Bundle Public Trust Board Meeting - Velindre University NHS Trust 30 July 2020

1.0.0 STANDARD BUSINESS

Led by Prof Donna Mead (Chair)

1.1.0 APOLOGIES

Led by Prof Donna Mead (Chair)

Mr Carl James, Director of Strategic Transformation, Planning & Digital
Dr Jacinta Abraham, Medical Director

1.2.0 IN ATTENDANCE

Led by Prof Donna Mead (Chair)

Mr Phil Hodson, Assistant Director of Planning
Mr David Cogan, Patient Liaison Group (PLG)

1.3.0 DECLARATIONS OF INTEREST

Led by Prof Donna Mead (Chair)

1.4.0 MATTERS ARISING

1.4.1 Action Log

Led by Prof Donna Mead (Chair)

1.4.1 Action Log updated from 25 06 2020.docx V2.docx

2.0.0 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

Led by Prof Donna Mead (Chair)

2.1.1 Minutes from the Public Trust Board meeting held on the 25th June 2020

Led by Prof Donna Mead (Chair)

2.1.1 Draft Trust Board Minutes 25 06 2020 .docx

2.1.2 Contract Acceptance & Expected Urgent Decisions over £100,000 (Procurement)

Led by Mark Osland, Executive Director of Finance

2.1.2 TB Proc Submission Summary 30 July 20 docx.docx

2.1.2 NWIS Data Centre 2 Final.docx

2.1.3 Quarter 2 Plan Update

VNHST Quarter 2 Operating Plan received under consent - Mr Phil Hodson, Assistant Director of Planning

o The presentation was received at the 25th June Board
o Plan covers Velindre Cancer Centre, Welsh Blood Service and Corporate services
o Plan was submitted in draft on 3rd July 2020 - Welsh Government were aware and knew that plan was submitted in draft and that it would be going to Trust Board on 30th July
o Trust Board are being asked to approve the plan

2.1.3 Quarter 2 Operating Plan - Trust Board 30th July 2020.docx

2.1.3 Annex 1 - VUNHST Quarter 2 Operating Plan - Final Draft.pdf

2.1.3 Annex 2 - VUNHST Quarter 2 Operating Plan - Appendices Final Draft.pdf

2.1.4 Velindre University NHS Trust - Review of the Standing Orders

Led by Lauren Fear, Interim Director of Corporate Governance

2.1.4 Amendment to Standing Orders - Trust.docx

2.1.5 Shared Services Partnership Committee - Review of the Standing Orders

Led by Lauren Fear, Interim Director of Corporate Governance

2.1.5 VUNHST Review of Standing Orders 30072020.docx

2.1.5 Appendix 2 DRAFT Standing Orders for Operation of SSPC 15072020.doc

2.1.6 Chairs Urgent Action (Period 25th June - 24th July)

Led by Lauren Fear, Interim Director of Governance

2.1.6 Chairs Urgent Action 30 07 2020.docx

2.2.0 FOR NOTING

Nil

3.0.0 PRESENTATION - CHALLENGES / NEXT STEPS / Q3 PLAN

Presentation led by Steve Ham, CEO

Trust Board CEO Presentation 30th July 2020.pptx

4.0.0 KEY REPORTS

4.1.0 Chairs Update

Led by Prof Donna Mead (Chair)

4.1.0 - Chair Update Report- 30 July 2020 -Final.docx

4.2.0 CEO Update

Led by Mr Steve Ham, CEO

4.2.0 CEO Update Report - July 2020 -final.docx

5.0.0 QUALITY & SAFETY

5.1.0 Quality and Safety Highlight Report

Led by Mrs Janet Pickles, Chair of the Q&S Committee

Quality Safety Committee July 2020 Highlight Report Final.docx

Appendix 1 PTR Report.docx

5.2.0 Trust Risk Register

Led by Lauren Fear, Interim Director of Corporate Governance

Note: Full Trust Risk Register received at June Board

5.2.0 - Trust Risk Register - Cover Paper.docx v2.docx

5.2.1 Trust Risk - EU Exit - Risk 14860

Led by Lauren Fear, Interim Director of Corporate Governance

5.2.1 Appendix 1 - 14860 TRR_EU Exit_21.07.20.docx

6.0.0 PLANNING & PERFORMANCE

6.1.0 Delivering Excellence Performance Report Period

Led by Cath O'Brien, Chief Operating Officer

6.1.0 Final Delivering Excellence Performance Report - 30th June 2020 (002).docx v2.docx

6.1.0a VCC Performance Report - June 2020 TB.pdf

6.1.0b WBS Performance Report - final June 2020.pdf

6.1.0c Workforce Performance Report - June 2020 (003).docx

6.2.0 Financial Report Period - Month 3

Led by Mark Osland, Executive Director of Finance

6.2.0 20-21 Month 3 Finance Report TRUST BOARD 30.07.2020.docx

6.2.0 M3 VELINDRE NHS TRUST FINANCIAL POSITION TO JUNE 2020 - TRUST BOARD.docx v2.docx

6.3.0 Transformating Cancer Services Programme Scutiny Highlight Report 28th July 2020

Oral update by Stephen Harries, Chair of the TCS Scrutiny Committee

6.4.0 Transforming Cancer Services Communications and Engagement Update

Led by Lauren Fear, Interim Director of Corporate Governance

6.4.0 Trust Board TCS Comms and Engagement 30 July 2020.docx

7.0.0 WORKFORCE & ORGANISATIONAL DEVELOPMENT

7.1.0 Trade Union Partnership - Update

Oral update led by Sarah Morley, Executive Director of Workforce & OD

7.2.0 Remuneration Committee Highlight Report

Oral update led by the Chair, Prof Donna Mead

8.0.0 RESEARCH, DEVELOPMENT AND INNOVATION

8.1.0 Academic Partnership Board Highlight Report

Led by the Chair, Prof Donna Mead

8.1.0 Highlight Report - Academic Partnership Board 22 07 2020.docx v2.docx

8.1.0a ACADEMIC PARTNERSHIP BOARD ToR REVISED.docx v4.docx

9.0.0 INTEGRATED GOVERNANCE

9.1.0 Audit Committee Highlight Report

Led by Martin Veale, Chair of Audit Committee

9.1 Audit Committee Highlight Report 09 July 2020 final.docx

9.2.0 NHS Wales Shared Services Partnership - Audit Committee Assurance Report

Led by Martin Veale, Chair of Audit Committee

9.2.0 30062020 VUNHST Audit Committee Assurance Report.docx

10.0.0 ANY OTHER BUSINESS

Prior Approval By the Chair Required

11.0.0 DATE AND TIME OF THE NEXT MEETING

The next Trust Board meeting and AGM is the 24th September 2020 - timing and schedule to follow

12.0.0 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 25TH JUNE 2020

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
Public Trust Board 28.11.2019				
28-11-19 2.2.5	**Health Technology Wales – Annual Report** **Action:** Paper for Trust Board of Audit Committee outlining Steve Hams role in HTW and its governance	**CLOSED** Steve Ham, CEO will be a member of the Executive Group (starting the 30th July) and the Stakeholder Group (awaiting dates from HTW). HTW, like all hosted organisations, will be mapped into the revised proposed Committee structure Management group meetings are set up to ensure connectivity with the Trust and a planned schedule of reporting into Board is being developed which will feed into the revised cycle of business mapping through the Committee structure review. .	**SC/SH** **Now, LF/SH**	**CLOSED**
7.3	**Radiotherapy Performance**	**UPDATE JULY 2020**		

	COB and MO will keep the Board appraised of the management of the financial risk. The detailed operational plan will be kept at operational level.	**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 as part of the ongoing commissioning dialogue.	**COB**	**CLOSED for 2019/20 position** **OPEN for 2019/20 position – Update due in September 2020**
28-09-17 **4.3**	**Velindre NHS Trust Risk Appetite Statement** • **Action:** Collect emerging themes and report back to the Board in 6 months. • **Action:** Training event and practical plan to implement this process	**UPDATE JULY 2020** Risk Appetite workshop scheduled with the Board for 27th August, as part of the Board Briefing. All IM-Exec lead pre-meets now scheduled.	**LF**	**OPEN** **September 2020**

	The Board APPROVED on the basis that the above comments are noted and the actions taken forward.	Consideration for approval of new Risk Appetite strategy and refreshed risk appetite statements then scheduled for 24th September Trust Board.		
19.12.2019 – Extraordinary Public Trust Board				
2.0	**Urgent Decisions Over £100k** 1. Mr Mark Osland and Mrs Lauren Fear will be addressing the process supporting the "Over 100k Commitments" with Procurement colleagues in January 2020, and this will include a review of the detail captured within the reports as well as improving consistency of content. An update will be received at the January Trust Board meeting.	**UPDATE SEPTEMBER 2020** A plan has been being drawn up to include a full review of the whole process and to determine procedural responsibilities. Also now incorporated into the revised on-going process will be the learnings from the process working through the COVID response period – to report back to September Board	**MO/LF**	**OPEN** **September 2020**
30.04.2020 Public Trust Board				
	• 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 25th 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** • 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 27th August Board Briefing	**CJ**	**CLOSED**
7.1.0	**Q2 VUNSHT Operational Plan** • Mr Carl James agreed to meet with CHC to agree reporting templates for Q2 and performance reports.	**UPDATE JULY 2020**	**CJ**	

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

MINUTES OF THE PUBLIC TRUST BOARD – PART A

VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
THURSDAY 25TH JUNE 2020 @ 11:00AM

PRESENT:

Professor Donna Mead	Chair (Chair)
Mr Stephen Harries	Interim Vice Chair
Ms Janet Pickles	Independent Member (left the meeting at 12:30pm)
Mr Martin Veale	Independent Member
Mrs Hilary Jones	Independent Member
Mr Gareth Jones	Independent Member
Mr Steve Ham	Chief Executive
Mr Mark Osland	Executive Director of Finance and Informatics
Dr Jacinta Abraham	Executive Medical Director
Mrs Nicola Williams	Executive Director of Nursing, Allied Health Professionals and Health Scientists
Mrs Sarah Morley	Executive Director of Workforce and OD

IN ATTENDANCE:

Mr Carl James	Director of Transformation, Planning, & Digital
Mrs Lauren Fear	Interim Director of Corporate Governance
Mr Daniel Price	Community Health Council (CHC) Representative
Ms Cath O'Brien	Interim Chief Operating Officer
Mrs Katrina Febry	Audit Wales
Mrs Rebecca Goode	Secretariat

DRAFT

1.0.0	**STANDARD BUSINESS** Led by Prof Donna Mead (Chair) Prof Donna Mead welcomed everyone to the Trust Board Meeting, 25th June 2020 and confirmed that the intention was record the meeting today, technology permitting, with the intention to live stream in July.	

1.1.0	**APOLOGIES** Led by Prof Donna Mead (Chair) Apologies were received for:- • Prof Donald Fraser, Independent Member • Stephen Allen, CHC **NOTED.**	
1.2.0	**IN ATTENDANCE** Led by Prof Donna Mead (Chair) • Susan Myles, HTW • James Quance, NWSSP Audit	
1.3.0	**DECLARATIONS OF INTEREST** Led by Prof Donna Mead (Chair) Nil	
1.4.0	**Action Log** Led by Prof Donna Mead (Chair) The action log was reviewed and updated. **DISCUSSED** and **UPDATED**	
2.0.0	**CONSENT ITEMS** Led by Prof Donna Mead (Chair) The consent agenda was reviewed and items 2.1.1. Minutes of the Public Trust Board meeting held on the 4th June 2020, 2.1.3 Chairs Urgent Action Endorsements and Policies for Approval were **APPROVED.** Item 2.2.1 Charitable Funds: Financial & legal implications in the event of cancelling a fundraising Event. **NOTED.**	
3.0.0	**UPDATE: Health Technology Wales (HTW)** Led by Susan Myles, Director of HTW Dr Susan Myles thanked the Board for inviting her to the meeting and confirmed, for the Board, that the remit of HTW is to facilitate the identification, appraisal and adoption of non-medicine health technologies. In recent months, HTW has diverted its research capacity and skills to focus on COVID-19 topics to inform the response to the ongoing pandemic.	

DRAFT

In summary:

- Produced C-19 evidence digest and this has been updated weekly and well received.
- HTW continues to horizon scan to identify new technologies that offer diagnostic and therapeutic potential in C-19 technologies using the UK wide Health Technology Connect Platform.
- Appraisal of C-19 technologies - HTW has prepared a number of rapid evidence reviews to appraise the quality and quantity of evidence available to support their potential adoption and use within Wales.
- Adoption of C-19 technologies providing evidence appraisals and expert advice into a number of strategic Welsh Government C-19 committees, to inform the adoption, or otherwise, of C-19 technologies that offer potential.
- C-19 national and international collaborations providing evidence appraisals and expert advice into a number of strategic Welsh Government C-19 committees, to inform the adoption, or otherwise, of C-19 technologies that offer potential.
- C-19 national and international collaborations using its HTA networks to identify opportunities for collaborations on C-19 evidence synthesis to maximize economies of scale and minimize duplication of effort both nationally and internationally.
- C-19 General support activities **-** undertaking a range of other general support activities including:
  - Working closely with the Surgical Materials Testing Laboratory to answer specific research questions as required.
  - Contracting external consultant support to screen and review medical device certification and test compliance reports for C-19 equipment.
  - Contracting subject specific expertise in specific areas e.g. personal protective equipment.
  - Facilitating contacts between technology developers and UK regulators on authorisation queries (e.g. Ventilators and CPAP machines).
  - Triaging and signposting C-19 enquiries received by HTW that are out with our remit to appropriate support.

In summary, it has been challenging but offered many opportunities.

We have witnessed a disruption of the traditional research and evidence paradigm and HTW need to reflect and learn from this. HTW is a relatively new organisation and the Team have been fantastic in meeting the challenges and opportunites of the pandemic. Unfortunately, the HTW Team are unlikely to return to life Sciences Hub office until September but our virtual board meetings will commence in July.

Mr Steve Ham congratulated Dr Susan Myles on a great work programme and one of the objectives agreed was to work with the Health Boards and demonstrate the contribution that HTW can make and make HTW more visible in NHS Wales. The Chair confirmed that she had shared the papers, received today, with Chair's Peer group scheduled for the 30th June 2020. Dr Susan Myles confirmed that she was very grateful for the Board's support and that COVID-19 has

DRAFT

	certainly raised the profile of HTW. Mr Steve Ham asked to collect further feedback from colleagues in Wales and Dr Susan Myles confirmed that they have an evaluation tool that does collate this feedback and would be happy to share that data in due course. The Chair was delighted to receive the HTW update and asked to convey the Board's appreciation to the Team for their hard work. The Board **NOTED** the update.	
4.0.0	**KEY REPORTS**	
4.1.0	**Chair's Update** Led by Prof Donna Mead (Chair) The Chair updated the Board and confirmed that the report was for noting and highlighted the following news:- • Mr Simon Lawrence, promoted to Colonel and Commanding Officer, supporting the Field Hospitals and this will be reported in the daily communications brief. • Confirmed the 24th September as the date of the AGM The Board **NOTED** the update.	
4.2.0	**CEO Update** Led by Steve Ham, CEO Mr Steve Ham summarised the report and briefed the Board on some of the challenges facing the Trust as we move forward and resume essential services, whilst working within social distancing rules in both our services and corporate headquarters. Mr Ham informed the Board that there is an intense piece of work being undertaken which involves improved structures and new ways of working that will support a new fluid and agile way of working. There has been an MHRA Inspection in Welsh Blood Service which will report in the usual way but very pleased with initial review outcome. Mr Ham informed the Board of the development of the Transformation Cancer Services (TCS) Programme and how the communications team is working hard to engage with the community and stakeholders to ensure that the Trust convey the benefits of the new hospital, the ambition for the site and the contribution to the community. The Board were informed that Mrs Karen Wright, Assistant Director of Workforce had taken a one year secondment with the Cwm Taf Morgannwg University Health Board. Finally, Mr Ham informed the Board of the social media activity aimed at patients and donors to continue using our services. Mr Daniel Price's comments regarding 'boosting the credits' to get a much wider platform to reach service users will be taken on board.	

DRAFT

	The Board **NOTED** the update.	
4.3.0	**COVID-19 Update** Led by Cath O'Brien, Chief Operating Officer Mrs Cath O'Brien updated the Board on the activity that is underway to support the return to services and which is covering three main themes: • Estates • People • Clinical Pathways To confirm the Trust is working within Welsh Government (WG) guidelines and working to meet demand based on accumulated demand known within our Trust, understanding the accumulated demand within the Health Boards (HBs) and the accumulated demand within the Community. The Trust is working closely with WG and the Delivery unit to ensure we meet demand and is undertaking a thorough capacity review to look at what is required in additional capacity. To assure, the board, the Trust is also reviewing the working practices of our staff, in terms of their working patterns (at home and in the office) and their well-being. Mr Carl James confirmed that good progress had been made with the modelling of radiotherapy and the Trust is using a sophisticated model to understand the lag time and will be reviewing the outputs next week. Mr Carl James confirmed that he would share the radiotherapy (RT) modelling detail with Board colleagues at the 9th July board briefing. In Welsh Blood Service (WBS), there has been an increase in patient referrals and the Service is expecting to see an increase in demand from Q3/4 onwards. Mrs Cath O'Brien summarised, for the Board, the detail of the staff testing programme at VCC. This has been a collaborative apporach between WBS, C&V & PHW with 300 staff invited to be tested and 80% of the staff accepted the offer, which is a testament to the commitment of the staff. The resuults are being analysed and will follow in due course. **Action:** Include the capacity and demand modelling for radiotherapy (RT) and wider service on the Board Briefing agenda for the 9th July. The Board **NOTED** the update.	CJ
5.0.0	**QUALITY & SAFETY**	
5.1.0	**Quality and Safety Highlight Report from Committee Meeting 22nd June 2020**	

DRAFT

	Led by Jan Pickles, Chair of the Q&S Committee Mrs Janet Pickles confirmed that the Q&S Committee were meeting monthly and managing to conduct the full business within the time allocated for both Part A and Part B. Mrs Pickles drew the Board's attention to the section on the equality part of the report and confirmed that she had attended two working groups; Diasbability and LGBT and there is a lot of anxiety with some of the staff groups about returning to work. However, she felt assured by the work being undertaken by workforce and the oversight being captured at Q&S Report. The Board **NOTED** the update.	
5.2.0	**Nurse Staffing Act (Wales) Act 2016** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists Mrs Nicola Williams updated the Board on the Nursing Staffing Act (Wales) Act 2016 and the requirement for an annual report to be submitted to the full Board each year. The only section of the Act that is relevant to the Trust is 25A. This is an excellent report and highlighted just a couple of other areas that will require further support, such as Allocate, which is a new nurse staff rostering system for both divisions. In addition, Mrs Williams summarised for the Board the work undertaken during the pandemic around the staffing and bed capacity with minimal and optimal modelling to ensure patient safety. To confirm that that these were not required as bed requirements did not increase The Chair acknowledged the work that was done in planning for the pandemic and expressed delight with the implementation of the electronic rostering system. The Board **APPROVED** the Nurse Staffing Act (Wales) 2019-20 Annual Report. The Board **NOTED** the actions taken during the acute phase of the COVID-19 pandemic to ensure safe staffing levels within Velindre Cancer Centre and **NOTED** the actions being taken to further enhance monitoring and compliance with the Nurse Staffing Act (Wales) 2019-20.	
5.3.0	**VUNHST Risk Register** Led by Lauren Fear, Interim Director of Corporate Governance Mrs Lauren Fear presented the report and risk register and confirmed that the report updates on the development of the risk assurance framework and the risk appetite workshop now scheduled for Board Briefing in August.	

DRAFT

	There were 3 changes that were endorsed at EMB on the 23rd June 2020 for discussion at Trust Board:- • **Ventiliation at VCC** – Mr Carl James outlined the risk, the actions being taken and the Programme Business case (PBC) that is being developed to carry out the work at VCC and note the Trust is awaiting some air sampling tests which will inform the necessary action. It is important to note the PBC also includes fire safety. However, it is important to note that capital is now limited due to COVID expenditure. The Board will be updated on prgress. To give assurance, to the Board, the wellbeing of staff and patients is very much in focus. Mrs Nicola Williams confirmed that additional measures are being put in place to support staff with more frequent breaks, lighweight uniforms, risk assessing the use of fans and issuing of cold drinks. • **Social Distancing** – Mrs Catherine O'Brien confirmed that she is the Chair of the Social Distancing Cell and outlined the various strands to consider in a COVID world. Mrs Janet Pickles requested that reassurance and guidance is put in place for those workers who are not so keen to return to the workplace for various reasons. Mrs Cath O'Brien confirmed that vulnerability assessments were taking place in a structured and individual approach given the importance and to ensure that staff feel supported. • **CCT Scanning risk** – this risk has been de-escalated following a series of actions as detailed on the register. The Chair asked about the funding for COVID related activities. Mr Mark Osland, Director of Finance confirmed that there are two significant main risks; COVID costs acrued during the pandemic and also the wider aspect with the commissioners/contractual arrangements and confirmed this will be picked up in the finance section of the report. The Trust Board **APPROVED** the Trust Risk Register.	
6.0.0	**WORKFORCE & ORGANISATIONAL DEVELOPMENT**	
6.1.0	**Local Partnership Forum Update** Oral update by Sarah Morley, Executive Director of Workforce and Organisational Development Ms Sarah Morley confirmed that the Trust continued to engage with Trade Union (TU) colleagues and to build on previous conversations at weekly meetings. Social distancing is very much on the agenda, along with PPE. In additon to these meetingsTU colleagues are invited to attend the relevant cells.	

DRAFT

	In terms of the broader engagement - there is a plan to build on the partnership forum established in WBS with the same being estabslished in VCC. Mrs Nicola Williams confirmed that the Trust meetings with the Trades Unions were orgininally weekly meetings but will move to fortnightly. These meetings have always had formal minutes and action logs taken to support the process. The Trust Board is asked to **NOTE** the update	
7.1.0	**Q2 VUNSHT Operational Plan*** Led by Carl James, Director Strategic Transformation, Planning & Digital Mr Carl James led the presentation for the Board and outlined the key principles as below. In summary there are three main areas that WG have asked the Trust to plan for, which are: 1. Our planning arrangements for Covid-19 Patients 2. Planning for Covid-19 patients plus the return to essential services 3. The provision of a Covid safe and secure model for our services – whilst meeting social distancing guidelines and continuing the staff test, trace and protect process Mr James explained the Q1 Plan was about developing the plans. The Q2 plan is about establishing essential service models and updated the Board on the following: • Clinical models framework • The financial assumptions/contractual arrangements • Exploring extended hours and new ways of working • Working with Health Boards and Outreach to align plans • Review of models of delivery:- - 60% of services delivered in the home or outreach services which have been brought back into the VCC service - The change of programme and venues in WBS to make it safe for the donors • SACT capacity ensuring a robust plan for outreach and exploring opportunities with our commissioners • Radiotherapy service change programme and plans to reprioritise the programme of work • The Test, Trace and Protect Cell has been running for 3 weeks and the Board will receive regular updates as the work progresses • Workforce elements permeate through all of the plans - ensuring that staff are supported • Building on partnerships with Trade Unions	

DRAFT

	The Chair acknowledged that the Trust had an IMTP plan in place and these additional arrangements were due to the COVID environment that has necesitated the quarter plans. The Chair confirmed that there will be an out of Board Chair action for approving the final document on 2nd July. If the Board approves the Q2 plan, the deadline for submitting to Government is the 3rd July. **Action:** • Mr Carl James agreed to meet with CHC to agree reporting templates for Q2 and performance reports. The Trust Board is therefore asked to **NOTE** the update today.	CJ
7.2.0	**Delivering Excellence Performance Report Period** Led by Cath O'Brien, Chief Operating Officer Mrs Cath O'Brien summarised the Delivering Excellence Performance Reports, highlighting the following points. **Velindre Cancer Centre:** • A number of Radiotherapy Patients missed their target dates which was due to the impact of the pandemic. The Chair asked for clarification about the 35 day breach and asked if the narrative could be clearer to show only the number of 'day's of breach' (from the date when the patient breaches past 35 days) and Mrs O'Brien confirmed that report is under development and the new report will provide a more detailed picture; • Therapy data is not correct in the report and will be corrected for next time. To confirm that there is Dietetic post out to advert to increase resilience in therapies. **Welsh Blood Service** • Missed the targets on waste red platelet and red cells but this is being addressed. **Trustwide**: • The reports focuss on the data until the end of April but May is showing a similar picture. PADR activity and Mandatory & Statutory Training activity has reduced due to the impact of COVID but will have increased focus as we move forward into the recovery phase. The Chair confirmed that the Trust is doing well with PADR and M&S under the circumstances . **Action:** • A request from Mr Martin Veale to include some narrative in the report that provides a more detailed picture about staff that are shielding and to include another tier of sickness to show where there are gaps. The Trust Board **NOTED** the update.	SfM

DRAFT

7.3.0	**Financial Report Period 2** Led by Mark Osland, Director of Finance Mr Mark Osland summaried the May 2020 financial report and highlighted the following:- In summary the Trust is forecasting a breakeven postion but there are some fairly big capital spends that the Trust may want to pursue if funding for Capital bids do not materialise from WG. Mr Martin Veale asked if the extra COVID expenditure was mostly capital. Mr Osland confirmed that the revenue was estimated at £2.6m (but the Trust has already secured £1.1m for the Convalesent Plasma) – the outstanding value for COVID both from revenue and capital are roughly the same. Mr Osland confirmed that there is a table forecasting £1.5m in capital and the revenue £2.6m in the report. Mr Gareth Jones asked if there were sufficient discretionary funds, which stands at £1.8m, to cover these costs. Mr Mark Osland confirmed that was not the case. Mr Osland confirmed that there were some commitments against the discretionary spend and some of the requirements ie ventiliation, fire safety – is identified in the report are significant spends. If there is shortage of funds from WG then agree there will be some difficult decisions to be made. The TCS financial positon as at the end of May is attached as (appendix 1) outlined the substantial spend of £9m and to note that the Trust has not secured the budget yet but the interim request of £1.6m looks promising and will be in addition to the COVID request. Mr Mark Osland confirmed that this was a new reporting template and invited the Board to comment/feedback on the report. The Trust Board **NOTED** the update.	
7.4.0	**The Accountability & Accounts for 2019-20 for Velindre University NHS Trust** Led by Mark Osland, Director of Finance Mr Martin Veale confirmed that the reports had been considered in Audit Committee ahead of this Board meeting on the 25th June 2020. The Audit Committee endorsed these for submission to Board today. Mr Mark Osland confirmed that this is the annual suite of documents. Mrs Lauren Fear presented the Accountability Report and thanked Emma Stephens for this report which includes the board's view of	

DRAFT

	Board/Committee effectiveness. To note that there are some minor amendments to be made to the report. Mr Osland confirmed the Annual Accounts and confirmed that page 25 explains that the Trust met its financial duty. Also includes an approved IMTP. Mr Osland acknowledged the work of the finance team, considering the challenges due to remote working. Mr Veale also reiterated his thanks to the finance team as did the chair on behalf of the Board. Mr Osland said the ISA260 report is included but a more detailed report will follow in August but this highlights the observations of the ISA 260 report (unqualified opinion). There is one matter which is included in the report and refers to 'emphasis of matter' which will be referenced and relates to the pension tax liabilities. To note that this expenditure is recorded as irregular and it affects all NHS bodies. It is a unique matter and one that the government will advise on. There are some changes that will need to be made, largely presentable, but nothing that has affected the financial statements. The Chair on behalf of the Board thanked the finance team and the wider NHS colleagues for their hard work. The Board **APPROVED** the Accountability Report and Annual Accounts for 2019-20 and **DULY AUTHORISED** the Chairman, Chief Executive and Executive Director of Finance to sign the Accounts Certificates, Letter of Representation and Accountability Report as appropriate.	
8.0.0	**INTEGRATED GOVERNANCE**	
8.1.0	**Structured Assessment and Internal Audit Report** Led by Lauren Fear, Interim Director of Corporate Governance Mrs Lauren Fear summarised the Structured assessment and internal audit review field work which will start in June and to note the timetabling of the work. This review is a joint approach primarily for internal audit but also with external audit and the full details are contained with the report. The Board is asked to **NOTE** the content of this update report from the Interim Director of Corporate Governance.	
8.3.0	**NWSSP COVID Approval Update** Led by Mark Osland, Director of Finance Mr Mark Osland explained that NWSSP have requested an extension to the revised financial scheme of delegation in respect of COVID 19 related contracts until 30 September 2020, when they will be reviewed again.	

