and approve all Business Cases above Chief Executive's authorised limits in line with agreed policy.
 - Provide initial scrutiny of all business cases above Chief Executive's authorised limits.
 - Monitor & review the Trust's Capital Programme Expenditure.
 - Ensure a system is in place and running effectively to prioritise schemes from the Trust Capital Programme.
 - Monitor and review performance against the Trust's Assurance Framework.
 - Ensure areas of significant service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation.
 - Monitor outcomes/outputs from service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery.
- 3.2 The Committee will, in respect of its assurance role, seek assurances that governance, including risk management arrangements, are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities.
- 3.3 To achieve this, the **Committee's programme of work** has been designed to ensure that, in relation to all aspects of quality, safety, performance, workforce, digital and information governance:
- Ensure that the Trust Policies, Procedures and Strategies consistent with internal and external requirements are implemented as appropriate.
 - The organisation, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor safety and safeguarding above all other considerations;
 - The care and services planned or provided across the breadth of the organisation's functions (including divisional/team and those provided by the independent or third sector) is consistently applied, based on sound evidence, clinically effective and meeting agreed standards;
 - The organisation, at all levels (divisional/team) has the right systems and processes in place to deliver, from a patient or donor perspective - efficient, effective, timely and safe services;
 - The workforce is appropriately selected, trained, supported and responsive to the needs of the service, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;
 - There is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- The integrity of data and information is protected, ensuring valid, accurate, complete and timely data and information is available to support decision making across the organisation;
- There is an ethos of continual quality improvement and a safety culture that supports safe high quality care prevails;
- There is good team working, collaboration and partnership working to provide the best possible outcomes for citizens;
- Risks are actively identified and robustly managed at all levels of the organisation;
- Decisions are based upon valid, accurate, complete and timely data and information;
- The Standards for Health Services in Wales are used to monitor and improve standards across the whole organisation;
- All reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:
 - sources of internal assurance are reliable
 - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
 - lessons are learned from concerns, incidents, complaints and claims.
- There is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board.

3.4 The Committee will advise the Board about key indicators of quality, safety and performance, which will be reflected in the organisations performance framework, against which the Trust's performance will be regularly assessed and reported on through Annual Reports.

Authority

3.5 The Committee is authorised by the Board to investigate or commission investigation of 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 Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

- Employees (and all employees are directed to cooperate with any reasonable request made by the Committee); and
- Any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.
- Obtain legal or other providers of independent professional advice, and to secure the attendance of individuals external to the organisation who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.
- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Organisation at any meeting of the Committee.

3.6 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

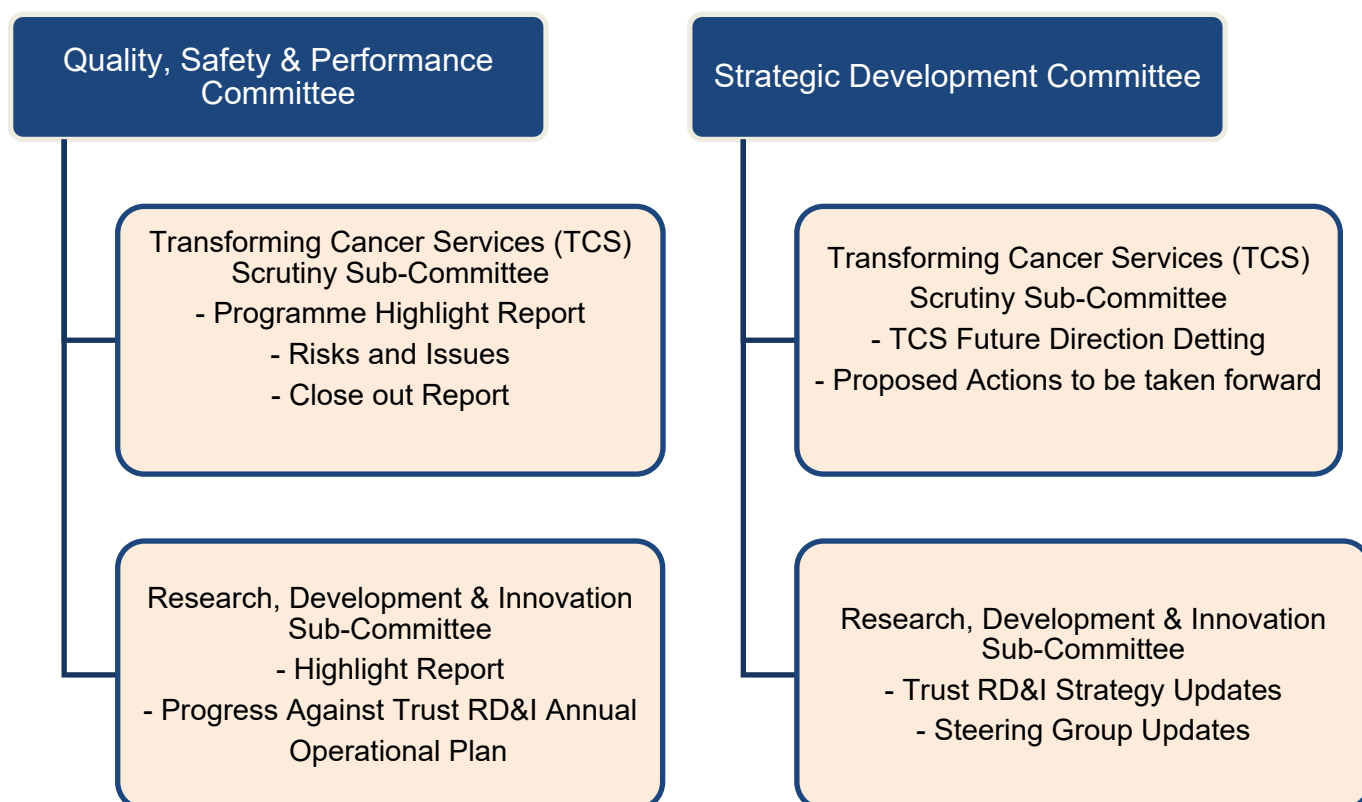
3.7 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.8 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

MEMBERSHIP

Members

3.9 A minimum of two (2) members, comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

3.10 **Attendees:**

- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director (*also Caldicott Guardian*)
- Chief Operating Officer
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance
- Executive Director of Finance (*also Information Governance*)
- Executive Director of Organisational Development and Workforce
- Director of Strategic, Transformation, Estates, Planning & Digital

In Attendance:

- Chief Executive Officer
- Deputy Director of Nursing Quality & Patient Experience
- Divisional Directors from WBS and VCC
- Associate Director of Digital (*also cyber/data outtages/performance*)
- Quality & Safety Manager
- Claims Manager
- Head of Corporate Governance

3.11 By invitation

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.

The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of Partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Wales Audit Office
- Trade Unions
- Community Health Council

Secretariat

3.12 Secretary - as determined by the Executive Director Nursing, Allied Health Professionals and Health Scientists

Member Appointments

3.13 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.

- 3.14 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.

Support to Committee Members

- 3.15 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 Executive Director of Organisational Development & Workforce

4. COMMITTEE MEETINGS

Quorum

- 4.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

- 4.2 Meetings shall be held no less than quarterly and otherwise, as the Chair of the Committee deems necessary.

Withdrawal of individuals in attendance

- 4.3 The 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.

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

- 5.1 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 ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.
- 5.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

5.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) 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.

5.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

5.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

6. REPORTING AND ASSURANCE ARRANGEMENTS

6.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes verbal updates on activity, the submission of Committee Highlight Reports and other written reports, as well as the presentation of an annual Quality, Safety & Performance 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 of any urgent/critical matters that may compromise patient care and affect the operation and/or reputation of the Trust.

6.2 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 including that of any Sub Committees established.

7. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

7.1 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.

8. REVIEW

8.1 Terms of reference and operating arrangements, and the Committees Programme of Work will 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 normally 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.

Quality, Safety & Performance Committee Cycle of Business 2020-21 (commencing November 2020)

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Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Risk Management & Safe Services																
Trust Risk Register	Director of Corporate Governance	Quality & Safety Co-ordinator	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Highlight Report Medicines Management	Executive Medical Director	Chief Pharmacist	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Review of IG Incidents and Trends	Executive Director of Finance	Information Governance Manager	Private	Each Meeting		✓		✓		✓		✓		✓		✓
Trust Serious Untoward Incidents (SUIs) and No Surprise Notifications (NSNs) Report	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Private	Each Meeting (as required)		✓		✓		✓		✓		✓		✓
NWIS Serious Untoward Incidents (SUIs) and No	Director of NWIS	Head of Clinical & Informatics Assurance	Private	Each Meeting (as required)		✓		✓		✓		✓		✓		✓

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Surprise Notifications (NSNs) Report																
Mortality Reviews	Executive Medical Director		Private	Each Meeting (as required)		✓		✓		✓		✓		✓		✓
Medical Devices Report	Executive Medical Director	Medical Physicist	Public	Bi Annually				✓ (Dec)						✓ (Jun)		
Trust-wide Nurse Staffing Levels (Wales) Act 2016 Report	Executive Director of Nursing, AHPs & Health Scientists		Public	Annually										✓ (Jun)		
Medical Education Governance Framework Annual Report	Executive Medical Director		Public	Annually										✓ (Jun)		
Workforce																

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Advisory Appointments Committee Highlight Report	Executive Director of OD & Workforce		Public	The next Cmt following AAC Meeting [1] ad hoc												
Welsh Language Standards Compliance Report	Executive Director of OD & Workforce		Public	Quarterly		✓				✓				✓		
GMC Medical Revalidation Updates	Executive Director of OD & Workforce		Public	Twice Yearly				✓ (Dec)				✓				
NMC Nursing Revalidation Updates	Executive Director of OD & Workforce		Public	Twice Yearly						✓						✓
Strategic Equality Plan & Annual Report	Executive Director of OD & Workforce		Public	Annually								✓				

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Local Partnership Forum Annual Report	Executive Director of OD & Workforce		Public	Annually						✓						
Consultant Contract Annual Report	Executive Director of OD & Workforce		Public	Annually		✓ (Sep)										✓
Gender Pay Gap Report	Executive Director of OD & Workforce		Public	Annually								✓				
Welsh Language Annual Report	Executive Director of OD & Workforce		Public	Annually						✓						
Listening & Learning																
Patient/Donor/Staff Story	Chief Operating Officer	Director of VCC & WBS	Public	Each Meeting		✓		✓		✓		VCC ✓		WBS (Jun) ✓		✓
Service Presentation (if required by the Committee)	Chief Operating Officer	Director of VCC & WBS	Public	Each Meeting – where relevant		✓		✓		✓		✓		✓		✓

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Clinical Audit Highlight Report	Executive Director of Nursing, AHPs & Health Scientists		Public	TBC												
Infected Blood Inquiry Proceedings	Chief Operating Officer		Private	Quarterly		✓				✓				✓		
Planning & Performance																
Delivering Excellence Performance Reports	Chief Operating Officer	Director of VCC and WBS	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Finance Reports	Executive Director of Finance		Public	Each Meeting		✓		✓		✓		✓		✓		✓
Quarterly Concerns Report – Incident & Claims	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		

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Highlight Report from the Trust-wide Infection Prevention & Control Management Group	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse – Infection Prevention & Control	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		
Highlight Report from the Trust-wide Safeguarding & Public Protection management Group (S&PPMG)	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse – Safeguarding & Public Protection	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		
Highlight Report from the Trust-wide Patient Safety Alerts Group (PSAG)	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Co-ordinator	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		

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Highlight Report from the Medical Gas Committee (MGC)	Executive Medical Director	Chief Pharmacist	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		
Datix Project Board Report	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Public	Quarterly		✓ (Sep)				✓				✓ (Jun)		
Quarterly Claims and Redress Report	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Private	Quarterly		✓ (Sep)				✓				✓ (Jun)		
Highlight Report from the Trust Estates Assurance Group	Director of Transformation and Digital	Assistant Director of Estates, Environment & Capital Development	Public	Bi-Annual		✓ (Sep)				✓				✓		

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Annual Performance Report	Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Planning and Performance	Public	Annually						✓						
End of Year Assessment	Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Planning and Performance	Public	Annually								✓				
Annual Estates Update	Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Environmental, Estates and Capital Development	Public	Annually		✓ (Sep)										✓
Annual Sustainability Report	Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Environmental, Estates and Capital	Public	Annually										✓		

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		Development														
Trust Travel Survey	Director of Strategic Transformation, Planning, Performance and Estates	Assistant Director of Environmental, Estates and Capital Development	Public	Annually										✓		
Integrated Governance																
Trust-wide policies and procedures for approval (several)	Director of Corporate Governance	All	Public	Each meeting		✓		✓		✓		✓		✓		✓
Freedom of Information Requests (IG & IM&T)	Director of Corporate Governance	Associate Director of Informatics	Public	Each Meeting		✓		✓		✓		✓		✓		✓

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Health & Care Standards Self-Assessment Action Plan	Director of Corporate Governance	Quality & Safety Manager	Public	Bi Annually		✓ (Sep)				✓						✓
Annual Quality Statement Guidance	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Public	Annually						✓						
Annual Quality Statement	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Public	Annually										✓		
Patient & Donor Experience Annual Report	Chief Operating Officer	Director of VCC & WBS	Public	Annually										✓		
Infection Prevention & Control Annual Report	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse – Infection Prevention Control	Public	Annually		✓ (Sep)										✓

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Safeguarding & Public Protection Annual Report	Executive Director of Nursing, AHPs and Health Scientists	Senior Nurse – Safeguarding & Public Protection	Public	Annually										✓ (Jun)		
Putting Things Right Annual Report	Executive Director of Nursing, AHPs and Health Scientists	Quality & Safety Manager	Public	Annually										✓ (Jun)		
Clinical Audit Annual Plan	Executive Director of Nursing, AHPs and Health Scientists		Public	Annually										✓ (Jun)		
Clinical Audit Annual Report	Executive Director of Nursing, AHPs and Health Scientists		Public	Annually												✓
Health & Safety Annual Report	Executive Director of Nursing, AHPs	Quality & Safety Manager	Public	Annually												✓

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	and Health Scientists															
Annual Report from the Controlled Drugs Accountable Officer	Executive Medical Director	Chief Pharmacist	Public	Annually												✓
Medicines Management Annual Report	Executive Medical Director	Chief Pharmacist	Public	Annually												✓
Review of IG Toolkit	Executive Director of Finance	Associate Director of Informatics		Annually								✓				
Committee Effectiveness																
Committee Terms of Reference and Operating Arrangements	Director of Corporate Governance	Head of Corporate Governance	Public	Annually						✓						

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Committee Cycle of Business	Director of Corporate Governance	Head of Corporate Governance	Public	Annually						✓						
Committee Effectiveness Survey Report	Director of Corporate Governance	Head of Corporate Governance	Public	Annually										✓ (Jun)		
Committee Annual Report for Trust Board	Director of Corporate Governance	Head of Corporate Governance	Public	Annually										✓ (Jun)		
Programmes																
LIMS Updates	Chief Operating Officer	Director of WBS	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Radiotherapy Satellite Centre Update	Director of Strategic Transformation, Planning, Performance and Estates		Public	Each Meeting		✓		✓		✓		✓		✓		✓

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- = Item of business previously received by Planning & Performance Committee
- = Item of business previously received by Research, Development & Innovation Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
TCS Programme Update	Director of Strategic Transformation, Planning, Performance and Estates		Public	Each Meeting		✓		✓		✓		✓		✓		✓
Information Governance																
Workforce and OD Assurance Schedule	Executive Director of OD & Workforce		Public	Annually						✓						
Divisional Reports																
Welsh Blood Service																
WBS Regulation, Accreditation & Inspection Report(s)	Chief Operating Officer	Director of WBS	Public	Each Meeting (as required)		✓		✓		✓		✓		✓		✓
Service Q&S Reports	Chief Operating Officer	Director of WBS	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Velindre Cancer Centre																

Quality, Safety & Performance Committee Cycle of Business 2020-21 (commencing November 2020)

Key:

- = Item of Business previously received by more than one Committee
- = Item of business previously received by Quality & Safety Committee
- = Item of business previously received by Digital & Information Governance Committee
- = Item of business previously received by Workforce & Organisational Development Committee
- = Item of business previously received by Planning & Performance Committee
- = Item of business previously received by Research, Development & Innovation Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
VCC Regulation, Accreditation & Inspection Report(s)	Chief Operating Officer	Director of VCC	Public	Each Meeting (as required)		✓		✓		✓		✓		✓		✓
Service Q&S Reports	Chief Operating Officer	Director of VCC	Public	Each Meeting		✓		✓		✓		✓		✓		✓
Digital Service Operational Report																
Progress against Digital Service Operational Report to include: - Review of Strategic Informatics Programme - Progress on Delivery of all Programmes/ Projects - IG Strategy Action Plan	Director of Transformation, Planning & Digital	Associate Director of Informatics	Public	Quarterly		✓				✓				✓		

Quality, Safety & Performance Committee Cycle of Business 2020-21 (commencing November 2020)

Key:

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- = Item of business previously received by Quality & Safety Committee
- = Item of business previously received by Digital & Information Governance Committee
- = Item of business previously received by Workforce & Organisational Development Committee
- = Item of business previously received by Planning & Performance Committee
- = Item of business previously received by Research, Development & Innovation Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Trust RD&I Annual Operational Plan																
Progress Against Trust RD&I Annual Operation Plan to include: - R&D Activity Report - Healthcare Standards - IMTP	Executive Medical Director	Head of Research & Development	Public	Quarterly		✓				✓				✓		
Workforce Report																
Workforce report to include: -Capacity -Health and Well Being of Staff	Executive Director of OD and Workforce		Public	Each Meeting		✓		✓		✓		✓		✓		✓
NHS Staff Survey (Staff Engagement Update)	Executive Director of OD and Workforce		Public	Ad hoc		✓										

Quality, Safety & Performance Committee Cycle of Business 2020-21 (commencing November 2020)

Key:

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- = Item of business previously received by Digital & Information Governance Committee
- = Item of business previously received by Workforce & Organisational Development Committee
- = Item of business previously received by Planning & Performance Committee
- = Item of business previously received by Research, Development & Innovation Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Equality & Diversity Report (including dignity)	Executive Director of OD and Workforce	Diversity & Equality Manager	Public	Bi-Annual		✓						✓				

Strategic Development Committee

Terms of Reference & Operating Arrangements

Developed:	September 2020
Approved:	
Next Review Due:	

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly 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".
- 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 **Strategic Development Committee**. 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 Strategic Development Committee "the Committee" is to provide:
- Evidence based and timely **advice** to the Board to assist it in discharging its functions and responsibilities with regard to the:
 - strategic direction;
 - organisational development;
 - digital development; and
 - **Assurance** to the Board in relation understanding the level of risk affecting the strategic direction and organisational development of the Trust.
- 2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board on strategic direction and organisational development, the Committee will:
- Oversee the initial development of the Trust's strategies and plans for the development and delivery of high quality and safe services, consistent with the Board's overall strategic direction and any requirements and standards set for NHS bodies in Wales.
 - Undertake a full and proper consideration of whether the Trust is fulfilling its duties under the Well-being of Future Generations (Wales) Act 2015 by means of the application of the Act's Sustainable Development Principle in support of the development and delivery of safe, high quality services.

- Develop the Trust's Integrated Medium Term Plan (IMTP) in accordance with above.
 - Develop the Trust's Capital Plan in line with the IMTP and long-term strategy.
 - Develop the Trust's Sustainability Framework Strategy.
 - Oversee any Trust developments involving significant investment or modernisation.
 - Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.
- 3.2 To achieve this, the Committee's programme of work will be designed to provide assurance that:
- There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.

Authority

- 3.3 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 Committee's 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
 - Any other Committee, sub Committee, or group set up by the Board to assist it in the delivery of its functions.
 - 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.
 - 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.
 - To approve policies relevant to the business of the Committee as delegated by the Board.

Access

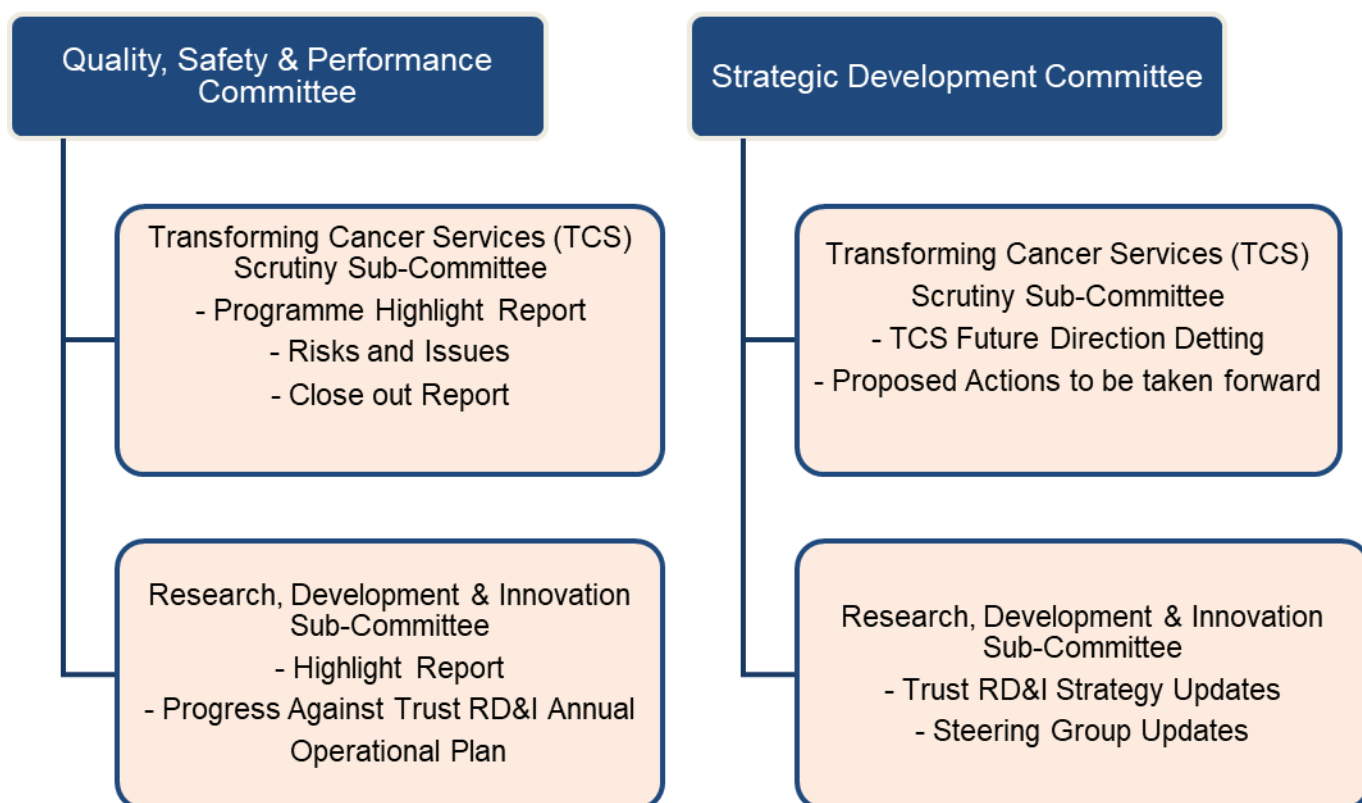
3.4 The Chair of the Strategic Development Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.4 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted to the current committee by Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference.

The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

4.1 **Members**

A minimum of two (2) members comprising:

Chair Independent member of the Board (Non-Executive Director)

One independent member of the Board (Non-Executive Directors)

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.2 **Attendees:**

- Executive Director of Nursing, Allied Health Professionals and Health Scientists
- Executive Medical Director
- Chief Operating Officer
- Director of Corporate Governance
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic, Transformation, Estates, Planning & Digital
- Director of Commercial and Strategic Partnerships

4.3 **In Attendance:**

- Chief Executive Officer
- Assistant Director of Planning
- Associate Director of Organisational Development and Workforce
- Associate Director of Digital
- Assistant Director of Communications & Engagement
- Chief Operating Officer
- Directors of WBS and VCC (TBA)

The Committee welcomes attendance at Committee meetings by staff from within the organisation, representatives of partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

4.3 **Secretariat**

As determined by the Director of Corporate Governance.

4.4 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.

4.5 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 independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.

5.2 Frequency of Meetings

Meetings shall be held bi-monthly, consistent with the Trust's annual plan of Board Business.

5.3 Withdrawal of individuals in attendance

The 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.

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.
- 6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.
- 6.4 The Committee shall embed the Trust's corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- Report formally, regularly and on a timely basis to the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.
 - Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and
 - Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.
- 7.2 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 including that of any Sub Committees established.

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.

9. REVIEW

- 9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 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 two other 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.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Trust Strategic Development Committee Cycle of Business 2020-21 (commencing October 2020)

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- = Item of business previously received by Research, Development & Innovation Committee
- = Item of business previously received by Digital & Information Governance Committee
- = Item of business received by Transforming Cancer Services (TCS) Scrutiny Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Risk Management & Safe Services																
Trust Risk Register	Director of Corporate Governance	Quality & Safety Co-ordinator	Public	Each Meeting	✓		✓		✓		✓		✓		✓	
Planning & Performance																
Integrated Medium Term Plan – For Approval	Director of Strategic Transformation, Planning & Digital	Director of WBS/VCC	Public	Annually					✓							
Capital Plan – For Approval	Executive Director of Finance	Director of WBS/VCC	Public	Annually					✓							
Strategy Development and Implementation																
Education Strategy Update	Executive Director of		Public	Bi Annual					✓						✓	

Trust Strategic Development Committee Cycle of Business 2020-21 (commencing October 2020)

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 = Item of business previously received by Digital & Information Governance Committee
 = Item of business received by Transforming Cancer Services (TCS) Scrutiny Committee

	OD & Workforce															
Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
People Strategy Update	Executive Director of OD & Workforce		Public	Bi Annual					✓						✓	
Trust RD&I Strategy Updates	Executive Medical Director	Head of Research & Development	Public	Bi Annual					✓						✓	
Sustainability Framework Strategy	Director of Strategic Transformation, Planning & Digital	Environmental Development Officer	Public	Bi-Annual					✓						✓	
Strategic Areas of Focus	All	All	Public	Each meeting	✓		✓		✓		✓		✓		✓	
TCS Highlight Report	Director of Strategic Transformation		Public	As Required												

Trust Strategic Development Committee Cycle of Business 2020-21 (commencing October 2020)

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	on, Planning & Digital															
Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Health & Wellbeing Framework	Executive Director of OD & Workforce		Public	Annually											✓ (Sep)	
Review of Road Map/Strategy	Director of Transformation, Digital Planning & Digital	Assistant Director of Informatics	Public	Annually					✓							
Integrated Governance																
Trust-wide policies and procedures for approval	Director of Corporate Governance	All	Public	As Required												
Audit Action Plan Updates	Director of Corporate Governance	All	Public	As Required												

Trust Strategic Development Committee Cycle of Business 2020-21 (commencing October 2020)

Key:

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- = Item of business previously received by Research, Development & Innovation Committee
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- = Item of business received by Transforming Cancer Services (TCS) Scrutiny Committee

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Committee Effectiveness																
Strategic Development Committee Terms of Reference and Operating Arrangements	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually					✓ (Mar)							
Strategic Development Committee Programme of Business	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually					✓ (Mar)							
Strategic Development Committee	Executive Director of Transformation	Head of Corporate Governance	Public	Annually									✓			

Trust Strategic Development Committee Cycle of Business 2020-21 (commencing October 2020)

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- = Item of business previously received by Digital & Information Governance Committee
- = Item of business received by Transforming Cancer Services (TCS) Scrutiny Committee

Effectiveness Survey Report	on, Planning and Digital															

Item of Business	Exec. Lead	Owner	Session	Frequency	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021
Strategic Development Committee Annual Report for Trust Board	Executive Director of Transformation, Planning and Digital	Head of Corporate Governance	Public	Annually									✓			

Audit Committee

Terms of Reference & Operating Arrangements

Reviewed:	September 2020
Next Review Due:	September 2021

1. INTRODUCTION

- 1.1 The 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"*.
- 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 **Audit Committee**. The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.
- 1.3 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.

2. PURPOSE

- 2.1 The purpose of the Audit Committee ("the Committee") is to:
- **Advise** and **assure** the Board and the Accountable Officer on whether effective arrangements are in place - through the design and operation of the Trust's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the Trust's objectives, in accordance with the standards of good governance determined for the NHS in Wales.
- 2.2 Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 With regard to its role in providing advice to the Board, the Committee will comment specifically upon:
- The adequacy of the Trust'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 (both clinical and non-clinical) designed to support the public disclosure statements that flow from the assurance processes, including the Annual Governance Statement, providing reasonable assurance on:
 - the organisation's ability to achieve its objectives,
 - compliance with relevant regulatory requirements, standards, quality and service delivery requirements and 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 the organisation safeguards and protects all its assets, including its people

to ensure the provision of high quality, safe healthcare for its citizens;

- The Board's Standing Orders, and Standing Financial Instructions (excluding the Terms of Reference of other Committees; and including associated framework documents, as appropriate);
- The accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, the ISA 260 Report 'Communication with those charged with Governance' and managements' letter of representation to the external auditors;
- The Schedule of Losses and Compensation;
- The planned activity and results of internal audit, external audit, clinical audit and the Local Counter Fraud Specialist (including strategies, annual work plans and annual reports);
- The adequacy of executive and managements' response to issues identified by audit, inspection and other assurance activity via monitoring of the Trust's audit action plan;
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the Board or the Accountable Officer may seek advice from the Committee.