DRAFT

	To confirm that approvals have slowed down and whilst the Board are in agreement, the Board were keen to see a more planned approach going forward with procurement activity. Mr Stephen Harries was keen to highlight the good work of the NWSSP who have worked to support the huge amount of requests in dealing with demands of COVID. To reassure the Board, the Trust relays the absolute importance of comprehensively documenting on every step of the entire process leading up to the final recommendation and decision-making with the senior finance team in NWSSP. The Board **APPROVED** the extension to revised financial scheme of delegation in respect of COVID 19 related contracts until 30 September 2020. As part of confirming the extension of delegated authority approval, the Board would like to convey to the senior team at Shared Services the Board's expectation that their various teams are documenting absolutely everything appropriately. Also to highlight the guidance and auditors review of the policy direction.	
9.0.0	**ANY OTHER BUSINESS** Prior Approval By the Chairman Required Nil	
10.0.0	**DATE AND TIME OF THE NEXT MEETING** Led by Prof Donna Mead (Chair) The next Trust Board Meeting is the 30th July 2020 - details to be confirmed.	
11.0.0	**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).	

DRAFT

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENTS EXCEEDING £100k FOR THE PERIOD 30th July 2020 to 23rd September 2020

DATE OF MEETING	30th July 2020
PREPARED BY	Helen James
PRESENTED BY	Mark Osland, Executive Director of Finance
EXECUTIVE SPONSOR	Mark Osland, Executive Director of Finance

REPORT PURPOSE	For Approval

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

ACRONYMS	NWIS - NHS Wales Informatics Service

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	NWIS	Data Centre Services	1st July 2021 and expire on 30 June 2026, with the option to extend for a further two (2) years, in annual increments	7,700,000

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.

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

BOARD DECISION REQUIRED FOR COMMITMENT EXCEEDING £100k

1. *SCHEME TITLE*

DATA CENTRE SERVICES

2. *CONTRACT DETAILS*

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

In 2014, NHS Wales Informatics Service ("NWIS") executed an Agreement to provide co-location services for the hosting of networking and server equipment. The Agreement was for the provision of a new Tier 3 Data Centre to be paired with the existing Data Centre located in Blaenavon to host NHS Wales IT systems, which replaced the Hosting Service provided by British Telecommunications plc out of their Cardiff Bay Data Centre.

The Agreement was for a period of five (5) years, which commenced on 01 July 2014 and concluded on 30 June 2019, with the option to extend for a further two (2) years, up to 30 June 2021.

The final extension option has been executed and NWIS is seeking to begin the re-procurement of this requirement. Commencing the procurement process with immediate effect will ensure that the provision of this critical service continues during a potential transitional period, in the event that there is a change in Contractor.

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 30 June 2021 and NWIS is seeking to commence the procurement process with immediate effect to ensure that the provision of this critical service continues while discussions are undertaken regarding the future data centre strategy.

- **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 mini competition via the Crown Commercial Services, Network Services 2 Framework, Lot 1, Data Access Services (RM3808/L1).

2.4. ***Timescales for implementation***

The implementation timescales will vary depending on the outcome of the mini competition. If the contract is awarded to the incumbent Contractor then there will be no implementation required. If there is a change in Contractor, there will be a transition period, however, the timescales for this will become clearer when the contract is awarded.

2.5. ***Period of Contract***

It is anticipated that the contract will be for a period of five (5) years, to commence 01 July 2021 and expire on 30 June 2026, with the option to extend for a further two (2) years, in annual increments.

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	Qty	Unit Price exc VAT	Total Price exc VAT	Total Price inc VAT
CORE REQUIREMENTS				
Initial Contract Term – Anticipated costs from 01 July 2021 to 30 June 2026	55	*£20,000 per rack per annum	£5,500,000	£6,600,000
OPTIONAL REQUIREMENTS				
Contract Extension – Anticipated costs from 01 July 2024 to 30 June 2028	55	*£20,000 per rack per annum	£2,200,000	£2,640,000
Anticipated Contract Value			**£7,700,000**	**£9,240,000**

*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.

2.7. ***Source of Funds***

This will be funded from Revenue.

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

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

Service Area: NHS Wales Informatics Service

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

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST - QUARTER 2 OPERATING PLAN

DATE OF MEETING	30/07/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Deputy Director of Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning and Digital

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	21st June 2020	ENDORSED FOR BOARD APPROVAL

ACRONYMS	
VUNHST	Velindre University NHS Trust
Q2	Quarter Two

1. SITUATION/BACKGROUND

1.1 We have developed our Quarter 2 Operating Plan in line with the requirements of the *NHS Wales COVID-19 Operating Framework Quarter 2 (2020 / 2021)*. The Presentation was received at the 25th June Trust Board and the plan covers Velindre Cancer Centre, Welsh Blood Service and Corporate Services.

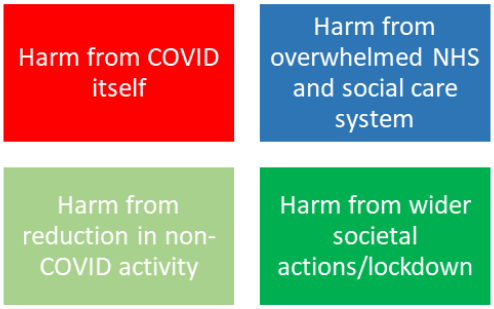
The plan was submitted in draft on the 3rd July 2020 with the agreement that this would be formally approved at the 30th July 2020 Trust Board Meeting.

1.2 Our Quarter 2 Operating Plan (*see Annex 1 and Annex 2*) sets out our intentions for the period from July - September 2020, in the context of the COVID-19 pandemic. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines 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.

1.3 The Plan sets out how we will maintain supplies of blood and blood products to the whole of NHS Wales, deliver essential tertiary cancer services to South East Wales and the enabling activities that will be undertaken by Corporate Departments. It builds upon the foundation 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 exponential increase in demand for cancer and blood services in Quarter 3 and 4 as essential services continue to increase their ability to deliver required care and patients feel more assured to present for it. It also provides a strong foundation for planning and delivery of our services as we enter the winter period with the risk of resurgence in COVID-19 infection rates.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Our Quarter 2 Operating Plan aims to ensure that we can continue to provide essential services to patients requiring cancer treatment and to Health Boards who require secure supplies of blood and blood products and support for transplant services. In developing our plans a key focus has been to minimise harm across the following four key areas which have identified by the Welsh Government.



2.2 We have worked closely with the Welsh Government, Health Boards, our internal teams and other partners e.g. Wales Cancer Network to review the range of factors which may impact our services. There is agreement across the system that we need to ensure that we are able to deliver essential health services for our population and, where possible, recommence more routine care. However, we need to do this progressively, and with caution, through short planning cycles that maintain the flexibility and agility we have demonstrated over recent months.

2.3 We have also ensured that our Quarterly Operating Plan is aligned with, and informed by, the following principles and National guidance.

Planning Principles for Quarter 2:

Our Operating Plan is based upon the following planning principles:

- Our plan is aligned with our strategic goals and with our medium – long term plans and as outlined within our IMTP
- Our plan is based upon a clinically led risk management approach to service delivery in line with our clinical principles
- Our plan is in line with national policy and guidance e.g. social distancing
- Our plan has been developed in partnership with key stakeholders
- Our plan is based upon working regionally on solutions where appropriate
- Our plan is resilient and flexible so that we can adapt as the pandemic changes

National Guidance:
Summary of the Welsh Blood Service Plan:

2.4 The Welsh Blood Service Quarter 2 Operating Plan is summarised below:

- During Quarter 2 we will return to '*Business As Usual*' for all essential services
- A key focus for Quarter 2 is to review and revise clinic planning venues, locations and capacity requirements
- We have worked with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plan

> We have ensured that our Operating Plan is aligned with, and informed by, the following guidance:
> - NHS Wales COVID-19 Operating Framework Guidance Quarter 2
> - Operational guide for the safe return of healthcare environments to routine arrangements following the initial COVID-19 response
> - Reducing the risk of transmission of COVID-19 in the hospital setting
> - A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during COVID-19
> - A Framework for the Reinstatement of Cancer Service in Wales during COVID-19
> - The restoration of solid organ transplant services in line with NHS Blood & Transplant guidance
> - Maintaining Essential Health Services during COVID-19 Pandemic
> - Specialty guides for patient management during the coronavirus pandemic (NHS) and in the recovery phase

- Based upon our assumptions we will be able to collect enough blood to meet Health Board demand
- We have identified a number of key risks which could impact delivery of our plan

Note: The Welsh Blood Service Quarter 2 Operating Plan is included as *Annex 1*.

Summary of the Velindre Cancer Centre Plan:

2.5 The Velindre Cancer Centre Quarter 2 Operating Plan is summraised below:

- We aim to develop a resilient, quality driven, service model for VCC patients, which is able to respond to peaks and troughs in demand during COVID-19 throughout 2020-2021
- Our plan is flexible and includes options for the expansion of services in order to respond appropriately should a return to the acute phase be required and to accommodate patients repatriated from Health Boards and expected demand growth
- During Quarter 2 we will continue to deliver all essential services
- Our key focus for Quarter 2 is to maximise available service capacity within existing resources and to '*reset*' our clinical service model to prepare for the return of outreach services in local communities
- We have worked with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plan
- Based upon our assumptions we will be able to meet demand for our services

Note: The Velindre Cancer Centre Quarter 2 Operating Plan is included as *Annex 1*.

Delivering our Quarter 2 Operating Plan – Management Arrangements:

2.6 In order to support the delivery of our COVID-10 operating plans we have strengthened our existing management arrangements by establishing seven response '*cells*' which cut across all parts and levels of the organisation. Each cell is led by an Executive Director and supported by an operational lead. The purpose of each '*cell*' is to ensure that there is a single, timely, proportionate, coordinated and authoritative overview of the most critical elements of our pandemic response to assure service delivery, patient and staff safety.

2.7 Each of our '*cells*' reports to Trust Executive Management Board. The Trust Executive Management Board are then responsible for ensuring that are response plans are being delivered and that the strategic direction is still congruent with the developing situation.

2.8 The seven cells are as follows:

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

- Digital Staff and Patient Connectivity Cell.

Monitoring the Delivery our Quarter 2 Operating Plan:

2.9 We have developed detailed Quarter 2 action plans for the Welsh Blood Service, the Velindre Cancer Centre and for our Corporate Support functions. Each action within the plan has an accountable lead officer identified and a stated timescale for delivery. Delivery against the action plan is reported to the Executive Management Board on a monthly basis.

Risks to Delivery:

2.10 We have identified a number of risks to the successful deliver of our Quarter 2 Operating Plan. In response we have developed a comprehensive set of mitigating actions to reduce the likelihood of each risk being realised.

Financial Plan:

2.11 The Quarter 2 Operating Plan sets out our financial strategy and plan, including our assumptions around income and expenditure, anticipated cost pressures, planned investments and financial risks.

2.12 The expectation is that the Trust will achieve a balanced financial positon in 2020-21. However, this is based on the assumption now that the new financial risk of committed COVID-19 expenditure (revenue & capital) will be funded by the Welsh Government. A summary of the Q2 forecast revenue financial position is shown below.

	July 2020 Actual £'000	August 2020 Forecast £'000	September 2020 Forecast £'000	Q2 Total Forecast £'000
Net Surplus/(Deficit)	0	0	0	0

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.

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

4. RECOMMENDATION

4.1 The VUNHST Board is asked to **APPROVE** the Quarter 2 Operating Plan.

Velindre University NHS Trust

Operating Plan for Quarter 2 (2020 / 2021)

(1st July to 30th September 2020)

(Draft - Subject to Trust Board Approval)

INDEX

Appendices (separate document)

1. **Welsh Blood Service Operational Plan as at Q2**
2. **Welsh Blood Service Capacity Plan & Activity Forecasts July to Sept 2020**
3. **Welsh Blood Service Operational Plan Q1 Action Log Delivery Update**
4. **Velindre Cancer Centre Operational Plan as at Q2**
5. **Velindre Cancer Centre Capacity Plan & Activity Forecasts – July to Sept 2020**
6. **Velindre Cancer Centre Operational Plan Q1 Action Log Delivery Update**
7. **Corporate Services Operational Plan Q1 Action Log Delivery Update**

Executive Summary

Our Quarter 2 Plan sets out the Trust's intentions for July - September 2020, in the context of the COVID-19 pandemic. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines 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.

The Quarter 2 Operational Plan sets out how we will maintain supplies of blood and blood products to the whole of NHS Wales; deliver essential tertiary cancer services to South East Wales and the enabling activities that will be undertaken by Corporate Departments. It builds upon the foundation 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 exponential increase in demand for cancer and blood services in Quarter 3 and 4 as essential services continue to increase their ability to deliver required care and patients feel more assured to present for it. It also provides a strong foundation for planning and delivery of our services as we enter the winter period with the risk of resurgence in COVID-19 infection rates.

This plan has been developed at a time when the whole country is living through a very challenging period, even as the current COVID-19 restrictions of lockdown, social distancing, school and business closures begin to be eased. Throughout, our staff continue to respond fantastically, demonstrating huge commitment and professionalism to ensure that essential services have been maintained for our patients during this health emergency.

It describes the context in which our Operational Plan is delivering cancer treatment and blood services in Quarter 2 and the underpinning assumptions we have made, followed by detailed Quarter 2 plans for the Welsh Blood Service, Tertiary Cancer Services and Corporate Departments.

The Q2 Operational Plan sets out how we propose to manage the continuing key COVID-19 challenges as well as a managed return to routine service provision:

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

The Structure of Our Quarter 2 Operating Plan

Part 1: We introduce our Quarter 2 plan and describe the context within which it has been developed.

Part 2: We summarise our planning approach and the key assumptions and principles which have shaped the development of our plan.

Part 3: We summarise our Quarter 2 delivery plans for the Welsh Blood Service and for the Velindre Cancer Centre and identify the key risks.

Part 4: We set out how our corporate support functions will support and drive the delivery of our Quarter 2 plan.

PART ONE: We introduce our Quarter 2 Plan and describe the Context within which it has been developed.

1. **Our Operational Plan for Quarter 2 2020/21 and the Planning National Context**

Note: The National Context for our Quarter Operating 2 Plan is outlined in detail within the NHS WALES COVID-19 OPERATING FRAMEWORK FOR QUARTER 2

There have been a number of developments since the publication of the Operating Framework Guidance for Quarter 1. In Wales lockdown measures are being eased in a steady and cautious approach, in line with the Welsh Government's recovery plan, focused on maintaining and controlling the R value. In parallel with this, the Test, Trace, Protect Programme has been launched across Wales to improve access to testing and contact tracing to help contain and isolate the virus.

From an NHS perspective, although our understanding of the virus is improving, there still remains a high degree of uncertainty in the months ahead. This will continue to make planning challenging as we interpret modelling, and new evidence emerges.

Since the first COVID-19 peak in April the NHS in Wales has been developing and implementing its plans for a dual track approach to delivery of services across all care settings. The World Health Organisation describes Track 1 as remaining ready to provide the full range of services needed to prevent, diagnose, isolate and treat COVID-19 patients, and Track 2 addressing accumulated demand from services that were paused to reduce exposure to and provide care for during outbreak peaks.

Whilst we prepared for the initial COVID-19 peak in March/ April, it is now apparent that NHS Wales will have to adapt to co-existing with, and addressing the challenges of, COVID-19 for some time to come, until a vaccine is developed.

Trust Planning Context

Note: The Trust Planning Context for our Quarter 2 Operating Plan is outlined in detail within our Quarter 2 Plans for the Welsh Blood Service and the Velindre Cancer Centre (see Sections 3 and 4 of our Plan).

The need to co-exist with COVID-19 whilst delivery safe and quality services to our patients and donors is a new challenge. It requires a continued focus on new ways of working, making it essential that we retain the agile and flexible approach used to respond to the challenge of COVID-19 itself.

For our Quarter 2 plan we need to reset the capacity plans we developed to meet the first peak of COVID-19 in response to a reduced but more sustained pressure.

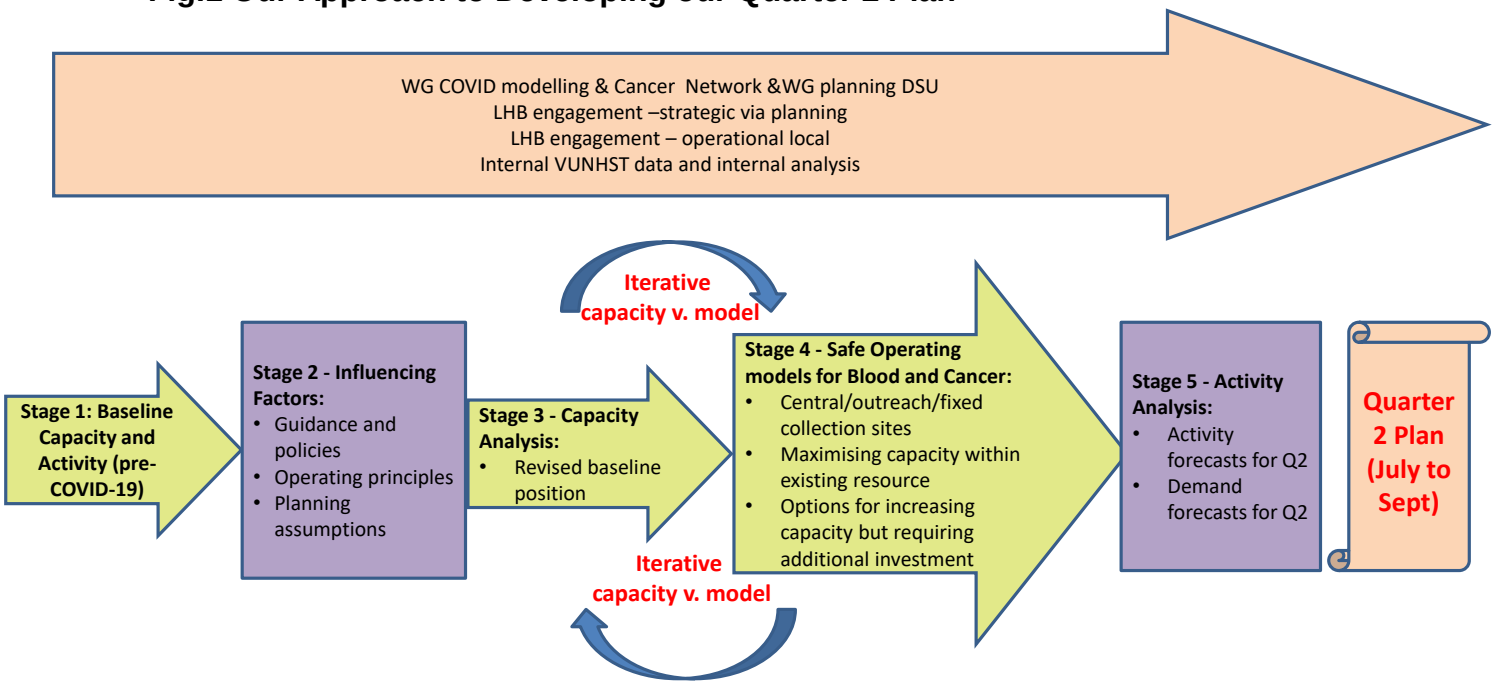
In line with Welsh Government guidance the underlying approach for our Quarter 2 plan is to continue to proceed with caution. However, there is also an opportunity to align the *'new normal'* with our own strategic objectives and with our transformational models of care. We have also embraced the use of digital technology over the Quarter 1 period and our committed to expanding our ambitions in this area over Quarter 2 and over the medium-ling term.

PART TWO: We summarise our Planning Approach and the Key Assumptions and Principles which have shaped our Quarter 2 Plan.

2. Our Operational Planning Approach

Our approach to the development of our Quarter 2 Operating Plan is set out in Figure1. This process has been managed through the Trust's COVID-19 Planning and Information Cell.

Fig.1 Our Approach to Developing our Quarter 2 Plan



Further detail in relation to each of these planning stages is outlined below.

2.1 Stage 1- Baseline Capacity and Activity – pre-COVID-19:

We have reviewed our baseline position (pre-COVID-19) in relation to:

- Available capacity – physical and operating hours (pre-COVID-19)
- Delivered activity i.e. what level of activity were we able to deliver from the available capacity (pre-COVID-19)

Understanding our baseline position has helped us to forecast what the impact may be on our Quarter 2 activity levels as a result of the various factors described in stage 2.

Note: Baseline capacity and activity data is available within the appendices.

2.2 **Stage 2- Factors which will Influence our Available Capacity:**

We have worked closely with the Welsh Government, Health Boards, our internal teams and other partners e.g. Wales Cancer Network to review the range of factors which may reduce our available service capacity. The factors are influenced by:

- Guidance and policy
- Trust Planning Principles
- Planning Assumptions

National Guidance:

We have ensured that our Quarter 2 Operating plan is aligned with, and informed by, the following guidance:

- NHS Wales COVID-19 Operating Framework Guidance Quarter 2
- Operational guide for the safe return of healthcare environments to routine arrangements following the initial COVID-19 response
- Reducing the risk of transmission of COVID-19 in the hospital setting
- A Principles Framework to assist the NHS in Wales to return urgent and planned services in hospital settings during COVID-19
- A Framework for the Reinstatement of Cancer Service in Wales during COVID-19
- The restoration of solid organ transplant services in line with NHS Blood & Transplant guidance
- Maintaining Essential Health Services during COVID-19 Pandemic
- Specialty guides for patient management during the coronavirus pandemic (NHS) and in the recovery phase

Planning Principles for Quarter 2:

Our Operating Plan for Quarter 2 is based upon the following planning principles:

- Our plan is aligned with our strategic goals and with our medium – long term plans and as outlined within our IMTP
- Our plan is based upon a clinically led risk management approach to service delivery in line with our clinical principles
- Our plan is in line with national policy and guidance e.g. social distancing
- Our plan has been developed in partnership with key stakeholders
- Our plan is based upon working regionally on solutions where appropriate
- Our plan is resilient and flexible so that we can adapt as the pandemic changes

Planning Assumptions for Quarter 2:

Our Operational Plan for Quarter 2 is based upon the following planning assumptions:

Corona Incidence and R Value
- The R value will remain below 1
- There will be not be a '2nd peak' during Quarter 2

Demand for the Welsh Blood Service and Velindre Cancer Centre
- There will be a gradual and phased increase in demand for cancer services from Health Boards. However, Q2 demand will continue below historic levels
- There will be a gradual and phased increase in demand for blood products from Health Boards

Social Distancing
- There will be the continued requirement to maintain social distancing of two metres within all healthcare setting environments

Staff and Patient Testing
- The implementation of the Trust's Test, Track and Protect strategy will result in 5-10% decrease in the availability of patient facing staff

Workforce
- Staff who have been identified as being extremely vulnerable will continue to shield at home
- There will be no further increase in staff sickness levels
- There will be a decrease in the number of staff working from home, but many staff members will need to continue
- Staff will be encourage to take annual leave in line with Trust guidance

Financial
- Through the establishment of a block contract there is a neutral financial impact on the Trust income from activity being different to contracted levels
- COVID-19 related additional costs (Revenue & Capital) will be funded by Welsh Government
- Reintroducing routine services – the "New normal" service costs will require an associated funding strategy
- Where there is non-delivery of savings targets identified in the IMTP, as a result of COVID-19, there will be funding provided from the Welsh Government to cover the gap

2.3 **Stage 3 - Capacity Analysis Review**

We have reviewed the anticipated impact that the guidance and assumptions summarised above will have upon the level of available service capacity; this has created our new 'COVID-19' baseline position.

Understanding our baseline position has helped us to forecast what the impact may be on our Quarter 2 activity levels as a result of the various factors described in stage 2.

Note: Revised baseline capacity and activity date is available within the appendices.

2.4 Stage 4 – Safe Operating Models for Blood and Cancer

We have focussed on the continued development of safe operating models for both blood and cancer services. Key considerations in the development of these operating models have been:

- How, and from which locations, can we most effectively deliver our core services following a safe controlled approach?
- How can we maximise available capacity within available resources?
- What options are there for increasing available capacity, but which would require additional investment?

Note: Further detail on our safe Operating Models for blood and cancer is available in section three of this plan.

2.5 Stage 5 – Activity Analysis Review

We have reviewed the outputs of stages 1-4 summarised above to:

- Determine the level of activity we will be able to deliver in Quarter 2
- Forecast the level of demand we expect for blood and cancer services
- Forecast whether we can deliver sufficient activity to meet demand.

Note: Revised baseline activity and demand data is available within the appendices.

2.6 Developing our Plans in Partnership

We have worked closely with our staff, service users and with a wide range of partners, stakeholders and advisors in developing our Quarter 2 Operating Plan. These include:

- Welsh Government
- Health Boards
- Third Sector
- Trade Unions.

PART THREE: We summarise our Quarter 2 Delivery Plans for the Welsh Blood Service and the Velindre Cancer Centre and identity Key Risks.

3. Welsh Blood Service Operational Plan as at Q2 and Key Risks

3.1 Quarter 2 Overview and Key Planning Assumptions

The Welsh Blood Service portfolio of services is listed below.

- Transplant Services
  - Welsh Bone Marrow Donor Registry (WBMDR)
  - Solid organ transplant
  - Haematopoietic Stem Cell Transplant
  - National External Quality Assurance Scheme for Histocompatibility and Immunogenetics (NEQAS) (global quality testing service)
- Red Cell Immunohematology (Patient Testing Services including antenatal testing)
- Blood and Blood products
  - Collection, processing and distribution of blood components
  - Wholesale distribution of commercial blood products

Impact to Services During COVID-19

Throughout the pandemic, the majority of these services were retained, in line with WHO guidance on high priority categories, and the Essential Services technical document developed by the Welsh Government.

Our plans for Quarter 2 has been developed and shaped through strategic engagement with Health Board planning colleagues, and through our close operational links with clinical teams and blood banks. The focus for Quarter 2 will be on reinstating the small number of services that have been paused, the phased increase in those services where activity levels have been reduced, particularly blood component supply, and the introduction of the new Plasmapheresis service to produce convalescent plasma as a treatment option for COVID-19.

Transplant Services and Red Cell Immunohematology

For solid organ transplant services, we are working closely with Cardiff and Vale UHB to recommence support for the programme in June. The delivery of services in Wales will be provided in line with the UK guidance issued by NHS Blood and Transplant who co-ordinate UK services.

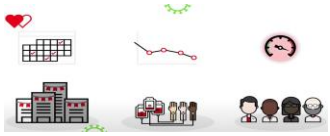
Whilst stem cell donations have been maintained throughout the pandemic by WBMDR, the ongoing access to facilities for cell donation is being reviewed due to potential use for other NHS service provision. Work to sustain stem cell collection is ongoing.

Blood and Blood Products

At the outset of the pandemic, the blood collections system in Wales came under considerable pressure as venues started to cancel bookings, staffing levels dropped through COVID-19 related absence and donor attendance levels started to fall. Donation process changes had to be introduced to ensure donor and patient safety.

The changes introduced by the service enabled us to sustain availability of blood components through donation at a smaller range of fixed sites. Reinforcement of the important message that travel to donate blood qualified as "essential travel" was also an important factor in sustaining donation.

COVID-19 Blood Collection Model



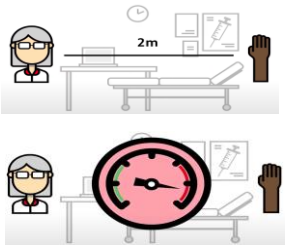
At the outset of the pandemic, the blood collections system in Wales came under considerable pressure:

- Venues started cancelling our bookings
- Staffing levels dropped through
- Donor attendance levels started to fall.

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

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

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



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

Where under normal circumstances donors would be invited to their preferred donation centre, the new model would require donors to be invited to their nearest regional donation hub - unlikely to be their usual venue of preference. Donors also undergo triage to ensure they are fit and well to donate.

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

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

As the pandemic comes under control, and lockdown is slowly lifted, the changes to call on donors' time and their location as well as the potential venues we can use will all impact on the future blood collection model and how it redevelops over the forthcoming months. The impact of infection control interventions such as social distancing will also fundamentally influence the plan.

Welsh Blood Service Assumptions

There are a number of other assumptions that underpin the Quarter 2 recovery model:

- WBS will need to continue to operate the new COVID-19 clinic model introduced in response to the pandemic with social distancing and donor screening requirements
- 5% increase in demand for blood compared to Quarter 1
- Appointment uptake rate to revert to pre-COVID-19 level of 90%
- Did Not Attend rate to revert to pre-COVID-19 level of 10%
- Attend to bleed rate to revert to pre-COVID-19 level of 90%
- Donor behaviour (such as lower DNA rates, higher appointment uptake and "attend to donation" rates and increased new donor numbers) will return to the pre pandemic figures as people return to work etc.
- 9% of the blood collection workforce currently shielding will not return to the workplace in Q2
- The deferral period required for donors who are recovering from COVID-19 has increased during the latter part of Q1, from 14 to 28 days. This will have an impact on the availability of donors who have contracted COVID-19.

3.2 **Essential Services Assessment: Transplant Services and Patient testing services**

In Quarter 1 services were sustained for the Welsh Bone Marrow Registry, support for haemopoetic stem cell transplant, red cell immunohematology, antenatal and other patient testing. These will continue to deliver through Quarter 2 and respond to any changing circumstances.

Services for the NEQAS external quality assurance testing scheme and support for solid organ transplant were paused and will be restarted.

3.3 **Activation Plans**

WBMDR stem cell collection service and the support for the Haematopoietic stem cell transplant: Programme will continue as normal to the end of Quarter 2. Operational arrangements with St Joseph's are being assessed due to use of the facility for LHB service provision, which may have an impact on the ability to provide support for stem cell collection.

Solid organ transplant: It is anticipated there will be a phased return to 'Business As Usual' as some services will recommence in C&V UHB in June 2020, first with deceased then with live donor transplants.

NEQAS: The NEQAS service at WBS, is a national programme that provides external quality assessment of laboratories. WBS has a Service Level Agreement with NEQAS to provide this programme. The programme has been on hold during COVID-19. It is anticipated services will return to 'Business As Usual' in June 2020 with the full EQA schedule planned to be delivered in a reduced timescale (10 months instead of the usual 12).

Patient Testing Services (Blood Reference Testing Service, Antenatal Service & Drugs): The RCI service has continued to throughout the pandemic. Antenatal referrals remained constant in Quarter 1 and it is not anticipated that there will be any issues maintaining service during Quarter 2.

3.4 **Essential Services Assessment: Blood Components and Blood Products**

The Welsh Blood Service produces a range of blood components from blood donations and also provides a wholesale distribution service for commercial blood products for NHS Wales. This includes:

Collection of Blood Donation, processing and distribution of blood components

- Whilst supply has met demand during Quarter 1, there are significant risks associated with continuing to meet hospital demand in Quarter 2 as a result of changes in donor behaviour as lockdown eases and the continuation of social distancing measures.

Wholesale Distribution of Commercial Blood Products

- The provision of commercial blood products has been sustained through Quarter 1 and will be throughout Quarter 2. However, as with all imported commercial products, there will need to be ongoing review of availability of stocks as a priority.

Forecasting Demand for Blood Components and Blood Products in Quarter 2

Demand planning for blood components is generally undertaken at an overall health system demand level due to the complexity of the factors that influence demand and availability of end-point use data. For Quarter 2, this has also been supported by historic data analysis, knowledge of the subject matter expert and discussions on service plans with Health Boards. This information has been used to provide an All-Wales picture.
The pandemic has created a 20% reduction in demand for blood across Wales. However, there is unlikely to be a linear increase in demand for blood over Quarter 2 as we are anticipating that there will be lag time as Health Boards recover their services. Therefore, and although we are assuming that there will be an increase

in demand from Health Boards for blood, we are still expecting that this will be lower than pre-COVID-19 levels when compared with the same time period of previous years.

As further detailed plans emerge from the Health Boards, we will continue to liaise closely with Health Board Blood Bank Managers and senior clinicians to actively manage the blood stocks across Wales. As services return, an opportunity will be taken to review blood use in line with the work that has been in progress through the Wales Blood Health Plan, promoting prudent use of blood products.

Blood Collection

The Planning department will aim to plan clinic sessions to collect enough blood to meet the estimated demand during Quarter 2. The number of appointments and the resultant number of donations and then components takes into account factors such as appointment uptake, Did Not Attend (DNA) rates from donors and how many who attend are able to donate.

During the outbreak, we saw an increase in positive donor behaviour resulting in increased appointment uptake, a high number of new donors and reduced DNA rates. However, we are anticipating that DNA and 'Attend to Bleed' rates will revert to pre-COVID-19 levels during Quarter 2.

Therefore, and to plan for the collection of an increased number of units of blood per week, consideration needs to be given to increasing venue donation capacity, workforce capacity and donor attendance rate.

Changes made during "lockdown" to clinic locations are being reviewed as we seek to reach out wider into the community again. A number of the temporary venues secured during this period are now required by organisations as they plan to reopen (e.g. schools and colleges). Many of our previous venues may now remain unsuitable due to the configuration required by the COVID-19 clinic operating model e.g. continuation of social distancing.

Work is ongoing to identify alternative opportunities at vacant public sector premises and priority is being given to assessing suitability and securing a portfolio of these venues as blood donation clinics capable of providing appropriate longer-term capacity. In the interim, Collections Services will continue to review current resourcing on a weekly basis to identify where additional clinics can be scheduled (staffing permitting).

Meeting Demand for Blood

Based upon our planning assumptions above we have modelled how much blood we expect to collect from our donors compared to the demand we expect from Health Boards for blood. This shows that we will be able to meet forecast demand during Quarter 2.

Welsh Blood Service Forecast Deliverable Activity Quarter 2 (July to September 2020) week by week Versus Required Activity					
July 2020					
(week by week)	1	2	3	4	5
Forecast - Units of Blood Collected	1572	1590	1575	1569	1534
Forecast Demand	1500	1517	1502	1497	1464
Variance (+/-)	72	73	72	72	71
August 2020					
(week by week)	6	7	8	9	10
Forecast - Units of Blood Collected	1526	1490	1463	1341	1471
Forecast Demand	1455	1421	1395	1177	1403
Variance (+/-)	70	69	67	164	68
September 2020					
(week by week)	11	12	13	14	
Forecast - Units of Blood Collected	1512	1544	1542	1522	
Forecast Demand	1443	1473	1471	1452	
Variance (+/-)	70	71	71	70	

However, it is important to highlight that there are significant risks associated with continuing to meet hospital demand in Quarter 2 as a result of changes in donor behaviour as lockdown eases and the continuation of social distancing measures. These are explored in detail in Appendix 2.

3.5 Convalescent Plasmapheresis (CP)

WBS commenced the production of plasma from whole blood collection in Quarter 1.

A Business Case was approved by the Welsh Government in June 2020 to commence plasma production through the use of plasmaphereses. This programme is overseen by the Welsh Government and is managed in WBS by a project group. It's delivery will be a key objective in Quarter 2 with an expectation that collections will commence in September 2020 by means of Plasmapheresis (Phase 2).

3.6 Welsh Blood Service – Key Actions to Support our Quarter 2 Plans:

We have developed a set of key actions for Quarter 2 which will support:

- The continued successful delivery of our core services
- The continued transition and development of our operating model
- The collection of sufficient blood to meet demand.

Welsh Blood Service – Key Actions for Quarter 2

Description	Ref	Action	Timeframe
Essential Services – Transplant Services	BQ2.1	Review resilience to service at St Joseph's Hospital and ensure service sustainability including staffing	July 2020
	BQ 2.2	Continue to work with C&V UHB to understand proposals for solid organ transplant restarting	June 2020
Communications and Engagement with Donors	BQ 2.3	Continue to work with Health Boards to understand plans for increase in demand for blood products	Ongoing throughout Q2
	BQ 2.4	Review donation capacity at current venues pending increase in numbers	July 2020
	BQ 2.5	Explore options for further permanent or temporary fixed sites for densely populated areas including WBS sites	July 2020
	BQ 2.6	Deliver workforce plan to include recruitment of additional staff, review of staff availability through contract increases, agency staff, recruitment and training	July 2020
	BQ 2.7	Explore the employment of third party make ready services to set up and pack down collection clinic equipment to ensure increased capacity for clinic	July 2020
	BQ 2.8	Increased number of donation opportunities available across Wales including working with public sector	September 2020
	BQ 2.9	Continue focused and adaptive donor engagement activity to promote attendance	Ongoing throughout Q2
Convalescent Plasmapheresis	BQ 2.10	IT configuration work to enable ePROGESA for plasmapheresis collection	September 2020
	BQ 2.11	Implement in-house HNA antibody testing to enable convalescent plasma collected from female donors to be used if model shows this to be a viable option	July 2020
	BQ 2.12	Implement in-house COVID-19 antibody testing	September 2020
	BQ 2.13	Scoping of suitable plasmapheresis venues and operational requirements	July 2020
	BQ 2.14	Recruitment and training of collection team staff to undertake plasmapheresis collections	September 2020
	BQ 2.15	Recruitment of plasmapheresis donors to the first clinics in anticipation for when they go live in Q3	July 2020
	BQ 2.16	Continued supply of whole blood derived convalescent plasma to hospitals to support participation in clinical trials	Ongoing throughout Q2

3.7 Welsh Blood Service – Risks to the Delivery of Quarter 2 Plans:

We have identified a number of potential risks to our Quarter 2 plan. We have then developed a set of mitigating actions to reduce risk rating as summarised below:

Service Area	Risk	Mitigation
WBMDR	Unable to continue to provide a service from lack of collection facility or staff	Staff recruitment underway Engaged with supplier to address issues
	Unable to manage stem cell process from outside of the UK due to continued disruption to international flights and border controls	Ongoing surveillance of systems and cross boarder support from Anthony Nolan Trust
NEQAS	Lack of staff or supplies may impact the delivery schedule and subsequently on reputation then participation	Ongoing engagement and communication with key partners
Collections	Unable to collect enough blood to meet demand due to lack of suitable venue availability	Review of venues and continue to work with external partners to secure appropriate sites
	Unable to collect enough blood to meet demand due changes in donor attendance following lifting of lockdown	Activity and demand monitored daily. Plan for active donor recruitment activity through all media channels.
	Unable to collect enough blood to meet demand due to insufficient staff	Workforce plan including effective skill-mix, agency use and recruitment programme in place
Wholesale Service	Potential for disruption of blood derived medicines (commercial products) across international supply chain	Service is holding increased stock against a range of products.
Manufacturing and Testing of Blood Products	Focus on collection of whole blood into donation bags suitable to produce Convalescent plasma may limit availability of blood in donation bags suitable to produce buffy coat derived platelets	Changes in CP collection activity monitored by the Manufacturing and Testing work stream
Convalescent Plasmapheresis	There will be insufficient suitably trained staff to commence plasmapheresis during Q2	Additional staff to be appointed within collection teams and will be trained throughout Q2 with a view to reducing the risk in Q3
	Potential delays due to IT testing and/or validation failures	Working with Business systems to prioritise work to enable support for convalescent plasma
	Risk of securing suitable venues to deliver plasmapheresis collection service	Exploring options that will facilitate the delivery of the service within constraints of social distancing
	Availability of a sufficient quantity of eligible donors is a concern although still an unquantifiable risk at present	Working with PHW and Donor engagement team on how to identify broader population of donors

3.8 Summary of the Welsh Blood Service Quarter 2 Plan

- During Quarter 2 we will return to 'Business As Usual' for all essential services
- A key focus for Quarter 2 is to review and revise clinic planning venues, locations and capacity requirements
- We have worked with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plan
- Based upon our assumptions we will be able to collect enough blood to meet Health Board demand
- We have identified a number of key risks which could impact delivery of our plan

Note: The complete Welsh Blood Service Quarter 2 Operational Plan is included as Appendix 1.

4. Velindre Cancer Centre Operational Plan as at Q2 and Key Risks

4.1 Quarter 2 Overview and Key Planning Assumptions

(Note: The following is a summary of our Velindre Cancer Centre Quarter 2 Operational Plan. The complete Quarter 2 plan is included in Appendix 4.)

Introduction

Cancer services have been severely disrupted as a result of COVID-19. The causes, specific to cancer services are summarised below:

- Patients being reluctant to present to primary care and secondary care tests/treatments, driven by the perceived risks of C-19 infection and/or an unwillingness to burden the NHS
- Reduced efficiency due to C-19 precaution measures and managing patients with C-19
- Some diagnostic tests and treatments being stopped or deferred due to the risks of C-19 infection outweighing their benefits
- Some services such as rehabilitation being stopped because the workforce has been diverted to respond to the C-19 pandemic
- The pausing of cancer screening programmes.

As highlighted within '*A Framework for the Reinstatement of Cancer Services in Wales*' it is likely that the full reinstatement of services impacted by COVID-19 will take at least 6-12 months.

The Framework also states:
"In reinstating services, there is a need for assurance that cancer services will be delivered as safely as possible, despite the ongoing risks of COVID-19. There will need to be major service redesign to create the capacity to meet the projected demand, especially as a result of reduced capacity due to reduced utilisation as a result of COVID-19 cleaning measures. Patients will need to be prepared prior to entering facilities. Staff will need to reduce risk through careful use of rotas and serious consideration given to regular testing of frontline staff"

Our VCC plan is therefore set within this context and is cognisant of the requirements laid out within this Framework.

Quarter 1 – A Summary

Throughout Quarter 1 we have maintained the delivery of our essential services. We have also undertaken a comprehensive review of those services to ensure that we have identified service transformations implemented in response to COVID-19 which we wish to keep and align with our pre-COVID-19 service development plans and strategic intent.

However, during Quarter 1, we were required to centralise the majority of our services to the Velindre Cancer Centre. This rapid migration to a centralised model was required to support the All-Wales objective of maintaining COVID-19 free sites where possible and to contribute to regional COVID-19 capacity requirements.

Whilst we were successful in continuing to deliver essential services during Quarter 1 the centralised model we have adopted conflicts with our strategic intent to deliver services 'locally' where possible.

Quarter 2 Plan – An Overview:
The key areas of focus for our Quarter 2 plan are to:

- Develop and/or implement plans to reinstate our outreach service model
- Develop plans for maximising service capacity:
  - Within existing resources at VCC
  - Within existing resources at outreach locations
- Ensure that staff and patients are safe when attending our treatment locations and to minimise the risk of COVID-19 transmission
- Develop plans for creating additional service capacity, but which will require additional investment, with third party providers.

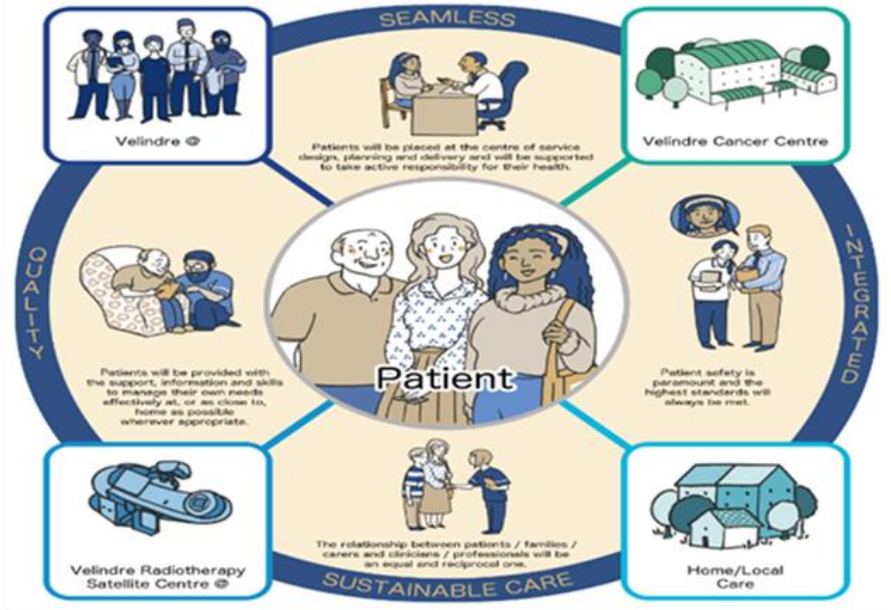
4.2 **Developing and/or Implementing Plans to Reinstate our Outreach Service Model**

Through the TCS Programme we have worked collaboratively with a range of stakeholders to design a clinical service model which that responds to the needs of patients and seeks to eliminate the activities that they least value and maximise the activities they most value.

The clinical service model operates on a '***hub and spoke***' principle where the **'hub'** is the patient and who will be empowered to pull a range of services towards them and to access other services as close to home as possible.

The '**spokes**' of the model reach out to fully integrated local community services that sit alongside a wide range of public services. It is envisaged that a high proportion of patients will be able to receive their full package of treatment, care and support within a local healthcare facility without the need to attend VCC.

Clinical Service Model



In line with the proposed clinical model we were delivering, pre-COVID-19, approximately 30% of our activity either in outreach locations or in patients home. However, with the exception of providing an increased number of virtual patient consultations and the continued delivery of SACT homecare/SACT mobile services, we were required to centralise all service activity to the Velindre Cancer Centre. A key focus of our plan for Quarter 2 therefore is the reinstatement of our outreach service model, and during Quarter 2 we will aim to:

- Re-commence delivery of a range of outreach services in ABUHB and CTBMUHB
- Continue to use the Tenovus Mobile Unit to deliver SACT
- Continue to delivery SACT homecare services.

4.3 Developing Plans for Maximising Service Capacity

Our available physical capacity at VCC has been reduced by 20-40% as a result of our requirement to comply with social distancing and infection prevention guidelines and policies. We have therefore explored a number of options to increase capacity at VCC. These include:

- Extension of the working day
- Extension of the working week
- Reconfiguration of the VCC estate
- Increased use of agency staff.

A key focus of our Quarter 2 plan is to evaluate these options and to then implement where applicable.

Similarly we are exploring options to increase capacity in outreach settings and through partnership arrangements. These options include

- Expansion of a range of outreach services in Health Boards
- Expansion of the Tenovus Mobile Unit to deliver SACT
- Expansion of the SACT homecare service
- Increase of radiotherapy capacity in partnership with Swansea Bay University Health Board and/or the independent sector.

4.4 **Ensure that Staff and Patients are Safe when Attending our Treatment Locations and to Minimise the Risk of COVID-19 transmission**

Throughout the pandemic we have worked tirelessly to protect the safety of our patients and staff. A range of measure relating to infection prevention (including cleaning), site access, social distancing, communication and engagement strategies (including the provision of advice and information) have been implemented and these will continue to remain in place through Quarter 2.

In addition a key area of focus in Quarter 2 will be to embed our Test, Trace and Protect Programme.

Test, Trace and Protect Programme

The Welsh Governments Test, Trace and Protect Programme (TTP) was issued on 13th May. This outlines how, across the nation, public health will be protected by enhancing public health surveillance and the response system, to enable the virus to be traced as lockdown, and other, restrictions are eased.

In response we have established a dedicated cell, led by the Medical Director for VUNHST, to oversee our approach to TTP. The key role of the cell is to support the Trust to:

- Prevent the spread of disease amongst our patients and staff
- Ensure early intervention with cases and contacts to prevent onward transmission
- Keep essential services operational

We have established the following three groups to support the TTP cell:

- Scientific advisory group
- Staff advisory group
- Patient and donor advisory group.

In addition, we have are represented at all relevant National groups.

Test, Trace and Protect – Key Actions for Quarter 2

- All patient facing staff will be tested on a weekly basis
- All patients will be tested two days prior to treatment
- Patients receiving radiotherapy treatment of 10 fractions or more will be re-tested at the mid-point of their treatment
- Guidance advice and support will be provided to patients and staff in relation to self-isolation.

In the event of a positive test we have agreed to utilise the services of our Health Board tracing teams who will in turn follow National guidance and procedures. We have however set up processes to support our staff and patients in terms of well-being support.

4.5 **Developing Plans for Creating Additional Service Capacity, but which will Require Additional Investment, with Third Party Providers**

Although we are only expecting a gradual increase in demand during Quarter 2 we are expecting a more significant and severe increase in demand for our services during Quarters 3 and 4. We will therefore be developing a range of options for creating additional capacity in partnership with third party providers. The aim of these plans is to provide maximal service resilience over the next 12-24 months.

Additional detail regarding these plans, including our activation plans, is included as Appendix 4.

Meeting Demand for Cancer Services

Demand for non-surgical cancer services at VCC has been increasing steadily over recent years. Notwithstanding the COVID-19 pandemic, demand for our services was predicted to increase by between 2%-5% which was derived based on growth, improved access and increasing treatment complexity.

However, during the COVID-19 pandemic attendance at GP surgeries and A&E have both fallen significantly. Given that the incidence of cancer as described earlier is not expected to have changed, it is expected that not only will referrals return to historic levels, but patients who have deferred presenting to their GP during the pandemic will present over the next 3-6 months. This will be significant as the level of unscheduled care referrals dropped by up to 75% in March and incidental findings at hospitals have also fallen dramatically. The presentation of this suppressed demand is expected to be significantly above earlier levels, if it is assumed that 50% of the recent suppressed demand will re-present over the next 6 months (July – December 2020), that would be equivalent to an additional 33% increase in referrals over that 6 month period**.**

Demand Plan for Quarter 2

We have worked closely with our internal teams, Health Boards and with the Welsh Government to try to understand how demand for our services will be impacted during Quarter 2. This has been challenging, and is largely based upon a set of planning assumptions, as there are still a number of unknowns related to COVD-19.

Our current assumption suggest that there will be a relatively gradual increase in demand for cancer services during Quarter 2. On this basis, we are confident that our service plans will enable us to meet predicted demand for services by:

- Maximising available service capacity from existing resources
- Re-introducing our outreach service model

However, it is important to highlight that our ability to meet demand, especially for Radiotherapy and SACT services, is highly sensitive and a change in our assumptions could present a risk in being able to meet demand.

A Forward Look – Cancer Service Demand for Quarters 2 and 3

We have worked closely with our internal teams, Health Boards and the Welsh Government to try to understand how demand for our services will be impacted over the medium-long term. Through this work our expectation is that there will be a significant and prolonged increase in demand for the majority of our services over Quarters 3 and 4. We will therefore develop a range of options for creating additional capacity in partnership with third party providers. This work, and the ability to utilise extra radiotherapy capacity is expected to be in place for possible use in Quarter 3.