3.2 The Committee will support the Board 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 Board;
- 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 the NHS Counter Fraud Authority.
- 3.3 In carrying out this work the 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 other assurance providers, regulators, directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.
- 3.4 This will be evidenced through the 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 Committee to review and form an opinion on:
- The **comprehensiveness** of assurances in meeting the Board and the Accountable Officer's assurance needs across the whole of the Trust's activities, both clinical and non clinical; and
 - The **reliability and integrity** of these assurances.
- 3.5 To achieve this, the 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 Board and the Accountable Officer through the 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 Board and the Accountable Officer through the Committee;
 - There is an effective clinical audit function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board and the Accountable Officer through the 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 Board and the Accountable Officer or through the work of the Board's Committees through the effective completion of Audit Recommendations and the Committee's review of the development and drafting of the Trust's Annual Governance;
 - The work carried out by key sources of external assurance, in particular, but not limited to the Trust'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 Board, and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, and the risks of failing to comply;
- The systems for financial reporting to the Board, including those of budgetary control, are effective; and that
- The results of audit and assurance work specific to the Trust, and the implications of the findings of wider audit and assurance activity relevant to the Trust'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 Committee will follow and implement the Audit Committee's Annual Work plan and will be evidenced through meeting papers, formal minutes, and highlight reports to Board and annually via the Annual Governance Statement and Annual Report to the Board.

Authority

- 3.6 The Committee is authorised by the Board to investigate or have investigated any activity (clinical and non clinical) 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 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 cooperate with any reasonable request made by the Committee); and
 - Any other Committee, sub Committee or group set up by the Board to assist it in the delivery of its functions.
- 3.7 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.
- 3.8 The Committee is authorised by the Board to approve policies relevant to the business of the Committee as delegated by the Board.

Access

- 3.9 The Head of Internal Audit and the Auditor General for Wales and his representatives 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.

- 3.10 The 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.
- 3.11 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.12 The Committee may, subject to the approval of the Trust Board, establish sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business. At this stage, no sub Committees/task and finish groups have been established.

4. MEMBERSHIP

Members

- 4.1 A minimum of three (3) members, comprising:

Chair Independent member of the Board (Non-Executive Director)

~~Vice Chair~~ ~~Independent member of the Board~~

~~Members~~ ~~Two~~ One independent members ~~–~~ of the Board (Non-Executive Directors)

[one member should be a member of the Quality, Safety & Performance ~~Safety~~ Committee]

The Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise
~~and expertise.~~

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

- 4.2 In attendance Chief Executive (*who should attend once a year as a minimum to discuss with the Committee the process for assurance that supports the Annual Governance Statement.*)
Executive Director of Finance ~~& Informatics~~
Director of Corporate Governance
Chief Operating Officer
Head of Internal Audit
Local Counter Fraud Specialist
Representative of the Auditor General for Wales

By invitation

The Committee Chair may invite:

- the Chair of the organisation
- any other Trust 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.

Secretariat

- 4.1 Secretary As determined by the Director of Corporate Governance

Member Appointments

- 4.2 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.
- 4.3 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.

Support to Committee Members

- 4.4 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 Executive Director of Workforce & Organisational Development.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present, an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

- 5.2 Meetings shall be held no less than 4 times per year, and otherwise as the Chair of the Committee deems necessary – consistent with the Trust's annual plan of Board Business.

The External Auditor or Head of Internal Audit may request a meeting with the Chair if they consider that one is necessary.

Withdrawal of individuals in attendance

- 5.3 The 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.

6. RELATIONSHIP & 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, the Board retains overall responsibility and accountability for ensuring 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 to provide advice and assurance to the Board by taking into account:
- 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 arrangements.
- 6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.
- 6.5 The Committee shall embed the Trust's corporate standards, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 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 and the submission of written highlight reports throughout the year;
 - Bring to the Board and the Accountable Officer'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 (and Accountable Officer) or Chairs of other relevant Committees 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 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 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 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.

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 on Committee meetings]*
- Notice of meetings
- Notifying the public of Meetings
- Admission of the public, the press and other observers

Cross reference with the Trust Standing Orders.

9. REVIEW

9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 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 Committee, after first consulting with two 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.

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

Date Terms of Reference Approved:

Date:

Draft

Remuneration & Terms of Service Committee

Terms of Reference & Operating Arrangements

Reviewed:	September 2020
Next Review Due:	September 2021

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Assembly 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"*.
- 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 **Remuneration & Terms of Service Committee**. 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 Remuneration & Terms of Service Committee "the Committee" is to provide:
- **advice** to the Board on remuneration and terms of service for the Chief Executive, Executive Directors and other senior staff within the framework set by the Welsh Government; and
 - **assurance** to the Board in relation to the Trust's, including hosted bodies, arrangements for the remuneration and terms of service, including contractual arrangements, for all staff, in accordance with the requirements and standards determined for the NHS in Wales.

and to perform certain, specific functions on behalf of the Board.

3. DELEGATED POWERS AND AUTHORITY

- 3.1 The Board had delegated the following specific powers to the Committee;
- To consider and ratify Voluntary Early Release scheme applications and severance payments in line with Standing Orders and extant Welsh Government guidance.
- 3.2 With regard to its role in providing advice and assurance to the Board, the Committee will comment specifically upon the:

- remuneration and terms of service for the Chief Executive, Executive Directors and other Very Senior Managers (VSMs) not covered by Agenda for Change; ensuring that the policies on remuneration and terms of service as determined from time to time by Welsh Government are applied consistently;
- objectives for Executive Directors and other VSMs and their performance assessment;
- performance management system in place for those in the positions mentioned above and its application;
- proposals to make additional payments to consultants to include any additional sessions or allowances payable to Senior Medical Staff for managerial duties; and
- proposals regarding termination arrangements, ensuring the proper calculation and scrutiny of termination payments in accordance with the relevant Assembly Government guidance.

Authority

3.3 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 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 cooperate with any reasonable request made by the Committee); and
- any other Committee, Sub Committee or Group set up by the Board to assist it in the delivery of its functions.

3.4 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 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.6 The Chair of the Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

- 3.7 The Committee may, subject to the approval of the Trust Board, establish Sub Committees or task and finish groups to carry out on its behalf specific aspects of Committee business.

4. MEMBERSHIP

Members

- 4.1 A minimum of two (2) members, comprising:

Chair ~~or Vice Chair~~ of the Board (Non Executive Director)

Members At least one other independent member of the Board (Non Executive Director). For the avoidance of doubt, Independent Members are not staff.

The Chair of the Audit Committee (or equivalent) will be appointed to this Committee ~~either as Vice Chair or as~~ a member.

The Trust Chair may decide the business of the Remuneration Committee requires the attendance of all Independent Members and as such extend an invite to all Independent Members

In attendance

- 4.2 By invitation The Committee Chair may invite:
- the Chief Executive
 - the Executive Director of Organisational Development & Workforce
 - any other Trust officials; including a Trade Union Representative from the Trust Board 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 (except when issues relating to their personal remuneration and terms and conditions are being discussed).

Secretariat

- 4.3 Secretary As determined by the Director of Corporate Governance

Member Appointments

- 4.4 The membership of the Committee shall be determined by the Board, based on the recommendation of the Trust Chair, and subject to any specific requirements or directions made by the Welsh Government.
- 4.5 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee with reference to Velindre University NHS Trust Chair.

Support to Committee Members

- 4.6 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 Organisational Development programme developed by the Executive Director of = Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

- 5.1 At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair, ~~or Vice Chair.~~

Frequency of Meetings

- 5.2 The Chair of the Committee, in agreement with Committee Members, shall determine the timing and frequency of meetings, as deemed necessary. It is expected that the Committee shall meet at least once a year, consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

- 5.3 The Committee may ask any member or individual who is normally in attendance but who is not a member to withdraw to facilitate open and frank discussion of any particular matter.

6. RELATIONSHIP & 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 in relation to its role as Corporate Trustee.
- 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 appropriate 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 assurance framework. *This will be achieved primarily through the Independent Members Group who will include 'Integrated Governance' on their agenda at least twice a year.*

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

7. REPORTING AND ASSURANCE ARRANGEMENTS

- 7.1 The Committee Chair shall:
- report formally and on a timely basis to the Board on the Committee's activities, in a manner agreed by the Board;
 - bring to the Board's specific attention any significant matter under consideration by the Committee;
 - ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive (and Accountable Officer) or Chairs of other relevant Committees 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

9. REVIEW

- 9.1 These terms of reference and operating arrangements shall be reviewed.

10. CHAIR ACTION ON URGENT MATTERS

- 10.1 There may, occasionally, be circumstances where decisions which would 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 Member 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.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision. Declarations of interest include family members.

Charitable Funds Committee

Terms of Reference & Operating Arrangements

Reviewed:	September 2020
Next Review Due:	July 2020

1. INTRODUCTION

- 1.1 The Trust's standing orders provide that *"The Board may and, where directed by the Assembly 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"*.
- 1.2 In accordance with standing orders (and the Trust's scheme of delegation), the Board shall nominate annually a Committee to be known as the **Charitable Funds Committee** "the Committee". The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. CONSTITUTION

- 2.1 The Velindre University NHS Trust Board was appointed as corporate trustee of the charitable funds by virtue of the Velindre National Health Service Trust (Establishment) Order No. 2838 that came into existence on 1st December 1993, and that its Board serves as its agent in the administration of the charitable funds held by the Trust.
- 2.2 The purpose of the Committee" is to make and monitor arrangements for the control and management of the Trust's Charitable Funds.

3. SCOPE AND DUTIES

- 3.1 Within the budget, priorities and spending criteria determined by the Trust as trustee and consistent with the requirements of the Charities Act 1993, Charities Act 2006 (or any modification of these acts) to apply the charitable funds in accordance with their respective governing documents.
- 3.2 To ensure that the Trust policies and procedures for charitable funds investments are followed. To make decisions involving the sound investment of charitable funds in a way that both preserves their value and produces a proper return consistent with prudent investment and ensuring compliance with:-
- Trustee Act 2000
 - The terms outlined in the Velindre NHS Trust Charity's Governing Documents
- 3.3 At least twice a year, receive highlight reports from the Executive Director of Finance & ~~Informatics~~ in respect of investment decisions, performance and action taken through delegated powers upon the advice of the Trust's Investment adviser.
- 3.4 To oversee and monitor the functions performed by the Executive Director of Finance & ~~Informatics~~ as defined in Standing Financial Instructions.
- 3.5 To respond to, and monitor the level of donations and legacies received,

including the progress of any Charitable Appeal Funds where these are in place and considered to be material.

- 3.6 To monitor and review the Trust's scheme of delegation for Charitable Funds expenditure and to set and reflect in Financial Procedures the approved delegated limits for expenditure from Charitable Funds.
- 3.7 To ensure that funds are being utilised appropriately in accordance with both the instructions and wishes of the donor, and to ensure that fund balances are maintained in accordance with the Reserves Policy.

4. DELEGATED POWERS AND DUTIES OF THE EXECUTIVE DIRECTOR OF FINANCE & INFORMATICS

- 4.1 The Executive Director of Finance ~~& Informatics~~ has prime responsibility for the Trust's Charitable Funds as defined in the Trust's Standing Financial Instructions. The specific powers, duties and responsibilities delegated to the Executive Director of Finance ~~& Informatics~~ are:-

- Administration of all existing charitable funds.
- To identify any new charity that may be created (of which the Trust would also be Trustee). Ensuring that all legal requirements are followed in the creation of any new charity in order to formalise the governing arrangements.
- Provide guidelines with response to donations, legacies and bequests, fundraising and trading income.
- Responsibility for the management of investment of funds held on trust.
- Ensure appropriate banking services are available to the Trust.
- Prepare reports to the Trust Board including the Annual Accounts and Annual Report.

5. AUTHORITY

- 5.1 The Committee is empowered with the responsibility for:-
- Overseeing the day to day management of the investments of the charitable funds in accordance with the investment strategy set down from time to time by the Trustee and the requirements of the Trust's Standing Financial Instructions
 - The appointment of an Investment Manager (where appropriate) to advise it on investment matters. Delegating, where applicable, the day-to-day management of some or all of the investments to that Investment Manager. In exercising this power the Committee must ensure that:
 - a) The scope of the power delegated is clearly set out in writing and communicated with the person or persons who will exercise it.

- b) There are in place adequate internal controls and procedures which will ensure that the power is being exercised properly and prudently.
 - c) The performance of the person or persons exercising the delegated power is regularly reviewed.
 - d) Where an investment manager is appointed, that the person is regulated under the Financial Services Act 2012.
 - e) Acquisitions or disposal of a material nature must always have written authority of the Committee or the Chair of the Committee in conjunction with the Executive Director of Finance & ~~Informatics.~~
- Ensuring that the banking arrangements for the charitable funds are kept entirely distinct from the Trust's NHS funds.
 - Ensuring that arrangements are in place to maintain current account balances at minimum operational levels consistent with meeting expenditure obligations, the balance of funds being invested in interest bearing deposit accounts.
 - The amount to be invested or redeemed from the sale of investments shall have regard to the requirements for immediate and future expenditure commitments.
 - The operation of an investment pool when this is considered appropriate to the charity in accordance with charity law and the directions and guidance of the Charity Commission. The Committee shall propose the basis to the Trust Board for applying accrued income to individual funds in line with charity law and Charity Commission guidance.
 - Obtaining appropriate professional advice to support its investment activities.
 - Regularly reviewing investments to see if other opportunities or investment services offer a better return.

5.2 The Committee is authorised by the Board to:

- Investigate or have investigated any activity within its Terms of Reference and in performing these duties shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust relevant to the Committee's remit. It can seek any relevant information it requires from any employee and all employees are directed to co-operate with any reasonable request made by the Committee;
- 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.

5.3 Approve policies relevant to the business of the Committee as delegated by the Board.

5.4 Sub Committees

As part of its function, the Charitable Funds Committee has determined to establish a Sub Committee, the '*Charitable Funds Investment Performance Review Sub Committee*', to specifically monitor the performance of the Investment portfolio on its behalf whilst recognising that the Trust Board as Corporate Trustee is ultimately accountable.

In addition, the Trust Research, Development & Innovation Sub-Committee has been established to act as the 'front door' for all RD&I business at Board level. The RD&I Sub Committee will feed into the Charitable Funds Committee for alignment with strategy and funding.

6. MEMBERSHIP

Members

6.1 A minimum of four members, comprising:

Chair	Independent member of the Board (Non - Executive Director)
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Members	Independent Member of the Board (Non-Executive Director)
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The Trust's Chief Executive and Executive Director of Finance & ~~Informatics~~ (one of which at any one meeting may be ~~represented~~ by a Nominated Representative in their absence)

Attendees

6.2 In attendance The Committee may require the attendance for advice, support and information routinely at meetings from:

- Charity Director
- Director Velindre Cancer Centre (or their deputy)
- Director of Welsh Blood Service (or their deputy)
- Investment Manager/Advisor
- Patient Representative
- Charitable Funds Accountant
- Deputy Director of Finance
- Head of Fundraising

- Head of Corporate Governance (*Charity Governance Lead*)
- Head of Communications

By invitation The Committee Chair may invite:

- any other Trust 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.

Secretariat

- | | | |
|-----|-----------|---|
| 6.3 | Secretary | As determined by the Director of Corporate Governance |
|-----|-----------|---|

Member Appointments

- | | |
|-----|--|
| 6.4 | 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. |
| 6.5 | <u>Applicable to Independent Members only.</u> 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. |
| 6.6 | In order to demonstrate that there is a visible independence in the consideration of decisions and management of charitable funds from the Trust's core functions, the Board should consider extending invitations to the Charitable Funds Committee to individuals outside of the Board. One option might be to seek representation from the Patient Liaison Group. |

Support to Committee Members

- | | |
|-----|--|
| 6.7 | <p>The Director of Corporate Governance, on behalf of the Committee Chair, shall:</p> <ul style="list-style-type: none"> ▪ Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and ▪ Ensure and co-ordinate the provision of a programme of organisational development for Committee members as part of the Trust's overall Organisational Development programme developed by the Executive Director of Organisational Development & Workforce. |
|-----|--|

7. COMMITTEE MEETINGS

Quorum

- 7.1 At least two members must be present to ensure the quorum of the Committee. Of the two, one must be an Independent Member (~~Non-Executive Director – one of whom is the Chair~~) and one must be the Executive Director of Finance or Nominated Representative.

Frequency of meetings

- 7.2 Meetings shall be held every three months and otherwise as the Committee Chairs deems necessary - consistent with the Trust's annual plan of Board Business.

Withdrawal of individuals in attendance

- 7.3 The 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.

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

- 8.1 The Committee will only consider Research and/or Innovation proposals seeking charitable funding that have been scrutinised and endorsed by the Research, Development & Innovation Sub - Committee. This will ensure that the quality and safety of RD&I activity has been considered and is consistent with the RD&I Strategy.

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

- 8.3 The Committee, through its Chair and members, shall work closely with the Board and, *[where appropriate, its Committees and Groups]*, through the:

- joint planning and co-ordination of Board and Committee business; and
- appropriate 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 arrangements.

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

9. REPORTING AND ASSURANCE ARRANGEMENTS

- 9.1 The Committee Chair shall agree arrangements with the Trust's Chair to report to the Board in their capacity as Trustees. This may include, where appropriate, a separate meeting with the Board.
- 9.2 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 and the submission of written highlight reports throughout the year.
- 9.3 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.

10. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

- 10.1 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

Cross reference with the Trust Standing Orders.

11. REVIEW

- 11.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

12. CHAIR'S ACTION ON URGENT MATTERS

- 12.1 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 Board Secretary as appropriate, may deal with the matter on behalf of the Board, after first consulting with two other Independent Members of the Committee. The Board Secretary must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.
- 12.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Transforming Cancer Services Programme

Scrutiny Sub-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.~~
- The Quality, Safety & Performance Committee and Strategic Development Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare and the strategic and organisational development of the Trust.
- 1.3 As part of their functions, the Quality Safety and Performance Committee and the Strategic Development Committee are supported by ~~The Trust Board has approved the creation of~~ the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee to scrutinise the programme governance arrangements for the TCS Programme, which extends to its constituent projects. At a project level the Sub-Committee will examine, Project arrangements, the application and project management methodologies, monitor project performance, risk management, progress and provide assurance to the Quality, Safety and Performance Committee. Assurance on development or proposed changes to the programme scope will be provided to the Strategic Development Committee.~~Board.~~
- 1.4 The detailed terms of reference and operating arrangements set by the Quality, Safety and Performance Committee and Strategic Development Committee~~Board~~ in respect of this Sub-Committee are set out below.

2. PURPOSE

- 2.1 The purpose of the Transforming Cancer Services (TCS) Programme Scrutiny ~~Committee~~ Sub-Committee is to:
- Provide assurance that the leadership, management and governance arrangements are sufficiently robust to deliver the outcomes and benefits of the programme.
 - Scrutinise 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 [Trust](#) 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 [Trust](#) Board, the [Sub-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 [Sub-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 Sub-Committee is authorised by the Board to investigate or have investigated any activity within its terms of reference. In doing so, the Sub-Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Sub-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 ~~Sub~~–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 ~~Sub~~–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 three (3) members to include:

Chair Independent member of the Board (Non-Executive Director)

~~Vice Chair Independent member of the Board (Non-Executive Director)~~

~~One Two (12)~~ other Independent members 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~~ If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.-

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

The Committee Chair shall:

7.1

- Report formally, regularly and on a timely basis to the Quality, Safety and Performance Committee, the Strategic Development Committee~~Board~~ and the Accountable Officer on the Sub-Committee’s activities. This includes verbal updates on activity and, the submission of written highlight reports by exception throughout the year, ~~and an annual Committee Report.~~
- ~~B~~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 Sub-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.

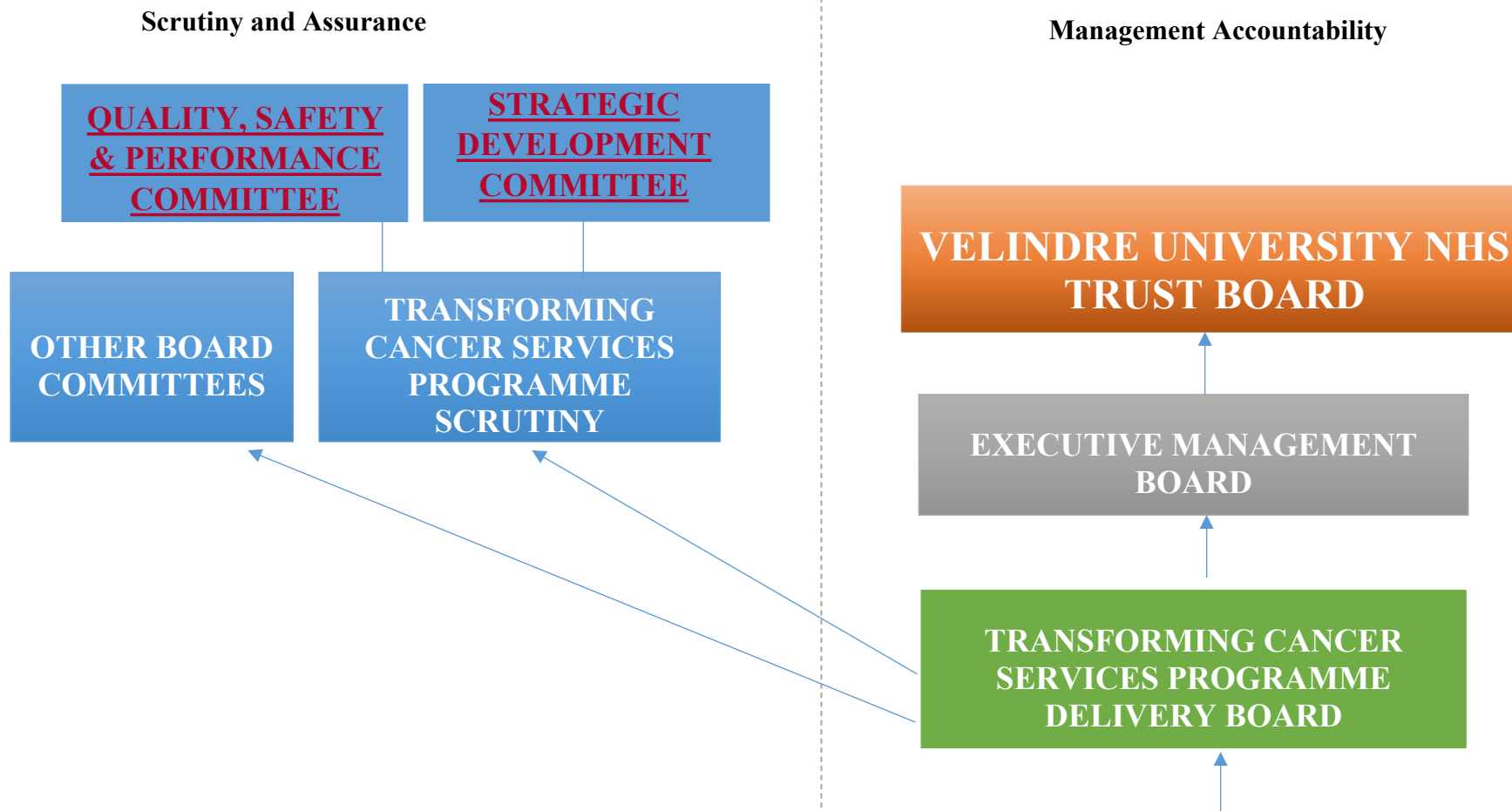
8. REVIEW

- 8.1 These Terms of Reference shall be reviewed annually by the Sub-Committee with reference to the Trust 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





GIG
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NHS Trust

Research, Development & Innovation Sub-Committee (RD&I)

Terms of Reference & Operating Arrangements

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 The Quality, Safety & Performance Committee, Strategic Development Committee and Charitable Funds Committee have been established by the Board to assist in discharging its functions and meeting its responsibilities with regards to the quality, safety and performance of healthcare, strategic and organisational development and to make and monitor arrangements for the control and management of the Trust's charitable funds.

1.3 As part of the aforementioned Committee functions, the Research, Development & Innovation (RD&I) Sub-Committee has been established to act as the "front door" for all RD&I business at Board level and will perform the following functions on their behalf:

- i. monitor the performance and delivery of RD&I on behalf of the Quality, Safety & Performance Committee;
- ii. develop the RD&I Strategy on behalf of the Strategic Development Committee;
and
- iii. review and approve business cases for alignment with strategy and funding on behalf of the Charitable Funds Committee.

~~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 Research, Development & Innovation Committee (RD&I). The detailed terms of reference and operating arrangements set by the Board in respect of this Committee are set out below:~~

~~1.3.1.4~~ Innovation and Research are defined as follows:

- **Innovation** - is the exploration of emerging technologies and / or processes that positively impact healthcare by improving the care experience, individual and population health, and reducing costs.
- **Research** - is designed and conducted to generate new knowledge.

2. PURPOSE

2.1 The purpose of the RD&I Sub-Committee is to provide:

- Strategy and Policy oversight for Research, Development and Innovation activities at the Trust – and for any Strategy that requires Board approval this to then be taken to the Trust Strategic Development Committee.

Commented [ST(-R&D1)]: In previous discussions it was agreed that the Sub committee was an assurance committee which is in keeping with this point stating that the Sub committee would review business cases for alignment with strategy and funding on behalf of the CFC. If the intention is that they approve then this should be added here. To read review and approve . If not then what is the mechanism for approval? Also I wouldn't expect business cases for divisional operational staff to go through this committee but through RD&I OMG for agreement and then Corporate scrutiny?

~~Strategy and policy oversight for Innovation and Research activities at the Trust and advise on and monitor performance in these areas:~~

- ~~• Receive assurance on the monitoring of performance – [through Quality lens]~~
- ~~• [Exception reporting] and as defined by the Trust Quality, Safety and Performance Committee, elements of this performance monitoring assurance may need to also be taken there – according to performance, quality, assurance frameworks and exception reporting criteria for that Committee.~~
- ~~• Promotion and encouragement of an a Research and Innovation and Research ethos and culture, which is integral to the Trusts vision, mission and values.~~
- ~~• Evidence based timely advice to the Board to assist it in discharging its functions and meeting its responsibilities with regards to the quality and safety of Innovation and Research activity. In the relation to research this includes activity carried out within the Trust both as a research sponsor and host organisation.~~
- ~~• Assurance to the Board in relation to the Trust's arrangements for ensuring compliance with the Research Governance Framework for Health and Social Care in Wales, second edition 2009, and the EU Clinical Trials Directive 2004 as amended from time to time. With the UK Policy Frameworks for Health & Social Care Research as amended from time to time.~~
- ~~• Foster collaboration and make recommendations on adoption and dissemination.~~
- ~~• Consideration of relevant matters with reference to the parameters identified for risk appetite in relation to research, development and innovation as set by the Board.2 —, Where appropriate, the Committee will advise the Board and the Accountable Officer on where, and how, its system of assurance may be strengthened and developed further.~~

Commented [LF(-TG2): Amended as per July 2019 version

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 & Policy Development

- ~~• Promote and encourage an Innovation and Research ethos and culture within the Trust.~~
- ~~• Oversee the development of all Innovation and Research and Innovation strategies and implementation plans ensuring the conduct of good quality projects within the Trust's portfolio of Innovation and Research activity.~~
- ~~• Consider the governance implications arising from the development of Trust Innovation and Research related corporate strategies and plans as well as those of its stakeholder Organisations.~~

- Consider the strategic implications for the Trust from the findings arising from national developments, review, audit and/or inspection, and monitor the successful implementation of any actions required resulting from these findings.
- Matters of Strategic development for the assurance and all approval of the Trust Board to be escalated to Trust Strategic Development Committee and, as appropriate, on to Trust Board.

3.2 Strategy & Policy Approval

- Approve policies relevant to the business of the Committee as delegated by the Board.
- Scrutinise Research ~~and/or Innovation Proposals and/or~~ and Innovation Business cases which exceed the delegated limits of the Chief Executive to consider prior to formal Trust Board approval.

3.3 Monitoring and Review

- The Sub-Committee will, in respect of its assurance role, seek assurance that research governance and innovation arrangements are appropriately designed, implemented and are operating appropriately to ensure the provision of a high quality Innovation and Research service.
- To achieve this, the Sub-Committee will ~~ensure need assurance that the following aspects of in relation to all aspects of Innovation and Research~~ and Innovation development that are being effectively managed:
 - The safety, rights, dignity and wellbeing of participants in Innovation and Research development projects is above all other considerations.
 - There is clear, consistent strategic direction, strong leadership and transparent lines of accountability.
 - The diversity of the organisation's patients, service users, donors and staff is valued and that their active participation in the development, undertaking and use of Innovation and Research is promoted.
 - There is close collaboration with partner Organisations in higher education to improve quality, promote joint working and avoid unnecessary duplication of functions. In this respect the work of the Research, Development and Innovation RD&I Sub-Committee will be reflected in the agenda and priorities of the Trust's Academic Partnership Board
 - The Organisation ensures compliance with appropriate legislation and regulation such as the, UK Policy Framework for Health and Social Care Research 2017 Research Governance Framework for Health and Social Care in Wales, second edition 2009, the EU Clinical Trials Directive 2004 as amended, Good Laboratory Practice, Good Manufacturing Practice in manufacturing products for clinical trials and Good

Clinical Practice in the conduct of all clinical Innovation and Research activities as appropriate.

Commented [LF(-TG3): Amended to reflect July 2019 version

- Systems are in place to monitor compliance with standards and to investigate complaints and deal with irregular or inappropriate behaviour in the conduct of Innovation and Research activity.
- ~~The Committee will monitor the cost of supporting Innovation and Research and Innovation, and will seek assurance that all~~ expenditure is accounted for and complies with audit requirements and requirements of external funders or sponsors as appropriate.
- When research or innovation findings have commercial potential the Trust takes action to protect and exploit them in collaboration with its Innovation and Research partners and where appropriate commercial Organisations.
- ~~Scrutinise performance against key metrics.~~

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 Committee's 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 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.~~
 - ~~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.~~
 - ~~To approve policies relevant to the business of the Committee as delegated by the Board.~~

3.5 Access

The Chair of the [RD&I Sub-Research, Development & Innovation](#) Committee shall have reasonable access to Executive Directors and other relevant senior 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. At this stage, no sub-Committees have been established.~~

4. MEMBERSHIP

4.1 Members

A minimum of two (2) 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 independent member of the Board (Non-Executive Director)~~

4.2 Attendees

In attendance

- Executive Director with responsibility for [R&D&I](#) currently Medical Director
- Executive Director of Finance & Informatics or nominated officer with R&D funding responsibilities
- ~~Medical Director — Welsh Blood Service~~
- ~~Associate Medical Director with responsibility for R&D~~
- Clinical Director (or Nominated Deputy) – Velindre Cancer Centre
- Executive Director of Nursing [AHP](#) and [Health Science Service Improvement](#)
- Director of Corporate Governance
- Representative - Velindre Cancer Centre Strategic Management Team
- ~~Representative – Welsh Blood Service Strategic Management Team~~
- ~~WBS RD&I Lead~~
- ~~Divisional Innovation and Research Leads~~
- ~~Trust Research & Development Lead~~
- Trust [Head of](#) Research & Development [Manager and Sponsorship Representative](#)
- Service User/Lay representatives
- Staff Side Representative

4.3 By invitation

The [Sub-Committee](#) Chair may extend invitations as required to the following:

- Information Governance Manager (in advisory capacity)
- Divisional Directors
- Representatives of [stakeholderpartnership](#) Organisations

As well as others from within or outside the Organisation who the [Sub-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 [Sub-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. [SUB-COMMITTEE MEETINGS](#)

5.1 Quorum

At least two members must be present to ensure the quorum of the Committee, one of whom should be the Committee Chair ~~or Vice Chair. If the Chair is not present an agreement as to who will chair from the Independent Members in their absence.~~

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 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 Sub-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 Sub-Committee is directly accountable to the Quality, Safety and Performance Committee, Strategic Development Committee and Charitable Funds Committee 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.~~

~~6.4 The Committee will consider the assurance provided through the work of the Board’s other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust’s overall framework of assurance.~~

6.4 The Committee shall embed the Trust’s corporate objectives, priorities, and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Report formally, regularly and on a timely basis to the:
 - i. Quality, Safety & Performance Committee by exception on the performance and delivery of RD&I;

- ii. Strategic Development Committee on strategic development and updates to the RD&I Strategy; and
- iii. Charitable Funds Committee to recommend for approval business cases aligned with the RD&I Strategy and Trust's overarching strategic objectives.

- ~~the Board on the Committee's activities. This includes verbal updates on activity and the submission of written Highlight Reports.~~
- ~~Bring to the Board's and the Accountable Officer's specific attention any significant matters under consideration by the Committee; and~~
- ~~Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient care and affect the operation and/or the reputation of the Trust.~~

- 7.2 The Director of Corporate Governance, on behalf of the Board, shall oversee a process of regular and rigorous self assessment and evaluation of the Sub-Committee's performance ~~and operation including that of any Sub-Committees established.~~

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 Sub-Committee.

9. REVIEW

- 9.1 These terms of reference and operating arrangements shall be reviewed annually by the Committee with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

- 10.1 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 two other 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.
- 10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

TRUST BOARD

PARTNERSHIP MEETING HIGHLIGHT REPORT

DATE OF MEETING	24/09/2020
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Sarah Morley, Executive Director of OD & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of OD & Workforce
REPORT PURPOSE	FOR NOTING
ACRONYMS	

1. PURPOSE

- 1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Covid-19 Partnership Meeting. The final meeting was held on 29.07.2020.
- 1.2 Key highlights from the meeting are reported in section 2.

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	Nothing to Note
ADVISE	<p>Fire Evacuation Procedure</p> <ul style="list-style-type: none"> The meeting requested the fire evacuation procedure be reviewed taking into consideration social distancing measures. An action was taken to address this via the Social Distancing Cell. <p>Staff Survey</p> <ul style="list-style-type: none"> The first of a series of staff surveys launched. <p>Work in Confidence Platform</p> <ul style="list-style-type: none"> The meeting noted that the Work in Confidence Platform will be launching in September 2020.
ASSURE	<p>Partnership Meetings.</p> <ul style="list-style-type: none"> The final COVID Partnership meeting took place on 29.07.2020. Monthly Local Partnership Meetings now take place in both The Welsh Blood Service and Velindre Cancer Centre. The Local Partnership Forum will meet in October, as per the Trust's standing orders.
INFORM	Nothing to Note
APPENDICES	NOT APPLICABLE



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NHS Trust

TRUST BOARD

DELIVERING EXCELLENCE PERFORMANCE REPORT

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Cath O'Brien, Interim Chief Operating Officer
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PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
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EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer
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REPORT PURPOSE	FOR DISCUSSION / REVIEW
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board*	14/09/20	ENDORSED

ACRONYMS	
IMTP	Integrated Medium Term Plan
PADR	Performance Appraisal and Development Review

VUNHST	Velindre University NHS Trust
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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 July 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 key areas of performance across the Trust. A number of areas from these reports is highlighted below.

2.2 Velindre Cancer Centre:

2.2.1 Radiotherapy Waiting Times (page 3 and 4)

VCC continues to operate under its COVID 19 modified service model during this period. Due to the nature of the patient pathways and these service changes, there has been an impact on service performance against waiting times for radiotherapy.

July saw 366 referrals for radiotherapy, an increase of 18% on the 310 referrals received in June. There was a slight increase in the number of breaches over the June figures. None of these patients breached the tier 1 target for 1st definitive treatment and the clinical prioritisation in keeping with the current advice of the Royal College of Radiologists (RCR).

Palliative Radiotherapy target for treatment within 14 days achieved 93% with 8 breaches from a total 116 treated. Breaches were as a result of reduced Covid related capacity and changes of intent from radical to palliative treatment.

2.2.2 Systemic Anti-Cancer Therapy (SACT) treatment (page 5 and 6)

The SACT service has observed an increase in demand due to the recommencement of patients whose treatment had been deferred on a clinically managed basis in response to the Covid pandemic.

In response to the challenge of providing sufficient capacity in response to the Covid 19 impact on the service delivery, a number of innovations have been introduced. There has been an increase in the delivery of oral SACT and Medicines at Home (270 extra per month as compared to pre-Covid levels), simple procedures performed in Outpatients have been increased by a 120 per month (from an historical norm of approximately 60 per month), extended capacity has been made available at VCC for SACT delivery and the workforce plan has been re-aligned. Through these actions we have increased capacity, although we are not yet at pre Covid 19 levels we continue to work towards those.

Active engagement with health boards is continuing with a view to securing extra capacity for SACT delivery in outreach settings. It is important to acknowledge that health boards are also currently operating subject to severe constraints.

It is not envisioned that available SACT capacity will return to pre-Covid levels until November 2020.

We are continuing to work with Welsh Government and Local Health Board colleagues in modelling the system demand anticipated for the forthcoming months.

2.2.3 % of patients with NEWS score ≥ 3 that receive all 6 elements in required timeframe (page 18)

Every patient who required it received the sepsis bundle within 1 hour. This marks an improvement with respect to performance in both May and June.

2.2.4 Unscheduled Care

In the June meeting we were asked to provide information about work on unscheduled care. A Task and Finish Group on Unscheduled Care has been established which is one of four groups which are looking at developing and refining our clinical model. The group is being led by Paul Wilkins, Director of the Velindre Cancer Centre and includes representatives of all the specialties involved. It is meeting weekly and undertaking an assessment of the care model to identify development needs. It is looking at care pathways as well as identifying data and information that we use to monitor the service.

2.3 **Welsh Blood Service**

Supply of all blood components to meet demand has been sustained in difficult operating environment. We are continuing to experience difficulties in booking venues as businesses return to use their facilities and introduce new Covid restrictions. This has resulted in a considerable number of venue cancellations and constraints that we are working through.

with providers. To support this, we are working with PHW to agree, articulate and authorize the particular position of WBS in terms of its needs to maintain the blood supply chain and the IPC measure that we use.

There are also staff capacity challenges that have been created from staff isolation and the risk assessment for shielding staff. We are continuing to work through this with WOD colleagues to ensure safe and effective working and maintenance of the supply chain.

2.3.1 Stem Cell Donation (page 4)

The WBMDR has not met its monthly or annual target to date due to a number of cancellations in July. These each related to the individual patient need and not any WBMDR practice. It is normal to experience this type of variation and does not indicate the performance expected by year end.

2.3.2 Incidents closed within 30 days (page 5)

Work is still ongoing to improve the process for undertaking this activity through a root cause analysis exercise following the recent MHRA audit. A risk based approach to managing the workload made sure all immediate actions required were taken.

2.3.4 Whole Blood Efficiency and Manufacturing and Production Efficiency and Platelet Waste (page 8 and 9)

As previously advised in July, WBS has had to increase the resource requirements in the Collections Team in order to support the introduction of social distancing measures and PPE. Similarly, the laboratories has been impacted by the lower collections and other changes. These changes account for whole blood efficiency and manufacturing and production efficiency showing as below target however we have experienced an increase in efficiency for production for July.

Platelet stocks expiry remained high in July due to continued production of pooled platelets to maintain stocks against uncertainty in demand profile. Changes put in place to more effectively manage this will show in August.

2.4 **Corporate Services:**

2.4.1 PADR compliance rates have decreased as a result of operational impacts. As we move Recovery Phase local target plans to improve compliance and target hotspots ongoing. There will also be a focus on improved recording with guidance on PADR completion rolled out via WOD Business Partners and Workforce information supporting to ensure PADRs on ESR system.

2.4.2 Sickness absence remains above target. We are continuing to review as we move through the next phase of the pandemic and will ensure we sustain the daily wellbeing updates in Trust communications to signpost internal and external interventions and resources, this

includes webinars; support lines; tools; resources for families etc. Managers are being supported to undertake risk assessments and wellbeing discussions. We are working with managers to support staff returning to the workplace including psychological support.

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: <ul style="list-style-type: none"> • 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.

At a Glance Highlights - July 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 foreseeable 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 outpatient referrals seen within 2 weeks.
- % of routine therapies outpatient referrals seen within 6 weeks.
- % of outpatients seen within 20 minutes.
- % outpatient DNA rates.
- Number of potentially avoidable 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 acquired 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 information is reflected in the pages that follow with the arrows below describing changes to target attainment for individual targets relative to the previous month



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



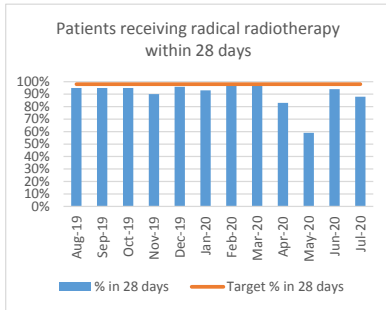
4 KPIs fell below the previous month's performance.



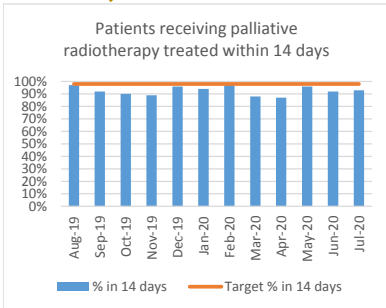
18 KPIs remained unchanged relative to the previous month's performance of these all 16 KPIs met or were above target.

Equitable and Timely Access to Services - Radiotherapy

Jul-20



Last month   Target Not Achieved

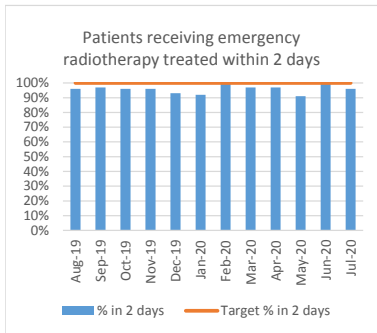


Last month   Target Not Achieved

Target: 98%	SMT lead: Radiotherapy Services Manager	
Reason for performance:	Actions being taken to improve performance:	Expected completion date
<p>No patient who failed to begin treatment in July within the timescales set by these internal stretch targets breached a tier 1, national Urgent Suspected Cancer (USC) or non-Urgent Suspected Cancer (nUSC) target as defined by the Service and Financial Framework (SaFF).</p> <p>Demand for radiotherapy services has leveled with 390 new patient referrals received in July. In light of the COVID pandemic, a number of clinical staff are unable to provide patient facing care. To ensure a robust service and patient safety, a linear accelerator (linac) has been stood down and capacity on a second has been dedicated to the treatment of COVID positive or suspected-positive patients. Such changes have reduced available linac capacity and impaired the service's overall flexibility.</p> <p>140 patients were referred for treatment with radical intent. 18 did not begin treatment within 28-days (performance rate of 87%). Of these 18 patients:</p> <ul style="list-style-type: none"> • 3 were as a result of clerical error within booking • 2 were as a result of the COVID recovery pathway • 5 were as a result of delays in completion of pre treatment planning CT in line with attendance at Consultant specific clinic • 3 were as a result of delays in the target volume mark up • 2 were as a result of a change in the clinical situation mark up <ul style="list-style-type: none"> • 1 was as a result of a planning error • 1 was as a result of brachytherapy capacity • 1 was as a result of patient choice <p>116 patients were referred for treatment with palliative intent. 8 did not begin treatment within 14-days (performance rate of 93%). 1 breach was due to a change of intent from radical to palliative on day 20. 2 breaches were due delays in the target volume being marked up</p> <ul style="list-style-type: none"> • 3 breaches were as a result of a change in the mark up of target volumes • 2 breaches were as a result of the need for a highly complex plan 	<p>A1: A major programme of work in radiotherapy and medical physics instigated in response to performance issues and the findings of an external review.</p> <p>A2: Formal monthly performance review to be introduced with VCC senior management team to focus on performance, capacity, finance, workforce, etc..</p> <p>A3: VCC performance team with business intelligence support and service input to implement system for the monitoring of whole patient pathway in radiotherapy.</p> <p>A4: Weekly waiting times and patient tracker meetings to be reinstated.</p> <p>A5: Radiotherapy and medical physics to identify individual roles responsible for waiting list management.</p> <p>A6: Radiotherapy Management Group (RMG) to be specifically tasked with supporting implementation of the Single Cancer Pathway (SCP).</p> <p>A7: RMG developing breach pathway coding in conjunction with BCUHB and SBUHB</p> <p>A8: Booking process review to be undertaken</p>	<p>E1: To begin in July 2020</p> <p>A2: Complete</p> <p>E3: To begin in July 2020</p> <p>E4: Complete</p> <p>E5: Complete</p> <p>E6: Complete</p> <p>E7: Complete</p> <p>E8: Complete</p>

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

Jul-20

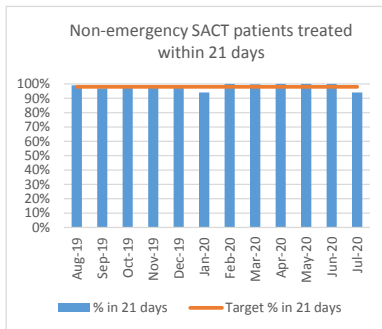


Last month   Target Not Achieved

Target: 98%	SMT lead: Radiotherapy Services Manager	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
28 patients were referred for emergency treatment. Of these, 27 patients were treated within 2-days (performance 96%). Of the patients that did not commence radiotehrapy reatment within 2 days of referral the breach was as a result of change of intent from palliative to emergency on day 6, radiotherapy treatment began within 7 days.	<p>A1: Weekly waiting times and patient tracker meetings to be reinstituted.</p> <p>A2: Radiotherapy and medical physics to identify individual roles responsible for waiting list management.</p> <p>A3: Radiotherapy, Medical Physics and Consultant Clinical Oncologist developing breach pathway coding in conjunction with BCUHB and SBUHB</p>	<p>E1: Complete</p> <p>E2: Complete</p> <p>E3: Complete</p>

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

Jul-20

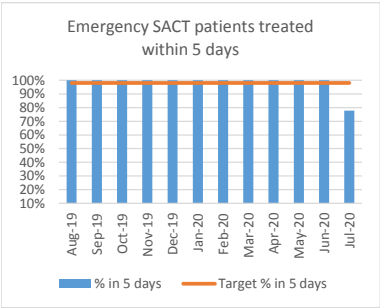


Last month   Target Not Achieved

Target: 98%	SMT lead: Chief Pharmacist	
Reason for performance:	Actions being taken to improve performance:	Expected completion date
<p>279 non-emergency new patients began treatment in month.</p> <p>18 of these patients breached: 17 due to capacity issues 1 due to an isolated communication issue.</p> <p>Referrals have increased considerably in comparison to earlier months of the COVID-19 pandemic. All SACT delivery continues to be undertaken at VCC (with exception of the Mobile Unit located at Nant Garw)</p> <p>The repatriation of SACT delivery services to VCC as part of the response to the pandemic, whilst a necessary means to optimise patient safety during the early phases, has had the effect of severely limiting capacity. As the number of referrals increases this issue has become acute.</p>	<p>A1: The SACT Strategic Group to commission an operational plan to ensure safe, sustainable delivery of the service in the long-term.</p> <p>A2: The Macmillan Unit at Prince Charles Hospital will re-open for 3 days a week from 7 September. Capacity at the Unit will be reduced from 10 to 5 chairs in recognition of the need for social distancing.</p> <p>A3: 6 additional chairs will open at VCC in August.</p> <p>A4: Active engagement is underway with local health boards to continue planning the return of SACT capacity at outreach sites. Other options which would deliver extra capacity are also being actively explored.</p>	<p>E1: Complete</p> <p>E2: September 2020</p> <p>E3: August 2020</p> <p>E4: To be reviewed in October 2020</p>

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

Jul-20

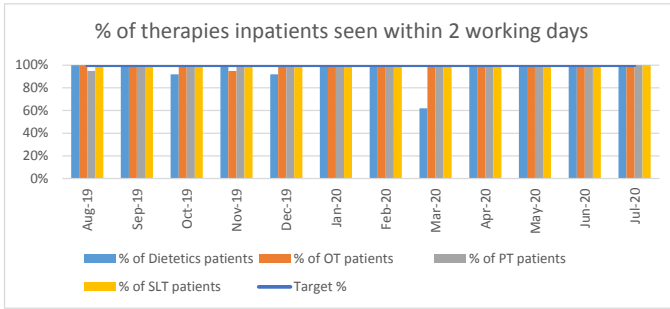


Last month   Target Not Achieved

Target: 98%	SMT lead: Chief Pharmacist	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
There were 9 emergency patients treated in July. Two patients were not treated within the 5 day target (one patient was treated on day 6 and the second on day 10). The delay in both cases was caused by the fact that patients were not subject to the appropriate SACT escalation process.	A2: All staff involved to receive training on proper application of the SACT escalation process.	E1: Complete

Equitable and Timely Access to Services - Therapies (Inpatients)

Jul-20

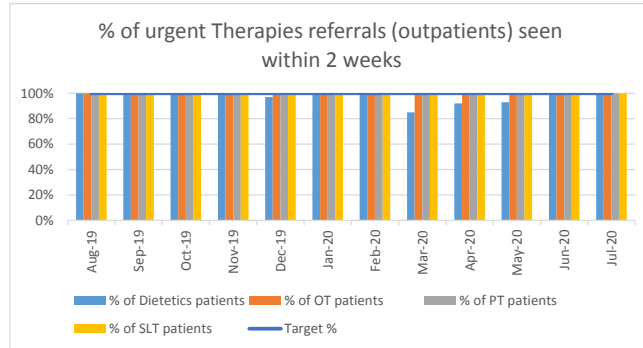


Dietetics - last month →
 OT - last month →
 PT - last month →
 SLT - last month →

Target: 100%		
Reason for performance:		
All inpatients were seen within target. Routine, face to face, outpatient appointment were suspended with effect from the 16th March as part of the Trust's response to the COVID-19 pandemic.	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: Complete
	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. A completion report has been compiled and feedback on possible next steps is awaited.	E2: Complete
	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: Complete

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

Jul-20

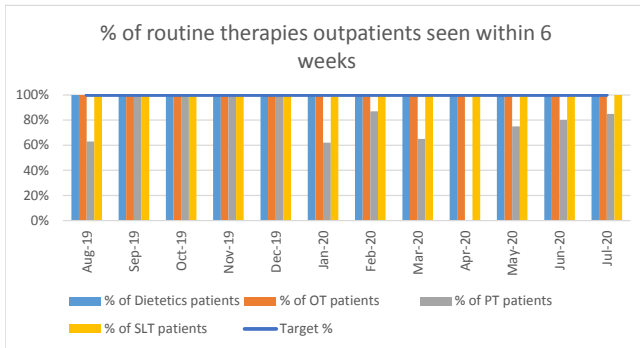


Dietetics - last month →
OT - last month →
PT - last month →
SLT - last month →

Target: 100%	
Reason for performance:	
<p>.All patients were seen within the two week target.</p> <p>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.</p>	
<p>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.</p> <p>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.</p> <p>A3: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.</p>	<p>E1: Complete</p> <p>E2: Complete</p> <p>E3: Complete</p>

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

Jul-20



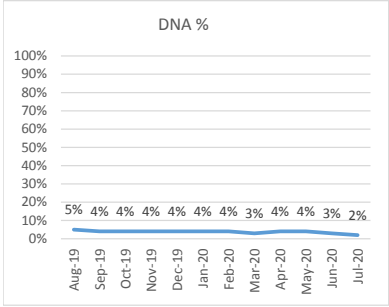
Dietetics - last month →
OT - last month →
PT - last month →
SLT - last month →

Target: 100%	
Reason for performance:	
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: Complete
	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: Complete
	A3: Breaches to be reviewed monthly with Head of Planning and Performance. Actions arising from breach analysis to form monthly improvement plan going forward.
	Complete
	E3:

Equitable and Timely Access to Services - Outpatient Waiting Times

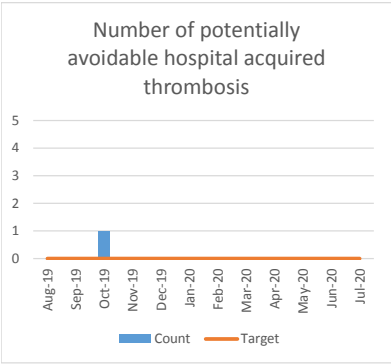
Jul-20

Target: <20 minutes	SMT lead: Head of Nursing	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
<p>More than 40% of Outpatient activity was conducted virtually in July. Data capture issues are being actively addressed which may reveal that the actual percentage of virtual activity is still higher in reality. The limited number of face-to-face outpatient appointments meant that performance with respect to this metric could not be meaningfully measured.</p> <p>In response to the COVID-19 pandemic, VCC instituted a phlebotomy service to support regional oncology services and the health boards more broadly as patient access to such facilities became restricted.</p> <p>All Outpatient activity carried out in outreach contexts was repatriated to VCC as part of the organisation's pandemic response. The repatriation of these services to VCC, whilst a necessary means to optimise patient safety during the early phases, has had the effect of severely limiting capacity. As demand increases, this will become acute unless addressed.</p>	<p>A1: Detailed plans to be developed and implemented to allow the Outpatient activity to re-start in outreach contexts.</p> <p>A2: Weekly waiting times and patient tracker meetings to be reinstituted.</p> <p>A3: Outpatient department to identify individual roles responsible for waiting list management.</p>	<p>E1: Plans fully implemented by September 2020.</p> <p>E2: Complete</p> <p>E3: Complete</p>



Last month Target Achieved

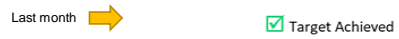
Outpatients - Did Not Attend (DNA) Rates			Jul-20
Target: <5%	SMT lead: Head of Nursing		
Reason for performance:	Actions being taken to improve performance:	Expected completion date:	
Performance on track.			



Last month ➡ ☒ Target Achieved

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

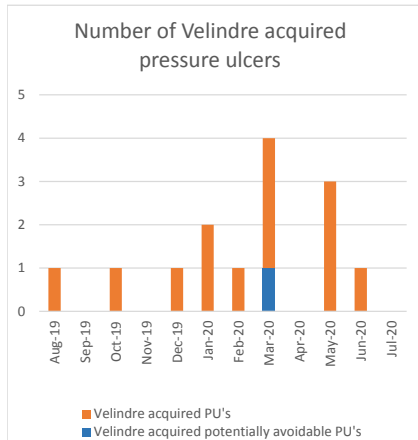
Jul-20



Target: zero	SMT lead: Head of Nursing	
Reason for performance:	Actions being taken to improve performance:	Expected completion
There were no DTOC's for the month of July 2020. Performance on track.	A1: Head of Nursing to continues to review all Delayed Transfers of Cares to determine underlying trends, etc.	E1: Business as usual with effect form March 2020.

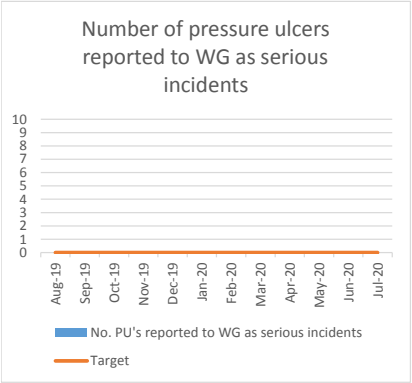
Safe and Reliable Services - Velindre Acquired Potentially Avoidable Pressure Ulcers

Jul-20



Last month Target Achieved

Target: zero pressure ulcers	SMT lead: Head of Nursing	
Reason for performance:	Actions being taken to improve performance:	completion date:
<p>There were no Velindre acquired pressure ulcers reported in July.</p> <p>Performance on track.</p>	<p>The Pressure Ulcer Scrutiny Panel is responsible for monitoring the implementation of any agreed actions or recommendations.</p>	

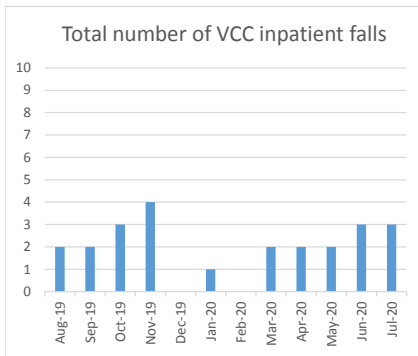


Last month Target Achieved

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

Safe and Reliable Services - Falls

Jul-20



Last month → ✗ Target Not Achieved

SMT lead: Head of Nursing		
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
There were three falls reported in July.	<p>A1: 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.</p> <p>A2: Contribute to development of all-Wales standardised falls prevention care plan.</p> <p>A3: Post falls assessment of all falls reported in July was carried out. All three were deemed unavoidable.</p>	<p>E1: Activity on hold due to requirements of pandemic response.</p> <p>E2: Activity on hold due to requirements of emergency response.</p> <p>E3: Complete</p>

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

Jul-20

Number of Velindre-acquired infections:

C.diff infections = 0

MRSA infections = 0

MSSA infections = 0

E.coli infections = 1

Klebsiella infections = 0

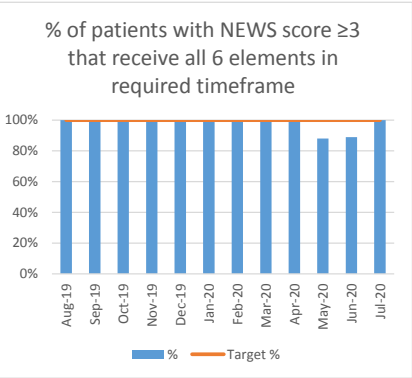
Pseudomonas Aeruginosa infections = 0

Target: 0 infections			SMT lead: Clinical Director		
Reason for performance:			Actions being taken to improve performance:		Expected completion date
One case of E.coli was reported in July.			A1: A root cause analysis was conducted and appropriate learning disseminated.		E1: Complete

Last month   Target Not Achieved

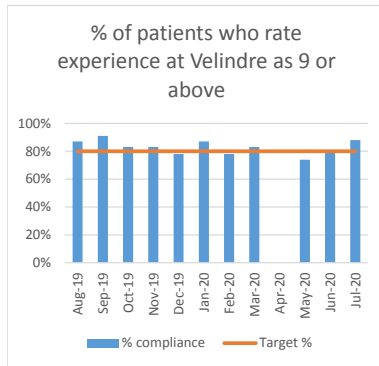
Annual figures for Velindre-acquired infections:												
	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
<i>C.Diff</i>	0	0	0	0	0	0	0	0	1	0	0	0
<i>MRSA</i>	0	0	0	0	0	0	0	0	0	0	0	0
<i>MSSA</i>	0	0	0	0	1	0	0	0	0	0	0	0
<i>E.Coli</i>	0	0	1	0	0	0	0	0	0	0	1	1
<i>Klebsiella</i>	0	0	0	0	0	0	0	0	0	0	0	0
<i>P. Aeruginosa</i>	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 Jul-20
(newly presenting patients only)



Last month   Target Achieved

Target: 100%	SMT lead: Clinical Director	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
11 patients met criteria for sepsis requiring response – All 11 Patients received sepsis bundle within 1 hour. Of these 11 patients only 5 went on to receive a diagnosis of sepsis. In total 8 patients received a diagnosis of sepsis and all 8 received sepsis bundle within 1 hour. Performance on track.	This target remains the focus of active review as part of normal management arrangements.	



Last month   Target Achieved

Target: 80%	SMT lead: Director of Operations	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
<p>Patients returning lower scores in July in relation to their experience of treatment at VCC commented on several themes, including:</p> <ul style="list-style-type: none"> • Social distancing in the Outpatient Department • Waiting times for bloods • Compassionate communication 	<p>A1: All patients who were contactable (ie not anonymous) contacted to discuss concerns further.</p> <p>A2: 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.</p>	<p>E1: Business as usual</p> <p>E2: Activity on hold due to requirements of emergency response.</p>

Concerns:

The Trust Board's Quality and Safety Committee receive a report on the detail of all concerns received.

3 Early Resolution concerns were received and closed within 2 working days.

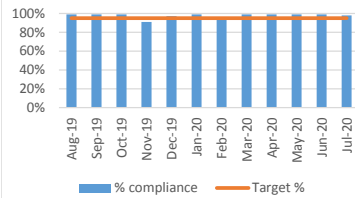
2 Formal concerns were received and managed under PTR. Both were closed within 30 working days and the other is under investigation.