4.6 **Velindre Cancer Centre – Key Actions to Support our Quarter 2 Plans**

We have developed a set of key actions for Quarter 2 which will support:

- The continued successful delivery of our core services
- The continued transition and development of our operating model, including the re-establishment of outreach services
- The provision of sufficient service capacity to meet demand

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre Cancer Centre – Key Actions for Quarter 2

Service	Ref	Action	Timeframe
SACT	VQ2.1	Continue to treat all patients regardless of priority level	July to September
	VQ 2.2	Ensure deferred patients are reviewed and planned on an individual basis	July to September
	VQ 2.3	Continue to manage repatriated patient activity until safe plans are agreed with HBs	July to September
	VQ 2.4	Develop plans with all HB partners to deliver a safe return of outreach services	August
	VQ 2.5	Deliver planned activity levels included in week on week profiles	Weekly through Q2
	VQ 2.6	Implement capacity increase delivery options to meet demand changes	July to September
Radiotherapy	VQ 2.7	Detailed Capacity plan options to be finalised and agreed by the Trust	July
	VQ 2.8	Re-establishment of RTD programme based upon the recommendations of the independent service review	July
	VQ 2.9	Risk based clinical model proposals to be agreed by Trust including the potential use of the independent sector	July
	VQ 2.10	Workforce development and recruitment plan to be developed to support options	August
	VQ 2.11	Demand modelling to inform increases in activity from suppressed demand	July to September
	VQ 2.12	Impact of Radiotherapy delivery options to ensure pre-treatment capacity is covered	July to September
	VQ 2.13	Deliver planned activity levels included in week on week profiles.	Weekly through Q2
Outpatients	VQ 2.14	Continue to treat patients at all levels of priority	July to September
	VQ 2.15	Continue to manage repatriated patient activity until safe plans are agreed with HBs	July to September
	VQ 2.16	Develop plans with all HB partners to deliver a safe return of outreach services	August
	VQ 2.17	Develop a service model for running virtual and face to face clinics which will be adopted by all SSTs	July to September
	VQ 2.18	Progress Outpatient Accommodation plans	July to September
	VQ 2.19	Continue to offer Phlebotomy services and monitor activity levels	August
	VQ 2.20	Continue to deliver ambulatory care in Outpatient setting to relieve pressure on SACT day case units	July to September
	VQ 2.20	Gather patient feedback on the use of virtual appointments	July to September
Radiology	VQ 2.21	MRI focus on small number of deferred patients to reinstate and to maintain normal service	August
	VQ 2.22	Extended working days and out of hours routine scanning in CT planned. Once established can be switched to MR scanning as CT waiting lists come down	September
	VQ 2.23	Ultrasonographer to be trained to perform neck US so allowing more capacity	September
Therapies	VQ 2.24	Further work in establishing weekend therapy community services in the post COVID-19 phase.	September
	VQ 2.25	Continue physio cover for Saturday and Sunday	August

4.7 **Velindre Cancer Centre – Risks to the Delivery of Quarter 2 Plans**

We have identified a number of potential risks to our Quarter 2 plan. We have then developed a set of mitigating actions to reduce the risk rating. These are summarised below:

Service Area	Risk	Mitigation
SACT	Limited physical capacity at VCC requires choices on priorities for estate utilisation	Senior Management Team to consider all capacity delivery options and give clear direction for service implementation
	Ability to flex capacity to accommodate potential surges or reduction in demand if future COVID-19 peaks occur	Senior Management Team to agree capacity maximisation options
	Uncertainty as to when HB partners will be in a position to offer SACT day case and associated support services	Establish clear timelines with all Health board partners to plan safe returns
	The capacity for HBs to support the provision outreach services	Plan for re-introducing outreach services developed in partnership with HBs
	The ability for third parties to provide capacity for SACT services if required	Develop service specification and develop service plans in partnership
Radiotherapy	Insufficient capacity to meet demand leading to poorer outcomes for patients	Detailed plans have been developed for increasing and maximising capacity
	Requirement to consider treatment options against the risk to patients of exposure to COVID-19	Risk assessment process to be fully agreed and supported by Senior Management Team
	Additional staff required to support extended days working	Workforce and recruitment to provide rapid response plan
	Future demand profiles are uncertain and volatile due to anticipated impact of suppressed demand	Demand modelling completed in partnership with HBs. Flexible and agile capacity plans developed to meet changing patient profile
	Extending LINAC working hour's increases risk of failure of older machines	Full risk assessment of proposals V likelihood of failure to be undertaken
	Some treatment options which reduce radiotherapy machine result in an increase in pre-treatment capacity required	Full effect on pre-treatment capacity to be finalised to inform delivery option decision making
Outpatients	Need for Virtual Clinic Hub to be established, but set against there being limited physical capacity at VCC	Senior Management Team to consider all accommodation options and give clear direction for service implementation
	Uncertainty as to when HB partners will be in a position to offer Outpatient and Phlebotomy services	Establish clear timelines with all Health board partners to plan safe returns

Service Area	Risk	Mitigation
	Insufficient Phlebotomy service capacity due to increased demand	Review options for delivery of Phlebotomy services, including use of a mobile unit. Progress with replacement of Haematology Analyser through VCC Capital allocation.
	Ability to manage face-to-face activity whilst complying with social distancing requirements	Medical Directorate Manager, with SSTs, to review numbers of patients who require face to face appointments and those who can been seen 'virtually'
Inpatients	COVID-19 continues to circulate in community	Increased rapid testing for patients.
Radiology	Unable to recruit additional staff to support extended days working	Rationalisation of part time working and restrictions on leave may be required.
Therapies	Ability to provide sufficient workforce to meet deferred demand due to the relatively small size of the therapies department	Workforce plan developed, but will require investment
Nuclear Medicine	Insufficient Radiopharmacy (provided by C&VUHB) capacity to meet service requirements	Continued liaison with C&VUHB regarding return to normal operating levels
	Delay in re-starting Thyrotoxic treatments	Continued liaison with ABUHB regarding restart of service

4.8 **Summary of the Velindre Cancer Centre Quarter 2 Plan**

- We aim to develop a resilient, quality driven, service model for VCC patients, which is able to respond to peaks and troughs in demand during COVID-19 throughout 2020-2021
- Our plan is flexible and includes options for the expansion of services in order to respond appropriately should a return to the acute phase be required and to accommodate patients repatriated from Health Boards and expected demand growth
- During Quarter 2 we will continue to deliver all essential services
- Our key focus for Quarter 2 is to maximise available service capacity within existing resources and to 'reset' our clinical service model to prepare for the return of outreach services in local communities
- We have worked with our internal teams, Health Boards and with the Welsh Government to develop a set of planning assumptions which support the delivery of our plan
- Based upon our assumptions we will be able to meet demand for our services

PART FOUR: We set out how our Corporate Support Functions will support and drive the Delivery of our Quarter 2 Plan.

5. Corporate Support Functions and Guidance

5.1 Overview

The original Welsh Government framework guidance on Essential Services for NHS Wales provided important guidance during the pandemic for Velindre UNHST as significant number of the Trust's services are specifically identified, including:

- **Urgent cancer treatments**, including access to urgent diagnostics, chemotherapy and radiotherapy
- **Blood Services**, products and collection
- **Palliative Care** in all hospitals & community settings

The recent updated Framework (including the Framework for the Reinstatement of Cancer Services in Wales during COVID-19 and plans for the restoration of solid organ transplant services in line with the clinical guidance developed and published by NHS Blood and Transplant), provide important revised guidance for Quarter 2. Both are central to the Trust's clinical plans and relevant actions are included in the Divisional operational action plan for quarter 2.

Specifically, the following Policies and Welsh Government national guidance has been received and acted upon in developing our Operational Plans and COVID-19 Response.

- Maintaining Essential Health Services during COVID-19 Pandemic – summary of services deemed essential (Welsh Government)
- NHS Wales Operating Framework Guidance Quarters 1 and 2 (Welsh Government)
- A Principles Framework to assist return urgent and planned services in hospital settings during COVID-19 (NHS Wales)
- Maintaining essential health services operational guidance for the COVID-19 context (World Health Organisation)
- Operational guide for the safe return of healthcare environments to routine arrangements following the initial COVID-19 response (Nosocomial Transmissions Group)
- Specialty guides for patient management during the coronavirus pandemic (NHS) and in the recovery phase e.g. rehabilitation

During quarter 2 the Board Quality and Safety Committees will continue to gain assurance that harm is minimised from the reduction in non-COVID-19 activity, by triangulating timely information from difference sources such as quantitative data, quality impact assessments, audit, harm reviews and risk profiles. This will

include analysing local information to understand any potential service gaps and outliers. This is likely to focus ensuring equitable access to and delivery of services, including those not always empowered to access services and testing for unconscious bias in development of service recovery plans.

Corporate Actions for Q2

	Action	Timeframe
CQ2.1	Complete further iteration of Essential Services self-assessment and return to NHS Wales Delivery Unit	July 2020
CQ2.2.	Develop Essential Services update and assurance report for Quality & Safety Committee	August 2020
CQ2.3	Undertake analysis to ensure equitable access to and delivery of services	September 2020

During quarter one, the Cancer Services Recovery Plan for Wales, developed through the Wales Cancer Network, was particularly helpful. The Welsh Blood Services worked with colleagues in the National Blood Oversight Group to develop guidance for Health Boards on the effective use of blood and products and this was circulated through the Essential Services Group.

A self-assessment against the framework was undertaken in May and reported the outcomes to the Delivery Unit and the Trust's Quality and Safety Committee.

5.2 Workforce & Organisational Development

5.2.1 COVID-19 Programme Quarter 2

The Workforce Operational Plan for Q1 re-focused in response to COVID-19 to establish a workforce hub to support additional recruitment, deployment of staff, manage the flow of workforce information and ensure the provision of an effective infrastructure for staff wellbeing. The hub is supported by a workforce helpline to provide additional guidance, help and support to managers and staff. Two key elements to ensure the delivery of the COVID-19 Workforce plan are the ***relationships established with Trade union colleagues*** and the ***Workforce Cell*** infrastructure to monitor and ensure delivery of actions.

5.2.2 Partnership working during COVID-19

Throughout COVID-19 the Trust has built on its good partnership arrangements with Trade union. Since the commencement of the COVID-19 programme the Trust has run weekly meeting with unions. These meeting have provided a forum to gain feedback from staff, discuss concerns and agree a productive partnership arrangement moving forward.

As a result of these strong partnership arrangements the Trust has run surveys to staff in partnership on issues of PPE, developed communication campaigns

to ensure all vulnerable staff have received a risk assessment and agreed consensus on key policy areas including the provision of annual leave.

To further enhance partnership arrangements, union membership is a key element of the COVID-19 infrastructure - the Workforce Cell, Social Distancing and PPE Cell all have Trades Union representation to ensure issues relating to staff safety and wellbeing are addressed and actioned accordingly. This will continue throughout Quarter 2.

5.2.3 **Workforce Cell**

The Workforce Cell monitors key COVID-19 measures relating to staff safety and wellbeing. The Workforce Cell oversees the management of the Workforce COVID-19 related activity reports and reports to the Executive Management Team.

This includes the training compliance data in relation to PPE and completion of risk assessment for those staff who may be at increased risk - including BAME and older colleagues, pregnant women, returnees, and those with underlying health conditions. In relation to Social Distancing, in collaboration with union colleagues, guidance on social distancing measures are in place and work is ongoing to implement different ways of working/working patterns to meet social distancing measures. Annual leave uptake is monitored via the Cell to mitigate impact in Quarter 2 of school summer holidays and lack of child care facilities. A process of staff testing is in place and communicated to staff. The Trust's Frequently Asked Questions are monitored regularly and daily staff communication updates are provided. The Cell will run throughout Quarter 2.

5.2.4 **Business as Usual**

Whilst the COVID-19 infrastructure still remains in place for Quarter 2 the Workforce and OD work programme will now focus more on the priorities of the IMTP with a focus on positive lessons learnt from COVID-19. The priority areas for Quarter 2 are a focus on a ***Healthy and Engaged Workforce, Skilled and Developed Workforce and a Planned and Sustained Workforce***. The following detail provides an overview Trust wide priorities to support divisional action plan

5.2.5 **Healthy and Engaged Workforce**

As we move into the Recovery phase of the COVID-19 pandemic, the health and wellbeing of our staff is of paramount importance. The CARE (Create, Assist Rapid, and Engage) Recovery Response Plan will continue to deliver the following in Quarter 2.

The **CARE** Plan will **Create** opportunities for anonymous feedback. We are launching a confidential on-line platform for staff which provides opportunities to listen, respond to concerns, and collect data on how people are feeling and gain

ideas and opinions for improvement. This platform will be launched and promoted with our Trade Union colleagues to ensure engagement at all levels in the organisation.

The plan **Assists** staff with an ongoing range of **Rapid** targeted wellbeing interventions. COVID-19 highlighted the need for specialised targeted staff Psychology intervention and a Business Case is being progressed to engage the services of a Staff Psychologist in the Trust to work with the Workforce and OD team.

The anonymous on-line platform together with the development of management support to retain and return staff to work will ensure we **Engage** effectively and support our staff wellbeing in Quarter 2. Weekly COVID-19 Union meeting have been taking place to ensure a proactive partnership approach to issues and policy decisions. Strong Partnership working arrangements will continue to be in place through Quarter 2.

5.2.6 **Skilled and Developed Workforce**

In Quarter 2 the Trust will continue its Inspire Programme of Management and Leadership development, promoting a culture of compassionate leadership and management at all levels. Whilst COVID-19 halted our skills agenda for a few weeks, Quarter 2 will be focused on the continued programme of Management Development Training. Three Cohorts are planned for 2020/21. The delivery will now encompass a blended approach of virtual classrooms supported by tutorial support by the Education and Training team. Lessons learnt from COVID-19 is now built into the agenda. As well as the cohort development programme, a bespoke offering of management interventions (Just for Me, Just in Time) will be offered to managers to support with COVID-19 related as well as developmental matters (coaching, mentoring, on-line tutorials, masterclasses). In addition to management development a bespoke programme of Leadership development will be finalised and a programme of Board development will commence, thus supporting management and leadership at all levels in the Organisation.

The Education and Training Steering Group will continue throughout Quarter 2 to oversee the development of virtual reality learning with the development of an HR App and agreed MDT training plans to support commissioning requests. The Trust's programme of widening access will continue to grow, increasing its cohort of Apprentices in IT and Workforce, recruiting graduate trainees, supporting where possible assisted recruitment - working with learning disabilities organisations and developing a virtual engagement campaign for school work placements. Student Clinical Placements will commence in Quarter 2 with a pilot in the use of the Physician Associate role in Velindre Cancer Centre.

5.2.7 **Planned and Sustained Workforce**

As we move back to Business as Usual the focus will be on ensuring we have the right people in place at the right time. Working with the Cancer Centre and Planning colleagues to ensure a robust plan around capacity and capability, particularly in Radiotherapy, to support demand, will be a key delivery in Quarter 2.

In relation to the Welsh Blood Service COVID-19 related absences comprising of shielding, 7 and 14 day self-isolation exclusion and sickness, have led to a reduction in the whole blood collection workforce.

As an interim measure, and to meet the more immediate issues, offers of temporary increases in contracts for existing collections team staff are being made as well as reviewing plans for annual leave. In addition, work is taking place to temporarily appoint a number of additional staff through the re-deployment and agency pathways, for some less specialist roles.

In summary with the underpinning Workforce Cell infrastructure, a focus on workforce development and planning is a key theme for Quarter 2.

Workforce & OD Actions for Q2

	Action	Timeframe
WQ1.5	Working with planning colleagues assess the workforce demand and utilise the existing supply channels as required	July 2020
WQ1.6	Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas,	August 2020
WQ1.7	Working in partnership develop surveys based on feedback to improve staff communication and partnership working	August 2020
WQ1.8	Developing H&WB plan into recovery phase where staff are more likely to require support (based upon CARE model – create, assist, rapid, engage)	August 2020
WQ1.9	Ongoing Communication on wellbeing offer to staff via all stakeholders routes	July – Sept 2020
WQ1.10	Management development to support effective team management incorporating a blended delivery approach – building on our Manager Development Programme	July 2020

5.3 **Digital**

Building on the successes of Quarter 1 plan, our Quarter 2 plan for digital continues to focus on the 3 main objectives:

- Creating Capacity & Developing New Services
- Connecting & Remote Monitoring of Patients, Donors and our Workforce
- Strategic Projects

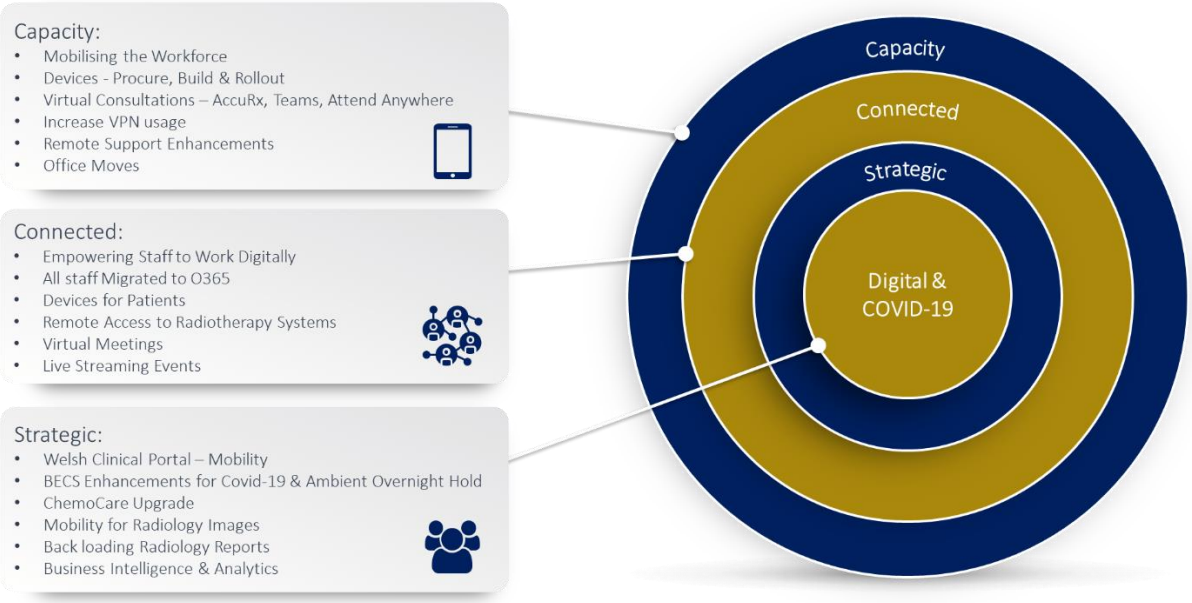


Fig.1 – Velindre University NHS Trust Digital Response to COVID-19/Quarter 1

5.3.1 **Attend Anywhere is now Live in Velindre Cancer Centre**

During the first quarter, a significant milestone for the Trust was the first Velindre patient seen using the NHS Wales Video Consulting (VC) Service – Attend Anywhere. The service is now live in a number of tumour sites with a view to all tumour sites being covered by the end of July and a full coverage of the service by Mid-September 2020. Some clinicians had already started using temporary Video solutions as part of COVID-19 response, but Attend Anywhere is embedded as part of our operational process and supported nationally. It provides the ability for our clinicians to not only see patients on an ad hoc basis but also to schedule virtual follow up appointments and offer the patients more choice on how they would like to be consulted.

Dr Jacob Tanguay Velindre University NHS Trust Chief Clinical Information Officer and Consultant Oncologist has said….
"*Attend Anywhere is a useful addition to our suite of applications. It really helps to see the patient during a remote consultation and improves the ability to communicate especially with patients who are less well and those who need to connect with their clinician for emotional support"*

Initial patient feedback has been positive and comments include…
"As good as good as face to face", "Better and more personal than a phone call", "Excellent, the way forward", "not having to travel, saving time and cost"

5.3.2 **Moving to Quarter 2**

The projects highlighted during Quarter 1 are rolling on as planned into Quarter 2. In addition to this, the Trust continues to review capacity across the digital and operational teams to restart projects paused during the outbreak of COVID-19.

Under the objectives set out above and aligned to our overarching strategic direction, the following digital projects and associated actions will be undertaken in Quarter 2.

Digital Actions for Q2

	Action	Timeframe
DQ1.2	Connecting & Remote Monitoring of Patients, Donors & Workforce: Virtual Consultation/Attend Anywhere	September 2020
DQ1.3	Connecting & Remote Monitoring of Patients, Donors & Workforce: Primary/Secondary & Tertiary Connectivity/Consultant Connect	August 2020
DQ1.4	Connecting & Remote Monitoring of Patients, Donors & Workforce: Remote Monitoring Apps	August 2020

5.4 **Communications**

We are now undertaking an exercise to review lessons learned from the initial COVID-19 outbreak to inform our plans for both external and internal communications and engagement in future. A new draft communications and engagement strategy was considered and agreed by EMB on 30 June 2020. A detailed Year 1 work-plan will be submitted for their consideration in July. This will provide a comprehensive roadmap for delivering fundamental improvements to the way in which we deliver internal and external staff communications and engagement.

This will build on the new ways of working established since March.

Communications Actions for Q2

	Action	Timeframe
CQ2.	Deliver public engagement and communications plan to support new Velindre Cancer Centre planning applications submitted in June	By end of planning process scheduled for end September 2020
CQ2.	Support NHS Wales birthday celebration	By early July 2020
CQ2.	EMB approval of Year 1 communications and engagement strategy implementation plan 2020-2023	By mid July 2020
CQ2.	Approve annual plan for Team all-staff meetings and continue to implement	By end July 2020
CQ2.	Revised plan for use of Trust social media	By end July 2020
CQ2.	Deliver new Trust website	For end September 2020
CQ2.	Provide support for Trust strategy engagement	From mid July 2020
CQ2.	Recommenced public engagement with the new Velindre Cancer Centre planning applications	From mid June 2020
CQ2.	Continue direct communication on key topics with special emphasis on PPE, wellbeing, TTP and social distancing as we prepare for safe workplaces	Until end September 2020

5.5 Nursing and Quality

As outlined in the Quarter one submission the Trust is committed to continuous quality improvement of our services and strive to always ensure that we achieve our aim of providing 'excellent care for our patients, donors, families and carers'. This means providing person-centred care that is safe, effective, dignified, timely, and individual. It is our intention to support and enable our staff to always strive for excellence, through an ongoing cycle of review, learning and improvement of the services we provide. Organisationally our quality aims can be categorised as:

- Fostering a culture of safety and quality improvement
- Providing safe care, and learning when things go wrong
- Using data to measure performance and inform improvement
- Recruiting and retaining skilled, competent and compassionate staff.

Throughout the Pandemic the frequency of both the Trusts Executive Management Board (for a period converted to Gold Command) and the Quality & Safety Committee has been increased in order that the Trust Executive Team and Independent members can adequately discharge their responsibilities during this rapidly changing and challenging time. Always putting quality, safety, experience of patients, donors and staff front and centre.

Throughout quarter 1 the Trust has been working on meeting all identified areas of priorities as well as those that had been identified in the Trust's IMTP and good progress has been made. In particular strengthening the COVID-19 assurance and delivery processes through the development of a number of COVID-19 cells, to

ensure the Trust is adequately meeting specific COVID-19 accountabilities and responsibilities across all services. Each cell reports strategically to the Executive Management Board and is supported by a nominated Executive Director. Initially these were:

- PPE
- End of Life/Death processes – cell met most of objectives and was closed on 11th June 2020
- Digital
- Planning
- Information & Performance
- Quality & Safety
- Workforce

During June two additional cells were developed:

- Social Distancing
- Testing

During the early stages of the COVID-19 pandemic the Trust established a multi-disciplinary Clinical Touchpoint Group so that the clinical leaders can ensure robust and aligned clinical prioritisation, impact assessment processes, support and direction. This group has supported clinical teams develop patient prioritisation processes in line with national best practice with ongoing review as the pandemic has developed.

In addition to ensuring that all Quarter 1 priorities are developed and embedded, the Quarter 2 additional priority is to build on, and further develop COVID-19 assurance systems and processes, to ensure that robust mechanisms for learning from the impact of COVID-19 and decisions made during the pandemic to date are embedded and yield initial outcomes so that the Trust can ensure that any remedial action (on patient /donor/divisional or Trust basis) can be taken, as well as ensuring the learning influences planning for the predicated 2nd Wave.

Nursing & Quality Actions for Q2

	Action	Timeframe
NQ2.2	Additional Q2 actions: • Complete & implement IPC Board assurance framework • Complete & implement IPC accountability framework Finalise & Implement VCC & WBS COVID-19 checklist	September 2020
NQ2.3	Fully Implement COVID-19 Operational Guide requirements within VCC & WBS	September 2020
NQ2.4	Fully implement Patient & staff testing procedures	September 2020

	Action	Timeframe
NQ1.2 & NQ2.5	VCC Electronic Nurse Rostering Implement Allocate electronic rostering system & bank management system during June 2020	Procure - Q1 August 2020
NQ1.3 &NQ2.6	Quality & Safety Framework to be completed and implementation commenced Commence recruitment of Quality & Safety Project Manager	September 2020
NQ2.7	Ensure all Trust Policies & procedures are reviewed and any COVID-19 related amendments/changes where relevant made	September 2020
NQ2.8	Review of all 'deferred' cancer centre patients to be undertaken to ensure patient now on appropriate treatment regime & any harm/impact of deferred treatment is identified and captured	September 2020
NQ2.9	A Review of all Staff who have received a COVID-19 positive swab to have had the screening & review undertaken in line with Staff diagnosed with COVID-19 Policy.	All currently known to be completed by September 2020
NQ2.10	Review the Quality Metrics and outcome measures within Trust Performance Management Framework	September 2020
NQ2.11	Undertake service level to Board quality & assurance mapping across Divisions feeding into Trust wide assurance mechanisms	September 2020

5.6 **Finance**

Summary of Financial Strategy & Plan Phases

IMTP Financial Strategy: Normal Service Models

- Balanced Financial Plan
- Remove underlying deficit
- Small element of financial headroom to allow limited investment choices
- Savings targets set broadly in line with previous years to cover cost pressures and planned investments above Income

Financial Impact: COVID-19 changed service models

- Decisions taken to commit resources without normal certainty of funding
- Financial & procurement governance adapted to enable rapid decion making & commitment of resources to respond to the pandemic
- Financial consequences of surge capacity, new service models & digital response
- Recording, reporting & justification of COVID-19 related costs
- Revised Financial Plan assumes COVID-19 costs committed will be covered by WG funding
- Financial risk identified of total costs committed with no funding agreed

Financial Modelling: COVID -19 Recovery "New normal" Service model Scenarios

- Undertake financial modelling of cost of each service capacity & demand scenarios for return to "new normal" services
- Modelling impact on Trust income of different contracting scenarios and activty for "new normal" service.

5.6.1 **Summary of Current Situation**

The Trust IMTP sets out the financial strategy and plan for the Trust revenue and capital, including our assumptions around income and expenditure, anticipated cost pressures, planned investments and financial risks.

The expectation is that the Trust will achieve a balanced financial positon in 2020-21 as indicated in the IMTP. However, this is based on the assumption now that the new financial risk of committed COVID-19 expenditure (revenue & capital) will be funded by Welsh Government.

Table A summary of the Q2 forecast revenue financial position is shown below:-

	July 2020 Actual £'000	**August 2020 Forecast £'000**	**September 2020 Forecast £'000**	**Q2 Total Forecast £'000**
Net Surplus/(Deficit)	0	0	0	0

5.6.2 **New ways of working**

The financial impacts of new service models to respond to COVID-19 have been captured. Actual costs for April and May 2020 are known, June is forecast within Q1 return, and we have developed forecasts for Jul to Mar 2020/21. The capital expenditure identified in Q2 is in respect of Convalescent Plasma, which has an identified funding stream. Capital considerations may arise as additional capacity options are developed through Q2, however, no specific financial implications are identified at this point.

Table Summary of COVID-19 Revenue & Capital Financial Expenditure & Commitments for Q2

	REVENUE					**CAPITAL**				
Division	July	Aug	Sept	Q2 Total	Forecast to 31.3.21 Total	July	Aug	Sept	Q2 Total	Forecast to 31.3.21 Total
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
VCC	67	62	46	175	538	0	0	0	0	656
RD&I	8	8	8	24	83	0	0	0	0	0
WBS	185	185	185	555	1,827	190	0	0	190	397
Corp.	13	13	13	39	156	0	0	0	0	311
Total	273	268	252	793	2,604	0	0	0	0	1,364

Table COVID-19 Revenue Financial Expenditure/Commitments for Q2 and Forecast by expenditure type

Financial Impact Grouping	July 2020	August 2020	September 2020	Total Q2	Forecast year-end
	£'000	£'000	£'000	£'000	£'000
Establishment & Bank Additional Hours	118	118	118	354	1,019
Agency	19	16	7	42	121
Returners	0	0	0	0	28
Students	0	0	0	0	0
Other Temp Staff	0	0	0	0	0
Sub-total Pay	137	134	125	396	1,168
Estate/Security Expenditure (Revenue Only)	10	10	3	23	96
M&SE Consumables	8	8	8	24	340
COVID-19 Testing Units	0	0	0	0	208
Cleaning	5	3	3	11	36
Legal Fees	0	0	0	0	2
PPE (not from National Supply)	6	6	6	18	82
Transportation	13	13	13	39	56
IT & Software Licences	0	0	0	0	30
Venue Hire	13	13	13	39	65
Equipment	0	0	0	0	39
Other–Training, provide services externally	1	1	1	3	9
Reduction in non-pay - reduced activity	-40	-40	-40	-120	-250
Sub-total Non-Pay	16	14	7	37	713
Sub-total Additional Cost	153	148	132	433	1,881
External Income Loss	74	74	74	222	448
Unachieved Savings (Workforce Related)	46	46	46	138	275
TOTAL	273	268	252	793	2,604

Key Issues

1. Updates of COVID-19 costs will be submitted as part of the normal monthly financial monitoring process as per the following:-

   Schedule of monitoring dates

   Organisations are required to submit their year to date and forecast financial position information of the 5th working day, for Months 2 to 12. A brief explanation has to be provided on the template, for any movement in year-end outturn since the previous month.

The main monitoring returns are required on the 9th working day of each month, with the exception of Month 12.

For period ended	Day 5 Submission Date	Day 9 Submission Date
Month 4 – 31st July 2020	7th August 2020	13th August 2020
Month 5 - 31st Aug 2020	7th September 2020	11th September 2020
Month 6 - 30th Sept 2020	7th October 2020	13th October 2020

2. To date there has been no confirmation of funding from WG for the COVID-19 costs, apart from £92,100 of capital for IT devices – Tablets, and the funding of the Convalescent Plasma Service (£397k Capital and £1,153k Revenue). WG has indicated that at this stage, there is no certainty of funding beyond the specific areas of;
   - set-up costs and committed running costs of the field hospitals (funding to be confirmed during June);
   - costs of student and returning staff;
   - provision of PPE;
   - support for early discharge arrangements, and
   - the costs of the testing programme

   Funding will be allocated for these specific areas of support as costs are confirmed.

   A risk assessment has been completed of the impact and likelihood of financial risk that COVID-19 committed and forecast costs expose the Trust to. Whilst the confirmation of funding for the Convalescent Plasma service has reduced the risk materially, the remaining COVID-19 costs remain a significant risk. The risk is presented within the Trust Risk Register reported to Velindre Board, as the impacts the Trust ability to meet its statutory financial duty to break-even. Actions will be taken over the next 3 months to control or mitigate the financial risk.

3. The DoF & Deputy DoF have reviewed all items included within the above table to test the justification of the expenditure in relation to COVID-19. This has resulted in some items of expenditure being transferred into Trust normal expenditure and requirement to be funded from core budgets

4. The above does not include costs of additional capacity required above that in place to accommodate the “new normal” service models that will need to deal with the backlog activity and future demand assumptions as the Trust re-introduces routine services and ensures the maintenance of its essential services as it moves into recovery.

5.6.3 **Reintroducing Routine services**

In order to forecast COVID-19 related expenditure for the rest of the financial year the Finance team are working with service and planning colleagues to model the service scenarios in terms of activity, capacity and demand assumptions etc. and their impact of workforce, non-pay & outsourcing costs.

5.6.4 **Q1 Operational plan**

IMTP Financial Strategy & Plan

The 2020–2023 IMTP sets out the financial strategy & plan for the Trust revenue and capital. It identifies the assumptions around income and expenditure, anticipated cost pressures, planned investments, financial risks. The expectation is that the Trust will achieve a balanced financial positon in 2020-21 as indicated in the IMTP.

The IMTP balanced financial plan was agreed prior to the COVID-19 pandemic outbreak. The Trust has incurred additional expenditure in its response to the pandemic. If the Trust is to now deliver a balanced financial position in 2020-21 there is an assumption that the additional COVID-19 expenditure incurred to date and costs forecast to Mar '21 (revenue & capital) will be funded by Welsh Government.

New ways of working

The actual costs of managing COVID-19 for April and May 2020 are known and we have developed forecasts to March 2021 but these need to be reviewed following the completion of the work to assess additional capacity requirements and whether any of this additional capacity will be commenced in May or June. This may lead to an increase in the May and June COVID-19 forecast expenditure.

The financial implications of WBS and VCC operational plans are covered in the main by the Trust IMTP Income. The additional costs of managing COVID-19 have been identified/estimated in the table in 5.3.5.2. As stated above, these do not yet reflect the costs of the additional capacity required to re-introduce routine services and maintain essential services.

Reintroducing Routine services – the "New normal"

One of the key pieces of work for the finance team is to forecast COVID-19 related expenditure for the whole financial year. A fundamental element of this forecast is the cost of the additional capacity (Internal and External) above that in place that will be required to accommodate the "new normal" service models.

These "new normal" service models will need to be implemented to deal with the backlog activity and enable capacity to be flexed in an agile way to provide resilience against uncertain future demand as the Trust re-introduces routine services and ensures the maintenance of its essential services as it moves into recovery. The Finance Team will be modelling the cost of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell).

Identified Divisional Risks

There are risks identified in the Division sections of this operational plan that should they crystallise could lead to additional cost/or further loss of income above that reflected in the Q1 COVID-19 forecast or Trust annual forecast. The Trust will actively work to mitigate or remove these risks, but should they crystallise the forecast costs will be updated to reflect them.

Summary

At this stage the core underlying financial plan contained within our IMTP submitted to WG in March has not changed substantially. What has changed is the greater uncertainty and financial risks surrounding our activity levels and capacity implications as we move into the recovery phase and potential future spikes of further COVID-19. The more significant risks are:

Financial Risk	Mitigating Actions	Lead
Reduced contracting income from activity levels	Seek clarity through DoF forum and DoF NHS Wales whether the current "Block Contract" arrangement will continue and anticipated time period	DoF & DDoF
Non reimbursement of certain COVID-19 costs	Seek confirmation from WG the revenue & capital funding the Trust will receive to cover COVID-19 financial implications	Chief Exec & DoF
Non reimbursement of costs of additional internal capacity or outsourcing to address future capacity constraints from "new normal" service models	Future service models to be developed and identify financial impact to cover COVID-19 financial implications	Chief Exec & DoF
Non delivery of savings	Seek confirmation from WG of what revenue & capital funding the Trust will receive impact to cover COVID-19 financial implications	Chief Exec & DoF

5.6.5 **Summary of Finance Team Key Actions for Q2**

The essential day to day areas of finance work not included in the below table of key actions continue to be provided to support the Trust in delivering its Strategic and operational plans.

	Action	Time frame
FQ3.3	LTAs with all HB's & WHSSC signed securing core income - although operating block arrangement beyond Q1 as per National DoF agreement	Q2 Position June, Q3 Assess September 2020
FQ2.4	Development of revised RD&I Financial Strategy & Plan	August 2020
FQ2.5	Ensure WG are clear that the revenue (£1.371m Q1&Q2) & capital (£1.181m) financial sums the Trust has already incurred / committed in its response to COVID-19, and that the Trust Financial Plan assumes that these costs will be funded.	July 2020
FQ2.6	Undertake financial modelling of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell) to enable the Trust to flex capacity in an agile way, provide resilience against uncertain demand and ensure patient and staff safety is maintained through social distancing.	July 2020
FQ 2.12	Supporting to the PET CT Strategic Programme Board	Monthly
FQ 2.13	Supporting Acute Oncology Service business case	July 2020
FQ 2.14	Identification of alternative savings delivery	July 2020
FQ 2.14	Working with Internal Audit on Governance Assurance for COVID-19 responses	July 2020

	Action	Time frame
FQ 2.15	Review of Policies required in light of COVID-19 and/or falling due to review	September 2020(may extend into quarter 3 dependent on consultation process)
FQ 2.16	Complete information submission to HMRC regarding Cost of Sales (COS) Review ongoing since March 2020.	Submission should be completed by 31/07/2020 but review will remain ongoing for some time.
FQ 2.17	Develop programme of lessons learned to be shared within the Finance teams and other staff / teams as appropriate to aid completion of the year end accounts 2020/2021	March 2021
FQ 2.18	Continue to manage cash flow of Trust tightly in view of large and often urgent financial purchases being made by NWSSP relating to COVID-19	Ongoing during pandemic
FQ 2.19	Support new services being provided by NWSSP: Single lead employer model for Junior Doctors and establishment of Collaborative Bank	Dependent on NWSSP timeframes
FQ 2.20	Support financial elements of NWIS transition to SHA	Ongoing pre and for a short period post transition
FQ 2.21	Engage with Finance colleagues across Wales and the NWSSP Central E Business Team to upgrade the Oracle Financial System	Ongoing until 2021/2022

	Action	Time frame
FQ 2.22	Recruit to posts previously agreed as part of the restructuring of the Finance Team that have to date been filled by temporary staff	October 2020
FQ 2.23	Engage with the Internal Audit of COVID-19 Financial Governance and any other Internal Audit relevant to Finance (likely Core Financial Systems Audit to commence in Q3)	Dependent on Internal Audit timeframes
FQ 2.24	Recommence meetings and work of Trust Procure to Pay Group to focus on key ways of improving internal processes (not those managed within NWSSP Accounts Payable)	July 2020
FQ 3.25	Hold on site meeting with HMRC to review previous information submission and the Trust's Business Risk Review	Ideally September – December 2020

Quarterly Progress BRAG Rating	
Action Successfully Completed	**BLUE**
Challenges causing problems	**RED**
Progress Issues identified and being resolved	**AMBER**
Satisfactory progress being made	**GREEN**

6. Approval Process by Trust Board

The VUNHST Board has approved the submission of our draft Quarter 2 Operating Plan on 3rd July 2020 in line with Welsh Government requirements. The plan will formally be considered for approval by the Trust Board on or before 30th July 2020.

Velindre University NHS Trust

Operating Plan for Quarter 2 (2020 / 2021)
(1st July to 30th September 2020)

APPENDICES

INDEX

Appendices

APPENDIX 1

Welsh Blood Service Operational Plan as at Q2

1 Quarter 2 Current Situation and Assumptions

The Welsh Blood Service portfolio of services is listed below.

- Transplant Services
  - Welsh Bone Marrow Donor Registry (WBMDR)
  - Solid organ transplant
  - Haematopoietic Stem Cell Transplant
  - National External Quality Assurance Scheme for Histocompatibility and Immunogenetics (NEQAS) (global quality testing service)
- Red Cell Immunohematology (Patient Testing Services including antenatal testing)
- Blood and Blood products
  - Collection, processing and distribution of blood components
  - Wholesale distribution of commercial blood products

Quarterly Planning Assumptions

Quarter 1	April – June 2020	Continuation of 'Lockdown
Quarter 2	July – September 2020	Some relaxation of rules. Social Distancing continues to apply
Quarter 3	October – December 2020	Containment – 'business as usual'
Quarter 4	January – March 2021	'Backlog

Impact to services during COVID-19

Throughout the pandemic, the majority of these services were retained, in line with WHO guidance on high priority categories, and the Essential Services technical document developed by the Welsh Government.

Our plans for Quarter 2 has been developed and shaped through strategic engagement with Health Board planning colleagues and through our close operational links with clinical teams and blood banks. The focus for Quarter 2 will be on reinstating the small number of services that have been paused, the phased increase in those services where activity levels have been reduced, particularly blood component supply, and the introduction of the new Plasmapheresis service to produce convalescent plasma as a treatment option for COVID-19.

Transplant Services and Red Cell Immunohematology

For solid organ transplant services, we are working closely with Cardiff and Vale UHB to recommence support for the programme in June. The delivery of services in Wales will be provided in line with the UK guidance issued by NHS Blood and Transplant who co-ordinate UK services.

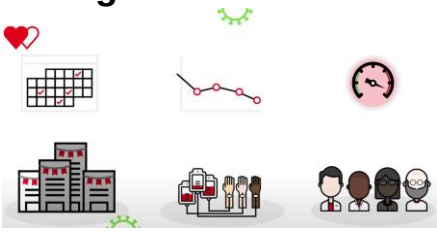
Whilst stem cell donations have been maintained throughout the pandemic by WBMDR, the ongoing access to facilities for cell donation is being reviewed due to potential use for other NHS service provision. Work to sustain stem cell collection is ongoing.

Blood and Blood Products

At the outset of the pandemic, the blood collections system in Wales came under considerable pressure as venues started to cancel bookings, staffing levels dropped through COVID-19 related absence and donor attendance levels started to fall. Donation process changes had to be introduced to ensure donor and patient safety.
The changes introduced by the service enabled us to sustain availability of blood components through donation at a smaller range of fixed sites. Reinforcement of the important message that travel to donate blood qualified as “essential travel” was also an important factor in sustaining donation.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Change in Collection model



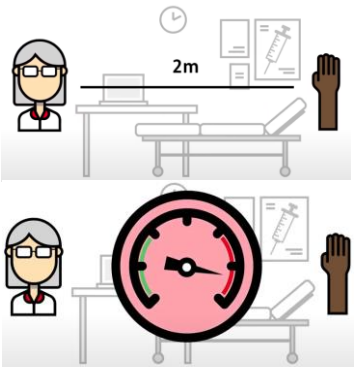
At the outset of the pandemic, the blood collections system in Wales came under considerable pressure:

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

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

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

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



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

PPE has also been introduced for Collection Staff

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

Donors also undergo triage to ensure they are fit and well to donate.

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

---

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

As the pandemic comes under control, and lockdown is slowly lifted, the changes to call on donors' time and their location as well as the potential venues we can use will all impact on the future blood collection model and how it redevelops over the forthcoming months. The impact of infection control interventions such as social distancing will also fundamentally influence the plan.

Welsh Blood Service Assumptions

There are a number of other assumptions that underpin the Quarter 2 recovery model:

- WBS will need to continue to operate the new COVID-19 clinic model introduced in response to the pandemic with social distancing and donor screening requirements
- 5% increase in demand for blood compared to Quarter 1
- Appointment uptake rate to revert to pre-COVID-19 level of 90%
- Did Not Attend rate to revert to pre-COVID-19 level of 10%
- Attend to bleed rate to revert to pre-COVID-19 level of 90%
- Donor behaviour (such as lower DNA rates, higher appointment uptake and "attend to donation" rates and increased new donor numbers) will return to the pre pandemic figures as people return to work etc.
- 9% of the blood collection workforce currently shielding will not return to the workplace in Q2
- The deferral period required for donors who are recovering from COVID-19 has increased during the latter part of Q1, from 14 to 28 days. This will have an impact on the availability of donors who have contracted COVID-19.

2 Essential Services Assessment: Transplant Services

The table below outlines the status of Transplant services deemed 'essential services' at the end of quarter 1 and anticipated status at the end of Quarter 2.

	Q1 status	Q2 anticipated status
WBMDR	No change to service provision.	No change to service provision. No issues anticipated in terms of collection and

	Q1 status	Q2 anticipated status
	Workload for stem cell collection has continued as normal.	support to importation and exportation of stem cells. However this is under continued review due to the support St Josephs is providing to Aneurin Bevan Health Board.
Solid organ Transplant	Service on hold	Phased return commencing in June 2020
Haematopoietic Stem Cell Transplant	No change to service provision	No change to service provision.
NEQAS	Service On hold	Business as usual to have resumed.

In Quarter 1 services were sustained for the Welsh Bone Marrow Registry, support for haemopoetic stem cell transplant, red cell immunohematology, antenatal and other patient testing. These will continue to deliver through Quarter 2 and respond to any changing circumstances.

Services for the NEQAS external quality assurance testing scheme and support for solid organ transplant were paused and will be restarted.

2.1 Activation Plans

WBMDR: Stem cell collection is via a private hospital (St Josephs, Newport) and services have continued throughout the COVID-19 pandemic. Stem Cell transplantation has continued for both national and international patients. Numbers of requests for stem cell products has not decreased in Q1. Stem Cell products are being cryopreserved to allow results of donor testing for COVID-19 to be issued before infusion. It is anticipated that this service will continue as normal to the end of Quarter 2. Operational arrangements with St Joseph's are being assessed due to use of the facility for LHB service provision, which may have an impact on the ability to provide support for stem cell collection.

Solid organ transplant: It is anticipated there will be a phased return to 'Business As Usual' as some services will recommence in C&V UHB in June 2020, first with deceased then with live donor transplants.

Haematopoietic stem cell transplant: Services for stem cell transplantation have continued throughout the COVID-19 pandemic, with 6 patients receiving an

allogeneic transplant in C&V UHB between mid March and 31st May. It is anticipated that this service will continue as normal to the end of quarter 2.

NEQAS: The NEQAS service at WBS, is a national programme that provides external quality assessment of laboratories. WBS has a Service Level Agreement with NEQAS to provide this programme. The programme has been on hold during COVID-19. It is anticipated services will return to 'BAU' in June 2020 with the full EQA schedule planned to be delivered in a reduced timescale (10 months instead of the usual 12). In response to this, it will be necessary to re-call staff currently on deployment to other services within WBS. It is not anticipated there will be any issues associated with returning to BAU within the identified timeframe. Full risk assessments have been completed for these services areas to ensure social distancing is implemented where individuals will need to return from home-working.

2.2 Actions for Q2 Transplant Services

	Action	Lead	Timeframe
BQ2.1	Review resilience to service at St Joseph's Hospital and ensure service sustainability including staffing	Chief Scientific Officer	July 2020
BQ2.2	Continue to work with C&V UHB to understand proposals for solid organ transplant restarting.	Chief Scientific Officer	June 2020

3 Essential Services Assessment: Patient Testing Services (Blood Reference Testing Service, Antenatal Service & Drugs)

The RCI service has continued to run as BAU throughout the pandemic. Antenatal referrals remained constant. It is not anticipated that there will be any issues maintaining BAU.

	Q1 status	Q2 status
Red Cell Immunohaematology activity	service continued to meet demand	Service will continue to meet demand

3.1. Essential Services Assessment: Blood Components and Blood Products

Collection of Blood Donation, processing and distribution of blood components:

- Whilst supply has met demand during Quarter 1, there are significant risks associated with continuing to meet hospital demand in Quarter 2 as a result of changes in donor behaviour as lockdown eases and the continuation of social distancing measures.

Wholesale Distribution of Commercial Blood Products:

- The provision of commercial blood products has been sustained through Quarter 1 and will be throughout Quarter 2. However, as with all imported commercial products, there will need to be ongoing review of availability of stocks as a priority.

	Q1 status	Q2 anticipated status
Collections of blood donations, processing and distribution to hospitals	Supply is meeting demand through a revised donation session model	Supply will meet demand but is subject to a significant number of risks Assumed increase in demand of 5% from current service level.
Wholesale distribution of commercial blood products	No change to service provision	No change to service provision

3.2 Forecasting Demand for Quarter 2

Demand planning for blood components is generally undertaken at an overall health system demand level due to the complexity of the factors that influence demand and availability of end-point use data. For Quarter 2, this has also been supported by historic data analysis, knowledge of the subject matter expert and discussions on service plans with Health Boards. This information has been used to provide an All-Wales picture.

The pandemic has created a 20% reduction in demand for blood across Wales. However, there is unlikely to be a linear increase in demand for blood over Quarter 2 as we are anticipating that there will be lag time as Health Boards recover their services. Therefore, and although we are assuming that there will be an increase in demand from Health Boards for blood, we are still expecting that this will be lower than pre-COVID-19 levels when compared with the same time period of previous years.

As further detailed plans emerge from the Health Boards, we will continue to liaise closely with Health Board Blood Bank Managers and senior clinicians to actively manage the blood stocks across Wales. As services return, an opportunity will be taken to review blood use in line with the work that has been in progress through the Wales Blood Health Plan, promoting prudent use of blood products.

Blood Collection

The Planning department will aim to plan clinic sessions to collect enough blood to meet the estimated demand during Quarter 2. The number of appointments and the resultant number of donations and then components takes into account factors such as appointment uptake, Did Not Attend (DNA) rates from donors and how many who attend are able to donate.

During the outbreak, we saw an increase in positive donor behaviour resulting in increased appointment uptake, a high number of new donors and reduced DNA rates. However, we are anticipating that DNA and 'Attend to Bleed' rates will revert to pre-COVID-19 levels during Quarter 2.

Therefore, and to plan for the collection of an increased number of units of blood per week, consideration needs to be given to increasing venue donation capacity, workforce capacity and donor attendance rate.

Changes made during "lockdown" to clinic locations are being reviewed as we seek to reach out wider into the community again. A number of the temporary venues secured during this period are now required by organisations as they plan to reopen (e.g. schools and colleges). Many of our previous venues may now remain unsuitable due to the configuration required by the COVID-19 clinic operating model e.g. continuation of social distancing.

Work is ongoing to identify alternative opportunities at vacant public sector premises and priority is being given to assessing suitability and securing a portfolio of these venues as blood donation clinics capable of providing appropriate longer-term capacity. In the interim, Collections Services will continue to review current resourcing on a weekly basis to identify where additional clinics can be scheduled (staffing permitting).

Meeting Demand for Blood:

Based upon our planning assumptions above we have modelled how much blood we expect to collect from our donors compared to the demand we expect from Health Boards. This shows that we will be able to meet forecast demand during Quarter 2.

Welsh Blood Service Forecast Deliverable Activity Quarter 2 (July to September 2020) week by week Versus Required Activity					
July 2020					
(week by week)	1	2	3	4	5
Forecast - Units of Blood Collected	1572	1590	1575	1569	1534
Forecast Demand	1500	1517	1502	1497	1464
Variance (+/-)	72	73	72	72	71

August 2020					
(week by week)	6	7	8	9	10
Forecast - Units of Blood Collected	1526	1490	1463	1341	1471
Forecast Demand	1455	1421	1395	1177	1403
Variance (+/-)	70	69	67	164	68
September 2020					
(week by week)	11	12	13	14	
Forecast - Units of Blood Collected	1512	1544	1542	1522	
Forecast Demand	1443	1473	1471	1452	
Variance (+/-)	70	71	71	70	

However, it is important to highlight that there are significant risks associated with continuing to meet hospital demand in Quarter 2 as a result of changes in donor behaviour as lockdown eases and the continuation of social distancing measures. These are explored in detail in Appendix 2.

Workforce planning Recruitment of Additional Staff

COVID-19 related absences, have led to a reduction in the whole blood collection workforce from 8 to 5 operational teams across Wales. In addition, in line with service improvement plans, staffing levels had been held prior to the outbreak pending changes. A skill mix and workforce review has enabled us to flex this workforce effectively and support non specialist tasks with redeployed staff. . Increasing the donation capacity in venue size or clinic number will require additional workforce to be in place and the recruitment has been implemented to supplement staff levels to previous levels.

This will increase the establishment of registered nurses and clinic care assistants to meet the demand required as lockdown is lifted.

The recruitment process is being proactively managed and monitored and a modular based approach to training will allow staff to be upskilled in certain imperative clinic roles quicker than completing the whole programme.

As an interim measure temporary increases in contracts and reviewing plans for annual leave. For existing collections team staff are being explored together with ongoing staff redeployment and occasional agency use.

Communication and Engagement with Donors:

WBS always relies on proactive engagement with its donors and with the public to encourage new donors. Throughout the pandemic, WBS has continued regular

contact with donors through its direct channels; phone, SMS and social media.to invite donors to donation sessions provide information on all aspects of donation and to inform donors of any change in service. A number of information resources were produced to reassure donors. As we move into Q2, the contents of this communication is adapting to respond to changes in restrictions to lockdown and donor behaviour. In our experience the people of Wales respond well when asked and we will continue to actively engage to meet demand. However we will monitor closely as we make the required changes to venues.

3.3 Actions for Q2

BQ2.3	Continue to work with Health Boards to understand plans for increase in demand for blood products	Blood Health Team	Ongoing throughout Quarter 2
BQ2.4	Review donation capacity at current venues pending increase in numbers	Supply Chain Lead – Collections Services	July 2020
BQ2.5	Explore options for further permanent or temporary fixed sites for densely populated areas including WBS sites	Supply Chain Lead – Collections Services	July 2020
BQ2.6	Deliver workforce plan to include recruitment of additional staff, review of staff availability through contract increases, agency staff, recruitment and training.	Supply Chain Lead – Collections Services	July 2020
BQ2.7	Explore the employment of third party make ready services to set up and pack down collection clinic equipment to ensure increased capacity for clinic.	Supply Chain Lead – Collections Services	July 2020
BQ2.8	Increase number of donation opportunities available across Wales including working with public sector	Supply Chain Lead – Collections Services	September 2020
BQ2. 9	Continue focused and adaptive donor engagement activity to promote attendance	Supply Chain Lead – Collections Services	Ongoing throughout Quarter 2

4 Convalescent Plasmapheresis (CP)

WBS commenced the production of plasma from males who have recovered from COVID-19 through whole blood donation in Q1.Further development to enable female donation is in development as it requires additional tests to be performed.

A business case was approved by the Welsh Government in June 2020 to commence plasma production through the use of plasmaphereses. This

programme is overseen by Welsh Government and is managed in WBS by a project group. The project requires the establishment of venues and a donation process for blood donation using apheresis. It requires enabling changes to the WBS IT platform and regulatory validation.