Themes included:

1. Clinic waiting times / delays in being seen.
2. Unhappy with treatment received.

Type of concern	No.
Early resolution	3
PTR (formal concern)	2
Claims	0

% of episodes clinically coded
within 1 month post episode
end date



Last month   Target Achieved

Target: 98%	SMT lead: Head of IM&T	
Reason for performance:	Actions being taken to improve performance:	Expected completion date:
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)

- All clinical demand was met with overall stock position of red cells was 2892 at the end of July.
- All stock groups were maintained above 3 days.
- All clinical demand for platelets was met.
- Stem Cell collections remain on target for year end position
- Whole blood collection efficiency is below the target for the fourth consecutive month as a consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point and to support the introduction of social distancing and PPE. this is likely to continue whilst COVID 19 is present in the community
- Manufacturing productivity continues to remain below target, as the result of decreased collections due to COVID 19 and increased staffing due to partial implementation of the ambient overnight hold staffing model. There has been an improvement in productivity in July.
- Time expired red cells was below 1% target due to changes in issuing practice to issue oldest units first (rather than a range of shelf life) due to change in demand from hospitals as a result of COVID
- Platelet expiry remained high in July, this is due to continued production of pooled platelets to maintain stocks against the uncertainty of platelet demand. following a review, a revised platelet production plan will be put in place from August onwards. this should result in a significant reduction in time expiry from August onwards
- 81% of quality incidents closed within the required 30 days. This is just below the target position - as part of the MHRA inspection findings a root cause analysis exercise is being undertaken to determine reasons for reports being closed outside of the expected 30 day timeframe.
- UKAS undertook an accreditation audit against ISO standards and accreditation for the red cell immunohaematology, antenatal screening, molecular genetics and clinical antibody testing laboratories was retained.
- No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in June.
- No formal concerns requiring a formal response in 30 days were received in July
- All concerns were acknowledge within 2 working days of receipt, in line with target.
- Overall donor satisfaction continued to exceed target position at 96.7%.



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



5 Key Performance Indicators remained the same as the previous month's performance, however 3 achieved target.



7 Key Performance Indicators were down on the previous month's performance, however 4 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 Stem Cell Collections	90%	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

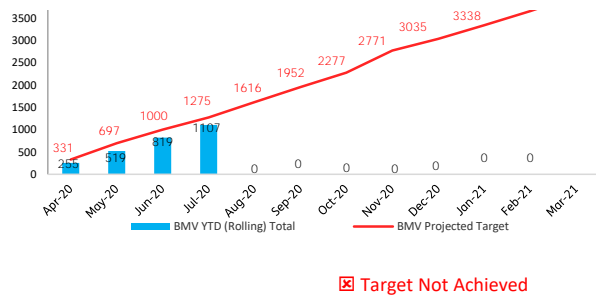
Jul-20

4500
4000

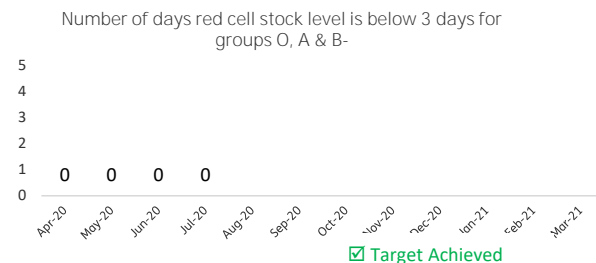
BMV Donors



Annual Target: 4000	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



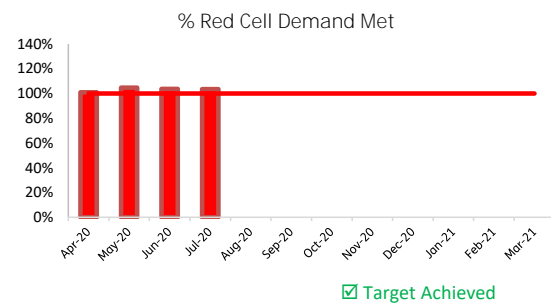
There were 288 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in July.	Develop a new donor recruitment and retention strategy for the WBMDR aligned with the development of the revised WBS strategic intent. The new Donor Recruitment & Retention Strategy will be informed by: - a review of the existing donor panel to assess the required growth; - a review of the outcomes of the new bone marrow pilot recruitment to provide proof of concept and operational readiness for a recruitment strategy that is not solely dependent on blood-donors.	TBC - original deadlines delayed due to COVID. Task and Finish group has been established to take forward recruitment of non blood donors
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Safe and Reliable Service

Jul-20

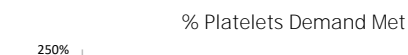
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All stock groups were maintained above 3 days. Stock levels are robust. Effective collaboration between the Collections, Laboratory, BI and BHT teams and supported 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

Jul-20

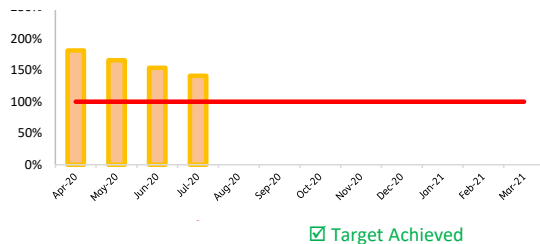
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All demand for red cells was met. Stock levels remain robust across the blood groups. This is the result of established daily communications between the Collections, Laboratory, BHT and BI 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 Usual



Safe and Reliable service

Jul-20

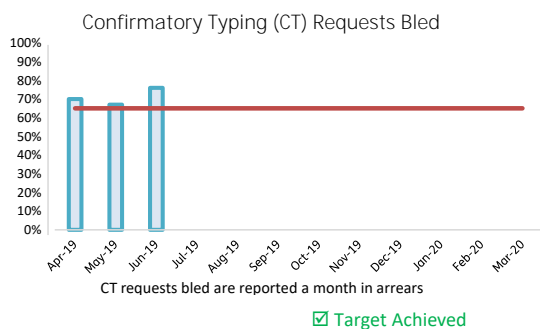
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When



All clinical demand for platelets was met.		TBC Currently on hold due to other priorities as a result of COVID
This is the result of established daily communications between the Collections, Laboratory, BHT, BI teams enabling agile responses to variations of stock levels and service needs.	Revised production plan for platelets in August will see reduced production of platelets.	

Safe and Reliable service

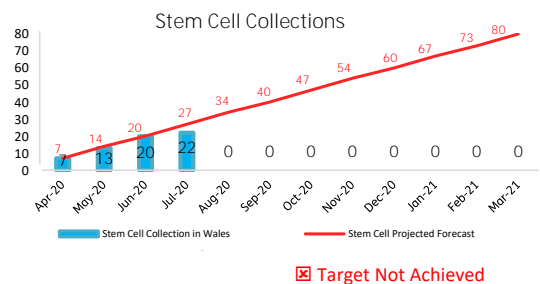
Jul-20



<u>Monthly Target: 65%</u>	<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The number of CT requests for June was 17: - 13 donors were bled (76%) (0 cancellation) - 54% of samples were bled within 7 days - 92% of requests were completed within 14 days. (Industry KPI's are 50% and 80% respectively)	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.	Business as Usual

Safe and Reliable service

Jul-20



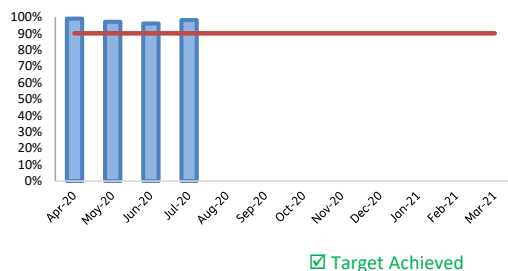
<u>Annual Target: 80</u>	<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 2 Stem Cell Collections in July with YTD collections on target position. 3 x Cancellations at work up stage and one postponed until August.	Define 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.	TBC delayed due to COVID but will form part of the Collection Centre review

Safe and Reliable service

Jul-20

Antenatal Turnaround Times

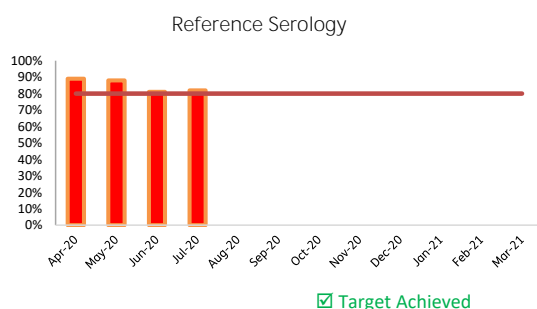
<u>Monthly Target: 90%</u>	<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



Turnaround times for routine Antenatal tests in July 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
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Safe and Reliable service

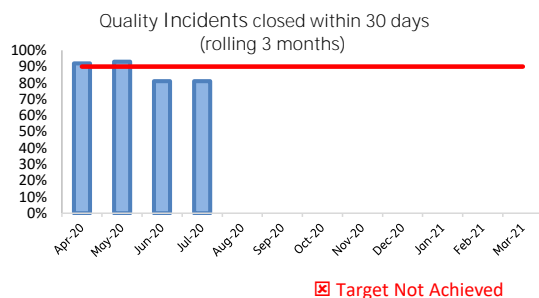
Jul-20



<u>Monthly Target: 80%</u>	<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for specialist referrals in July above target at 82%. Workload returning to 'near normal' (159 referrals in July compared to average of 219 in 2019).	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. The laboratory modernisation programme has been suspended due to COVID. It is anticipated this will recommence early Autumn 2020	4425600%

Safe and Reliable service

Jul-20



<u>Monthly Target: 90%</u>	<u>SMT Lead: Peter Richardson</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Performance in July is below the target position, with 81% of quality incidents closed within the required 30 days. This indicates the same performance as the previous month. The number of incidents reported in the three month rolling period has increased slightly (80 reports); 15 reports were not closed within this period, compared with 14 in the previous reporting period.	The agreed SMT action plan will remain in place to ensure that the improved performance is sustained. As part of the WBS response to the recent MHRA inspection findings, a root cause analysis exercise is being undertaken to determine reasons for reports being closed outside of the expected 30 day timeframe. The outcome of the investigation will be used to inform the corrective and preventive action required to improve performance against the 30 day target.	Continue with close monitoring and feedback issues to SMT huddle weekly.

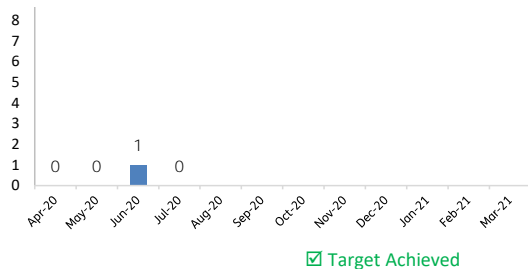
Safe and Reliable service

Jul-20

10
9

Critical Findings

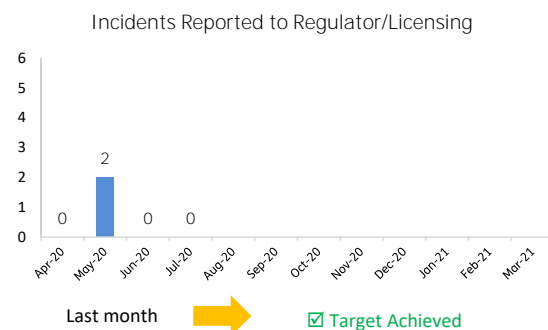
<u>Target: 0</u>	<u>SMT Lead: Peter Richardson</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
UKAS undertook an accreditation audit against ISO	An action plan has been drawn up to address each point in	Evidence to support



<p>UKAS accreditation was retained for the Red Cell Immunohaematology, Antenatal Screening, Molecular Genetics and Clinical Antibody Testing laboratories.</p> <p>There were 16 audit findings and 5 recommendations.</p>	<p>UKAS accreditation was retained for the Red Cell Immunohaematology, Antenatal Screening, Molecular Genetics and Clinical Antibody Testing laboratories.</p> <p>There were 16 audit findings and 5 recommendations.</p>	<p>Completion of the action plan to be submitted to UKAS by 3rd September, for review.</p>
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Safe and Reliable service

Jul-20



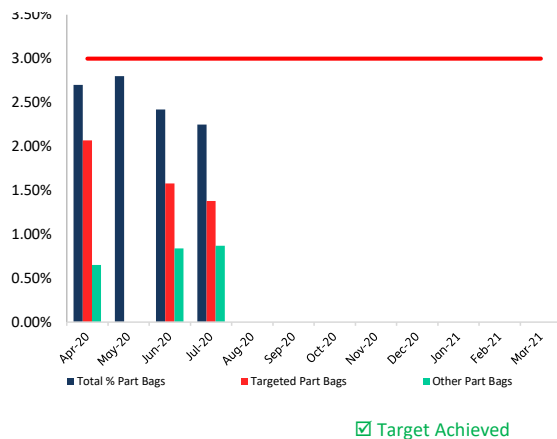
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in July.	None required.	<p>A confirmation report is still to be submitted to MHRA via the SABRE website for one of the two incidents reported in May. A full RCA report has been reviewed by the Regulatory Assurance & Governance Group and a request made to further explore one aspect of the investigation. The final report has been submitted to relevant SMT members for review.</p> <p>MHRA have been informed that the investigation has been extended.</p> <p>Confirmation report to be submitted on completion of extended investigation.</p>

Spending Every Pound Well

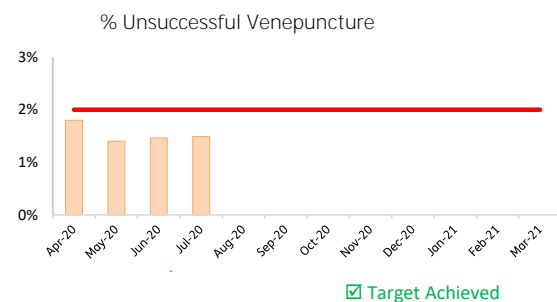
Jul-20

% Part Bags

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



<p>The overall Part Bag rate for July 2020 remains within the 3.0% tolerance at 2.25% of donors who donated.</p> <p>The overall Part Bag figure gives general reassurance that this is not an area of concern.</p> <p>The value of the breakdown of this data into 'targeted' and 'other' should be reviewed going forward.</p>	<p>Ongoing work to maintain the part bag rate under tolerance threshold include (but is not limited to) the following:</p> <ul style="list-style-type: none"> - Ongoing cycle of Points Of Care Audit - Review of Audit findings and implementation of associated action plans - Task and Finish groups with clinical teams with trend of exceedance tolerance levels to determine and implement service improvement projects <p>The factors that comprise the 'reasons for part bags' will continue to be monitored on an individual team and collective basis.</p>	<p>Business as Usual</p> <p>Business as Usual</p> <p>Business as Usual</p> <p>Business as Usual</p>
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Spending Every Pound Well

Jul-20

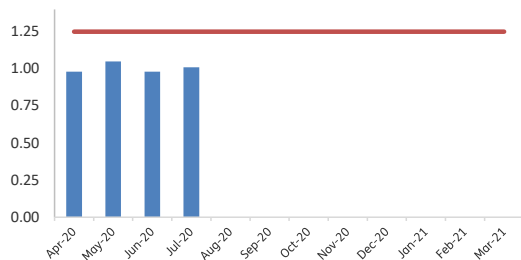
Monthly Target: Maximum 2%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Failed Venepuncture (FVP) rate in June 2020 successfully remained within the tolerance threshold at 1.46%.	Monitoring of FVP rates by team continues.	Business as Usual

Whole Blood Collection Productivity

Spending Every Pound Well

Jul-20

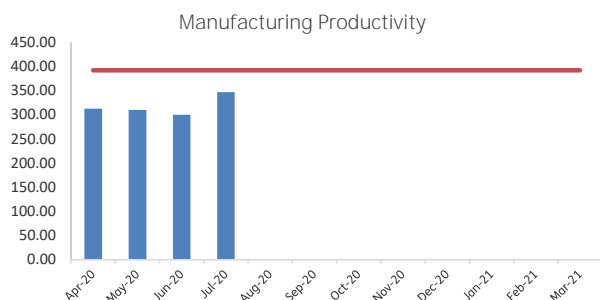
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



❌ Target Not Achieved

Collection efficiency is below the target of 1.25 for the fourth consecutive month as a consequence of the ongoing need to increase resource requirements due to COVID 19, which has resulted in additional staffing being sent out per team to man a newly added triage point, and to support the introduction of social distancing and PPE. Depending on the number of chairs put out, this could see an increase of up to 3 staff per team. This is likely to continue for the long term while COVID 19 is present within the community.	The changes which were due to be brought in under the Blood Supply Chain 2020 have been put on hold during the COVID 19 pandemic. It is anticipated the Blood Supply Chain 2020 Programme will recommence Autumn 2020.	4416600%
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Spending Every Pound Well



❌ Target Not Achieved

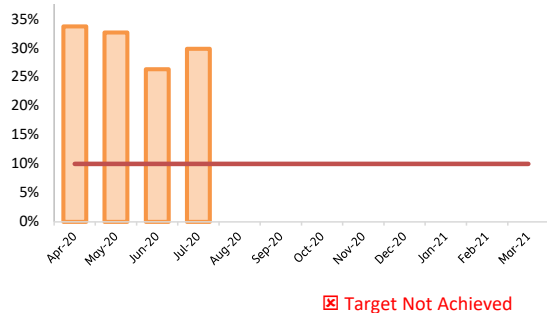
<u>Monthly Target 392</u>	<u>SMT Lead: Trcaey Rees</u>	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
Production efficiency continues to remain below the target. The principle influences on this are lower collections and increased staffing reflecting changes in service provision and hospital demand during COVID. This include recruitment to support the introduction of partial ambient overnight hold.	Recruitment of staff to replace leavers and bring staffing in line with the ambient overnight hold model is underway. Staffing is expected to reamin under pressure through February with improvement as staff are recruited and trained in March 2020. Target to be reviewed in line with processing / staff changes as part of the Blood Supply Chain 2020 initiative. The Blood Supply Chain 2020 Programme has been put on hold during the COVID 19 pandemic. This under review and it is anticipated will recommence early Autumn 2020	4416600%

Spending Every Pound Well

Jul-20

40% | Time Expired Platelets

<u>Monthly Target: Maximum 10%</u>	<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



<p>Platelet expiry remained high in July, this is due to continued production of pooled platelets to maintain stocks against the uncertainty of platelet demand. Platelet demand remained low in July</p> <p>Production targets have been reduced for pooled platelets</p>	<p>Following a review of platelet time expiry and stabilisation of platelet issues, a revised platelet production plan has been put in to place for August 2020 onwards. This should result in a significant reduction in time expiry from August 2020 onwards.</p>	<p>See above project on hold due to other priorities.</p>
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Spending Every Pound Well

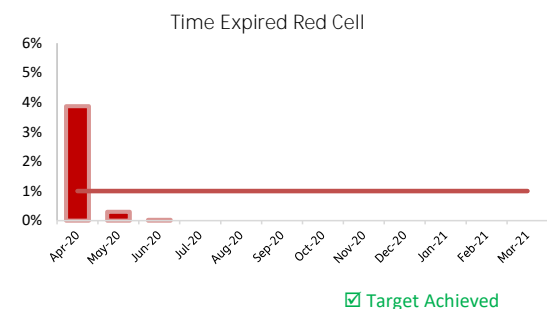
Jul-20



Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
<p>The controllable red cell losses were :</p> <p>Incorrect Storage : 1</p> <p>Heat Seal Failure : 4</p> <p>Performance is within specified parameters</p>	<p>Local reporting and management of incidents where they occur for monitoring of losses and lessons learnt.</p>	<p>Business as Usual</p>

Spending Every Pound Well

Jul-20



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
<p>Time expired red cells are below the target of 1%.</p>	<p>monitoring continues</p>	<p>Business as usual</p>

First Class Donor Experience

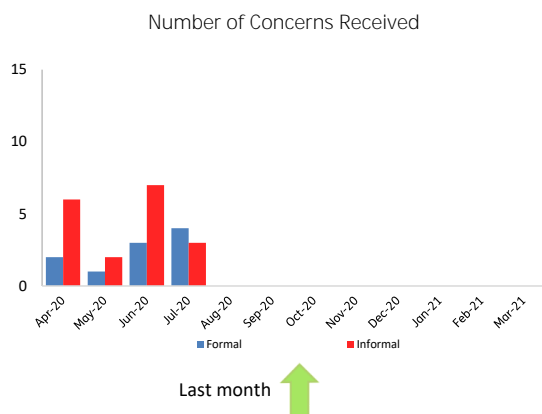
Jul-20



Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



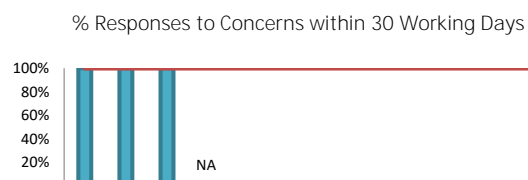
Overall donor satisfaction continued to exceed target at 96.7%. In total there were 1,282 respondents, who had made a full donation, that shared their donation experience, 251 were from North Wales and 1,031 were from South Wales (where location was able to be defined).	A review of the revised donor satisfaction survey tool that has been trialled over the past few months is to be presented to the February SMT for evaluation.	business as usual
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First Class Donor Experience

Jul-20

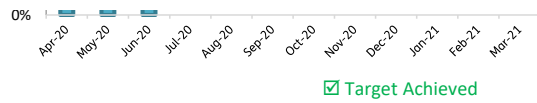
<u>Target: N/A</u>	<u>SMT Lead: Alan Prosser</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In July 2020 a total of 7518 donors were registered at clinic. A total of 7 concerns (0.09%) were reported within this period with 3 being managed as Early Resolution (ER) within 2 working days and 4 managed as a Formal Concern, within 30 days. Reasons for concerns during this period include: - Inability to book appointment at tea table (N Wales) - Staff attitude x2 - Maximum weight permissible on donation chair - Management of syncope - Late attendance at clinic x2	All concerns have been investigated and lessons learnt identified and actioned as appropriate. Work continues to robustly respond to COVID19 pandemic and consistently improve communication and training regarding required actions and donor communication in line with national advice. The 4 concerns that were managed as 'Formal' were managed all due to the breach in the 48 hours (2 working day) timeline from receipt of complaint to contact of complainant. A more focused approach has been adopted, being very clear on timeline restriction. Awareness raised with staff involved in contacting donors of this requirement.	Business as usual



First Class Donor Experience

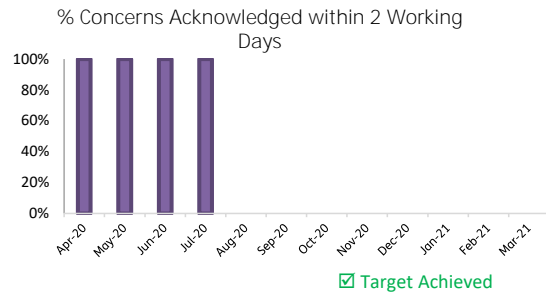
Jul-20

<u>Monthly Target: 100%</u>	<u>SMT Lead: Alan Prosser</u>	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
No formal concerns requiring formal response in 30 days received in July 2020.	Continue to monitor 30 day response compliance.	Business as Usual



First Class Donor Experience

Jul-20



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

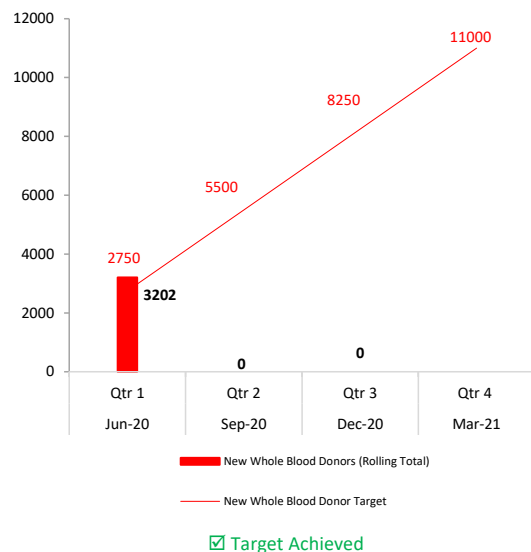
Quarterly Reporting

Equitable and Timely Access to Services

Jul-20

New Whole Blood Donors

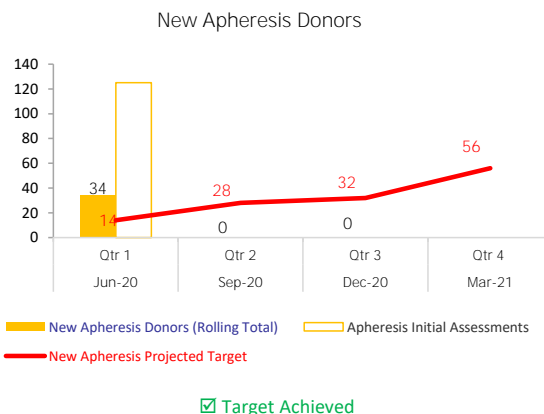
<u>Quarterly Target: 2750</u>		<u>SMT Lead: Jayne Davey</u>	
What are the reasons for performance?		Action(s) being taken to improve performance	By When



885 new donors attended a donation session in July with 776 of these proceeding to give a full donation. .

New donors accounted for 11.8% of the total donations taken in July, a considerable drop from previous months. New donors typically account for between 11-13% of total donations so 11.8% marks a return to pre-Covid levels. This drop could be indicative of a change in public attitudes towards supporting the NHS during Covid-19.

Business as Usual



Quarterly Target: 14

What are the reasons for performance?

There were 14 new apheresis donors in June 2020, taking the total number of new apheresis donors in the quarter to 34, a 143% increase on target.

SMT Lead: Jayne Davey

Action(s) being taken to improve performance

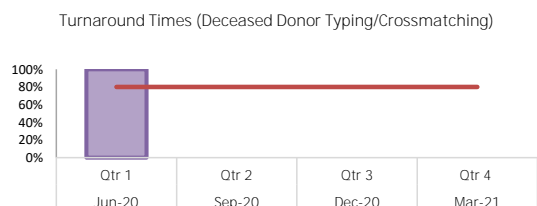
Continue to recruit new apheresis donors.

By When

Business as usual

Jul-20

Safe and Reliable service



Quarterly Target: 80%

What are the reasons for performance?

Turnaround times were above target at 100%. It should be noted that workload was severely impacted by COVID-19. No crossmatching was performed due to pausing of the local transplant programme. Also deceased donor typing numbers were reduced due to increased

SMT Lead: Tracey Rees

Action(s) being taken to improve performance

Continued monitoring and active management is in place.

By When

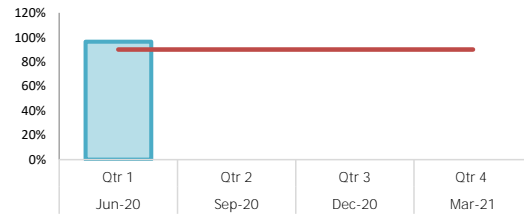
TBC delayed due to COVID but will form part of the Collection Centre review

Jul-20

☑ Target Achieved

typing numbers were reduced due to increased restrictions on eligibility to donate

Anti D & -c Quantitation



☑ Target Achieved

Safe and Reliable service

Jul-20

<u>Quarterly Target: 90%</u>		<u>SMT Lead: Tracey Rees</u>	
What are the reasons for performance?		Action(s) being taken to improve performance	By When
Turnaround times remain above target for June 2020 at 93%		Continued monitoring and active management is in place.	Business as Usual

Workforce Report provides the following:

- Overview of Key Performance Indicators 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

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted)	Current Month	Previous Month	Target
	Jul-20	Jun-20	
PADR	61.92	59.89	85%
Sickness	5.18	5.20	3.54%
S&M Compliance	82.49	81.74	85%

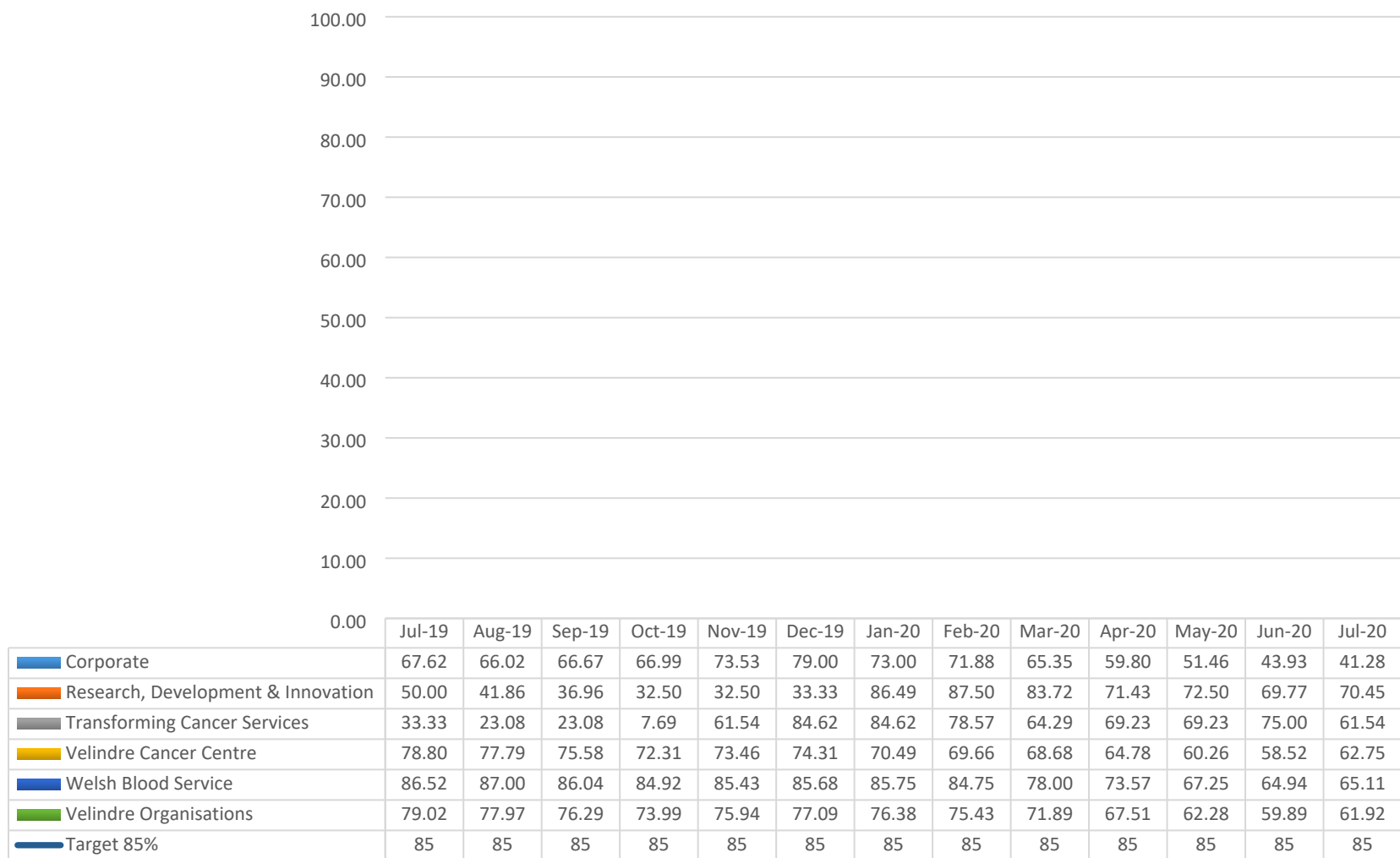
Workforce Dashboard Highlights

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.