The development of this service model will be a focus for the organisation over the coming months with Welsh Government expectations that collections will commence in September 2020 by means of Plasmapheresis (Phase 2).

	Action	Lead	Timeframe
BQ2.10	IT configuration work to enable ePROGESA for plasmapheresis collection	General Service Manager	September 2020
BQ2.11	Implement in-house HNA antibody testing to enable convalescent plasma collected from female donors to be used if model shows this to be a viable option	Chief Scientific officer	July 2020
BQ2.12	Implement in-house COVID-19 antibody testing	Chief scientific officer	September 2020
BQ2.13	Scoping of suitable plasmapheresis venues and operational requirements	Head of QA	July 2020
BQ2.14	Recruitment and training of collection team staff to undertake plasmapheresis collections	Head of Blood Supply Chain	September 2020
BQ2.15	Recruitment of plasmapheresis donors to the first clinics in anticipation for when they go live in Q3	Head of Blood Supply Chain	July 2020
BQ2.16	Continue supply of whole blood derived convalescent plasma to hospitals to support participation in clinical trials	Head of QA	ongoing

5 Financial Impact

The appointment of agency and core staff to support the collections model proposed in Q2 will incur expenditure in excess of budgeted establishments. In addition to the introduction of expenditure above budgeted levels, WBS has experienced a loss of income against planned levels, whilst the majority of services have remained available, the demand has decreased against a largely fixed cost.

The introduction of the Convalescent Plasmapheresis service has been supported financially by Welsh Government. The Q2 financial impact has been separately identified from the wider impact of COVID-19.

The table below outlines the Quarter 2 planned financial impact:

Q2	Forecast	Forecast	Forecast
	July	August	September
Pay Revenue Expenditure	£48,512	£48,512	£48,512
Non Pay Revenue Expenditure	£31,700	£31,700	£31,700
Loss of Income	£38,042	£38,042	£38,402
Total Financial Impact	£118,254	£118,254	£118,254

Q2 – Convalescent Plasmapheresis	Forecast	Forecast	Forecast
	July	August	September
Funded Revenue expenditure	£56,436	£56,436	£56,436

6 Risks to Delivery of Q2 Plans

	Risk	Mitigation
WBMDR	Unable to continue to provide a service to support stem cell collection (in line with SLA) due to the capacity in St Joseph's Hospital being reduced as a result of supporting ABUHB and an increased number of staff shielding.	WBMDR is supporting stem cell collection using current nurses. In addition approval for WBMDR to appoint 0.6wte Registered Nurse to support collections. This will support the future service model for stem cell collection
	Unable to manage stem cell process from outside of the UK due to continued disruption to international flights and border controls.	Ongoing surveillance and revision of transport and logistics for import and export of haematopoietic stem cells in conjunction with partner organisations. SLA in place with Anthony Nolan trust to manage courier across boundaries.
NEQAS	Staffing levels, participating laboratories and key suppliers are not available to support the EQA	ongoing engagement and communication with key partners to

	Risk	Mitigation
	schedule, which may impact on the accreditation status of other laboratories and reputational risk, clients may choose to go elsewhere.	ensure SLA requirements can be delivered
Collections	Unable to collect enough blood to meet demand due to cancellation of fixed venue sites as a result of the venues re-opening and alternative venues, that can support social distancing are unable to be sourced. Over 50% of established venues are not available for the foreseeable future due to inability to support social distancing. Currently unable to use mobile donations clinics which also accounts for around 25% of hold blood supply.	Collections will continue to review availabilities of venues and continue to work with external partners in Wales to secure venues, which support social distancing and collection planning model.
	Unable to collect enough blood to meet demand due to higher DNA rates, deferral rates, lower uptake, as a result of donors returning to work, schools reopening and a more normal life returning.	Activity and demand being monitored daily through WBS resilience meeting. Ongoing use of social media, SMS, email partnership organisation to engage with donors Option to escalate national blood shortage plans is available
	Unable to collect enough blood to meet demand due to insufficient staff available as a result of shielding, to support additional donation chairs required	Recruitment programme on going, will provide further mitigation in Q3.
		Agency staff to be appointed to release more experienced staff from nonskilled COVID-19 related tasked to support clinics whilst new staff are trained.
Wholesale licenses	Potential for disruption of blood derived medicines (commercial products) across international supply chain.	Service is holding increased stock against a range of products.
Manufacturing and testing of blood products	Focus on collection of whole blood into donation bags suitable to produce Convalescent plasma may limit availability of blood in	Changes in CP collection activity monitored by the Manufacturing and Testing work stream

	Risk	Mitigation
	donation bags suitable to produce buffy coat derived platelets	
Convalescent Plasmapheresis	There will be insufficient suitably trained staff to commence plasmapheresis during Q2.	Additional staff to be appointed within collection teams and will be trained throughout Q2 with a view to reducing the risk in Q3.
	Potential delays due to IT testing and/or validation failures	Working with Business systems to prioritise work to enable support for convalescent plasma.
	Risk of securing suitable venues to deliver plasmapheresis collection service	Exploring options that will facilitate the delivery of the service within constraints of social distancing
	Availability of a sufficient quantity of eligible donors is a concern although still an unquantifiable risk at present	Working with PHW and Donor engagement team on how to identify broader population of donors.

7 Contingency Planning

Scenario1

Whilst the above scenario has been modelled, the European Blood Alliance has indicated that some European countries have seen an increase in demand to 100% immediately following relaxation of social distancing.

Timeline: In order to respond to a request to return fully to 'business as usual' this will require a lead in time of approximately 20 weeks. Therefore WBS would need to work closely with NHS Wales in terms of appropriate use and best practice and could deploy the national blood shortage plan.

Scenario 2

In the event a second peak is triggered at any point between now and the end of quarter 4, the model for collections would revert to the service model in place at Q1 'continuation of lockdown' phase.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 2

Welsh Blood Service Capacity and Activity Forecasts - July to Sept 2020

Welsh Blood Service Forecast Capacity Quarter 2 (July to September 2020) week by week					
Blood Collection					
July 2020					
(week by week)	1 (29/6 - 5/7)	2 (6/7 - 12/7)	3 (13/7 - 19/7)	4 (20/7 - 26/7)	**5 (27/7 - 2/8)**
Available Appointments	2270	2296	2274	2265	2216
% Uptake	90	90	90	90	90
% DNA	10	10	10	10	10
Units of Blood Collected	1572	1590	1575	1569	1534
August 2020					
(week by week)	6 (3/8 - 9/8)	7 (10/8 - 16/8)	8 (17/8 - 23/8)	9 (24/8 - 30/8)	**10 (31/8 - 6/9)**
Available Appointments	2203	2151	2112	1936	2124
% Uptake	90	90	90	90	90
% DNA	10	10	10	10	10
Units of Blood Collected	1526	1490	1463	1341	1471
September 2020					
(week by week)	11 (7/9 - 13/9)	12 (14/9 - 20/9)	13 (21/9 - 27/9)	14 (28/9 - 4/10)	
Available Appointments	2183	2229	2226	2197	
% Uptake	90	90	90	90	
% DNA	10	10	10	10	
Units of Blood Collected	1512	1544	1542	1522	

Welsh Blood Service Forecast Deliverable Activity Quarter 2 (July to September 2020) week by week Versus Required Activity					
Blood Collection					
July 2020					
(week by week)	1 (29/6 - 5/7)	2 (6/7 - 12/7)	3 (13/7 - 19/7)	4 (20/7 - 26/7)	5 (27/7 - 2/8)
Forecast - Units of Blood Collected	1572	1590	1575	1569	1534
Forecast Demand	1500	1517	1502	1497	1464
Variance (+/-)	72	73	72	72	71
August 2020					
(week by week)	6 (3/8 - 9/8)	7 (10/8 - 16/8)	8 (17/8 - 23/8)	9 (24/8 - 30/8)	10 (31/8 - 6/9)
Forecast - Units of Blood Collected	1526	1490	1463	1341	1471
Forecast Demand	1455	1421	1395	1177	1403
Variance (+/-)	70	69	67	164	68
September 2020					
(week by week)	11 (7/9 - 13/9)	12 (14/9 -20/9)	13 (21/9 - 27/9)	14 (28/9 - 4/10)	
Forecast - Units of Blood Collected	1512	1544	1542	1522	
Forecast Demand	1443	1473	1471	1452	
Variance (+/-)	70	71	71	70	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

APPENDIX 3

Welsh Blood Service Operational Plan Q1 Action Log Delivery Update

	Action	Lead	Timeframe	Progress
THEME: MANAGING COVID-19				
BQ1.1	Recommendations from the Risk assessment will be implemented, including where appropriate Perspex screens and PPE.	Head of Labs	June 2020	Recommendations from social distancing assessments and FMEAs have been implemented/. Training records are available.
THEME: SUPPORTING HEALTH BOARDS TO MANAGE COVID-19				
BQ1.2	Establish internal Programme Board/group to progress implementation of Convalescent Plasma	Head of QA	May 2020	WBS Convalescent Plasma Project Group established, chaired by Director of WBS. Currently meeting weekly. Supported by Convalescent plasma Implementation Group. This group is responsible for coordination of the workstreams and programme of work. Meets weekly, chaired by Head of Quality Assurance.
BQ1.3	Scope and develop the programme of work to support roll out of the convalescent plasma programme	Head of QA	May 2020	WBS project board established. Project brief developed
BQ1.4	Continue to support Health Boards to manage COVID-19 patients through collecting convalescent plasma for their use. NB: none has been transfused to date	BSC lead, Collections	Ongoing	Service in place for whole blood males. Work ongoing to expand service Appointment booking for Convalescent Plasma donors in the process of transferring to 'business as usual' and managed via the Donor Contact Centre.
BQ1.5	Submission of business case to Welsh Government to support expansion of convalescent plasma progamme.	Head of QA	May 2020	Complete

	Action	Lead	Timeframe	Progress
THEME: SURGE CAPACITY AVAILABILITY AND ACTIVATION PLANS				
BQ1.6	WBS will continue to work with Health Board to ensure clear understanding of plans regarding utilisation of 'field hospitals and impact on blood and blood products'	Medical Director/ BHT	May 2020	Complete. Only C & V will be supporting their field hospital with a blood components fridge. This will be managed and supplied by C & V Blood Bank.
BQ1.7	Develop an agreed workforce plan to support each clinic option	BSC Lead, Collections	June 2020	Recruitment currently underway, incorporating review of Collections teams workforce to support delivery of whole blood collection clinic programme. 15CCAs have been recruited, 8RNs invited to interview June 2020. Paper gone to SMT outlining risk from reduced staffing levels requesting approval to recruit above staffing establishment. This would also support Convalescent plasma moving forward.
BQ1.8	Work with BHNOG and Health Boards to actively progress prudent use of blood and the use of alternatives to prevent demand outstripping supply when routine services are re-introduced.	Blood Health Team/Medical Director	June 2020	Letter sent to health boards from BH NOG requiring implementation of best practice guidance on use of blood.
BQ1.9	Work with independent sector to understand plans for recovery, impact on availability of fixed capacity and additional clinic capacity	BSC Lead, Collections	Ongoing	Working closely with independent sector in relation to identifying suitable venues for blood collection. Cancellations being received for large venues. List received of possible venues and plan in place to work through for suitability and availability – direction of travel to identify large venues, likely to be available for the longer term. Names received of estates managers for health boards and option being explored of currently field hospitals being used.

	Action	Lead	Timeframe	Progress
BQ1.10	Explore options to reduce minimum time required to recruit and train new workforce for collection clinics.	BSC Lead Collections	June 2020	Collections team reviewing options for developing a modular based training programme in conjunction with education and training leads. Paper gone to SMT outlining risk from reduced staffing levels requesting approval to recruit above staffing establishment. This would also support Convalescent plasma moving forward. Additional CCA staff and RNs have been appointed. Agency staff have been appointed to provide additional resilience whilst training is undertaken
THEME: MAINTAIN ESSENTIAL SERVICES				
BQ1.11	Work with C&VUHB to understand plans/timelines for UHW to restart solid organ transplant	Head of Labs	Ongoing	Correspondence received from C&V UHB in relation to possible re-start date mid-June 2020. Staffing in place to support return to BAU.
BQ1.12	Work with Welsh Government, C&V UHB, PHW and NHSBT to roll out convalescent plasma phase 1	Head of QA	June 2020	Complete. Phase 1 model in place – collection from whole blood males only. No CP has been issued to date.
BQ1.13	Work with Welsh Govt, NHS Wales, and linking closely with NHSBT to move forward with development of phase 2 of the Programme of work (Plasmapheresis).	Head of QA	June 2020	Business case submitted to WG. Letter confirming funding received for machines to support service model. Project Board in place, scoping document developed. Work progressing via Programme Board.
BQ1.14	Continue to participate in weekly briefings with national Organ Donation Teams (ODT) as part of recovery planning.	WTAIL	Ongoing	Ongoing
BQ1.15	Meet/liaise with TLMs/TPs to ensure appropriate use of blood in HBs	Blood Health Team	Ongoing	Meetings will continue until end of June and requirement to continue will be reassessed

THEME: ROLES AND ACTIVITY PLANS FOR INDEPENDENT SECTOR FACILITIES				
BQ1.16	WBS to work with Health Board to understand how independent hospitals fit into recovery plans and if there will be an impact on demand for blood and blood products to Health Boards.	Blood health Team	May 2020	Managed via discussions with health boards. With the exception of SPIRE in Cardiff which is supplied directly by WBS all other independent hospitals are managed and supplied by their HB Blood Bank
BQ1.17	Ensure recovery plans for collection clinics take into consideration loss of current independent venue capacity as the venues move towards 'business as usual' and workforce due to shielding	BSC Lead Collectio ns	May 2020	Recovery plan is being developed based on several scenarios, which make a number of assumptions based on capacity and workforce.
THEME: RE-INTRODUCTION OF ROUTINE SURGERY				
BQ1.18	WBS need to understand plans from health boards for re-introducing surgery and addressing any surgical backlog	Blood Health Team	May 2020	Letter sent from Trust to Health Board Planning Directors. Information received from some health boards. BHT to contact Trust to confirm if follow up letters are being sent. In interim assumptions made, 20% reduction on pre-COVID-19. Assume Q2 10%, Q3 20% (BAU), Q4 BAU plus 10% hospital backlog.
BQ1.19	WBS to communicate with health board's time lag required in order to ensure sufficient blood available to support any planned increase in activity.	Blood Health Team	May 2020	Letter sent via medical director to health boards in relation to considerate use of blood and blood products. Starting to see a positive change in health board practice
THEME: COMMUNICATION				
BQ1.20	Continue to address issues raised by donors, utilising direct and indirect channels of communication	Comms	Ongoing	
BQ1.21	Continue to work with the media to cascade core messages to donors.	Comms	Ongoing	

Quarterly Progress BRAG Rating	
Action Successfully Completed	**BLUE**
Challenges causing problems	**RED**
Progress Issues identified and being resolved	**AMBER**
Satisfactory progress being made	**GREEN**

APPENDIX 4

Velindre Cancer Centre Operational Plan as at Q2

1 Introduction

Cancer services have been severely disrupted as a result of COVID-19. The causes, specific to cancer services are summarised below:

- Patients being reluctant to present to primary care and secondary care tests/treatments, driven by the perceived risks of C-19 infection and/or an unwillingness to burden the NHS
- Reduced efficiency due to C-19 precaution measures and managing patients with C-19
- Some diagnostic tests and treatments being stopped or deferred due to the risks of C-19 infection outweighing their benefits
- Some services such as rehabilitation being stopped because the workforce has been diverted to respond to the C-19 pandemic
- The pausing of cancer screening programmes.

As highlighted within '*A Framework for the Reinstatement of Cancer Services in Wales*' it is likely that the full reinstatement of services impacted by COVID-19 will take at least 6-12 months.

The Framework also states:
"In reinstating services, there is a need for assurance that cancer services will be delivered as safely as possible, despite the ongoing risks of COVID-19. There will need to be major service redesign to create the capacity to meet the projected demand, especially as a result of reduced capacity due to reduced utilisation as a result of COVID-19 cleaning measures. Patients will need to be prepared prior to entering facilities. Staff will need to reduce risk through careful use of rotas and serious consideration given to regular testing of frontline staff"

Our VCC plan is therefore set within this context and is cognisant of the requirements laid out within this Framework.

In addition we have made the following quarterly planning assumptions.

Quarterly Planning Assumptions

Quarter 1	April – June 2020	Continuation of 'Lockdown
Quarter 2	July – August 2020	Some relaxation of rules. Social Distancing continues to apply. Limited impact of increasing demand through HBs. Reinstate internal deferred patients. Capacity planning internally to maximise activity.
Quarter 3	October – December 2020	Further relaxation of rules. Social Distancing continues to apply. Growing impact of increasing demand through HBs. Utilising demand model to inform capacity planning. Maximise activity including with external options where required.
Quarter 4	January – March 2021	Possible Social Distancing changes. Business as usual at Health Boards. Capacity planning to maximise activity with external options.

Quarter 1 – A Summary

Throughout Quarter 1 we have maintained the delivery of our essential services. We have also undertaken a comprehensive review of those services to ensure that we have identified service transformations, implemented in response to COVID-19, which we wish to keep and align with our pre-COVID-19 service development plans and strategic intent.

However, during Quarter 1, we were required to centralise the majority of our services to the Velindre Cancer Centre. This rapid migration to a centralised model was required to support the All-Wales objective of maintaining COVID-19 free sites where possible and to contribute to regional COVID-19 capacity requirements.

Whilst we were successful in continuing to deliver essential services during Quarter 1 the centralised model we have adopted conflicts with our strategic intent to deliver services 'locally' where possible.

Quarter 2 Plan – An Overview

The key areas of focus for our Quarter 2 plan are to:

- Develop and/or implement plans to reinstate our outreach service model
- Develop plans for maximising service capacity:
  - Within existing resources at VCC
  - Within existing resources at outreach locations
- Ensure that staff and patients are safe when attending our treatment locations and to minimise the risk of COVID-19 transmission
- Develop plans for creating additional service capacity, but which will require additional investment, with third party providers.

Aim of our Quarter 2 Plan:

To develop a resilient, quality driven, service model for VCC patients, which is able to respond to peaks and troughs in demand during COVID-19 throughout 2020-2021.

To achieve our aim we will review a number of options in parallel. These include within VCC, with Health Boards and with third party suppliers.

We will also need to build in flexibility and identify options for expansion of services in order to respond appropriately should a return to the acute phase be required and to accommodate patients repatriated from Health Boards and expected demand growth from HBs.

2 Essential Services SACT

2.1 Activation Plans

Fully costed plans and options for delivery have been developed to provide a roadmap to support the recovery of SACT services across South East Wales.

Within VCC

Although we are expecting a gradual increase in demand during Quarter 2 we are anticipating that SACT demand will exceed pre-COVID-19 levels during Quarters 3 and 4. Therefore we need to develop plans for increasing our available service capacity.

During Quarter 2 we will also be resuming treatment for patients who have had SACT deferred by clinicians due to risks during the first peak of the pandemic.

In the interim, VCC also continues to manage the University Hospital Llandough (UHL) lung service, which had been transferred to Velindre during Qtr 1.pending permanent reconfiguration

With Health Boards

Recovery and re-opening of outreach sites, are being actively pursued. We are working closely with Health Boards to re-establish the full staff and facility requirements to deliver these outreach services. Demand modelling will inform the optimal number of chairs and days of week when the VCC SACT service will be required for patients, taking into account that current consultant SACT pre-assessment clinic rotas will not change. This work will be important as it will inform the development of outreach locations which will be taken forward lining with the TCS Outreach programme as that recommences.

With third party suppliers outside of VCC

- The Tenovus Mobile Unit capacity for VCC SACT will continue where already established and expansion opportunities will be explored
- The VCC Immunotherapy service provided by Lloyds Pharmacy Clinical Homecare using the Tenovus Mobile Unit will continue to operate
- The VCC Medicines @ Home service will continue and expansion opportunities explored
- Other third party options are being explored, to deliver SACT.

Q1 status	Q2 status
We have managed to treat all levels of priority during the acute phase	Challenge to maintain activity as referrals increase
All deferred patients have been tracked and are monitored	As services re-start, SSTs have been asked to identify priority deferred patients for treatment
SACT outreach services from HBs were all repatriated to VCC. Equivalent to 19 outreach chair spaces	Discussions with HBs to repatriate SACT services to safe locations
Reduced capacity in VCC from 32 spaces pre-COVID-19 to 18 in qtr1	Detailed options and plans to increase capacity in VCC have been developed and will be implemented in line with demand growth

2.2 Risks

Risk	Mitigation
Limited physical capacity at VCC requires choices on priorities for estate utilisation	Senior Management Team to consider all capacity delivery options and give clear direction for service implementation
Demand for SACT services and ability to flex capacity to accommodate potential surges or reduction in activity if future COVID-19 peaks occur	Senior Management Team to agree capacity increase options and implement change when demand increases
It is unclear when HB partners will be in a position to offer VCC any SACT day	Establish clear timelines with all Health board partners to plan safe returns

case and associated phlebotomy (and outpatient) services	
The ability of HBs to revise provision of services and the outreach configuration model in line with what is/will be required during and post COVID-19.	SACT operational recovery plan outlines options for reconfigured services with HBs which has to be worked through in detail with HBs over Quarter 2
Ability of third parties suppliers to provide the right level of SACT service when required	Develop detailed specifications for service required and ensure third party suppliers are able to provide all elements of specification

2.3 Actions

SACT	**Action**	**Lead**	**Timeframe**
VQ2.1	Continue to treat patients at all levels of priority	SST Leads	Ongoing throughout Quarter 2
VQ2.2	Ensure deferred patients are reviewed and planned on an individual basis	SACT Lead/SST Leads	
VQ2.3	Continue to manage repatriated patient activity until safe plans are agreed with HBs	SACT Lead	
VQ2.4	Develop plans with all HB partners to deliver a safe return of outreach services	Planning Leads/SACT Lead	August
VQ2.5	Deliver planned activity levels included in week on week profiles	SACT Lead	Weekly throughout Quarter 2
VQ2.6	Implement capacity increase delivery options to meet demand changes	Senior Management Team.	Ongoing July to September

3 Essential Services Radiotherapy

3.1 Activation Plan

Detailed plans and options for delivery are in development to provide a roadmap to support the recovery of Radiotherapy services in the medium and long term. In addition, a *Radiotherapy Services Maximising Capacity* document has been developed which identifiers clear options for the service for 2020 until 2024. Several LINACs are at the end of their working life and planned replacement of two machines is in place for 2021/22. Further major changes planned are longer term in nature and neither of these will assist in the current challenge for Q2.

We have also recently received a report from Attain healthcare consultancy who undertook a review of radiotherapy services and this will shape our service options going forward.

We have been able to adapt our service to treat patients that were unable to be treated by other cancer services (e.g. ablative therapies). We have identified areas of low service resilience and put specific training packages together to minimise this.

There is adequate safety netting for patients whose pathways are affected and they are kept well and informed whilst waiting. This should also ensure that as services restart, patients with the highest clinical priority are dealt with first, where possible.

Q1 status	Q2 status
We have managed to treat all levels of priority during the acute phase	Challenge to maintain as referrals increase
All deferred patients have been tracked	As services re-start, SSTs have been asked to identify priority patients
We re-shaped our service to provide a Designated LINAC (DL) to manage COVID-19 +ve patients and separating COVID-19 free staff and patient flows as far as possible from COVID-19 +ve patients	During recovery this will revert towards normal, with initial plans including using the DL to treat COVID-19 free patients in the morning and only being designated for COVID-19 patients in the afternoon
Patients managed with minimal exposure to hospital environment	Strengthen our approach as we expand and bring deferred and vulnerable patients back into the service
Reduction in LINAC capacity of 22% due to staff illness/shielding/re-deployment	Re-establish staffed services by following latest guidelines
Demand reduced by 25% driven by limiting treatment of borderline benefit, deferral of prostate patients and hypofractionation for most breast patients and rectal cancer patients	Offering treatment to deferred patients, starting treatment for new patients, reinitiating RT to patients with borderline benefits, continue to manage demand by use of hypofractionation

3.2 **Risks**

Risk	Mitigation
Lack of capacity to meet demand will potentially affect patient outcomes as radiotherapy is a high-value effective treatment. Reduction in existing LINAC capacity of 22% for the remainder of 20/21 predicted	Detailed capacity planning work has been undertaken with proposals for increasing capacity
Treatment options during this phase are being developed as a balance between exposure to COVID-19, tumour control and risk of side effects	Risk assessment process to be fully agreed and supported by Senior Tea.

Capacity plans for the short term include extended days. This will require additional staff resource at all points in the treatment pathway with significant training requirement	Workforce and recruitment to provide rapid response plan
Demand profiles of anticipated impact of streams of suppressed demand are volatile and the impact of late stage presentation and the potential increase in palliative treatment and emergency presentation is challenging	Capacity plans need to be flexible to meet changing patient profile
Extending LINAC working hour's increases risk of failure of older, particularly with the existing high utilisation rates, machines and resultant further shortfall in provision	Full risk assessment of proposals v likelihood of failure to be undertaken
While some treatment options reduce radiotherapy machine time there is an associated increase in pre-treatment capacity required	Full effect on pre-treatment capacity to be finalised to inform delivery option decision making

3.3 **Actions Q2**

Radiotherapy	**Action**	**Lead**	**Timeframe**
VQ2.7	Detailed Capacity plan options to be finalised and agreed by the Trust	Radiotherapy Lead/Trust Board	July
VQ2.8	Re-establishment of RTD programme based on Attain report	Director of Cancer Services	July
VQ2.9	Risk based clinical model proposals to be agreed by Trust	Trust Board	July
VQ2.10	Workforce development and recruitment plan to be developed to support options	W & OD Lead	Aug
VQ2.11	Demand modelling to inform increases in activity from suppressed demand	Planning Leads	Ongoing throughout Quarter 2
VQ2.12	Impact of Radiotherapy delivery options to ensure pre-treatment capacity is covered	Radiotherapy Leads	
VQ2.13	Deliver planned activity levels included in week on week profiles	Radiotherapy Leads	Weekly through Qtr 2.

4 Essential Services Outpatients

4.1 Activation Plans

In order to maintain essential services during the current COVID-19 pandemic, we have had to refine our outpatient model. The model adopted was one which aimed to minimise the infection risk to both patients and staff by reducing the outpatient footfall to the cancer centre by offering 'virtual' appointments to patients instead of 'face-to-face' appointments where appropriate.

The Site Specific Teams (SSTs) were asked to review their patients and clinics and where possible offer them a 'virtual' appointment. Many patients who were undergoing Systemic Anti-Cancer Treatment (SACT) treatments were offered virtual assessments and many follow up /review patients were also being offered virtual appointments. Only urgent new patients and other patients who really needed a face-to-face appointment were brought into the cancer centre.