Key	85%-100%		50% - 84.99%		0% - 49.99%								
PADR	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Corporate	67.62	66.02	66.67	66.99	73.53	79.00	73.00	71.88	65.35	59.80	51.46	43.93	41.28
Research, Development & Innovation	50.00	41.86	36.96	32.50	32.50	33.33	86.49	87.50	83.72	71.43	72.50	69.77	70.45
Transforming Cancer Services	33.33	23.08	23.08	7.69	61.54	84.62	84.62	78.57	64.29	69.23	69.23	75.00	61.54
Velindre Cancer Centre	78.80	77.79	75.58	72.31	73.46	74.31	70.49	69.66	68.68	64.78	60.26	58.52	62.75
Welsh Blood Service	86.52	87.00	86.04	84.92	85.43	85.68	85.75	84.75	78.00	73.57	67.25	64.94	65.11
Velindre Organisations	79.02	77.97	76.29	73.99	75.94	77.09	76.38	75.43	71.89	67.51	62.28	59.89	61.92
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85
Key	85%-100%		50% - 84.99%		0% - 49.99%								
Stat and Mand Compliance (10x CSTF)	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Corporate	80.17	80.17	76.81	76.42	76.89	77.11	77.04	76.47	74.21	72.36	70.73	68.94	70.00
Research, Development & Innovation	61.25	61.57	60.59	60.20	61.04	59.58	68.57	74.00	74.51	75.10	75.92	76.27	75.96
Transforming Cancer Services	71.67	70.77	72.31	70.00	69.23	80.00	82.31	77.50	77.65	74.38	69.41	65.29	66.67
Velindre Cancer Centre	76.54	75.93	75.47	75.55	76.62	77.05	78.10	79.11	78.16	77.94	77.76	77.62	78.82
Welsh Blood Service	93.49	92.37	90.90	91.22	90.96	91.88	90.85	90.68	92.26	92.87	93.27	93.79	93.79
Velindre Organisations	81.79	81.02	79.94	80.00	80.60	81.15	81.75	82.30	82.08	82.00	81.83	81.74	82.49
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Corporate	4.44	4.48	4.65	4.79	4.93	4.92	4.84	4.70	4.78	4.98	5.12	5.19	5.14
Research, Development & Innovation	2.66	3.12	3.44	3.54	3.42	3.91	4.07	4.02	4.16	4.36	4.68	5.01	5.15
Transforming Cancer Services	11.52	11.28	10.02	8.57	7.17	5.77	4.90	4.17	3.91	3.99	3.81	3.69	3.08
Velindre Cancer Centre	4.20	4.09	4.01	4.02	4.05	4.15	4.25	4.30	4.62	5.05	5.22	5.40	5.49
Welsh Blood Service	4.91	4.78	4.79	4.80	4.79	4.82	4.76	4.83	4.99	5.13	5.09	4.92	4.73
Velindre Organisations	4.50	4.40	4.36	4.37	4.38	4.44	4.47	4.49	4.73	5.03	5.14	5.20	5.18
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54
Monthly Special Leave Absence %													
Special Leave Non Covid Related	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Corporate	0.12	0.06	0.00	0.39	0.13	0.19	0.94	0.90	0.68	0.24	0.02	0.11	0.00
Research, Development & Innovation	0.00	0.22	0.00	0.65	0.20	0.00	0.00	1.73	2.41	0.58	1.22	0.00	0.30
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.19
Velindre Cancer Centre	0.30	0.15	0.37	0.34	0.38	0.35	0.30	0.40	0.43	0.46	0.37	0.29	0.40
Welsh Blood Service	0.48	0.36	0.27	0.21	0.61	0.43	0.55	0.82	0.72	0.82	0.50	0.48	0.98
Velindre Organisations	0.33	0.21	0.29	0.31	0.42	0.34	0.42	0.62	0.61	0.55	0.40	0.32	0.53
Monthly Special Leave Absence %													
Special Leave Covid Related	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
Corporate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.04	2.07	0.86	0.83	0.83
Research, Development & Innovation	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.18	5.04	3.46	3.42	3.39
Transforming Cancer Services	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.06	3.64	5.19	3.70	3.07	2.41
Welsh Blood Service	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.98	4.00	3.13	3.13	1.65
Velindre Organisations	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04	2.93	4.46	3.20	2.85	2.03

PADR – The Figures

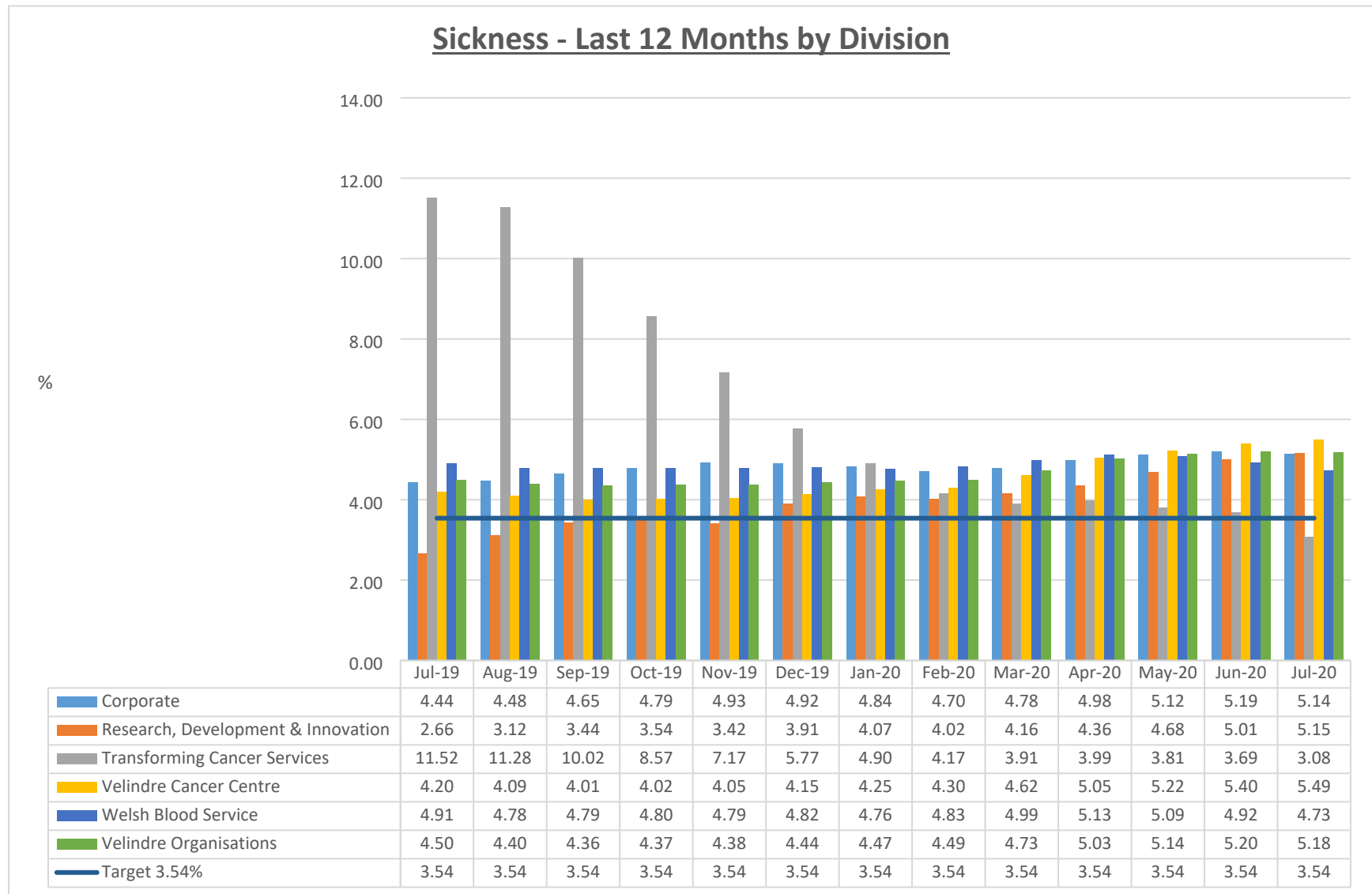
PADR Status - last 12 Months by Division



PADR – The Narrative

Organisational Context PADR	Issue	Actions	Timelines
<ul style="list-style-type: none"> Ongoing Impact of COVID affecting capacity to complete PADR 	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
	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 HR linked to hotspot areas and implementing an appraise and support approach to effective PADR management, ensuring best practice is shared	Triangulated performance reports provided to SMT

Sickness Data – The Figures

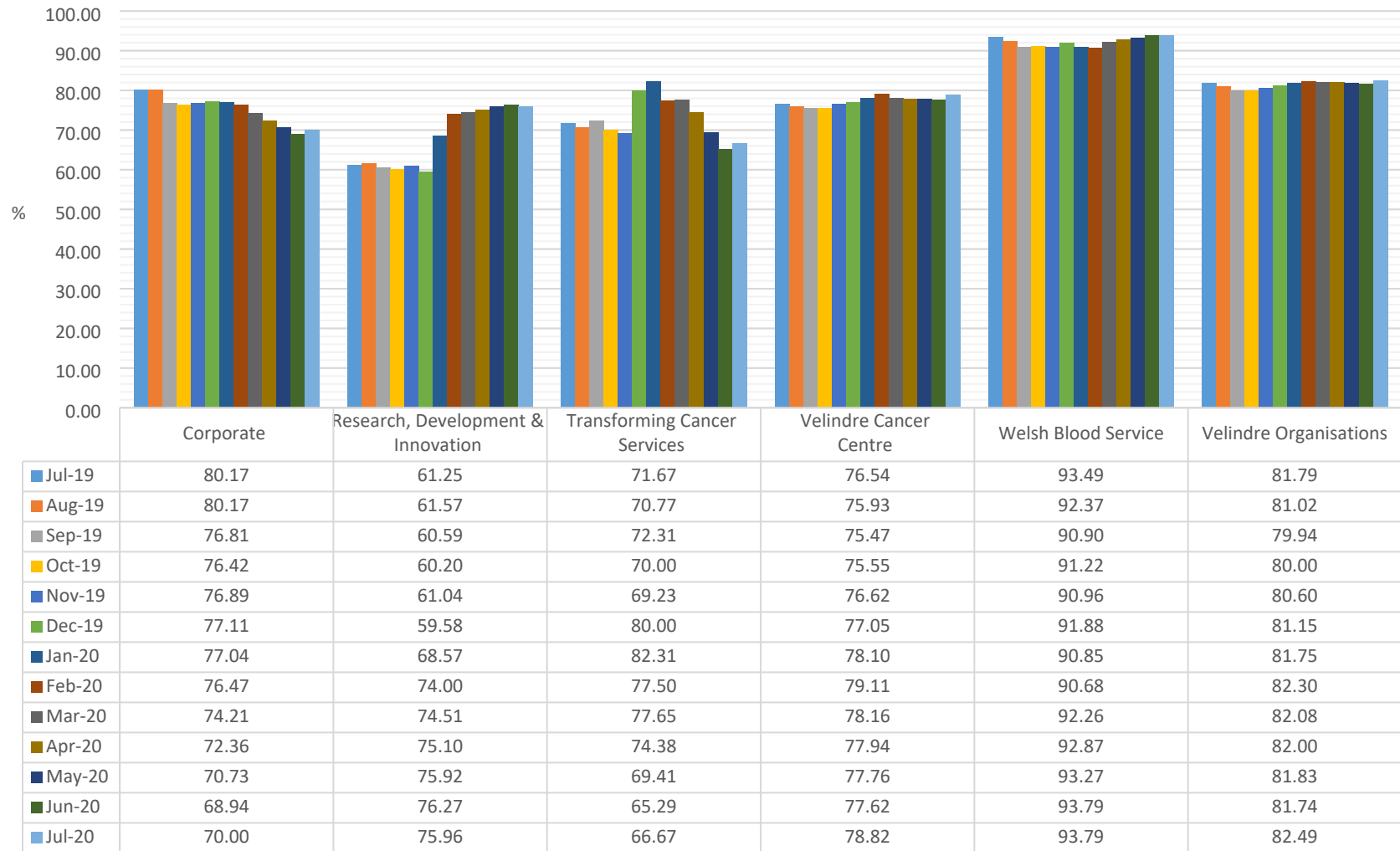


Sickness – The Narrative

Organisational Context Sickness	Issue	Actions	Timelines
<ul style="list-style-type: none"> COVID Related absence sickness not always work related Dedicated focus on staff's physical and psychological wellbeing Sickness deep dives note sickness not always work related 	Primary reason for sickness is stress/anxiety and depression	Ongoing utilisation of an Employee Assistance Programme, providing free advice and support in relation to personal and work related stress	Ongoing, utilisation show EAP usage is increasing, being targeted in areas of organisational change, impact reviewed by the H&W group
	Effective Management of difficult situations avoiding absence through stress	Mediation service in place	Service in place
		Focus on managing difficult situations and management support via management development programme and manager drop in sessions	Support via the management 'offer' product

Statutory and Mandatory Figures – The Figures

Statutory & Mandatory Compliance (10x CSTF) last 12 months by Division



Statutory and Mandatory Figures – The Narrative

Organisational Context	Issue	Actions	Timelines
<ul style="list-style-type: none"> Essential requirement for staff training is within individual compliance matrix, learning page in ESR, requirements increased due to COVID 	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
	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 and access to training	Dedicated computer training sessions, with laptops and support for all staff organised on different dates/times to accommodate shifts patterns – drop in sessions	Regular sessions planned throughout the Trust for 2020
	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



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

TRUST OPERATING PLAN - PROGRESS UPDATE

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
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PRESENTED BY	Cath O'Brien, Director - Welsh Blood Service
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EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Director - Welsh Blood Service
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REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME
Executive Management Board	14 th Sept 2020	Noted

ACRONYMS

VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
WG	Welsh Government

1. SITUATION/BACKGROUND

- 1.1 The Trust has been informed by the Welsh Government that there will be a requirement to submit an Operating Plan for the period October 2020 – March 2021 (Quarter 3 and Quarter 4 (2020/2021)).
- 1.2 The Trust is due to receive the Quarter 3 / Quarter 4 NHS Wales Operating Framework during the week commencing 21 September 2020. The NHS Wales Operating Framework will outline the key requirements of the Trust Operating Plan and will include a set of mandatory templates, covering finance, workforce and planning, which the Trust will be required to complete. The NHS Wales Operating Framework will also confirm the required submission date for the Operating Plan.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 We are currently in the process of developing our draft Operating Plan pending receipt of the NHS Wales Operating Framework. The following section summarises the proposed structure and content of our Operating Plan.

Important Note: Following the receipt of the NHS Wales Operating Framework from the Welsh Government we will make an assessment if our approach is in line with the requirements of the Framework. In parallel we are meeting with the Community Health Council on 18th September to seek their input into our Operating Plan.

- 2.2 It is currently proposed that the Operating Plan broadly follows the same structure as our Quarter 2 submission. This will be as follows:

Part 1: We will introduce our Operating Plan and describe the context within which it has been developed.

Part 2: We will summarise our planning approach and the key assumptions and principles which have shaped the development of our Operating Plan.

Part 3: We will summarise our delivery plans for the Welsh Blood Service and for the Velindre Cancer Centre and identify any key risks

Part 4: We will set out how our enabling support functions will support and drive the delivery of our Operating Plan.

- 2.3 Our Operating Plan will set out the Trust's intentions for October 2020 to March 2021, in the context of the COVID-19 pandemic. It will describe what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It will also outline the arrangements we have in place for managing our capacity so that we can meet the expected increase in uptake of services, together with the potential to provide surge capacity if COVID-19 increases in prevalence over this period.
- 2.4 Our Operating Plan will set out how we will maintain supplies of blood and blood products to the whole of NHS Wales; deliver essential tertiary cancer services to South East Wales and the enabling activities that will be undertaken by Corporate Support functions. It will build upon the foundations established since March, with further developments of safe and stable clinical operating models over the coming months. This is vital as we expect to see an increase in demand for cancer and blood services as essential services continue to increase their ability to deliver required care and patients feel more assured to present for it. It will also provide a strong foundation for planning and delivery of our services as we enter the winter period with the continued risk of resurgence in COVID-19 infection rates.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
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 **NOTE** the contents of this report.

TRUST BOARD

Project Review - Well-being of Future Generations (Wales) Act (2015) & Blood Supply Chain 2020

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Rhiannon Collins, Environmental Development Officer and Sarah Richards, Head of Programmes and Continuous Improvement
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, Interim Chief Operating Officer

REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
EMB	14/09/2020	IN SUPPORT

ACRONYMS	
WBFGA	Well-being of Future Generations (Wales) Act (2015)
BSC	Blood Supply Chain 2020
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 This paper outlines the contribution of the Blood Supply Chain 2020 (BSC20) programme in working towards achieving the seven Well-being Goals defined within the Well-being of Future Generation (Wales) Act 2015 (WBFGA).

1.2 In the initial phase, a review of the BSC20 outcomes achieved to date has been undertaken and these outcomes have been aligned to the Well-being Goals. Infographics (attached as appendix 1) have been developed and are in the process of being translated. Once this is complete, they will be promoted at Trust HQ and Welsh Blood Service HQ to raise awareness and demonstrate the impact of the BSC20 programme has had on achieving the seven Well-being Goals.

Further work is now underway to provide quantitative data to enable the Welsh Blood Service (WBS) to monitor its performance against delivery of the objectives outlined within the WBFGA.

1.3 The Blood Supply Chain 2020 (BSC20) initiative is reconsidering the WBS 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. The WBS began work on the BSC20 initiative in 2017 and it is due to be completed by March 2021. The programme has employed a holistic tri-partite approach based on three domains: human, technology and programme planning and delivery. To date, the BSC20 programme has realised a number of benefits, both expected and unexpected, alongside delivery of a large number of continuous improvement opportunities identified by WBS staff.

1.4 The Well-being of Future Generations (Wales) Act 2015 (WBFGA or 'the Act') is pioneering legislation in Wales. The Act outlines seven Well-being Goals; A Globally Responsible Wales, A Healthier Wales, A Resilient Wales, A Prosperous Wales, A More Equal Wales, A Wales of Cohesive Communities and A Wales of Vibrant Culture & Thriving Welsh Language.

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 A Globally Responsible Wales

A Globally Responsibly Wales is defined as a nation which, when doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being.



In order to achieve this goal, the project needs to ensure there is strong support from civil society for actions that have a positive global impact. It is accepted that diversity unites communities rather than divides them. The importance of global actions is appreciated and understood: they are not seen as a simple, nice-to-do 'add-on' to business as usual. Politicians and other senior leaders have the vision to support global projects, understand positive contribution and welcome international visitors.

Key highlights from the BSC20 contribution to this goal are –

- Introduced 'Leadership in a Clinical Environment' programme; Identified requirements to support RNs in delivering clinical leadership role.
- Enabled development of laboratory staff in key areas such as, Service Improvement, Communication and Interpersonal skills, Leadership and Management, Development, Innovation and Audit and Regulatory Compliance.
- Developed an irradiation calculation application that confirmed whether red cells are too old to be irradiated; reduction in number of red cells incorrectly irradiated due to being over 14 years old. Therefore, decreasing waste attributed to irradiating outside of parameters. Number of Datix raised reduced from 13 to 9 over an 18 month period.
- Reviewed transport stores runs which removed requirement for separate delivery for North Wales saving 240 hours per annum on the road.
- Introduced scanning of vehicle licences, MOTs & LGV service inspection sheets which negated requirement to print and file documents (approx. 900 vehicle documents per annum saving 20 hours staff time and reduced printing costs).

2.2 A Healthier Wales

A Healthier Wales is defined as a society in which people's physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.

This goal will be achieved by the Project if there is a shift in investment to a 'Wellness System', with integrated planning and investment. Furthermore, if it continually focuses on what matters to people whilst having a strong digital leadership and capability.



Key highlights from the BSC20 contribution to this goal are –

- 'What's My Type?' stand has improved its participant experience in February 2019 as individuals are now sent a bespoke SMS following their participation in 'WMT?' based on several unique factors following: donor's name and likely blood type; past donation experience; and, whether the participant booked or not.
- Enabled the ability to make seasonal adjustments aligned to demand.
- Developed and implemented a new hospital delivery schedule for South Wales hospitals; 86% of customer hospitals confirmed new schedule improved consignment delivery time (14% didn't respond to questionnaire).
- Enabled the Donor Contact Centre (DCC) to secure convenient appointments for priority blood groups at clinics with limited or no regular appointment slots.
- Reduced pressure on staff via structured workflow – clear and structured work plans, resulting in staff having advanced notification of working hours.

2.3 A Resilient Wales

A nation which maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change (for example climate change).



In order to successfully contribute to this Goal the Project needs to combat the loss of biodiversity. Whilst recognising that Green Infrastructure (GI) is an achievable and effective way to alleviate multiple social, economic and environmental challenges. Community organisations are enabled to drive change in their area, to ensure nature is something that can be accessed and appreciated by all.

Key highlights from the BSC20 contribution to this goal are –

- Reduced the carbon footprint of our activity by reducing the volume of paper used in promoting clinics by 75%
- Implementing a new Ambient Overnight Hold manufacturing process has allowed greater flexibility of product manufacturing options. The service can now flex its production of components based on accurate assessment of stock in production.
- The controlled pull system of blood has allowed the reorganisation of the production line and processing staff to maximise efficiency and effectiveness.
- Enabled donors to check their eligibility before attending a WBS clinic. By checking their eligibility prior to a clinic, donors can self-defer if they are ineligible, reducing the number of wasted journeys to WBS clinics.
- Developed a bespoke electronic rostering system.
- Used Quartix tracking software to carry out a review of journey times to clinics.
- Established a new management structure for transport department; increased the strategic capacity to keep pace with public sector decarbonisation requirements.

2.4 A Prosperous Wales

An innovative, productive and low carbon society which recognises the limits of the global environment and therefore uses resources efficiently and proportionately (including acting on climate change); and which develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities, allowing people to take advantage of the wealth generated through securing decent work.



In order to successfully achieve this Goal, the Project needs monitoring of social and environmental clauses in contracts – for example community benefits. The nVCC project needs to ensure there is meaningful engagement with local businesses in the development of local economic plans. Another way to achieve this Goal is to ensure a supportive policy environment for foundational economy and low carbon approaches to become mainstreamed. Furthermore, the development of skilled, multi-disciplinary workforces is a priority across organisations.

Key highlights from the BSC20 contribution to this goal are –

- Reduced the 'did not attend' (DNA) rate at clinics by ensuring donors receive adequate reminders (2017 DNA rates 19%; current average following introduction of reminder texts and cancellation links (see below) at 13%).

- Reduced the number of appointment reminder calls made by the DCC each month (from 2997 to 1307 each month).
- Reduced the DNA rate by making it easier for donors who are unable to attend to cancel their appointment (2017 DNA rates averaged 19%. Current average following introduction of reminder texts (see above) and cancellation links is 13%)
- Reduced the cost of SMS messages from 8p per text to 2p.
- Created a centralised planning function; benefits included reduction in overtime and reduced variation and duplication.
- Introduction of Clinical Link Training RNs to all collection teams.
- Introduced RN mentorship training and development days.
- Reduced the time taken to complete the form (from an average of 23 minutes to under 4 minutes per clinic), by removing a number of redundant fields that were still being completed by the teams.
- Alternative facilities located to reduce dependency for portable toilets provided for some donation clinics, reducing costs by £5,544.

2.5 A More Equal Wales

A society that enables people to fulfil their potential no matter what their background or circumstances (including their socio economic background and circumstances).



To ensure the Project successfully and efficiently contributes to this Goal, it needs to ensure diversity is celebrated. This includes recognising areas for improvement, particularly in terms of staff representation. It needs to be appreciated that by creating a more equal Wales has a positive impact on a number of the other well-being goals.

Key highlights from the BSC20 contribution to this goal are –

- Increased number of 'young' donors attending sessions with over 24,000 donations received from 17-30 year olds in 2018 (an increase of around 1,000 vs. 2017)
- Easier for donors to book appointments at their clinic of preference.
- The new Ambient Overnight Hold production method has allowed platelet production from donors in North Wales – previously not possible.
- Creation of staff development frameworks facilitated increased development opportunities for Laboratory staff.

- Utilised Quartix tracking software to review journey time to clinics which supported the work to reduce the variations in the length of working days for collections teams.
- Created a centralised clinic planning function which resulted in a pan-Wales overview of the blood collection programme and reduced variation in practice and duplication.

2.6 A Wales of Cohesive Communities

This Goal is defined as creating attractive, viable, safe and well-connected communities.

For the Project to contribute to this Well-being Goal it needs to ensure the best conditions to help communities do what matters to them. The Project needs to embed 'what matters' to people conversations into how they work. By utilising Community anchor organisations, the Project gives a voice to local people, are supported to hold assets and build resilience. The Project should ensure there is support for community leaders, activists, entrepreneurs and volunteers.



Key highlights from the BSC20 contribution to this goal are –

- Encouraged community influencers to share Welsh Blood Service promotional messages through more relevant channels of communication (social media, web, SMS, WhatsApp etc.).
- Introduced the role of Community Partnerships Officer to drive engagement with the community.
- Reviewed the balance of appointments and walk in slots enabling walk-in slots on appointment grids to become booked appointments for priority blood groups.
- Introduced updated timesheet to North Wales's teams.
- Implemented a single test for bacterial monitoring of platelets; increased platelet availability to customer hospitals (particularly North Wales).
- Centralised planning function provided equity of planning focus across Wales.

2.7 A Wales of Vibrant Culture & Thriving Welsh Language

This Well-being Goal aims to achieve a society that promotes and protects culture, heritage and the Welsh language, and which encourages people to participate in the arts, and sports and recreation



To contribute to this Well-being Goal, the Project needs to ensure it makes most of local assets such as libraries, play facilities, museums, galleries, sports facilities, arts organisations, natural resources and historic buildings. Furthermore, understand of the potential of creativity (particularly among cultural professionals) to support change in policy making and broader society. BSC20 should ensure, and has the opportunity, for innovative partnerships that allow for culture to be more visible in daily life, for example linking the culture and health agendas.

Key highlights from the BSC20 contribution to this goal are –

- Introduction of a communications folder on each collection team.
- Allowed information to be shared with remote staff.
- Improved access to information as electronic sources not always reliable.
- Introduced six new sixth form venues, strategically targeted based on geography and size of sixth forms, to our list of clinics, with an estimated intake of at least 300 new, young donors who are also eligible to join the Welsh Bone Marrow Donor Registry.
- Recognised the donors of Wales who have given milestone donations.
- Ensured donors are swiftly recognised for their achievements shortly after they reach their milestone
- Ensured the donor awards evenings are well organised and provide donors with a memorable experience.

3. IMPACT ASSESSMENT

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

EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There will be minimal financial implications for printing materials for internal promotion.

4. RECOMMENDATION

The Trust Board are asked to **NOTE**:

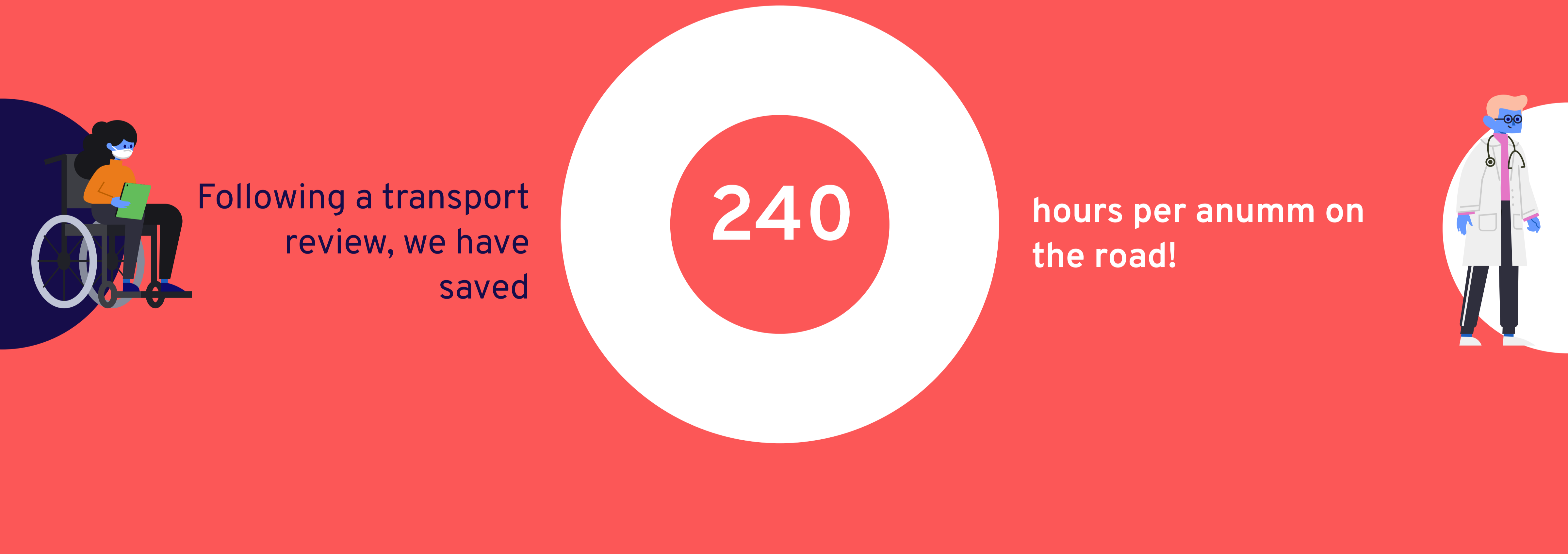
- 4.1 the BSC20 contribution to the Well-being of Future Generation (Wales) Act 2015 (WBFGA);
- 4.2 that Awareness Sessions have been held at WBS to promote the WBFGA (initially 2 half hour sessions run via Teams reaching over 60 members of staff across the organisation);
- 4.3 that the infographics (attached as appendix 1) will be translated and promoted around Trust HQ and Welsh Blood Service HQ to raise awareness and demonstrate the impact of the BSC20 programme has had on achieving the seven Well-being Goals.
- 4.4 that phase 2 is now underway to provide quantitative data to enable the Welsh Blood Service (WBS) to monitor its performance against delivery of the objectives outlined within the WBFGA.



● Blood Supply Chain 2020

A Globally Responsible Wales

When doing anything to improve the economic, social, environmental and cultural well-being of Wales, takes account of whether doing such a thing may make a positive contribution to global well-being.



Following a transport review, we have saved

240

hours per annum on the road!



Leadership and Skills

- Introduced ‘Leadership in a Clinical Environment’ programme
- Identified requirements to



New Ways of Working

- Introduced scanning of vehicle licences, MOTs & LGV service inspection



Waste Reduction

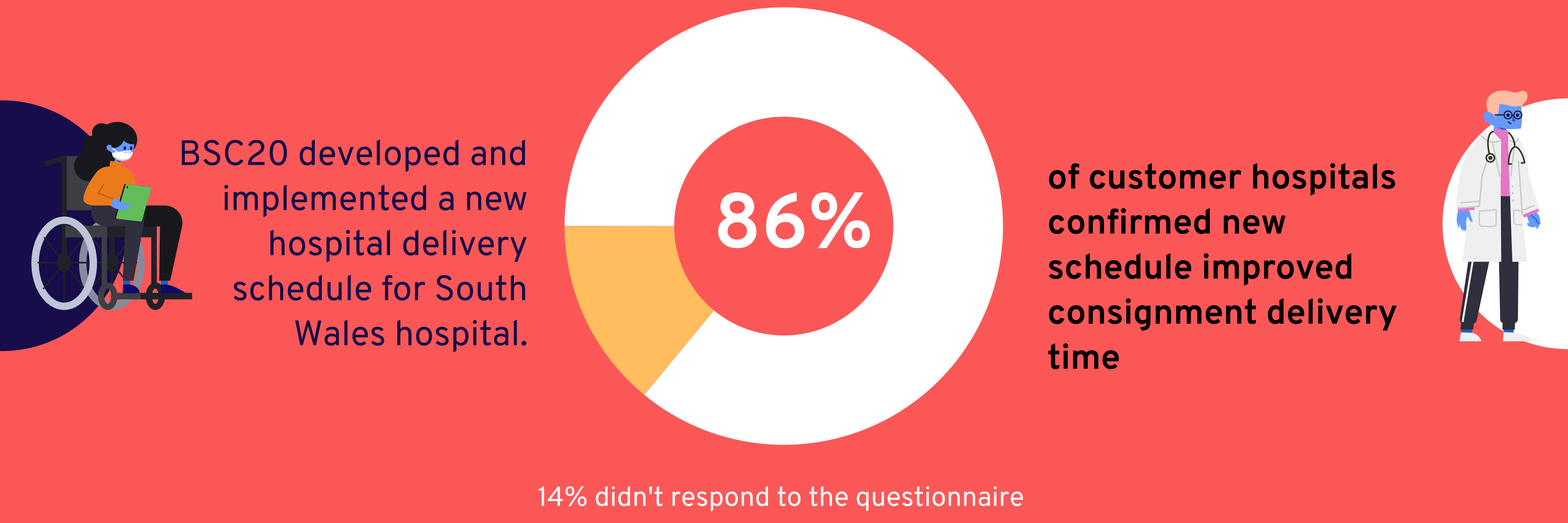
- Developed an irradiation calculation application that confirmed whether red cells



● Blood Supply Chain 2020

A Healthier Wales

A society in which people’s physical and mental well-being is maximised and in which choices and behaviours that benefit future health are understood.



Whats My Type?

- WYM campaign has improved its participant experience in February 2019



Priority Blood Groups

- Enabled the Donor Contact Centre (DCC) to secure convenient



Workflow

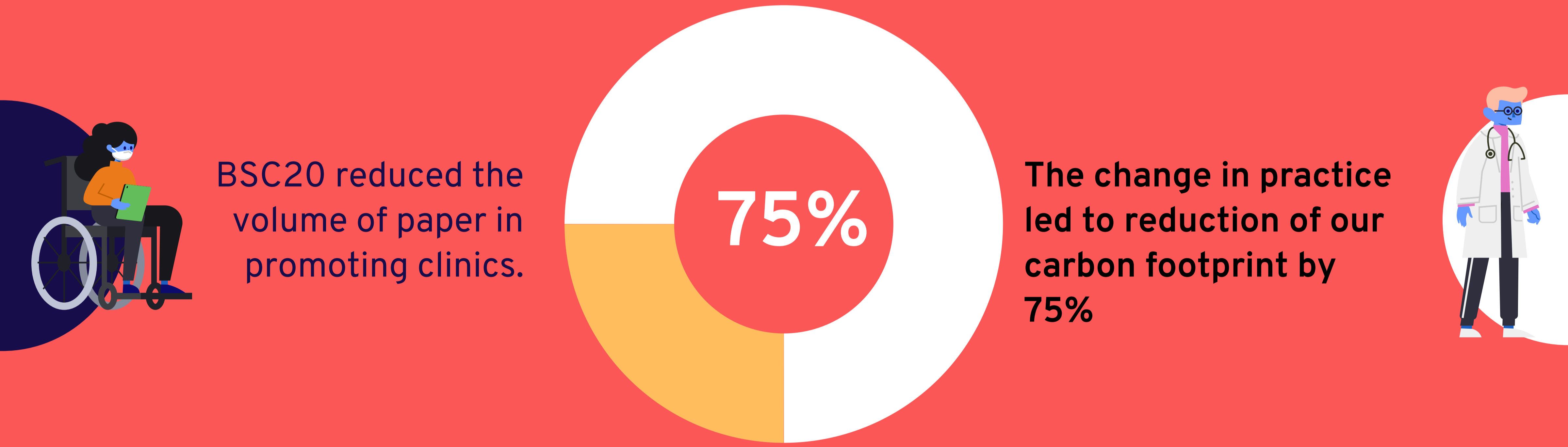
- Reduced pressure on staff via structured workflow



● Blood Supply Chain 2020

A Resilient Wales

Maintains and enhances a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience and the capacity to adapt to change



Waste Reduction

- Implementing a new Ambient Overnight Hold manufacturing process has



Reduced Travel

- Enabled donors to check their eligibility before attending a WRS clinic



Maximising Efficiency

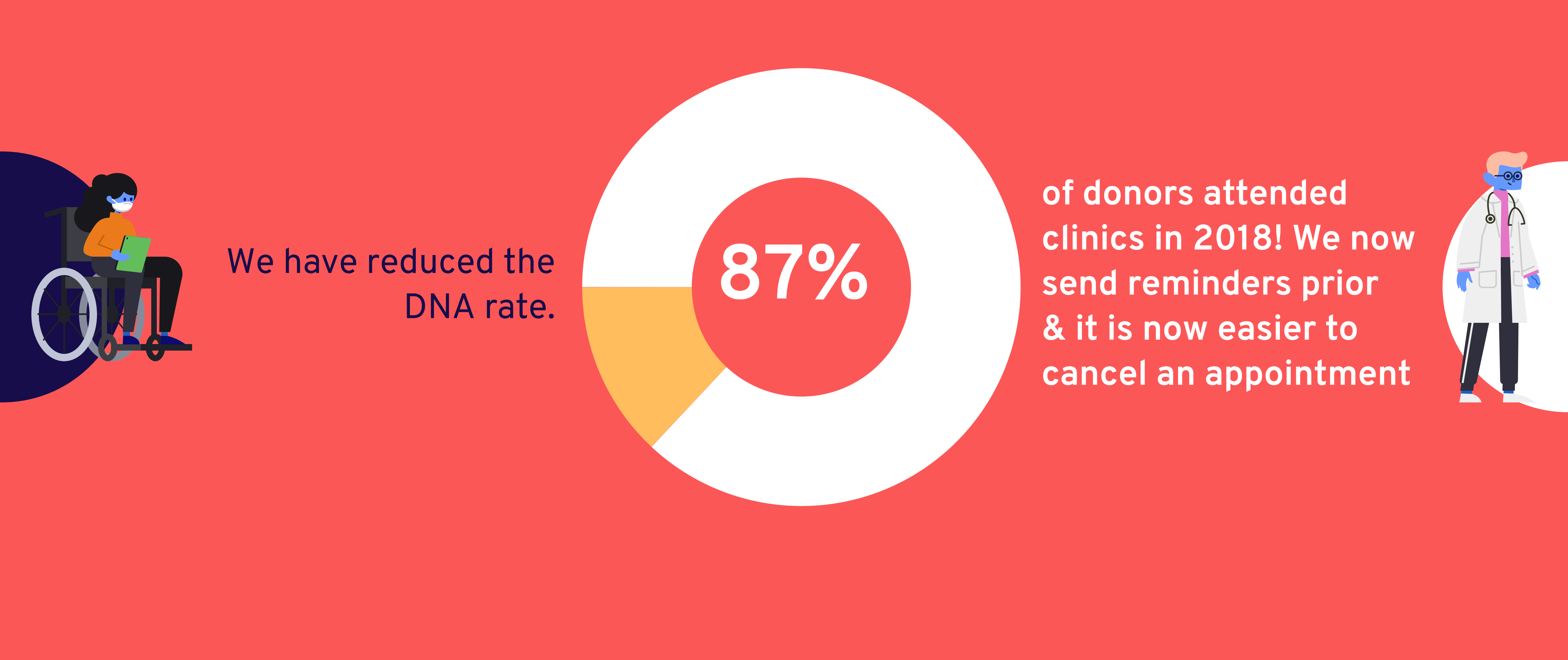
- The controlled pull system of blood has allowed the reorganisation of the




● Blood Supply Chain 2020

A Prosperous Wales


An innovative, productive and low carbon society which uses resources efficiently and proportionately and develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities.





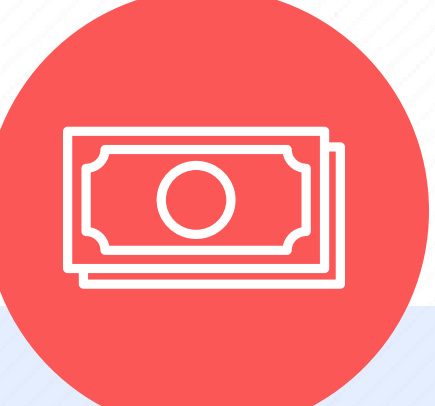
Centralised Planning Function

- Reduction in overtime
- Reduced variation and duplication




New Forms


- Reduced the time taken to complete the form from 23 minutes to 4 minutes




Alternative Facilities

- Reduce dependency for portable toilets provided for some donation clinics, reducing costs by £5,544












Enables people to fulfil their potential no matter what their background or circumstances.



- 

Ambient Overnight
- 

Pan- Wales Approach
- 

Easier Booking



● Blood Supply Chain 2020

A Wales of Cohesive Communities

This Goal is defined as creating attractive, viable, safe and well-connected communities.



BSC20 engaged community influencers

Influencers shared content via social media, web, SMS and Whatsapp



Community Partnership Officers



Planning Clinics



North Wales



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST AUGUST 2020 (M5)

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager
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PRESENTED BY	Mark Osland, Executive Director of Finance & Informatics
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EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance & Informatics
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REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING

COMMITTEE OR GROUP	DATE	OUTCOME

ACRONYMS

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1. SITUATION/BACKGROUND

- 1.1 The attached report outlines the financial position and performance for the period to the end of August. It includes the expenditure position, performance against financial savings targets and highlights the financial risks and forecast for the financial year, outlining the actions required to deliver the IMTP financial plan for 2020-21.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

KPI Target	Unit	Current Month £000	Year to Date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	(10)	(23)	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	120	3,203	5,938
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	99.3	97.4	95.0

2.2 Revenue Budget

Excluding the impact of costs directly associated with Covid, the overall revenue budget is broadly in line with expectations and we continue to forecast a breakeven position at the end of the financial year.

We are experiencing a number of cost pressures which have surfaced since the completion of the IMTP at the beginning of the year, but in line with normal budgetary control procedures these are being managed to ensure the delegated expenditure control limits are not exceeded.

Savings and income targets have been affected by Covid but these have been identified separately and the forecast outturn position is dependent upon these being funded by WG. Details of the financial implications of this and the rationale for the underachievement are being shared with WG each month.

2.3 Covid Expenditure

The overall gross expenditure directly associated with Covid is now forecast to be £10.2m. This includes Hospice funding of £2.9m which is passing through the Trust and is fully funded by WG. Also the Trust has received confirmation that it will be reimbursed for revenue expenditure associated with the Convalescent Plasmids project up to £1.153m and has also recently received payment of £257k for the additional pay costs that were incurred during quarter 1.

The gross forecast of £10.2m also incorporates estimated costs of £3.1m specifically to provide additional capacity to meet an expected increase in demand during the second half of the year. This has been revised down from a previous forecast due to an evaluation of our capacity to deliver more SACT capacity in house within existing resources.

At the time of reporting, the unfunded element of our forecast Covid expenditure amounts to £5.9m

2.4 Reserves

The financial strategy for 2020-21 included withholding a small level of unallocated budget to be used in support of the Trust transformation and delivery agenda. During the year a number of decisions have been made by the Executive Management Team to allocate funding from this unallocated sum to support priority purposes.

The remaining recurrent and non recurrent unallocated budget is £88k and £72k respectively.

In addition to the unallocated budget and in accordance with standard practice the Trust maintains an Emergency reserve to accommodate any emergency or unforeseen circumstance that may arise in the year. **This reserve remains at £522k.**

2.5 Financial Risks

The main financial risk relates to full reimbursement of the additional expenditure incurred as a direct result of Covid.

2.6 Update on Contracting Arrangements with Commissioners

Due to the uncertainties associated with Covid 19 a revised approach for the period April to September has been agreed to ensure providers are not financially de-stabilised as a result of the likely non-delivery of the previous levels of planned care. The all Wales Directors of Finance have agreed to a simple approach to LTA & SLA funds flow during the first two quarters of 2020-21. For Velindre this means that contracting income will be based on the 2019-20 outturn plus the agreed baseline uplifts until September.

The view from Velindre is that this arrangement should be retained for both Q3 and Q4. Q3 block arrangements will be considered at the DoF's meeting on the 18th September. It is important that this arrangement should be kept under close scrutiny.

2.7 Capital

There remains considerable uncertainty surrounding the Trust capital programme for the current financial year, primarily due to the absence of securing a formal budget allocation for the TCS programme and its consequential effect on the Trusts discretionary programme, together with a number of large schemes in the pipeline for which budget has also not yet been secured.

Performance against the current agreed All Wales budget allocations are generally on course to deliver as expected although some variances will occur. These have been highlighted to Welsh Government in a recent update provided on 15 September.

▪ TCS

The Trust remains in dialogue with Welsh Government regarding a budget allocation for projects 1 and 2 of the TCS programme with a current unfunded forecast requirement of **circa £4m**. In a recent meeting with WG we have been assured that this is acknowledged as a priority and Ministerial advice is being drafted. We are hopeful that a decision will be made very soon.

In the meantime we are having to rely on our discretionary capital budget to fund the on-going commitments which is now having a significant impact on our ability to deliver other urgent discretionary capital needs across the Trust.

▪ Covid-19

The Trust has received the majority of its funding request in relation to actual capital expenditure incurred which is directly associated with Covid. **This is circa £1m**. A

future forecast of **an additional £535k of capital expenditure related to Covid** has recently been submitted to Welsh Government.

▪ **WG All Wales Capital Programme Update**

In addition to the request for additional capital to cover future Covid related costs, as identified above, on the 15th September the Trust also provided WG with an update on other project funding which the Trust is seeking in the current year from the All Wales capital Programme. This amounted to **£2.6m** and covered the following projects.

VCC Fire Safety
VCC Ventilation
VCC Infrastructure
WBS HQ Infrastructure and Equipment.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of August 2020 is an overspend of £23k with a year-end

	forecast break-even position in accordance with the approved IMTP
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4. RECOMMENDATION

4.1 Trust Board is asked to **NOTE** the contents of the August 2020 financial report and in particular:

- the financial performance to date, and the year-end forecast to achieve financial break-even which is based on the assumption that all Covid19 related costs are fully funded by WG.
- also the TCS financial position as at the end of August attached as appendix 1.



Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust



FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED AUGUST 2020/21

**TRUST BOARD
MEETING
24/09/2020**

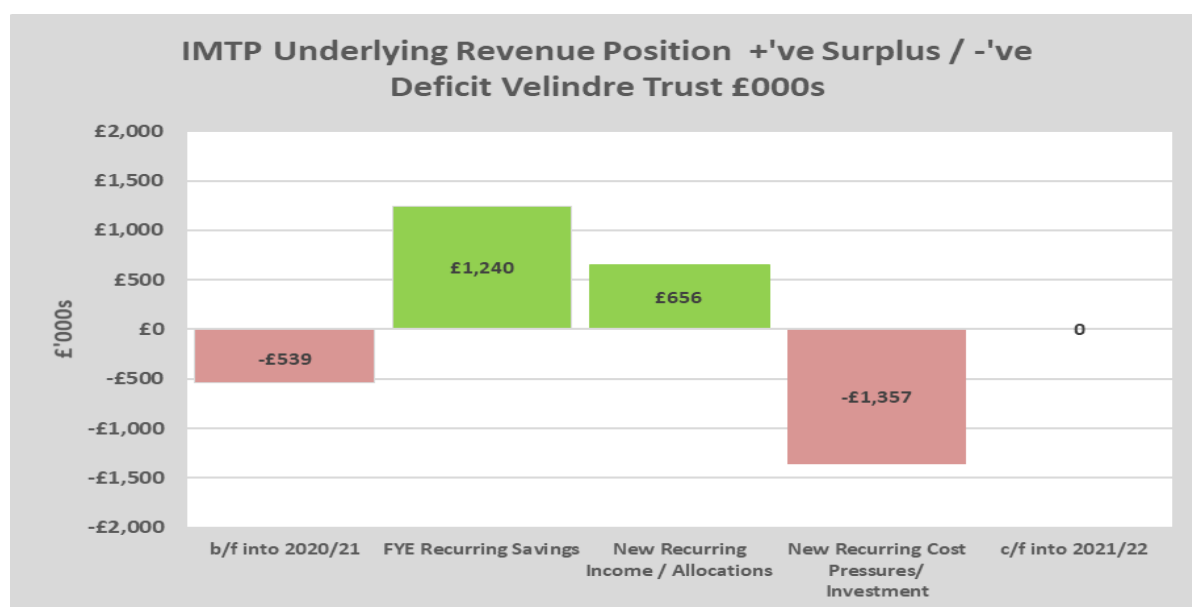
1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets and highlight the financial risks and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2020-21.

2. Background / Context

The Trust Financial Plan for 2020-21 was set within the following context.

- The Trust submitted a balanced Integrated Medium Term Plan (IMTP), covering the period 2020-21 to 2022-23 to the Welsh Government on 31 January 2020. The IMTP was submitted on the basis of delivering financial balance for each of the three years.
- For 2020-21 the IMTP included;
 - an underlying **deficit of £539k brought forward from 2019-20**
 - new cost pressures/ Investment** in 20-21 of **£1,517k** (Recurring FYE effect £1,357k),
 - offset by **new recurring Income allocation of £656k**,
 - and **savings schemes of £1,400k**, (£1,240k FYE recurring), which can be further split between savings schemes £1,000k (£940k FYE recurring), and income generating schemes of £400k (£300k: FYE recurring).
- The Trust is expecting to fully eliminate the underlying position in line with the approved IMTP, partly through the utilisation of growth funding, and partly through internal savings in order to take a balanced position into 2021-22. **However in order achieve a balanced carry forward position the savings target set for 2020-21 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2020/21	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2021/22
Velindre NHS Trust	- 539	1240	656	- 1357	-

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

KPI Target	Unit	Current Month £000	Year to Date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	(10)	(23)	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	120	3,203	5,938
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	99.3	97.4	95.0

Performance against Planned Savings

Efficiency Savings /	Variance	(48)	(232)	0
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Revenue

The Trust has reported a **£(10)k** in-month overspend for August '20, with a cumulative position of **£(23)k** overspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at August 2020 is currently **£5,938k** for 2020-21. This represents all Wales Capital funding of £2,653, Discretionary funding of £1,850k and funding for Covid-19 of £1,435k.

The current cumulative spend against the programme as at the end of August is **£3,203k**, (which includes £1,154k of Covid-19 expenditure) with a forecasted spend of **£5,938k** to match the current CEL.

The forecast spend against Capital excludes the costs of the TCS programme which is currently assumed to be funded by WG, although the Trust has yet to receive this confirmation.

PSPP (Excluding Hosted Organisations)

During August '20 the Trust (core) achieved a compliance level of **99.33%** (July '20: 97.6%) of Non-NHS supplier invoices paid within the 30 day target, which gives a cumulative compliance figure of **97.4%** to the end of August compared to the target of 95%. The Trust continues to work with its staff and NWSSPP Accounts Payable to ensure prompt authorisation of invoices and receipting of goods.

Efficiency/ Savings

The Trust is currently forecasting a full year underachievement of **£(700)k** against the savings plans, £(232)k year to date, which is a direct result of Covid-19. The Trust is currently working to the assumption that any savings which are not achieved and are directly related to Covid-19 will be fully funded by WG.

4. Revenue Position

Cumulative				Forecast		
£(22,597) Overspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(60,192)	(59,828)	(364)	(144,126)	(144,410)	284
Pay	27,094	27,096	(2)	64,388	64,664	(276)
Non Pay	33,097	32,754	343	79,738	79,745	(8)
Total	(0)	23	(23)	0	0	(0)

The overall position against the profiled revenue budget to the end of August is an overspend of £(23)k, with an underachievement against income offset by an underspend on Non pay. This is further analysed in the tables below.

The Trust continues to report a year end forecast breakeven position, however this is based on the assumption that all additional Covid-19 costs are fully reimbursed by WG.

4.1 Income Analysis

	Cumulative			Year End Forecast		
	£(364)k Underachievement			£284k Overachievement		
Income Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Core Income - HB / WHSSC	25,066	25,066	0	70,000	70,000	0
Nice/ High Cost Drugs	17,946	17,946	0	34,902	34,902	0
WBS Wholesale Blood Products	4,376	4,381	5	12,466	12,466	0
WBS WTAIL	1,313	1,135	(178)	3,027	2,719	(308)
WBS Blood Components	98	80	(18)	385	192	(193)
Home Care Drugs	234	275	41	575	673	98
Private Patient	717	714	(3)	1,872	1,864	(8)
VCC Over Activity	639	639	0	1,734	1,734	0
Radiation Protection	225	225	0	736	736	0
Staff Recharges	864	739	(125)	1,965	1,762	(203)
One Wales Palliative and EOL Care	3,078	3,078	0	4,447	4,447	0
Velindre Charity	1,041	972	(69)	2,580	2,578	(3)
Other Charity	443	408	(34)	962	965	3
RD&I*	1,467	1,456	(11)	3,896	3,896	0
HTW	386	386	0	1,100	1,100	0
Other Operating Income	2,299	2,327	29	3,479	4,377	898
Total	60,192	59,828	(364)	144,126	144,410	284

*RD&I full year budget includes £917k of Velindre Charity income.

The Trust has reported a cumulative year to date underachievement of **£(364)k** on Income, and is currently forecasting an outturn overachievement position of circa **£284k**.

- Welsh Transplantation and Immunogenetics Laboratory (WTAI) is currently £(178)k lower than planned and forecasting to be circa £(308)k which due to under activity which is in relation to Covid-19.
- Wholesale Blood components is not expected to achieve the £150k increased plasma income/ savings target this year due to Covid-19.
- Home Care Drugs overachievement due to increase homecare service with addition of Oral drugs provided in relation to SACT since April.
- Staff recharges are underachieving by £(125)k due to vacancies which are not being recharged to other organisations to recoup the income, and will be offset by an underspend in staff.
- Velindre Charity income is also under target by £(69)k due to vacancies within the service which are not being recharged to the Charity.
- The forecasted overachievement against other operating income of circa £898k is the expected income from WG to offset the costs incurred and savings underachievement in relation to Covid-19.

4.2 Pay Analysis by Staff Group

STAFF GROUP	Cumulative £(2)k Overspend			Year End Forecast £(276)k Overspend		
	YTD	YTD	YTD	Full Year	Full Year	Forecast
	Budget (£'000)	Actual (£'000)	Variance (£'000)	Budget (£'000)	Forecast (£'000)	Variance (£'000)
ADD PROF SCIENTIFIC AND TECHNICAL	935	928	7	2,321	2,304	17
ADDITIONAL CLINICAL SERVICES	2,717	2,570	148	6,332	5,872	460
ADMINISTRATIVE & CLERICAL	8,840	8,413	427	20,575	20,080	495
ALLIED HEALTH PROFESSIONALS	2,467	2,923	(456)	5,928	6,918	(990)
ESTATES AND ANCILLIARY	899	942	(42)	2,001	1,989	12
HEALTHCARE SCIENTISTS	3,307	3,085	222	7,952	7,520	432
MEDICAL AND DENTAL	4,613	4,576	37	11,087	11,020	67
NURSING	3,942	3,639	303	9,500	8,901	599
STUDENTS	33	33	0	33	33	0
SAVINGS & VACANCY FACTOR						
TARGET*	(659)	(11)	(648)	(1,339)	27	(1,366)
Total	27,094	27,096	(2)	64,389	64,664	(276)

The Trust has reported a cumulative year to date position overspend of **£(2)k** on Pay and is forecasting a year end outturn overspend position of circa **£(276)k**.

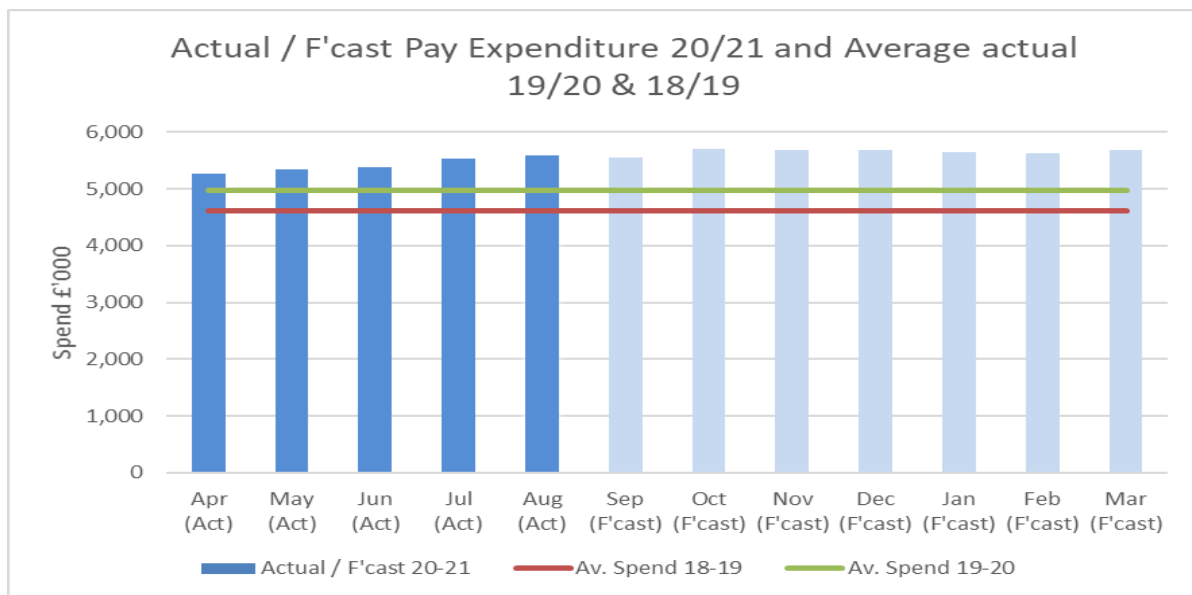
Included within the various staff group expenditure values showing within the above table, the total Agency spend for August was £212k (July £255k), giving a cumulative year to date spend of **£1,112k** and a forecasted spend of circa **£1,885k**. Of these totals the year to date spend on agency directly related to Covid-19 is £203k and forecasted spend is circa £371k.