This approach has worked well and it is a service model which we will need to continue with as we move into the next phase of the pandemic, i.e. one of 'recovery', i.e. emerging from peak demand but with ongoing service disruption.

Area	Q1 status	Q2 status
Outpatient Activity	All patients requiring an urgent Outpatient appointment were seen	Challenge to maintain Outpatient activity as referrals from Health Boards increase
Outreach Activity	Outpatients outreach clinics from HBs were all repatriated to VCC	Discussions with HBs to repatriate Outpatients services to safe locations, being led by Director of Planning and Planning Manager
Service delivery models	Change in service model where patients were offered 'virtual' appointments where appropriate	Embed virtual approaches as default modes of service delivery
Digital Transformation	The use of AccuRx and Microsoft TEAMS for virtual consultations	To include a transition from AccuRX/TEAMS to Attend Anywhere as the primary interface, in line with the National Programme. Plan to embed this and roll out for use in all Outpatient clinics by September 2020. This includes therapies

Area	Q1 status	Q2 status
Phlebotomy Services	All patients requiring blood tests offered appointments at VCC	Where HBs have re-started Phlebotomy services, encourage patients to have blood tests locally
Recording of Outpatient activity	Difficult to accurately record numbers of patients having virtual appointments due to CANISC restrictions	NWIS completed work to CANISC so all patient appointments will have intended visit type so activity can be accurately recorded. Retrospective updating of records to be completed

In developing the Quarter 2 plan for Outpatients, it is important to review how we have delivered services during Quarter 1 and in particular, what has worked well. Offering patients virtual appointments and minimising face to face attendances remains a pivotal strategy in developing our services going forward. This approach has worked well and allowed us to maintain essential services. It is also in line with the recommendations of the NHS Wales Outpatient Strategy.

The management of follow up outpatients is also key and could free up capacity for new patients and those with complex needs who need to be seen face to face.

In order to maintain significant levels of virtual activity, we need to ensure we have the correct infrastructure in place. Therefore, progress with the Outpatients refurbishments work is paramount which includes the completion of outstanding works and development of Phase 2 plans.

The management of the numbers of patients booked in for face to face appointments will be crucial and work is currently underway to map out how face to face and virtual clinics will work going forward to maximise efficiency and make the best use of the available resources.

4.2 Risks

Risk	Mitigation
Need for Virtual Clinic Hub to be established; however, limited physical capacity at VCC requires choices on priorities for estate utilisation	Senior Management Team to consider all accommodation options and give clear direction for service implementation
It is unclear when HB partners will be in a position to offer VCC any Outpatient and associated phlebotomy services	Establish clear timelines with all Health board partners to plan safe returns.

Risk	Mitigation
Pressure on Phlebotomy services	Review options for delivery of Phlebotomy services, including use of a mobile unit. Progress with replacement of Haematology Analyser through VCC Capital allocation
Manage levels of face to face activity whilst complying with social distancing	Medical Directorate Manager with SSTs to review numbers of patients who require face to face appointments and those who can been seen 'virtually'

4.3 **Actions Q2**

Outpatients	Action	Lead	Timeframe
VQ2.14	Continue to treat patients at all levels of priority	SST Leads	Ongoing throughout Quarter 2
VQ2.15	Continue to manage repatriated patient activity until safe plans are agreed with HBs	Planning Leads	
VQ2.16	Develop plans with all HB partners to deliver a safe return of outreach services	Planning Leads	August
VQ2.17	Develop a service model for running virtual and face to face clinics which will be adopted by all SSTs	Medical Directorate Manager with SST Leads	Ongoing throughout Quarter 2
VQ2.18	Progress Outpatient Accommodation plans	Director of Operations	
VQ2.19	Continue to offer Phlebotomy services and monitor activity levels	OPD Nurse Manager/ OPD Business Manager	Task & Finish Group to report in August.
VQ2.20	Continue to deliver ambulatory care in Outpatient setting to relieve pressure on SACT day case units	OPD Nurse Manager/ SACT Lead	Ongoing throughout Quarter 2
VQ2.21	Gather patient feedback on the use of virtual appointments	Patient Experience Manager/ OPD Business Manager	

5 Essential Services Inpatients

5.1 Activation Plans

During the COVID-19 pandemic, our Inpatients, wards changed their models of service delivery, in line with Public Health Wales and Welsh Government advice, and as detailed below.

Within Velindre Inpatients there have been no positive COVID-19 patients since 22nd May 2020.

Currently no inpatient staff are absent following a positive test.

	Q1 status	Q2 status
7 day working of the Assessment Unit Trial.	The Assessment Unit opened for 7 days over the first two weeks of May (inc BH) as a trial, with current staffing resource. Evaluation has been completed and noted by CDG on 18/06/20.	The trial was aimed at testing and showing benefit and sustainable cost model is being developed. A proof of concept, it concluded that there are benefits to opening 7 days a week but any further plans for 7 day working need to be considered in the overall plans for service wide 7 day working. There would need to be investment in the whole MDT to implement a sustainable 7 day model. We continue to consider 7 day operation as part of capacity modelling and Acute Oncology Service
Accommodation – Social distancing	The First Floor ward (FFW) has been reduced from 30 to 20 beds to comply with the 2m social distancing rule. At present patient numbers are manageable within this. The 10 beds that have been lost on FFW are being provided within CIU therefore there has been no overall reduction in bed capacity. First Flood Ward but additional bed capacity found during the outbreak has ensured no	As the requirement for SACT (systemic Anti-Cancer Therapy) increases, and the public regain confidence in services, we expect an increase in patients requiring admission to FFW for elective SACT where the regime requires a hospital stay. CIU provides us with additional 10 beds to enable us to remain at a 30 bed capacity, however future decisions around the clinical priority at VCC may affect the space available to

	Q1 status	Q2 status
	current reduction in bed numbers. From an administration point of view, social distancing measures are in place (e.g. maximum occupancy signage, office rota's), and alongside working from home capability, staff are managing to maintain a socially distanced approach at work.	inpatients as there are competing priorities for clinical space. With the administration areas, social distancing measures and procedures will continue. The all Wales guidance for visitors is being reviewed with a view to allow more flexibility for inpatient visitors. This will require us to provide a space away from the ward for patients and their families to meet in a socially distanced space. Space has been identified in anticipation of the guidance changing, This is being led by the Cancer Centre Accommodation Group.
Testing in Assessment Unit	All patients presenting at Assessment Unit are screened/swabbed. Access has been given for rapid testing for 5 patients per day at the Assessment Unit. These are being prioritised for patients requiring admissions, allowing inpatients areas to maintain the current green status.	Increase for rapid testing to assist with maintaining Velindre green status and allowing quicker throughput in the assessment unit.
Bed Manager	Ongoing work to evaluate the role of the Bed Manager/patient flow/acute versus unscheduled requests which could be managed on a routine basis.	Options paper will be developed and submitted to Clinical Development Group in July 2020.
Junior Dr Rota	Increased capacity to support inpatients demand during COVID – 19	Revert to previous junior doctor's rotas to ensure compliance with training requirements. This is being managed via the medical directorate
AOS Workshops for	After cancelling a stream of workshops planned for April	Complete the virtual workshops with colleagues

	Q1 status	Q2 status
Regional Service	2020, the AOS Velindre, and the AOS MDT steering groups have restarted and virtual workshops have been planned for July 2020	from across SE Wales. Complete a Business Case for submission at Collaborative Commissioning Leadership Group in September 2020
Ventilation	The ventilation in both inpatient wards but in particular on First Floor Ward is being assessed, and work is ongoing on preparing an options appraisal on for both short term and long term solutions with the Estates team. This will continue into Quarter 2.	As per Quarter 1.
Length of stay	Length of stay has reduced during COVID-19, as we work to discharge patients as soon as safely possible. Getting the patient home, has always been a priority. During COVID-19 daily board rounds and a more comprehensive weekly MDT have been implemented.	Continuation and evaluation of weekly MDT and board rounds. Continuation of monitoring of LOS, especially as inpatient numbers are beginning to rise back to a pre COVID-19 norm.
Admission Criteria	Updated to capture the admission of COVID-19 suspected and positive patients, and the possible impact of COVID-19 on the Local District General Hospitals.	Review and implement as per changes to the All Wales Guidance.

5.2 **Risks**

Service	Risk	Mitigation
Inpatients	COVID-19 continues to circulate in community	Increased rapid testing for patients

5.3 **Actions Q2**

No.	Action	Lead	Timeframe
VQ 2.22	Bed manager/patient flow/acute versus unscheduled requests which could be managed on a routine basis. options appraisal to be submitted	SI Team	July 2020 for scoping document to be presented to CDG

No.	Action	Lead	Timeframe
VQ 2.23	AOS workshops and business case to be completed	AOS Working Group	September 2020
VQ 2.24	Accommodation review in line with guidance changes	Velindre Accommodation Group and Inpatients Team	Ongoing
VQ 2.25	Increase in rapid testing if this is possible	Public Health Wales/VCC Test, Trace/Protect Cell	Ongoing
VQ 2.26	Continued work on the Ventilation Options for First Floor Ward	Corporate Nursing/Estates/Inpatients Operational group members	Ongoing

6 Essential Services Radiology

6.1 Activation Plans

Both CT and MRI appointments and throughput reduced during Quarter 1 due to social distancing and reducing footfall. Return to BAU in terms of bookings in June and activity in Quarter 2 planned to increase further to pre COVID-19 levels. Working from home for PACS/ Radis support staff proved efficient and well received. However, for Radiologists reporting from home has had mixed results. Services will continue to be developed based on experience to date.

Q1 status	Q2 status
MRI Scans - 120 Deferred MRI scans Severely reduced capacity and many deferrals	
CT Scans - Reduced Scans during COVID-19 phase	Final assurance required but confident all deferrals will have been scanned and reported by end of July 20 Plan to address all CT scan deferrals by end of July
Other Modalities - Non Neck Ultrasound, Echoes, interventional and CR exams Reduced demand met by capacity	Non Neck Ultrasound, Echoes, interventional and CR exams no backlog and currently normal bookings
Neck Ultrasound - Existing under capacity carried over from pre-COVID-19. Most scans are follow ups so were deferred early on	10 week waiting list for Neck US most exams are done within requested time frame so 10 weeks is approx what is required. Urgent and extras capacity exists in small numbers
Home Working - Limited capacity in Quarter 1 but some capability	Quarter 2 significant capability, capacity and efficiency savings and welcomed by staff that can work remotely. Actual examination performance requires a

Q1 status	Q2 status
	machine, staff to operate and the patient so limited application on core department function.

6.2 **Risks**

Risk	Mitigation
Extended Days - Unable to recruit required skill mix or numbers	Limited extensions within existing staffing. Rationalisation part time working and restrictions on leave may be required.
Staff Compliance - Overextend existing staff	Careful consultation and sensible management approach. Must employ more staff.
Staff & Consumables - Costs will increase proportionally on Extended days pro rata to patients scanned. Extra days above Mon-Fri will have significant cost implications	Extend existing working days rather than weekend working. Actions 1 Capacity modelling to re-instate backlog 2 workforce plan and implementing recruitment for H & N

6.3 **Actions Q2**

Radiology	**Action**	**Lead**	**Timeframe**
VQ2.27	MRI focus on small number of deferred patients to reinstate. Maintain normal service	Radiology Lead	August
VQ2.28	CT has increase capacity through reorganisation: +1 by 26 May, +2 by 15 June. Maintain through Q2	Radiology Lead	Ongoing throughout Quarter 2
VQ2.29	New staffing model should release staff for CPD Development other duties without reducing capacity. More use of HCSW and possibly Radiography Assistants/ Assistant Practitioners.	Radiology Lead	October 2020 new Staffing contingent
VQ2.30	Extended working days and out of hours routine scanning in CT planned. Once established can be switched to MR scanning as CT waiting lists come down	Radiology Lead	October 2020 new Staffing contingent

Radiology	**Action**	**Lead**	**Timeframe**
VQ2.31	Ultrasonographer to be trained to perform neck US so allowing more capacity.	Radiology lead Clinical lead in Neck US	Not until Post October 2020

7 Essential Services Therapies

7.1 Activation Plans

During the COVID-19 pandemic, VCC Therapy services prioritised acute inpatients whilst also seeing urgent outpatients following national guidance. Mid way through Quarter 1, Therapy services began the review of prioritisation of patients and the evaluation of alternative ways of working. This was to ensure the return of business as usual in a safe and modified way and to provide increased rehabilitation in line with Welsh Government guidance.

Q1 status	**Q2 status**
Extended Hours - All 4 therapy teams piloted working over a 7 day timetable – stretched over days within current resources to support MDT working and patient care. 02/05/2020 – 30/05/2020 Evaluation of & day working – SMT noting June 2020	See as per inpatients evaluation and Monitoring
Service delivery models -Throughout Q1 Therapies provided services in the following areas: **1. Dietetics:** Inpatients / Assessment unit / PSU /MDT Review clinics / some virtual 1:1 outpatients **2. Occupational Therapists:** Inpatient / Assessment Unit and some virtual outpatient reviews **3. Physiotherapy:** Inpatients / Assessment Unit / some face-face consultations where needed / preliminary planning for specialist gynae-oncology service	**1.Dietetics:** Inpatients / Assessment unit / PSU /MDT Review clinics / some virtual 1:1 outpatients and virtual drop in clinics **2.Occupational Therapists:** Inpatient / Assessment Unit / some virtual outpatient reviews and Neuro Oncology MDT virtual Clinic / Maggie's fatigue group session via virtual presentation **3. Physiotherapy:** Inpatients / Assessment Unit / some face-face consultations where needed / Virtual pre RT breast clinic / More detailed planning of specialist gynae-

Q1 status	Q2 status
4. SLT: Inpatients / PSU / MDT RT review clinics / Virtual 1:1	oncology service and commencement of virtual consultations and some face to face where required **4. SLT:** Inpatients / PSU / MDT RT review clinics / Virtual 1:1 / Neuro oncology virtual MDT clinic

To enable the Therapies team to achieve the planned activities, highlighted above, in Quarter 2, continued liaison with the SMT and the wider clinical MDT to ensure services develop holistically with appreciation of wider service demands.

Continued liaison with DoTHS / WCN and Health Board leads to ensure VCC Therapy activity is in line with local development and service provision.

7.2 Risks

Risk	Mitigation
Sufficient workforce to meet deferred demand and rehabilitation requirement. The Therapies workforce is a small and fragile resource. This increases the vulnerability of the services provided.	Workforce plan includes investment and needs to be modelled

7.3 Actions Q2

Therapies	Action	Lead	Timeframe
VQ2.32	Further work in establishing weekend therapy community services in the post COVID -19 phase	Therapy Lead	September
VQ2.33	Continue physio cover for Sat and Sunday am , to include a RV of 2 x qualified physios on a Sunday am following weekend pilot 7/6/20 to 12/7/20	Therapy Lead	August

8 Essential Services Nuclear Medicine

8.1 Activation plans

Steadily increasing workload and the reintroduction of some radionuclide therapy is detailed below. The dates identify when the changes were implemented. The service re-introduction is underway and there is a gradual increase in demand.

Q1 status	Q2 status
a) reduced service provision of radiopharmacy services maintained demand b) Radionuclide therapy service had stopped mid-March.	**Effective w/c 15/6/20:** Cardiff & Vale Radiopharmacy increased service delivery, operating 4 days/week (Mon-Thurs). [Date to return to 5 day working has not yet been agreed]. **Effective 11/6/20:** Ra223 service recommenced **Effective w/c 15/6/20:** Thyroid cancer treatments recommenced **Effective date: TBC** Restart I131 thyrotoxic service

Radiopharmacy increased delivery: The additional supply of radiopharmaceuticals one day/week, will help to distribute the increasing workload more evenly. Dates are awaited for a return to 5 day/week service

Thyroid cancer treatments: Swab testing and self-isolation for 14 days procedure prior to treatment has been introduced, allowing the service to re-start. Patient self-isolates following treatment.

Thyrotoxic treatment: Nationally there has been discussion on the best time to re-start this service. Some centres are planning to start treating again July/August (assuming there is not a second COVID-19 wave). Agreement needs to be reached with Royal Gwent), on when the service should re-start.

Some limitations on the available dates to treat the thyroid cancer patients and on the number of imaging investigations that may performed due to staffing resource issues.

8.2 Risks

Risk	Mitigation
Insufficient staff to deliver the required diagnostic & therapeutic service, in a timely manner due to vulnerable status of staff	If it is thought a decision as to when 'vulnerable' staff can return to full duties is not imminent, locum/local options will need to be reviewed urgently Risk assessment has been submitted
Radiopharmacy provision outside of our control or influence	Continued liaison with C&V regarding return to normal operating level.
Thyrotoxic treatment restarting led by Consultant at ABUHB	Continued liaison with ABUHB regarding restart of service

8.3 Actions Q2

No.	Action	Lead	Timeframe
VQ2.34	Continue discussion with C&V regarding return of Radiopharmacy to 5 days	Nuclear Medicine Lead	Ongoing throughout Quarter 2
VQ2.35	Agree return plan for Thyrotoxic treatments with ABUHB Endocrinology Lead	Nuclear Medicine Lead	July

APPENDIX 5

Velindre Cancer Centre Capacity and Activity Forecasts – July to Sept 2020
(Note - Excel Database Available Upon Request).

APPENDIX 6

Velindre Cancer Centre Operational Plan Q1 Action Log Delivery Update

	Action	Lead	Timeframe	Progress
THEME: DEMAND MANAGEMENT				
Q1.1	Complete our internal and external demand planning methodology to create a flexible model to respond to pandemic phases and understand the work we have to do internally to clear backlog.	Senior Management Team	June 2020	Work continues in conjunction with corporate planning leads to identify and understand HB demand projections. The Delivery unit and Improvement Cymru have been engaged to support this work.
Q1.2	*Internal* – continue departmental analysis of deferred demand.	Departmental Leads	June 2020	Internal deferred demand is understood and quantified and used to inform activity plans for Q2.
Q1.3	*External* - continue to engage with DU, WCN and LHBs to determine demand profile from deferrals and screening and align with pandemic modelling.	Planning Leads	June 2020	As Q1.1 above.
THEME: CAPACITY PLANNING				
Q1.4	Develop a capacity plan to meet the proposed COVID-19 protected clinical operating model (C19 PCOM) for each service area in the context of patient and staff factors and IPC measures.	Director of Operations & Departmental Operational and Clinical Leads	June 2020	Q2 plans include predicted capacity plans week on week from July to September.
Q1.5	Determine requirement for additional external capacity	Director of Operations	May 2020	Currently being determined through detailed operational capacity planning and ongoing discussions about reinstatement of outreach services. Qtr3 and 4 when activity from HBs increases will be when these requirements may be needed.
Q1.6	Explore additional capacity with external providers (Tenovus, Rutherford etc.)	Director of Strategic Transformation, Planning and Digital	May 2020	Discussions continue with SBUHB to collaborate on a joint venture with Rutherford to provide Radiotherapy capacity.

	Action	Lead	Timeframe	Progress
Q1.7	Continue to engage with LHBs on outreach provision	SACT Lead	May 2020	Discussions held with ABUHB and CTMUHB and detailed capacity requirements provided to recommence outreach services. No timelines yet agreed to re-establish outreach services.
Q1.8	Revisit estate utilisation (including the surge capacity provision of 47 beds and 8 AU beds) to meet the new C19 PCOM and establish an estate management plan for COVID-19 protected "green" and COVID-19 "red" zones in light of the demand profiles.	Head of Nursing Assistant Director of Estates	May 2020	Site review for Social Distancing is almost complete and this is reviewing capacity. Estate management work continues via TTP cell. See 1.11 below
Q1.9	Develop pan-regional partnership with Swansea Bay and Hywel Dda LHBs to purchase additional capacity and deploy it	Director of Strategic Transformation, Planning and Digital	June 2020	
THEME: DEVELOPING A COVID-19 PROTECTED OPERATING MODEL				
Q1.10	Compete review of the VUNHST Clinical Governance and Operating framework for Clinical patient pathway and decision making during COVID-19	Medical Director	May 2020	This has been completed and circulated in early June following board acceptance. This has guided the development of operational service plans for Q2, Q3 and Q4.
Q1.11	Complete Phase 2 of the patient triage model	Clinical Director	June 2020	This has been superseded by the use of screening: Test and trace and Zoning, utilising the estate and patient flows.
Q1.12	Engage with PHW and LHBs to enable the additional patient testing to deliver the triage model	Executive Director of Nursing, Therapies and Healthcare Scientists	May 2020	Incorporated into TTP cell see 1.11

	Action	Lead	Timeframe	Progress
Q1.13	Evaluate service changes and treatment protocols to develop model and understand the impact on capacity and demand (by service area for SACT, RT, medical physics, radiology, palliative care, therapies, patient support, nuclear medicine, CNS, outpatients, inpatients, ambulatory care) (by SST)	Clinical Director	June 2020	Qtr 2 plans developed for each service area with clear assumptions on service changes and treatment protocols. Lead SST clinicians are continually reviewing adapted SST pathways and plans during the recovery phase.
Q1.14	Review service changes against the service improvement and service development plans in IMTP to ensure next steps are in line with these plans and maximise efficiency and productivity.	Director of Operations	May 2020	The IMTP was written pre COVID-19. The COVID-19 response developed new ways of working which can be reversed if necessary. Plans for Qtr 2, Qtr 3 and Qtr 4 will more formally align with IMTP plans.
Q1.15	Evaluation of patient outcomes resultant of agreed treatment plans (curative and palliative care)	Clinical Director	June 2020	All curative treatments were maintained or safely deferred and no patients followed palliative pathways directly as a result of the COVID-19 changes.

	Action	Lead	Timeframe	Progress
Q1.16	Establish new staff testing regime to maintain COVID-19 protected status	Executive Director of OD and Workforce	June 2020	The Trust, Public Health Wales and Cardiff and Vale HB has commenced an Operational Feasibility Pilot of staff testing within VCC. This is to assess the operational feasibility of performing parallel serology (antibody/blood test) and swab testing on a cohort of 250 frontline staff within an organisation. It will also provide valuable information on the incidence of asymptomatic positive swab testing as well as the incidence of positive antibody results within this cohort and allow observational correlations to be performed. The pilot was a good example of joint working between WBS and VCC as the pilot operated out of the WBS mobiles using VCC staff to perform the tests. The pilot was very well received by staff and the results will be used by the Trust Test, Trace and Protect (TTP) cell for its work on developing ongoing processes for staff testing, in line with national guidance on staff testing.
Q1.17	Engage CHC in service change proposals	Director of Cancer Services	May 2020	Meeting held with representative from Cardiff CHC. The discussion will be ongoing Trust level discussion through regular meetings with CHC representatives.

THEME: OPERATIONALISING THE NEW MODEL				
Q1.18	Engage with LHBs via operational teams to determine their new ways of working and ensure effective two way engagement including agreement on care pathways.	Departmental and SST Leads	May/June 2020	This is being led by the individual SST leads. This is supported by clear protocols and scientific guidance to endure safe patient measures are in place.
Q1.19	Continue to establish a revised Clinical Development Group work programme and programme board for the next phase plans.	Director of Cancer Services	June 2020	All plans will be clinically led and developed and the CDG will oversee the next phase work plans.
Q1.20	Complete VCC workforce review to assess roles, responsibilities and priorities including redeployment and temporary staff and student workforce.	Workforce & OD Business Manager	June 2020	
Q1.21	Data flow and management – refine our data management and reporting to incorporate LHB data and establish planning model including pandemic indicators to signal service flex.	Information and Planning Leads	May/June 2020	Service and operational plans are being designed to flexibly respond to changing COVID-19 environments.
Q1.22	Data flow and management – revise operational planning tools for SSTs and operational departments to utilise additional data.	Information and Planning Leads	June 2020	Business intelligence team responding to Q2 information requirements to support service plan development.
Q1.23	Further develop RT capacity planning model based on Attain consultancy work	Information and Planning Leads	Ongoing	Implementation lead commenced to deliver recommendations of Attain work.
Q1.24	Review the recent SACT planning proposal and agree next steps	Director of Cancer Services & Clinical Director	May/June 2020	This plan forms the basis of the Q2 operational plan for SACT services and options for delivering increased capacity.
Q1.25	Continue to review patients on their care pathway to agree next steps in care plan including patient treatment alterations and ability to move to alternative treatment pathways.	Consultant workforce	May 2020	SST leads will continue to develop pathways in line with national guidance and the clinical framework developed by the Trust Medical Director.