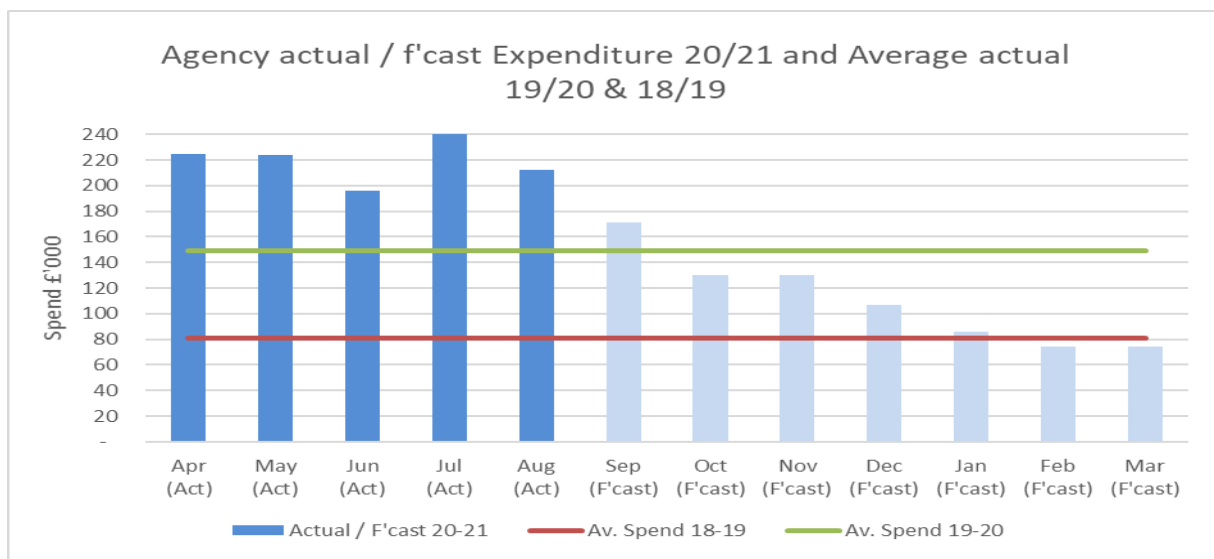
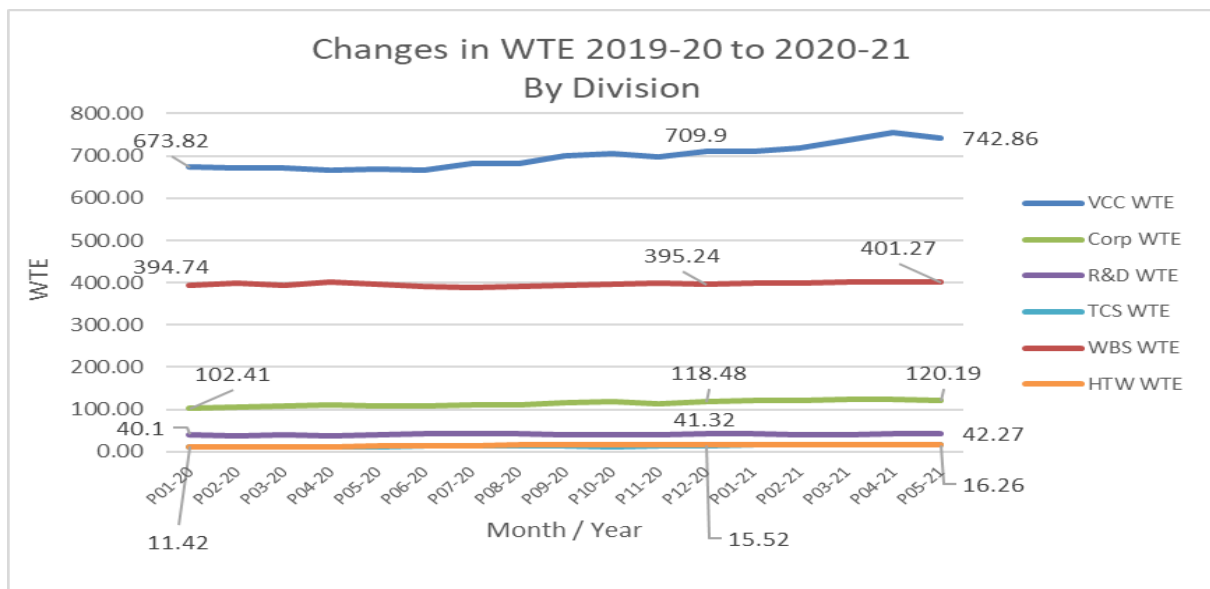
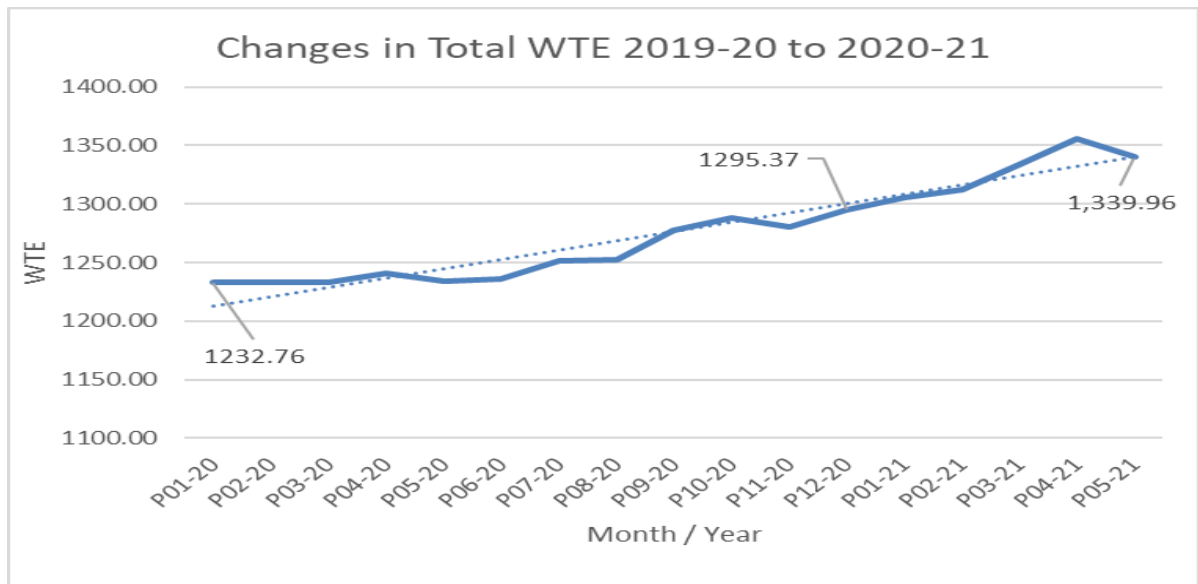
- Current vacancies against underspending staff groups are Clinical Services (4.41 wte), Admin & Clerical (15.41 wte), Healthcare Scientists (14.85 wte), Nursing (22.08 wte).
- Allied Health Professionals are experiencing an over spend of £(456)k which is due to the use of agency in Radiotherapy and Medical Physics to cover staff vacancies that the Trust has been unable to recruit to permanently, and staff off sick, or self-isolating due to covid-19.
- Through the impact of Covid-19 and the inability of the Trust to enact service redesign and generate staffing efficiencies the Trust is not expecting to achieve £350k of staff savings this year (£148k year to August), which is currently expected to be by funded by WG and was reflected within the income table earlier on. The remaining underachievement against the savings and vacancy factor targets within the divisions is being achieved through underspends across numerous staffing groups, as illustrated in the above table.

Pay Spend Trends (Run Rate)

The pay spend for 19-20 was 12% above av. pay 18-19. 3% can be attributed to the pay award. 1.3% (£822k in total) relates to an increase in use of agency staff, and 6.3% the Increase in pension award which was accounted for in month 12. The remaining difference is a result of the additional staff recruited since the end of March'19 (c. 63 wte).

The pay spend for 20-21 (excluding the 6.3% increase in pension) is circa 9.2% above av. pay in 2019-20. 3% can be accounted for by the pay award, 2% can be accounted for by an increase in use of agency, with the remaining being the additional staff recruited over the latter part of 19/20, and since the beginning of 2020/21 (c. 45 wte), and pay costs associated with Covid-19.





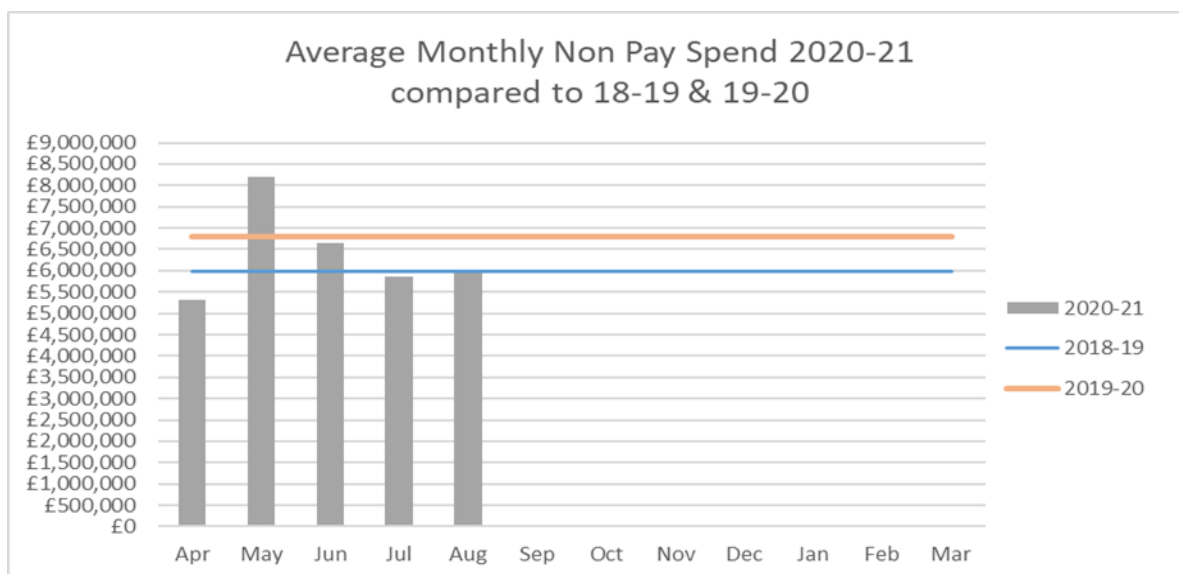
4.3 Non Pay Analysis

Income Type	Cumulative			Year End Forecast		
	£343k Underspend			£(8)k Overspend		
	YTD	YTD	YTD	Full Year	Full Year	Forecast
	Budget	Actual	Variance	Budget	Forecast	Variance
	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)	(£'000)
Nice & High Cost Drugs	15,013	15,013	0	34,371	34,371	0
Blood Wholesaling	4,407	4,388	19	12,540	12,540	0
Depreciation	2,673	2,673	0	6,416	6,416	0
Clinical Services & Supplies	2,326	2,189	137	5,625	5,559	66
Facilities Management	331	358	(27)	758	888	(130)
Maintenance & Repairs	1,199	1,146	53	2,848	2,825	23
General Drugs	1,089	926	163	2,579	2,451	128
Utilities/ Rent /Rates	921	890	31	2,191	2,183	8
General Services & Supplies	838	806	33	2,027	1,913	114
Blood Components	675	621	54	1,687	1,645	43
Transport	417	392	25	1,044	1,035	10
Printing / Stationary / Postage	289	265	24	817	866	(49)
Computer Maintenance & Supplies	287	377	(91)	687	843	(156)
Travel & Subsistence	201	117	85	567	508	59
Equipment & Consumables	144	153	(9)	275	335	(61)
Education & Development	107	80	28	313	258	55
NHS SLA	(448)	(446)	(1)	(857)	(856)	(2)
Audit Fees	123	124	(1)	306	306	(1)
Telecoms	86	93	(8)	187	218	(30)
One Wales End of Life Care	2,555	2,555	(0)	3,193	3,193	0
General Reserves / Savings Target	(138)	34	(172)	2,165	2,249	(84)
Total	33,097	32,754	343	79,738	79,745	(8)

The Trust has reported a cumulative year to date position of **£343k** underspent on Non-Pay and is forecasting an outturn forecast position of **£(8)k** overspent.

- Clinical Services is underspending due to a reduction in activity in both VCC and WBS as a result of Covid-19.
- General drugs is underspending due to low activity.
- Computer Maintenance & Supplies is over spending due to increased costs for maintenance costs including office 365.
- Transport, Travel & subsistence and Education are all underspending due to reduced activity in relation to Covid-19.
- General Reserves / Savings Target is currently reporting an overspend of £(172)k due to the Cost improvement Plans (CIP) held centrally within divisions. These CIP are being achieved throughout other areas of non-pay as illustrated in the table.

Non-pay (c£81.6m) av. monthly spend increased by c£800k (10%) from £6m in 18-19 to £6.8m in 19-20. The monthly av. for 20-21 to M5 has currently reduced to c£6.4m.



*The expenditure in period 2 includes extra £2,100k of end of life expenditure fully funded by WG and passed on to the hospices.

4.4 Covid-19

Covid-19 Revenue Spend		
Expenditure Type	YTD	Full Year
	Actual (£'000)	Forecast (£'000)
Pay	731	2,845
Non Pay	3,321	6,978
Non Delivery of Savings Plans	232	700
Reduction of non pay costs due to reduced elective activity	(210)	(250)
Total	4,074	10,273

The Trust has currently received or had confirmation of funding from WG to the sum of £4,377k which leaves a current funding gap of £5,896k.

The total year to date net additional expenditure on services directly related to Covid-19 is £4,074k. This incorporates actual gross expenditure of £4,052k, plus non delivery of savings of £232k, offset by a reduction in activity costs of £210k.

The full year net additional forecast cost amounts to £10,273k. Included within this forecast is expenditure of £2,967 relating to Hospice funding which is passing through the Trust and fully funded by WG. Additionally £1,153k relates to the all Wales Convalescent Plasma service which Welsh Government has asked the Trust to implement. The Trust has received a funding letter confirming that we will have access to funding up to a maximum of £1,153k for the Convalescent Plasma service during 2020-21. The Trust has also received £257k of funding from WG which covered the Covid-19 related staff costs for the period April- June. Consequently the current unfunded forecast revenue expenditure directly associated with Covid 19 is £5,896k.

The total forecast cost includes a large proportion of estimated costs to provide additional capacity to meet an expected increase in demand later this year.

Additional Capacity

On the assumption that demand does increase to or above 2019-20 levels at some point during 2020-21, the Trust will be unable to deliver those activity levels within its current available resources, as the capacity would need to be increased significantly to meet the guidance for the safe return of healthcare environments to routine arrangements following the initial Covid-19 response. There will be a requirement for additional physical space and workforce resource to deliver the 2019-20 activity levels in a safe way for both patients and staff. The Trust is considering options that could create sufficient additional physical capacity and resource it internally or commission it externally to meet the uncertain demand.

The financial assessment included within this report and contained within the month 5 submission to WG has a focus on creating capacity which could respond to demand increasing to pre-COVID levels within quarter 3 and at a level of 120% pre-COVID levels in quarter 4 to take account of suppressed demand within the system.

The amount required to provide this necessary additional capacity to cover Radiotherapy and SACT has been estimated at **£3.1m** at this point. This incorporates a combination of increased and extended hours/days from internal resources and possible outsourcing options. However, the practicalities of operational delivery are extremely challenging, such as availability of workforce aligned with recovery timelines and the availability of outsourcing capacity.

Work continues on refining these estimates and the options that will be available.

5. Savings

The Trust established as part of the IMTP a savings requirement of £1,400k for 2020-21, (£1,200k) recurrent and (£200k) non-recurrent, with £1,000k being categorised as actual saving schemes and £400k being income generating schemes. Following a review of the schemes since the IMTP submission in January the savings are now categorised as £800k being actual saving schemes, and £600k being income generating schemes.

Within the identified savings, £650k of the schemes are now RAG rated as green, £50k are RAG rated amber, and £700k have turned red in response to Covid-19. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation, which has been impossible to enact due to the capacity needs of delivering within the Covid-19 environment.

The Trust is currently forecasting a full year underachievement of **£(700)k** against the savings plans, £(232)k year to date, which is a direct result of Covid-19. The £700k is made up of four schemes within VCC (£550k) turning red, and one scheme within WBS (£150k). The Trust is currently working to the assumption that any savings that are directly affected by Covid-19 will be fully funded by WG.

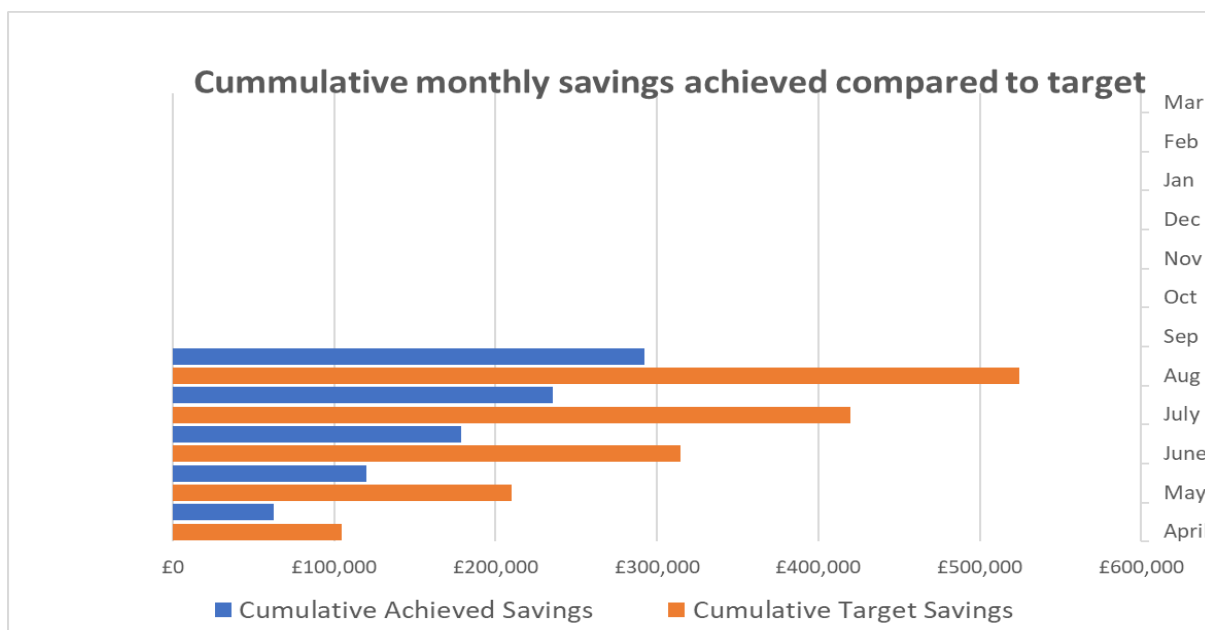
The Trust agreed as part of the IMTP submission that a balanced position will be carried into the next financial year. With the effect of Covid-19 having a huge impact (50%) against the savings target this year, it is extremely important that the Trust starts to develop plans for recurrent savings next year.

ORIGINAL PLAN		TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
VCC TOTAL SAVINGS		850	357	24	(333)	300	(550)
			7%			35%	
WBS TOTAL SAVINGS		450	126	120	(6)	300	(150)
			95%			67%	
CORPORATE TOTAL SAVINGS		100	42	42	0	100	0
			100%			100%	
TRUST TOTAL SAVINGS IDENTIFIED		1,400	525	186	(339)	700	(700)
TRUST ADDITIONAL NON-RECURRENT SAVINGS		0	0	107	107	0	0
ANTICIPATED WG COVID FUNDING FOR LOSS OF SAVINGS				0	0	700	700
TRUST TOTAL SAVINGS		1,400	525	293	(232)	1,400	0
			56%			100%	

Scheme Type	RAG RATING	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	Variance Full Year £000
Savings Schemes							
Service Redesign	Red	50	23	0	(23)	0	(50)
Premium of Agency Staffing	Red	150	63	0	(63)	0	(150)
Supportive Structures	Red	150	63	0	(63)	0	(150)
Procurement National and Local Value Plan	Amber	50	21	0	(21)	50	0
Non Pay targeted Savings	Green	84	35	35	0	84	0
Non Recurrent Gains - Stock Management	Green	100	41	35	(6)	100	0
Review of Staffing	Green	116	50	50	0	116	0
Changes in Staffing Establishment	Green	100	42	42	0	100	0
Total Saving Schemes		800	337	162	(175)	450	(350)

Income Generation							
Productivity Gains	Red	200	83	0	(83)	0	(200)
Maximising Meds@Home opportunities	Green	50	21	23	2	50	0
Medicines Management (Secondary Care)	Green	100	42	0	(42)	100	0
Maximum income opportunities	Green	100	42	0	(41)	100	0
Increased Sale of Products	Red	150	0	0	0	0	(150)
Total Income Generation		600	188	24	(164)	250	(350)

TRUST ADDITIONAL NON-RECURRENT SAVINGS		0	0	107	107	0	0
ANTICIPATED WG COVID FUNDING FOR LOSS OF SAVINGS				0	0	700	700
Trust Total Savings		1,400	525	293	(232)	1,400	0
			56%			100%	



6. Reserves

The financial strategy for 2020-21 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. This could only be accommodated on the basis that all income expectations are received, planned savings schemes are delivered and new emerging cost pressures are managed. In addition the Trust holds an emergency reserve of 522k.

The current remaining available funding is shown below:-

	Recurring £k	Non Recurring £k
Unallocated Budget	88	72

Emergency Reserve		522
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7. End of Year Forecast / Risk Assessment

As highlighted in the Executive summary, the Trust is currently reporting a year end breakeven position against its revenue budget, however there are a number of risks which are being managed and closely monitored.

The table below summarises the key financial risks & opportunities which have also been highlighted to Welsh Government.

Risks

Overview Of Key Risks & Opportunities	FORECAST YEAR END	
	£'000	Likelihood
Risks (negative values)		
Covid 19: Expenditure incurred funding not received from WG	(5,196)	Medium
Covid 19: Savings Slippage	(700)	Medium
Non Deliver of Savings Plans (Amber Schemes)	(50)	Medium
Private Patient Income	(150)	Medium
Further Opportunities (positive values)		
Additional in Year Vacancy Factor	200	Medium

Covid-19 (Medium)

As detailed earlier the total forecasted expenditure on Covid-19 is £10,273k. This includes £2,845k of pay costs, £6,978k of non-pay costs, £(250)k of cost reduction, and £700k of slippage expected on delivery of savings.

Of the £10,273k forecast Covid-19 revenue expenditure, £2,967k relates to funding from WG passed on to the Hospices, £257k of funding received to support the staff costs for the first quarter of the year, and £1,153k relates to the WG funded All Wales Convalescent Plasma Service. This reduces the Trust risk related to Covid-19 down to £5,896k.

The Trust is currently assuming full recovery of costs from WG in relation to Covid-19.

Private Patient Income (Medium)

The Trust has lost c£150k income to the Rutherford Cancer Centre and from a number of insurance companies reducing the funding they are prepared to pay the Trust for the provisions of drugs, on which the Trust was including a mark-up on cost. This is in addition to any loss of income associated with Covid-19.

Other Risks not included in table

Update on Contracting Arrangement with Commissioners

Due to the uncertainties associated with Covid 19 a revised approach for period April to September has been agreed to ensure providers are not financially de-stabilised 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 two quarters of 2020-21. For Velindre this means that contracting income will be based on the 2019-20 outturn plus the agreed baseline uplifts until September.

The view from Velindre is that this arrangement should be retained for both Q3 and Q4. Q3 block arrangements will be considered at the DoF's meeting on the 18th September. It is important that this arrangement should be kept under close scrutiny.

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.

NHS Pension final pay controls

From April 2014, if a member of the pension scheme receives an increase to pensionable pay that exceeds the allowable amount then the Trust will be liable for a final pay control charge. It is extremely difficult to calculate the potential cost of the NHS pension final pay as the information required is not readily available. We are however continually monitoring any person that could potentially fall into this category, and where possible minimising any further potential risk.

Opportunities

Additional vacancies that could arise during the year could bring a potential opportunity above what is currently planned and will be used to help offset potential risks £200k.

8. CAPITAL EXPENDITURE

Administrative Target

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

	Approved CEL £000s	YTD Spend £000s	Committed Orders Outstanding £000s	Budget Remaining @ M5 £000s	Forecast Year End Spend £000s	Year End Variance £000s
All Wales Capital Programme						
Transforming Cancer Services	0	900	0	(900)	4,006	(4,006)
TCS - Radiotherapy Procurement Solution	548	210	0	338	548	0
IT - WPAS (CANISC replacement phase 2)	0	141	0	(141)	742	(742)
VCC CT Sim Replacement x2	1,957	756	165	1,036	1,557	400
WBS DNA Extracting Kit	50	0	53	(3)	50	0
WBS Foetal D	54	0	34	20	54	0
VCC - Treatment Planning System	44	1	0	43	44	0
Total All Wales Capital Programme	2,653	2,007	252	393	7,001	(4,348)
Covid-19						
COVID-19 WBS Plasmapheresis	397	208	0	189	397	0
COVID-19 Digital Devices	92	0	0	92	92	0
COVID-19 Other	946	946	0	0	1,014	(68)
Total Covid-19	1,435	1,154	0	281	1,503	(68)
Discretionary Capital	1,850	42	72	1,736	1,850	0
Sub Total	5,938	3,203	324	2,411	10,354	(4,416)
Charitable Funded Capital Scheme	45	0	0	45	45	0
TOTAL	5,983	3,203	324	2,456	10,399	(4,416)

The approved Capital Expenditure Limit (CEL) as at August 2020 was £5,938k for 2020-21 (excl Charity). This includes All Wales Capital funding of £2,653k, Covid-19 funding to date of £1,435k, and discretionary funding of £1,850k.

TCS

The TCS Programme is primarily funded from a capital budget allocation provided by WG. The medium to longer term capital requirements are outlined in the formal business cases that have

been submitted to WG. The Trust has not received any budget allocation for the TCS programme for this financial year.

In the meantime we are having to rely on our discretionary capital budget to fund the on-going commitments which amount to a forecasted circa £150k to £200k per month. This is now having a significant impact on our ability to deliver other urgent discretionary capital needs across the trust. The total forecast unfunded Capital requirement for the TCS programme is £4m.

Covid-19

The Trust is forecasting to spend £1,503k (£1,149k to end of August) on Covid related capital expenditure. To date the Trust has received funding confirmation from WG of £1,435k leaving an unfunded balance of £68k. The £68k related to Capital items that were still undelivered at the last submission date. We have approached WG for confirmation of when the remaining funding will be released.

The service has identified a further capital demand in relation to Covid-, which is largely based around making arrangements for social distancing, response to additional capacity, and IT kit. An additional request for Covid funding of £535k has been requested to WG in a recent update provided on the 15 September.

WPAS

The WPAS project has been delayed slightly due to relocation of staff in response to Covid. Therefore the expected funding required for 2020/21 has reduced by £150k from £892k to £742k. The £150k will still be required and a request will be made to WG for the funding to be added to the £892k baseline funding for 2021/22.

The Trust is still in negotiations with NWIS and WG in regards to transferring the funding into Velindre's CEL for 2020/21 which has been on hold due to Covid and the issues highlighted above on slippage.

CT SIM

WG were notified in October last year of a potential underspend against the CT Sim project of circa £400k. As it stand the Trust is still expecting to give back this sum of money.

The remaining budget of c£600k is being held to decommission the third CT Sim, along with accommodation /refurbishment and costs for equipment, however due to an expected increase in activity as a result of Covid-19 the service are potentially looking to delay the decommission by three months for contingency planning which could take some of the work into next financial year. This work will be closely monitored and discussed with WG Capital colleagues over the course of the year.

Major Schemes in Development

In addition to the request for additional capital to cover future Covid related costs, as identified above, on the 15th September the Trust also provided WG with an update on other project funding which the Trust is seeking in the current year from the All Wales capital Programme. This amounted to **£2.6m** and covered the following projects as provided in the table below:

Scheme Title	2020/21 Requirement £k	2021/22 Requirement £k
VCC Fire Safety	600	650
VCC Ventilation	500	2,000
VCC Infrastructure	200	550
WBS HQ	300	2,400
Blood Gas Analyser	480	0
Flow Cytometer Replacement	550	0
Total All Wales Requirement	2,630	5,600

The Trust is current waiting on a response from WG on the 15th September submission.

Performance to date

The actual cumulative expenditure to August 2020 on the All Wales Capital Programme schemes was £2,007k, this is broken down between spend on the TCS Programme £900k, TCS Radiotherapy Procurement Solution £210k, WPAS £141k, and CT SIM Replacement £756k.

The year to date spend related to Covid-19 is £1,154k.

There has been little movement on the Discretionary capital funding programme with the current uncertainty around funding for the TCS programme. The Capital planning group has however allocated £100k to both VCC and WBS, and £100k to Estates, along with £81k to Digital in order to allow for urgent small schemes to progress. The Trust is also developing schemes that will be ready to proceed once the Trust receives confirmation of funding from WG on the TCS programme, however there may be an impact on what schemes can be delivered this financial year if a decision on TCS is further delayed.

Year-end Forecast Spend

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

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
- Small unfunded balance of £68k relating to Covid-19 spend
- Uncertainty over funding creates delays in decision making for use of Discretionary funds and impacts on deliverability.

9. BALANCE SHEET (Including Hosted Organisations)

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

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

Balance Sheet key movements between opening balance as at 1st Apr '20 and 31st August '20 and forecast closing balance as at 31st March '21.

Non -Current Assets

The **Increase of £8,145k** from 1st April to 31st August will relate to the agreed purchase from the Trust Capital programme, offset against the depreciation charges on Property, Plant & Equipment and Intangible assets.

Current Assets

Inventories (stock)

The **increase in stock of £48,959k** from 1st April to 31st August relates mainly to purchases of stock within NWSSP relating to Covid-19. The Trust is also still holding £7,000k of contingency stock from 2018-19 which WG asked both NWSSP and WBS to purchase in preparation for Brexit.

The Trust is intending to unwind the contingency stock during 2020-21 to repay the £7,000k cash provided by WG to purchase the Brexit, however given the precarious situation which has arisen due to Covid-19 the Trust is currently continuing to hold this stock

Cash and cash equivalents

Due to the high levels of purchases relating to Covid-19 within NWSSP, the cash levels are fluctuating significantly on a daily/ weekly basis. Cash levels are being continually monitored using a cash flow forecast in order to maintain appropriate levels.

Trade and other receivables

Trade and other receivables will move up and down each month depending on timing of when invoices are raised, and when the cash is physically received from debtors.

Current Liabilities & Non-Current Liabilities

Current Liabilities

Current Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

	Beginning of Apr 20	End of Aug-20	from 1st April to Aug-20	Balance End of Mar 21
	£'000	£'000	£'000	£'000
Non-Current Assets				
Property, plant and equipment	129,552	137,697	8,145	129,552
Intangible assets	17,646	17,646	0	17,646
Trade and other receivables	861,947	861,947	0	861,947
Other financial assets				
Non-Current Assets sub total	1,009,145	1,017,290	8,145	1,009,145
Current Assets				
Inventories	13,134	62,093	48,959	13,134
Trade and other receivables	415,289	498,888	83,599	415,289
Other financial assets				
Cash and cash equivalents	18,227	45,971	27,744	18,227
Non-current assets classified as held for sale				
Current Assets sub total	446,650	606,952	160,302	446,650
TOTAL ASSETS	1,455,795	1,624,242	168,447	1,455,795
Current Liabilities				
Trade and other payables	(166,041)	(775,679)	(609,638)	(166,041)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(273,929)	(32,757)	241,172	(273,929)
Current Liabilities sub total	(439,970)	(808,436)	(368,466)	(439,970)
NET ASSETS LESS CURRENT LIABILITIES	1,015,825	815,806	(200,019)	1,015,825
Non-Current Liabilities				
Trade and other payables				
Borrowings				
Other financial liabilities				
Provisions	(861,941)	(661,941)	200,000	(861,941)
Non-Current Liabilities sub total	(861,941)	(661,941)	200,000	(861,941)
TOTAL ASSETS EMPLOYED	153,884	153,865	(19)	153,884
FINANCED BY:				
Taxpayers' Equity				
PDC	113,119	113,119	0	113,119
Retained earnings	12,432	12,413	(19)	12,432
Revaluation reserve	28,333	28,333	0	28,333
Other reserve				
Total Taxpayers' Equity	153,884	153,865	(19)	153,884

10. CASH FLOW (Includes Hosted Organisations)

Cash held in the Trusts bank account is a key indicator of its financial health in terms of income, expenditure and surplus or deficit. The Trust is mainly reliant on its commissioners for cash, however if the Trust has a deficit it would need to secure a loan from Welsh Government to cover the cash shortfall created by the deficit.

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

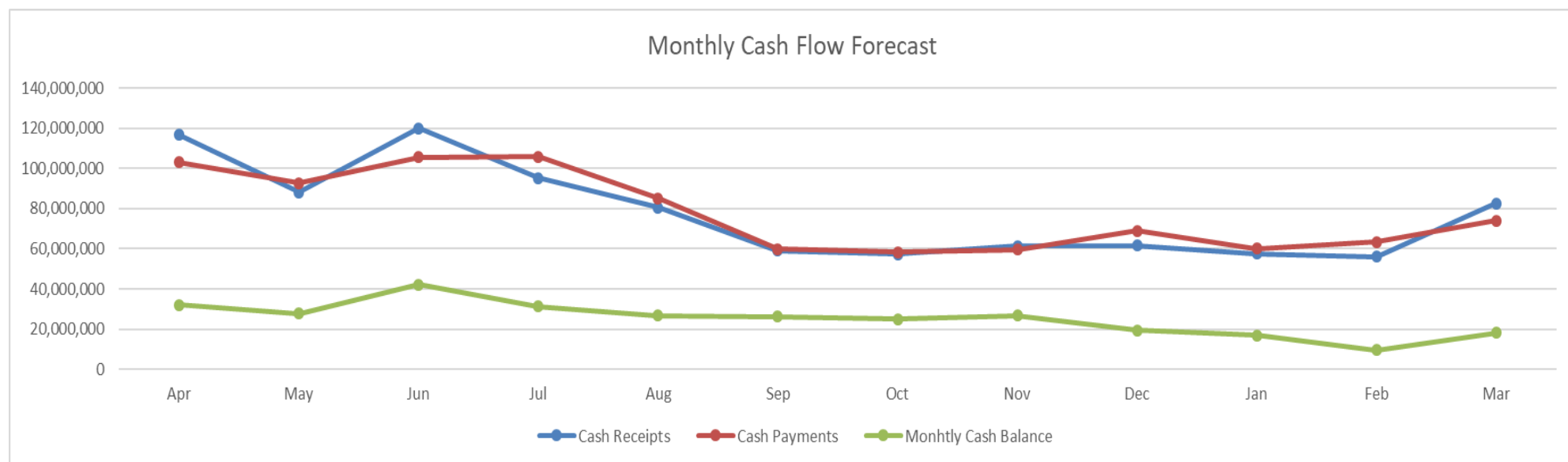
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products have been purchased by WBS, to provide resilience for NHS Wales due to the precarious decision around Brexit.

To aid the Trust's cash flow while the stock was being held for Brexit, Welsh Government have provided the Trust with additional cash of £7m during 2019/20 with the intention that it is repaid during 2020/21. WBS did intend on starting to run down the stock from April, however given the precarious situation with Covid-19 the Trust will continue to hold this stock until further notice. NWSSP are currently reviewing the timing of the All Wales Brexit stock run down.

Due to the high levels of purchases relating to Covid-19 within NWSSP the cash levels are expected to be significantly higher than usual for the first five months of the year and maybe beyond. The cash balance is also considerably fluctuating on a daily/ weekly basis.

Cash levels are being continually monitored using a cash flow forecast in order to maintain appropriate levels.

		Apr £'000	May £'000	Jun £'000	Jul £'000	Aug £'000	Sep £'000	Oct £'000	Nov £'000	Dec £'000	Jan £'000	Feb £'000	Mar £'000	Totals £'000
	RECEIPTS													
1	LHB / WHSSC income	20,362	26,383	20,839	55,869	25,973	18,500	22,300	21,200	21,800	20,850	25,800	34,400	314,276
2	WG Income	93,193	44,297	70,821	25,015	47,924	38,900	32,800	38,098	37,800	34,680	28,200	38,140	529,868
3	Short Term Loans													0
4	PDC	149											7,739	7,888
5	Interest Receivable	3	4	0	4	4	0	0	0	0	0	0	0	15
6	Sale of Assets													0
7	Other	3,162	17,499	28,494	14,317	6,817	1,664	2,150	2,075	2,075	2,000	2,000	2,425	84,678
8	TOTAL RECEIPTS	116,869	88,184	120,154	95,205	80,718	59,064	57,250	61,373	61,675	57,530	56,000	82,704	936,725
	PAYMENTS													
9	Salaries and Wages	15,946	15,958	16,323	16,424	18,048	19,495	19,845	20,359	20,377	20,507	22,787	22,878	228,947
10	Non pay items	84,539	75,671	88,129	87,538	65,800	38,200	36,600	37,250	39,800	38,005	37,850	46,527	675,910
11	Short Term Loan Repayment													0
12	PDC Repayment													0
14	Capital Payment	2,551	1,004	1,167	2,030	1,380	2,100	1,980	1,902	1,800	1,655	2,800	4,500	24,869
15	Other items									7,000				7,000
16	TOTAL PAYMENTS	103,036	92,633	105,619	105,992	85,228	59,795	58,425	59,511	68,977	60,167	63,437	73,905	936,725
17	Net cash inflow/outflow	13,832	(4,450)	14,535	(10,787)	(4,510)	(731)	(1,175)	1,862	(7,302)	(2,637)	(7,437)	8,799	
18	Balance b/f	18,227	32,059	27,610	42,145	31,358	26,848	26,117	24,942	26,803	19,501	16,864	9,428	
19	Balance c/f	32,059	27,610	42,145	31,358	26,848	26,117	24,942	26,803	19,501	16,864	9,428	18,227	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Variance
	£000	£000	£000	£000	£000	£000
VCC	11,375	11,623	(248)	34,396	34,396	0
RD&I	(25)	(95)	70	(473)	(473)	0
WBS	8,183	8,033	150	21,176	21,176	0
Sub-Total Divisions	19,533	19,561	(29)	55,100	55,100	0
Corporate Services Directorates	2,465	2,456	9	5,962	5,962	0
Delegated Budget Position	21,998	22,018	(20)	61,062	61,062	(0)
TCS	223	227	(4)	537	537	0
Health Technology Wales	5	5	(0)	0	0	0
Non recurrent measures to achieve financial breakeven	0	0	0	0	0	0
Trust Position	22,226	22,250	(23)	61,599	61,599	(0)

VCC

	YTD Budget	YTD Actual	YTD Variance	Full Year Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	23,924	23,790	(134)	48,300	48,921	621
Expenditure						
Staff	15,526	15,797	(270)	36,731	37,354	(623)
Non Staff	19,773	19,617	156	45,965	45,963	2
Sub Total	35,299	35,414	(114)	82,696	83,317	(621)
Total	11,375	11,623	(248)	34,396	34,396	0

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre at the end of August 2020 was an overspend of **£(248)k** representing 0.3% of the division's annual budget. VCC is currently expecting to achieve an outturn position of **breakeven**.

Income at month 5 was **£(134)k** under achieved, this primarily relates to non-achievement of the Income savings target. Canteen takings are also down due to reduced activity in the hospital. Partly

offset with overachievement of Physics Management HSST income, homecare VAT savings from increased chemo, and additional income from Top up Drugs along with other small variances

Staff was **£(270)K** overspent as at month 5. The major factor contributing to the overspend is the cost of agency which totals £(648)k as at the end of August, with additional activity in Radiotherapy and Medical Physics being the main cause. There are underspends across the division due to vacancies which is above vacancy factor and the service redesign savings target, which is helping to offset some of the agency costs.

Non Staff Expenditure at month 5 was **£156k** underspent. The main reason for the underspend is on the general drugs budget, and various underspends across other services due to low activity, such as Nursing, Radiology, and patient appliances (wigs). Partly offset with an overspend in Pharmacy due to one off maintenance costs for Chemo Care, Medical Oncotype spending, and the non-achievement of savings plans.

WBS

	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Full Year Forecast	Year End Projected Variance
	£000	£000	£000	£000	£000	£000
Income	6,264	6,063	(202)	16,565	16,273	(292)
Expenditure						
Staff	6,869	6,687	182	16,363	16,044	319
Non Staff	7,579	7,410	169	21,378	21,405	(27)
Sub Total	14,447	14,096	351	37,741	37,449	292
Total	8,183	8,033	150	21,176	21,176	0

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of August 2020 was an under spend of **£150k** representing 0.4% of the division's annual budget. WBS is currently expecting to achieve an outturn position of **breakeven**.

Income underachievement to date is **£(202)k**, where activity is lower than planned on Plasma Sales, Bone marrow and Neqas due to Covid-19 suppressed activity. Also an income risk against Renal of circa £73k if WHSSC don't agree the block contract.

Staffing underspend continues to be high with a **£182k** under spend reported to August, which is above the divisions vacancy factor target. Vacancies remain high though decreasing based on recruitment with additional staff commencing from August, and more expected in September. Convalescent plasma staff commences from August as part of phase 1, with Phase 2 and 3 expected from September which is fully funded by WG.

Non Staff underspend of **£169k** is largely due to reduced costs from suppressed activity, Underspend on collections services, Laboratory Services, and WTAIL, (business Systems & Centre service), and rephrasing of non-pay contingency into M12 to support increased activity and staff recruitment post Covid-19.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	3,085	3,067	(18)	4,265	4,219	(46)
Expenditure						
Staff	3,050	3,033	16	7,171	7,120	51
Non Staff	2,500	2,490	11	3,055	3,060	(5)
Sub Total	5,550	5,523	27	10,227	10,180	46
Total	2,465	2,456	9	5,962	5,961	0

Corporate Key Issues:

The reported financial position for the Corporate Services Division at the end of August 2020 was an under spend of **£9k** representing 0.09% of the division's annual budget. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Income underachievement of £18k is due to the Trust no longer receiving bank interest following the reduction to interest rates. The Finance team is currently reviewing if there are other options available such as switching banks.

Staff underspends are due to vacancies which are partly being offset by the use of agency staff.

A small underspend on Non-Staff general services which is being used to support the underachievement on bank interest and the divisional CIP target.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	1,467	1,456	(11)	3,896	3,896	0
Expenditure						
Staff	1,115	1,043	72	2,778	2,800	(22)
Non Staff	327	318	9	644	622	22
Sub Total	1,441	1,361	81	3,423	3,423	0
Total	(25)	(95)	70	(473)	(473)	0

RD&I Key Issues

The reported financial position for the RD&I Division at the end of August 2020 was an under spend of **£70k** representing 2.05% of the total divisional budget. RD&I is currently expecting to achieve an outturn position of **breakeven**.

A small under achievement of **£(11)k** on income, is due to underperformance on projects which is offset by underspends within staff and non-staff.

Staff underspend is due to Vacancies and maternity leave in the Trials delivery team.

TCS – (Revenue)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	0	0	0	0	0	0
Expenditure						
Staff	223	231	(7)	536	536	0
Non Staff	0	(4)	4	0	0	0
Sub Total	223	227	(4)	537	536	0
Total	223	227	(4)	537	536	0

TCS Key Issues

The reported financial position for the TCS Programme at the end of August 2020 was **£(4)k** overspent with a forecasted outturn position of **breakeven**.

A small overspend on staff £(7)k was partly offset by a small underspend in non-staff £4k.

HTW

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	386	386	0	1,100	1,100	0
Expenditure						
Staff	312	306	6	809	809	0
Non Staff	78	85	(6)	291	291	0
Sub Total	390	390	(0)	1,101	1,100	0
Total	5	5	(0)	0	0	0

HTW Key Issues

The reported financial position for Health Technology Wales at the end of August 2020 was **Breakeven**, with a forecasted outturn position of **breakeven**.

A small underspend of £6k in staff was offset by a £6k overspend in non-staff.

HTW is fully funded by WG.

Appendix 1

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2020-21 AUGUST 2020

DATE OF MEETING	14 th September 2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	Mark Ash, Assistant Director of Finance - TCS Programme
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PRESENTED BY	Mark Osland, Executive Director of Finance
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EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance
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REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	DATE	OUTCOME
N/A		Choose an item.

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
nVCC	New Velindre Cancer Centre
WG	Welsh Government
PMO	Programme Management Office

1. PURPOSE

- 1.1 The purpose of this report is to provide a financial update to the TCS Programme Delivery Board for the financial year 2020-21, outlining spend to date against budget as at Month 05 and current forecast.

2. BACKGROUND

- 2.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following the completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.
- 2.2 It should be noted that as at March 2020, the Cabinet Secretary for Health, Well-being and Sport, has approved capital and revenue funding for the TCS Programme and its associated Projects. The total cumulative expenditure as at the end of March 2020 was £17.375 Capital and £2.621m for Revenue.
- 2.3 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme, £0.400m of which was provided in 2018/19, £0.420m in 2019-20, and £0.420m in 2020-21.
- 2.4 In the financial year 2019-20, the Trust provided the nVCC and Enabling Works projects with £0.060m of revenue funding from its own baseline revenue budget. Previously direct revenue support for these projects had been provided by WG. .
- 2.5 The Radiotherapy Procurement Solution PBC (Project 3 – Equipment and Digital) was endorsed by WG in 2019-20. Capital funding of £1.110m was approved from July 2019 to December 2022, with £0.347m provided in 2019-20. Re-profiling of the funding resulted in a revised funding allocation of £0.250m for the 2019-20 financial year. The slippage of £0.097m has been reprovided in the next financial year, increasing the allocation for the financial year 2020-21 from £0.451m to £0.548m.

3. FUNDING

Funding provision for the financial year 2020-21 is outlined below. The following should be noted:

- 3.1 There are ongoing discussions with Welsh Government regarding the capital funding for the nVCC and EW Project(s). The funding envelope would be in the region of £3.0m and £3.5m.
- 3.2 No revenue funding has been provided by Welsh Government to date to cover project delivery costs for 2020-21 for the Enabling Works and nVCC Projects.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present Allocation from funding provided from Commissioners for 2020-21 to cover direct clinical/management support and PMO	£nil	£0.240m
Project 1 – Enabling Works for nVCC Project 2 – nVCC <i>WG Capital Funding</i> Capital funding from WG to be confirmed <i>Revenue Funding</i> No Revenue funding provided by WG for the financial year 2020-21 to date	£nil	£nil
Project 3 – Equipment and Digital £0.451m capital funding provided in 2020-21 plus £0.097m capital funding reprovided from 2019-20	£0.548m	£nil
Project 4 – Radiotherapy Satellite Centre Project is led and funded by the hosting organisation, Aneurin Bevan University Health Board, and no funding requirement is expected from the Trust for 2020-21	£nil	£ nil
Project 5 – SACT and Outreach Funding has been requested for this project however none has been provided to date	£nil	£nil
Project 6 – Service Delivery, Transformation and Transition No capital funding requirement at present Allocation from funding provided from Commissioners for 2020-21 to cover direct clinical/management support and PMO Funding transferred from the Trusts core revenue budget toward the costs of the Project Director post Funding transferred from Velindre Cancer Centre toward the costs for the Project Manager post	£nil	£0.180m £0.067m £0.049m

Description	Funding	
	Capital	Revenue
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	£nil	£nil
Total funding provided to date: £1.084m	£0.548m	£0.536m

4. FINANCIAL SUMMARY AS AT 31ST AUGUST 2020

4.1 The summary financial position for the TCS Programme for the year 2020-21 is outlined below:

TCS Programme Budget & Spend 2020/21						
CAPITAL	Current Month			Financial Year		
	Budget to Aug-20	Spend to Aug-20	Variance to Aug-20	Budget to Aug-20	Spend to Aug-20	Variance to Aug-20
	£	£	£	£	£	£
PAY						
Project Leadership	0	58,401	-58,401	0	171,067	-171,067
Project 1 - Enabling Works	0	15,436	-15,436	0	123,663	-123,663
Project 2 - New Velindre Cancer Centre	0	274,692	-274,692	0	835,080	-835,080
Project 3a - Radiotherapy Procurement Solution	173,333	162,224	11,109	416,000	388,537	27,463
Other Project Staff	0	49,248	-49,248	0	118,195	-118,195
Capital Pay Total	173,333	560,001	-386,667	416,000	1,636,541	-1,220,541
NON-PAY						
nVCC Project Delivery	0	12,811	-12,811	0	89,786	-89,786
Project 1 - Enabling Works	0	350,535	-350,535	0	2,325,470	-2,325,470
Project 2 - New Velindre Cancer Centre	0	194,171	-194,171	0	342,316	-342,316
Project 3a - Radiotherapy Procurement Solution	11,667	47,713	-36,047	132,000	159,463	-27,463
Capital Non-Pay Total	11,667	605,230	-593,563	132,000	2,917,035	-2,785,035
CAPITAL TOTAL	185,000	1,165,231	-980,231	548,000	4,553,576	-4,005,576
REVENUE						
	Budget to Aug-20	Spend to Aug-20	Variance to Aug-20	Budget to Aug-20	Spend to Aug-20	Variance to Aug-20
	£	£	£	£	£	£
PAY						
Programme Management Office	100,000	82,881	17,119	240,000	198,022	41,978
Project 6 - Service Change Team	123,163	124,405	-1,242	295,591	297,431	-1,840
Revenue Pay total	223,163	207,286	15,877	535,591	495,453	40,138
NON-PAY						
nVCC Project Delivery	0	10,401	-10,401	0	30,086	-30,086
Programme Management Office	0	276	-276	0	41,978	-41,978
Project 6 - Service Change Team	0	112	-112	0	267	-267
Revenue Non-Pay Total	0	10,788	-10,788	0	72,331	-72,331
REVENUE TOTAL	223,163	218,074	5,089	535,591	567,784	-32,194

5. **FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST AUGUST 2020**

CAPITAL SPEND

Projects 1 and 2 Pay Costs

5.1 ***WG Funded Staffing*** - An in year **spend of £0.349m** for posts funded by WG reflects the current 'interim' posts, with a **forecast spend of £1.130m** for the year. The pay costs have been analysed by each element of the Project(s).

5.2 ***Other Project Staff*** - There is an in-year **spend of £0.049m** to date with a **forecast spend of £0.118m** for the year.

Projects 1 and 2 Non Pay Costs

5.3 ***nVCC Project Delivery*** - There is a capital cost of **£13k** for the year to date for project support and running costs for Projects 1 and 2, made up of IT purchases, travel and subsistence, and general office costs. These are expected to resume later in the year. The forecast spend for the financial year 2020-21 is **£0.090m**, with the budget is to be confirmed.

5.4 ***Enabling Works*** - There is an in-year capital spend of **£0.366m**, with a forecast spend for the year of **£2.449m**. The budget is to be confirmed.

Work package	Spend to 31 st August 2020
Pay	£0.015m
Planning (inc TCAR & Asda)	£0.045m
Master Planning & Feasibility Study	£nil
Third Party Undertakings	£0.077m
Enabling Works - Design & Employers Requirements	£0.226m
Enabling Works – Works	£nil
Miscellaneous Works – Fol legal advice	£0.002m

5.5 ***nVCC*** - There is an in-year capital spend of **£0.527m**, with a forecast spend for the year of **£1.348m**. The budget is to be confirmed.

Work package	Spend to 31 st August 2020
Pay (including Project Leadership)	£0.333m
Project Agreement (PA)	£0.059m
Procurement Documents (PD)	£0.083m
Land Transfer	£0.013m
nVCC Technical Support	£0.036m
Competitive Dialogue Preparedness	£nil
Competitive Dialogue - PQQ & Dialogue	£nil
Miscellaneous works – Fol legal advice	£0.002m

Project 3 – Equipment and Digital

- 5.6 There is an in-year spend of **£0.210m** (£0.162m pay, £0.048m non-pay) for the Integrated Radiotherapy Solutions Procurement Project against a budget of **£0.185m**. There is a non-pay overspend of £36k due to legal work, however the majority of this is offset by an underspend in pay. The Project is currently forecasting a break even position against a budget for the year of **£0.548m**.

REVENUE SPEND

Programme Management Office

- 5.7 The PMO revenue spend to date is a pay cost of **£0.083m** against a budget of **£0.100m**. The forecast outturn is **£0.240m** against a budget of the same for the financial year 2020-21. The decrease in forecast spend from July's report is due to 50% of the costs for the Associate Director of Programmes being borne by the Integrated Radiotherapy Solutions Procurement Project from April 2020. There are negligible non-pay costs incurred by the PMO at present.

Projects 1 and 2 Delivery Costs

- 5.8 There is a revenue project delivery cost for the nVCC and Enabling Works Projects of **£10k** to date, with an expected spend for the year of **£30k**. This includes rates and other running costs. No revenue budget has been provided to date.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

- 5.9 Spend to the end of June 2020 is a pay cost of **£0.125m** against a budget of **£0.123m**. This overspend is due to an increase in pay costs. The project is forecasting a spend of **£0.298m** against a budget of **£0.296m**. There are negligible non-pay costs incurred by the Project at present.

6. CONSIDERATIONS FOR BOARD

- 6.1 An extract of this report is reported in the Trust Boards Finance Report.

7. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outlined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	See above.

8. RECOMMENDATION

- 8.1 The TCS Programme Board are asked to **ENDORSE** the financial position for the TCS Programme and Associated Projects for 2020-21 as at 31st August 2020.

TRUST BOARD

COMMUNICATIONS AND ENGAGEMENT

DATE OF MEETING	24/09/2020
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PUBLIC OR PRIVATE REPORT	Public
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IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
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PREPARED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
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PRESENTED BY	LAUREN FEAR, INTERIM DIRECTOR OF CORPORATE GOVERNANCE
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EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, INTERIM DIRECTOR OF CORPORATE GOVERNANCE
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REPORT PURPOSE	FOR NOTING
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COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
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COMMITTEE OR GROUP	DATE	OUTCOME
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TCS Programme Scrutiny Committee	17/09/2020	Paper noted
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ACRONYMS	
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VCC TCS	Velindre Cancer Centre Transforming Cancer Services
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1. BACKGROUND

- 1.1 The Transforming Cancer Services Programme Board approved its Communications and Engagement strategy in December 2019. The strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and community of interest.
- 1.2 A high level programme narrative was adopted to support the strategic alignment of the seven projects built around three messages:
- Wales has some of the lowest cancer survival rates in the western world
 - In future we will treat more patients and help more people live longer with cancer
 - In future we will treat more patients closer to home

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

- 2.1 The paper summarises key actions since July which includes the delivery of an agreed social media plan, progress made on a new programme of work relating to the development of the VCC clinical services model and engagement with the Senedd's petitions process. It also outlines key priorities for the next reporting period.
- 2.2 The work is overseen by a weekly meeting of the Communications and Coordination Group, including Trust and Executive Board membership and Independent Members, to review and coordinate activities.
- 2.3 The TCS Scrutiny Committee is asked to consider the content of the paper and consider the priority areas for the next reporting period.

3. IMPACT ASSESSMENT

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

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The TCS Scrutiny Committee is asked to **NOTE** the content of the paper.

TCS Communications and Engagement update Velindre University NHS Trust

Introduction

1. This paper provides the Trust Board with an update on programme communications and engagement since July 2020.

Background

2. The Programme Board approved the Transforming Cancer Services Programme Communications and Engagement strategy in December 2019. The strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and community of interest.
3. A high level programme narrative was adopted to support the strategic alignment of the seven projects built around three messages:
 - Wales has some of the lowest cancer survival rates in the western world
 - In future we will treat more patients and help more people live longer with cancer
 - In future we will treat more patients closer to home
4. Mainstream programme communications is delivered under the Velindre Cancer Centre brand and channels.

Update

Since July, we have been following a plan based on the narrative and principles of the communications and engagement strategy. The plan was based on a more proactive, high profile approach using social media and channels to put the facts straight and to make the positive case for the new cancer centre. In particular the plan addresses environmental concerns and explains our green ambitions.

Over the reporting period we have focused our efforts on:

- delivering a social media plan to support the development of the regional system of cancer care and also the new Velindre Cancer Centre. Our weekly reach is of about 40,000 with about 5,000 engagements. The sentiment of comment, on Facebook in particular, is more negative than positive although there has been improvement.
- delivering a new programme of work relating to the development of the clinical services model;
- responding to the Senedd's public petitions process;
- regular communications with staff by newsletter and supporting staff engagement sessions;
- responding to media queries;
- supporting the relevant Freedom of Information process;
- briefing Welsh Government officials.

A rolling weekly plan has been overseen by a Communications and Coordination Group, including Trust and Executive Board membership and Independent Members, to review and coordinate activities.

We will continue to deliver targeted, responsive communications and proactively seek engagement opportunities with the local community, including engagement with our local elected representatives, to raise awareness of the project and the good work that continues at the Velindre Cancer Centre today.

Clinical model engagement

The clinical model which underpins the Transforming Cancer Services programme has been developed in partnership with our regional colleagues, our staff, stakeholders and patients since 2015. A number of key findings and themes emerged from these initial engagement events and this information was used to inform the major process of developing a detailed clinical service model of care.

Any clinical model will continually evolve over time and it is essential that we continue to refresh our clinical future based on our learning and experiences.

In July, we undertook a commitment with our medical teams to further develop the clinical model that underpins the Transforming Cancer Services programme.

Work is ongoing at the Velindre Cancer Centre to develop our services and priority areas as identified in the Integrated Medium Term Plan. The Velindre Futures initiative will bring the work underway to deliver our current aspirations together with the work underway to develop our services in the future. It will help us design services which are fit-for-now and fit-for-the-future.

Velindre Futures will:

- develop detailed plans which describe how the key priorities will be delivered.
- drive a culture of excellence in clinical service design and delivery.
- annually review and refresh the clinical plan.

It will incorporate the work undertaken to date within Velindre Cancer Centre to scope and plan service development across services.

Public and staff engagement

We have continued to deliver targeted communications and engagement, including regular communications with staff by newsletter, staff engagement sessions.

During the reporting period a new private Supporters of a new Velindre Cancer Centre facebook group was created with more than 18k members. This group is privately managed and is not part of the Trust's communications structure.

The Velindre Cancer Centre Facebook page remains the main focus of online public engagement with members from both the protestors and supporters group posting regularly on the page during and out of office hours. Sentiment towards the original published posts is overwhelmingly positive. However, the tone and sentiment of the comments and threads that follow have been challenging and occasionally aggressive in tone leading to an internal discussion about how we continue to ensure that we are listening to all views whilst building consensus amongst our community and wider stakeholders.

Senedd Petition

On 16 July, a new petition was published on the Senedd Petitions website under the Heading “Hold an Independent inquiry into the choice of site for the proposed new Velindre Cancer Centre”. The petition closed at the beginning of September and was signed by 5,241 members of the public. A counter petition “Support for the current proposed plans to build a new Velindre Cancer Centre, Cardiff, in any future inquiry” closed on 8 September was signed by 11,392.

An initial correspondence was sent to the Clerk and Chair of the Petitions committee about the inclusion of factually incorrect statements in the protestors’ petition which potentially misled members of the public to sign. These include a reference to our organisation as Velindre University Health Board, an assertion that “£30M would be spent on roads alone to access the land on which the new Centre is proposed” when the cost of £26.9 million has been allocated to cover the cost of all our enabling works, and that “Heath Hospital offered Velindre space alongside Cardiff University cancer research in their new build due to start in 2023.”

A formal written response was issued on 2 September (as Annex A) and was published on the petitions committee website before 11 September. We were not asked to respond formally to the supporters’ petition but understand that both items will be taken together on 15 September. The committee will discuss next steps publically and an update on the outcome will be able to be provided during the meeting.

For the next two months, our priorities will be as follows:

- managing a public response to the decision of Cardiff County Council planning committee on the planning application;
- supporting the development of the service model work;
- establishing regular opportunities to raise awareness among key stakeholders about programme developments;
- reviewing how we keep staff informed about project updates
- raising awareness among Community Health Council representatives of the programme projects and opportunities for them to influence their development;
- continuing discussions with LHB engagement leads regarding the Outreach project;
- working with ABU LHB engagement lead to develop a strategy to support the Radiotherapy Satellite project.

Recommendation

The Trust Board is asked to:

- Note the update