Q1.26	Specific review of prostate care pathway and recommencement of services as a priority	SST Lead and Clinical Director	May/June 2020	Prostate patients will be planned in along with the recommencement of services following guidance. The SST will continue to review individual patients.
Q1.27	Patient communication – establish next stages in communication plan for patients based on WG framework	Director of Operations	May/June 2020	Process mapped and standardised letters produced.
Q1.28	Review the operating model for psychology service	Director of Cancer Services	June 2020	Needs analysis and business case under development.
THEME: NEW WAYS OF WORKING				
Q1.29	Establish new ways of home working supported by appropriate policy consideration	Workforce & OD Business Manager	June 2020	
Q1.30	Scope staff mental and physical wellbeing support interventions	Workforce & OD Business Manager	June 2020	Options for dedicated space within VCC currently being scoped.
Q1.31	Establishment of monitoring processes for workforce safety and risk assessment	Workforce & OD Business Manager	June 2020	

Q1.32	Establish and introduce estate capacity plan to meet social distancing needs (working safely)	Director of Strategic Transformation, Planning and Digital /Assistant Director of Estates, Environment and Capital Development.	June 2020	Please see full assessment undertaken against WG criteria for detail. And being addressed via Social Distancing Cell
Q1.33	Work in collaboration with estates and facilities to determine social distancing plans to ensure all staff are working safely	Workforce & OD Business Manager	June 2020	Please see full assessment undertaken against WG criteria for detail. And being addressed via Social Distancing Cell
Q1.34	Evaluate impact and success of virtual clinic processes and technology	Head of Nursing & Clinical Director	May/June 2020	The use of virtual consultations are seen as a great success. The OP development group will now establish a formal virtual strategy working with the service users to ensure all requirements are met.
Q1.35	Explore opportunities to improve audio/visual technological capability	Associate Director of Informatics	June 2020	

Quarterly Progress BRAG Rating	
Action Successfully Completed	**BLUE**
Challenges causing problems	**RED**
Progress Issues identified and being resolved	**AMBER**
Satisfactory progress being made	**GREEN**

APPENDIX 7

Corporate Services Operational Plan Q1 Action Log Delivery Update

	Action	Lead	Time frame	Progress
THEME: WORKFORCE AND ORGANISATIONAL DEVELOPMENT				
WQ1.1	Working in Partnership monitor Staff Safety ensuring:	WOD	June 2020	Weekly Partnership meetings established to monitor risk assessment via WOD dashboard
WQ1.2	Risk Assessment for High Risk staff are completed and updated	WOD/ Divisional Leads	June 2020	All risk assessment completed. Ongoing feedback and monitoring via staff networks for qualitative data feedback and via Workforce Cell to monitor ongoing risk assessment completion
WQ1.3	Working from home arrangements are monitored and updated, supporting staff re-entering the workforce from home working	Divisional Leads/ WOD	June 2020	Ad hoc Working from Home Policy in place, monitored via Divisions WOD provide guidance to manages on staff on issues
WQ1.4	Process for staff testing is managed, monitored and communicated	WOD	May 2020	Process completed, communicated to staff, ongoing guidance being managed via the Testing Cell and Workforce Cell
WQ1.5	Working with planning colleagues assess the workforce demand and utilise the existing supply channels as required	Planning/ WOD	Qtr 2	Workforce Plans in place – being developed for Radiotherapy
WQ1.6	Development of an anonymous staff feedback tool – Work In Confidence – enabling and encouraging a safe environment to raise concerns; put forward ideas,	WOD	Qtr 2	Toolkit to be launched July 2020
WQ1.7	Working in partnership develop surveys based on feedback to improve staff communication and partnership working	WOD/ Comms	Qtr 2	As part of the tool (above) surveys in partnership to be agreed – July onwards
WQ1.8	Developing H&WB plan into recovery phase where staff are more likely to require support (based upon CARE model – create, assist, rapid, engage)	WOD	Qtr 2	Wellbeing interventions in place to support staff Surveys planned to ensure interventions meet staff's requirements Detailed H&W plan formulated on feedback
WQ1.9	Ongoing Communication on wellbeing offer to staff via all stakeholders routes	WOD/ Comms	Qtr 2	Wellbeing interventions advertised extensively throughout Trust
WQ 1.10	Management development to support effective team management incorporating a blended delivery approach – building on our Manager Development Programme	WOD	Qtr 2	Currently piloting

	Action	Lead	Time frame	Progress
WQ1 IMTP	Beyond Business as Usual Programme – Programme Plan completed and initiated	Executive Director of WOD	Qtr 2	Plan to be completed July 2020
WQ1 IMTP	First Steps Management Development Programme completed	WOD	June 2020	Cohort completed via virtual classrooms
WQ1 IMTP	Leadership review completed and plan for Leadership communicated	WOD	Qtr 2	Report to EMB July 2020
WQ1 IMTP	Development of Virtual enabled learning (inc. HR App)	WOD	Qtr 3/4	Virtual Reality development delayed due to COVID-19 – focus to re-visit plan July onwards
WQ1 IMTP	Launch of Working In Confidence Platform to gain feedback on staff requirements for wellbeing	WOD	Qtr 2	Toolkit to be launched July 2020
WQ1 IMTP	Working with Psychology to continue to develop the Workforce Wellbeing Plan for COVID-19	WOD/ Psychology	Qtr 2	Plans to recruit a Staff Psychologist
WQ1 IMTP	Enhance the workforce information report in line with Trust performance management dashboard	WOD	Qtr 2	Competed, need to be incorporated into Trust wide performance management dashboard
THEME: DIGITAL				
DQ1.2	Connecting & Remote Monitoring of Patients, Donors & Workforce: Virtual Consultation / Attend Anywhere	Adam Lukaszewicz	Q2	Plan to enable Attend Anywhere for all tumour sites by the end of July 2020.
DQ1.3	Connecting & Remote Monitoring of Patients, Donors & Workforce: Primary / Secondary & Tertiary Connectivity / Consultant Connect	Dr Mick Button	Q2	Pilot being planned for Consultant to Consultant engagement within Velindre Cancer Centre in the first instance.
DQ1.4	Connecting & Remote Monitoring of Patients, Donors & Workforce: Remote Monitoring Apps	Suzanne Rodgers	Q2	Procurement of solution underway. Use cases identified and agreed for remote monitoring.
DQ1.5	Strategic Projects: Office 365 / Microsoft Teams & Power Apps	Elin Griffiths	Q4	Project Board formed. External support recruited to operationalise O365.
DQ1.6	Strategic Projects: Cancer Informatics Solution	Stuart Morris	2021/22	Plan to restart Project in July 2020

	Action	Lead	Time frame	Progress
DQ1.7	Strategic Projects: Patient Held Record	Dr Jacob Tanguay	Q4	Project Board has identified use case for tumour sites. Pilot planning underway. Information Governance issues identified and being resolved.
DQ1.8	Strategic Projects: Blood Establishment Computer System Enhancements in response to COVID-19 / Convalescent Plasma	Elin Griffiths	Q3	Technical work underway in alignment with project plan timescales.
DQ1.9	Strategic Projects: Integrated Radiotherapy Solution	David Mason-Hawes	2022	Competitive Dialogue process underway as planned.
DQ1.10	Creating Capacity & Developing New Services: Robotic Process Automation	Philip Richards	2022	Awaiting technical solution from potential supplier. Approach is to produce a solution/contract that could be scalable for All Wales.
DQ1.11	Creating Capacity & Developing New Services: eRostering	Stuart Morris	Q3	Timescales for implementation have not been confirmed
DQ1.12	Creating Capacity & Developing New Services: eConsent	Anna Harries	Q3	Pilot proposal underway
THEME: COMMUNICATIONS				
CQ1.1	Link in with cancer services campaign, led by WG	Lauren Fear	30th June 2020	Completed. Campaign to commence 15 June. VCC contributing by supporting social media campaign, joint presser and filming on the estate.
CQ1.2	Continue direct communication on key topics, e.g. well-being, PPE	Lauren Fear	30th June 2020	All-staff daily communications still in place. Survey to commence by end of June to inform future plans.
CQ1.3	Start to effectively use and embed TEXT messaging service, use of Teams for live events	Lauren Fear	30th June 2020	Feedback on use of text being considered as part of the organisational CORONAVIRUS communications survey.
CQ1.4	Creation of a Request for Information tracker (RFI) – with support from our military colleagues in the design - launch this as a way of all staff questions, concerns and answers being transparent and accessible to all	Lauren Fear	29th May 2020	Being taken forward in conjunction with review of team sessions.
CQ1.5	Start to use the social media Trust feeds more effectively, beyond sign-posting only. Start with direct support for those Execs already active on social	Lauren Fear	30th June 2020	To be included in new communications strategy for EMB approval in July.

	Action	Lead	Time frame	Progress
CQ1.6	Returning to work – planning internal communications about helping staff return to work	Lauren Fear	30th June 2020	Taken forward as part of the social-distancing cell.
THEME: NURSING AND QUALITY				
NQ1.1	***Infection prevention & control and public health*** There is insufficient capacity & capability within the Trusts IP&C and public health infrastructure to meet the ongoing public health and infection prevention needs throughout this pandemic. Teams needs to be strengthened by the appointment of: • A Respiratory Protection Advisor – PPE Lead & trainer • Infection Prevention & Control Support Worker – Support ICNs in ongoing audit & assurance in relation to IC & PPE practices- will release ICNs to take on core role / decontamination requirements (work on top of licence) • Increase current band 3 IPC administrator from 20 to 30 hours a week again to support ICN's to work at top of licence • PHW ICD / Microbiology SLA to be reviewed (due in April 2020) – to increase from 1 to 3 sessions / week of onsite ICD support– role & function to be described • Agree with PHW how Trust can obtain increased dedicated Public Health Support • A dedicated / trained IC Champion in each Team / department across the Trust – has dedicated training programme / IC Shadow time and competency framework.	Karen Jones, Lead Nurse IPC	Q1 – agree funding Q2-4 impleme nt in line with funding trajectory	Funding agreed from Q2 apart from medical ICD hours- Q4 JDs under development Band 7 &3 hours increased since COVID-19

	Action	Lead	Time frame	Progress
NQ1.2 & NQ2.5	***VCC Electronic Nurse Rostering*** Implement Allocate electronic rostering system & bank management system during June 2020	Nursing	Procure - Q1 Implement Q2	Allocate procured – project kick off meeting arranged for 24/6/2020. Full implementation to be undertaken during Q2
NQ1.3 &NQ 2.6	Quality & Safety Framework to be completed and implementation commenced Commence recruitment of Quality & Safety Project Manager	Quality & Safety	End of Q2	Development of role underway
NQ1.4	Develop COVID-19 'Cells' to deliver the core COVID-19 requirements across the Trust. To report through to EMB / relevant Board Committee. 8 cells in place currently: PPE; Q&S; End of Life / Death Processes; Staff & patient testing; Digital; Workforce; planning; & information / performance	Quality & Safety	Through out Q1	Cells all developed & reporting to Gold / EMB End of life completed
NQ1.5	Realign all Q&S investigative & reporting mechanisms to ensure all requirements of COVID-19 are met i.e. processes for: death of an employee diagnosed with COVID-19; reporting & investigating incidences of staff being diagnosed with COVID-19; & reporting & Investigating incidences of patients being diagnosed with COVID-19.	Quality & Safety	End of Q1	Staff incident process agreed & implementation underway Patient COVID-19 acquisition process in final stages of development
NQ1.6	Develop systems / processes and mechanisms for ongoing review in line with developing pandemic clinical prioritisation processes in line with national guidelines and patient needs	Jacinta Abraham, Medical Director	Ongoing throughout pandemic	Further clinical prioritisation principles developed and agreed by Board – ongoing widespread clinical leadership
NQ1.7	Establish a Clinical Ethics Committee	Lauren Fear, Interim Director Corporate Governance	End of Q1	Plans underway to develop before end June 2020

	Action	Lead	Time frame	Progress
THEME: FINANCE				
FQ1.1	Providing governance support to NWSSP & NWIS to enable rapid procurement of essential equipment & services to respond to COVID-19 at an All Wales level	DoF & Deputy DoF	*Apr – June '20 & ongoing*	Ongoing support as required, for example PPE procurement
FQ1.2	Monthly management of charity applications and production & reporting of financial position	Financial Planning & Reporting Manager	Monthly	*Complete for M1 & M2 and ongoing process*
FQ1.3	LTAs with all HB's & WHSSC signed securing core income - although operating block arrangement beyond Q1 as per National DoF agreement	DoF & Deputy DoF	Q2 Position June, Q3 Assess Sept	All LTA's with commissioners are signed for 2020-21. A paper recommending to DoF the decision as to whether the LTA block income arrangement should continue beyond Q1 is being written by Deputy DoF's Velindre Trust Deputy DoF has fed into the paper recommending that the block arrangement should continue for the whole of 2020-21, but as a minimum for Q2 with review, given the uncertainties around modelling activity, demand and capacity and the risk this poses to the Trust income if the LTA was not block.
FQ1.4	Development of revised RD&I Financial Strategy & Plan	DoF & Finance Manger RD&I	31.08.20	In progress: Initial plan developed by RD&I Division currently being reviewed by DoF & Head of Finance Business Partnering
FQ1.5	Ensure WG are clear that the revenue (£1.371m Q1&Q2) & capital (£1.181m) financial sums the Trust has already incurred / committed in its response to COVID-19, and that the Trust Financial Plan assumes that these costs will be funded.	Chief Executive & DoF	31.07.20	Revenue and Capital financial returns required by WG as part of the monthly financial monitoring returns have been submitted, As part of this financial submission the narrative to support the numbers has included an explanation regarding the Trust financial plan assumption that all it's COVID-19 costs will be funded.

	Action	Lead	Time frame	Progress
FQ1.6	Undertake financial modelling of each service capacity & demand scenario that planning and service colleagues develop (Planning Cell) to enable the Trust to flex capacity in an agile way, provide resilience against uncertain demand and ensure patient and staff safety is maintained through social distancing.	DoF, Deputy DoF & Head of Finance Business Partnering	31.07.20	In progress: The work to model for each service the capacity, demand and activity that can be delivered is in progress. The finance team is currently supporting the modelling of the Radiotherapy and SACT options / scenarios
FQ1.7	Month end close down and production of financial position (Revenue & Capital) for reporting to WG and internally, including COVID-19 expenditure and financial impacts	Deputy DoF & Head of Finance Business Partnering	Monthly	M1 & M2 financial position closed down successfully including the COVID-19 costs for these two months and refinement of the costs forecast for the year. Key aspect of understanding the future costs is the outcome of the modelling work described in action Q1.7
FQ1.8	Procurement of VCC Integrated Radiotherapy Solution Bidder Response & Dialogue days Financial Model	Deputy DoF & Head of Finance Business Partnering	June '20 and ongoing	Ongoing involvement of finance in this process over next 6 months, with competitive dialogue sessions via Teams every day over next 3 weeks
FQ1.9	Financial & Business support to WBS Convalescent Plasma service development	Head of Finance Business Partnering	*April – June '20 & ongoing*	Support provided by Deputy DoF & Head of Finance Business Partnering in development of the business case to WG. Ongoing support from Deputy DoF as member of the COVID-19 – Convalescent Plasma Steering Group and from the Business Partner through WBS SMT
FQ1.10	*Production of Year End Accounts, responding to associated Audit queries and presentation of accounts to Audit Committee*	*Head of Financial Operations*	*30.06.20*	Draft year end accounts submitted to WG by required deadline. Audit currently nearing completion with no major issues currently flagged. Audit committee on 25th June to sign-off audited accounts and submission of final accounts to WG due 30th June.
FQ1.11	*Development of Q2 – Q4 Action Plans*	*DoF, Deputy DoF*	*30.06.20*	In progress. Key action is to continue to work with service colleagues to model and cost the options for the new service models being developed.

Quarterly Progress BRAG Rating	
Action Successfully Completed	**BLUE**
Challenges causing problems	**RED**
Progress Issues identified and being resolved	**AMBER**
Satisfactory progress being made	**GREEN**

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

AMENDMENT TO STANDING ORDERS

DATE OF MEETING	30/7/2020

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**

ACRONYMS	
	None identified.

1. SITUATION/BACKGROUND

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

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 GOVERNANCE AND ASSURANCE

Revision of the document to ensure its relevance is a key element of the corporate governance arrangements of the Velindre University NHS Trust and provides assurance that the Standing Orders are compliant with Welsh Government directives and Model Standing Orders, up to date with emerging legislation and regulatory guidance and ensures consistency in managing the business of Committee.

In March 2020, in response to the COVID-19 pandemic the Welsh Government agreed to delay the date by which NHS bodies were required to hold their Annual General Meetings from before the end of July to before the 30 November 2020.

The following amendment, shown in italics is required to the Model Standing Orders issued in September 2019 with immediate effect. They will cease to have effect on the 31 March 2021:

Page 26 – Annual General Meeting (AGM):
7.2.5 The Trust must hold an AGM in public no later than ~~31 July each year~~ 30 November 2020.

In addition, Velindre University NHS Trust and the Shared Services Committee are also required to make the necessary amendments to the Standing Orders relevant to the Shared Services Committee. This is included as Agenda Item 2.1.5.

3. IMPACT ASSESSMENT

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

3 RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the amendments to the Trust Standing Orders as tracked.

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

PUBLIC TRUST BOARD

REVIEW OF THE NHS WALES SHARED SERVICES PARTNERSHIP COMMITTEE STANDING ORDERS (SSPC SOs)

Meeting Date:	30 July 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust
Report Presented by:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust

Trust Resolution to: (please tick) ☑							
APPROVE:	☑	**REVIEW:**		**INFORM:**		**ASSURE:**	☑
Recommendation:	For the Board to **APPROVE** and **NOTE**.						

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) ☑	
Equitable and timely services	☑
Providing evidence based care and research which is clinically effective	
Supporting our staff to excel	
Safe and reliable services	☑
First class patient/donor experience	
Spending every pound well	☑
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SMT – Senior Management Team	
Executive Summary:	
This paper has been prepared to provide the Trust Board with details of the proposed amended version of the SSPC Standing Orders, following review to ensure they remain relevant and fit for purpose following recent developments, which are summarised in the body of this report, for **APPROVAL**, as endorsed by the SSPC at the meeting on 23 July 2020.	

REVIEW OF SSPC STANDING ORDERS – JULY 2020

1. INTRODUCTION

To ensure effective, robust and up to date governance arrangements are in place for the SSPC, the SOs are reviewed on an annual basis and were last updated in June 2020, being endorsed by the SSPC and approved at Velindre Trust Board. Amendments have been made to the document since its last publication date and a summary of the amendments proposed are set out at **Appendix 1**. The fully updated document is included at **Appendix 2**, for **APPROVAL**, and it is noted that the proposed amendments were endorsed by the SSPC at the meeting on 23 July 2020.

2. GOVERNANCE AND ASSURANCE

Revision of the document to ensures its relevance is a key element of the corporate governance arrangements of the SSPC and provides assurance that the SOs are compliant with Welsh Government directives and Model Standing Orders, up to date with emerging legislation and regulatory guidance and ensures consistency in managing the business of Committee.

Section 10.0.1 of the SSPC SOs state:

"*These Shared Services SOs shall be reviewed annually by the SSPC, which shall report any proposed amendments to the Velindre Board for consideration. The requirement for review extends to all documents having the effect as if incorporated in Shared Services SOs, including the Equality Impact Assessment."*

Section 9.0.3 of Welsh Government's Model Standing Orders for NHS bodies states:

"Assurances in respect of the Shared Services shall primarily be achieved by the reports of the Managing Director of Shared Services to the Shared Services Partnership Committee, and reported back by the Chief Executive (or their nominated representative). Where appropriate, and by exception, the Board may seek assurances direct from the Managing Director of Shared Services. The Director of Shared Services and the Shared Services Partnership Committee shall be under an obligation to comply with any internal or external audit functions being undertaken by or on behalf of the HB."

3. RECOMMENDATION

The Committee is asked to:

- **NOTE** the inclusion of the wording regarding the extension of the increased financial limits for COVID-19 expenditure to 30 September 2020, which was approved by the June Velindre University NHS Trust Board; and

- **APPROVE** the amendments, as directed by Welsh Government, relating to the temporary disapplication of tenure of office**.**

Appendix 1 – Summary of Amendments to SSPC SOs (July 2020)

Page(s)	Amendment
16, 103 and 104	**Tenure of Chair** 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, in accordance with Welsh Health Circular 2020 011 (Model Standing Orders - LHBs Trusts WHSSC and EASC - Temporary Amendments July 2020). 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 2020, 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 National Health Service Trust Shared Services Committee (Wales) Regulations 2012.
74	**COVID-19 Expenditure** Sets out the agreed NWSSP Scheme of Delegation for COVID-19 and pandemic expenditure, which was approved at the Velindre University NHS Trust Board meetings of 18 and 30 March 2020, 4 and 25 June 2020. It was initially agreed to increase the delegated authorisation limits for the Chair and Managing Director for COVID 19 expenditure to £2M. This was subsequently increased to £5M from 30 March 2020. However, contracts and orders for COVID expenditure in excess of £5M still require approval of the Velindre Trust Board, which for expenditure may need to be through the existing mechanism of Chair's action. It was agreed that these increased limits for COVID expenditure would be reviewed on 30 June 2020 and the arrangements were subsequently reviewed and extended until a further review is undertaken on 30 September 2020 when these increased limits are due to expire.

Annexe 4

STANDING ORDERS FOR THE OPERATION OF THE SHARED SERVICES PARTNERSHIP COMMITTEE

This Annexe forms part of, and shall have effect as if incorporated in the Velindre University NHS Trust Standing Orders

Standing Orders

Reservation and Delegation of Powers

For the

Shared Services Partnership Committee

Originally Introduced June 2015

(updated ~~May~~ 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

(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

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 disciplinethey represent.

4.9 Appointment and Terms of Office

4.9.1 Management representative members shall be determined by the SSPC.

4.9.2 Staff representatives shall be determined by the staff organisations recognised by the NWSSP, subject to the following conditions:

- Staff representatives must be employed by **NWSSP** and accredited by their respective trade union; and
- A member's tenure of appointment will cease in the event that they are no longer employed by **NWSSP** or cease to be a member of their nominating trade union.

4.9.3 The *Management Representative Chair* shall be appointed by the LPF.

4.9.4 The *Staff Representative Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members in a manner determined by the staff representative members. The *Staff Representative Chair's* term of office shall be for one (1) year.

4.9.5 The *Management Representative Vice Chair* shall be appointed from within the management representative membership of the LPF by the Management Representative Chair.

4.9.6 The *Staff Representative Vice Chair* shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representative members. The *Staff Representative Vice Chair's* term of office shall be for one (1) year.

4.9.7 A member's tenure of appointment will cease in the event that they no longer meet any of the eligibility requirements determined for the position. A member must inform their respective LPF Chair as soon as is reasonably practicable to do so in respect of any issue which may impact on the conduct of their role.

4.10 Removal, Suspension and Replacement of Members

4.10.1 If an LPF member fails to attend three (3) consecutive meetings, the next meeting of the LPF shall consider what action should be taken. This may include removal of that person from office unless they are satisfied that:

(a) The absence was due to a reasonable cause; and
(b) The person will be able to attend such meetings within such period as the LPF considers reasonable.

4.10.2 If the LPF considers that it is not conducive to its effective operation that a person should continue to hold office as a member, it may remove that person from office by giving immediate notice in writing to the person and the relevant nominating body.

4.10.3 Before making a decision to remove a person from office, the LPF may suspend the tenure of office of that person for a limited period (as determined by the LPF) to enable it to carry out a proper investigation of the circumstances leading to the consideration of removal. Where the LPF suspends any member, that member shall be advised immediately in writing of the reasons for their suspension. Any such member shall not perform any of the functions of membership during a period of suspension.

4.10.4 A nominating body may remove and, where appropriate, replace a member appointed to the LPF to represent their interests by giving immediate notice in writing to the LPF.

4.11 Relationship with the SSPC and others

4.11.1 The LPF's main link with the SSPC is through the Managerial members of the LPF.

4.11.2 The Senior Management Team may determine that designated SMT members or NWSSP staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of SMT members or Trust staff, subject to the agreement of the Chair.

4.11.3 The SMT shall determine the arrangements for any joint meetings between the SMT and the LPF's staff representative members.

4.11.4 The Managing Director shall put in place arrangements to meet with the LPG's Joint Chairs on a regular basis to discuss the LPF's activities and operation.

4.11.5 The LPF shall ensure effective links and relationships with other groups/fora at a local and, where appropriate, national level.

4.12 Support to the LPF

4.12.1 The LPF's work shall be supported by two designated Secretaries, one of whom shall support the staff representative members and one shall support the management representative members.

4.12.2 The Director of Workforce and Organisational Development will act as Management Representative Secretary and will be responsible for the maintenance of the constitution of the membership, the circulation of agenda and minutes and notification of meetings.

4.12.3 The Staff Representative Secretary shall be elected from within the staff representative membership of the LPF, by staff representative members, in a manner determined by the staff representatives. The Staff Representative Secretary's term of office shall be for two (2) years.

4.12.4 Both Secretaries shall work closely with the NWSSP Head of Finance and Business Improvement who is responsible for the overall planning and co-ordination of the programme of SMT and Committee business, including that of its Advisory Groups.

5 WORKING IN PARTNERSHIP

5.1.1 The SSPC shall work constructively in partnership with others to plan and secure the delivery of the best possible healthcare for its citizens, in accordance with its statutory duties and any specific requirements or directions made by the Welsh Ministers.

5.1.2 The Chair shall ensure that the SSPC has identified all its key partners and other stakeholders and established clear mechanisms for engaging with and involving them in the work of the NWSSP through:

- NWSSP's own structures and operating arrangements, e.g., Advisory Groups;

5.1.3 The SMT shall keep under review its partnership arrangements to ensure continued clarity around purpose, desired outcomes and partner responsibilities. It must ensure timely action to change, adapt or end partnerships where they no longer serve a useful purpose, in accordance with its statutory duties; any specific requirements or directions made by the Welsh Ministers; and the agreed terms and conditions for the partnership.

6 MEETINGS

6.1 Putting Citizens first

6.1.1 The SSPC's business will be carried out openly and transparently in a manner that encourages the active engagement of its citizens and other stakeholders. The SSPC, through the planning and conduct of meetings held in public, shall facilitate this in a number of ways, including:

- active communication of forthcoming business and activities;
- the selection of accessible, suitable venues for meetings;
- the availability of papers in English and Welsh languages and in accessible formats, such as Braille, large print, easy read and in electronic formats;
- requesting that attendees notify the Committee Secretariat of any access needs sufficiently in advance of a proposed meeting, and responding appropriately, e.g. arranging British Sign Language (BSL) interpretation at meetings; and

where appropriate, ensuring suitable translation arrangements are in place to enable the conduct of meetings in either English or Welsh, in accordance with legislative requirements, e.g. Equality Act 2010 (Statutory Duties) (Wales) Regulations, Welsh Language (Health Sector) Regulations; as well as NWSSP's Communication Strategy and Velindre's Welsh Language Scheme.

6.1.2 The SSPC Chair will ensure that, in determining the matters to be considered by the SSPC, full account is taken of the views and interests of all citizens served by the SSPC on behalf of each Health Boards, Trust and Special Health Authority, including any views expressed formally. The Chair will ensure that, in determining the matters to be considered by the Committee, full account is taken of the views and interests of the Committee's stakeholders, including any views expressed formally to the Committee, e.g. through Community Health Councils.

6.2 Annual Plan of Committee Business

6.2.1 The Committee Secretariat, on behalf of the SSPC Chair, shall produce an annual Business Plan of Committee business. This plan will include proposals on meeting dates, venues and coverage of business activity during the year. The Business Plan shall also set out any standing items that shall appear on every SSPC agenda.

6.2.2 The Business Plan shall set out the arrangements in place to enable the SSPC to meet its obligations to its citizens as outlined in paragraph 6.1.1 whilst also allowing SSPC members to contribute in either English or Welsh languages, where appropriate.

6.2.3 The Business Plan shall also incorporate formal SSPC meetings, regular Committee development sessions and, where appropriate, and the planned activities of Sub-Committees, Expert Panel and Advisory Groups.

6.2.4 The SSPC shall agree the Business Plan for the forthcoming year by the end of March.

6.3 Calling Meetings

6.3.1 In addition to the planned meetings agreed by the SSPC, the SSPC Chair may call a meeting of the SSPC at any time. An individual SSPC member may request that the SSPC Chair call a meeting, provided that in at least one third of the whole number of Committee members supports such a request.

6.3.2 If the Chair does not call a meeting within seven days after receiving such a request from SSPC members, then those SSPC members may themselves call a meeting.

6.4 Preparing for Meetings

Setting the agenda

6.4.1 The SSPC Chair, in consultation with the Committee Secretariat and Managing Director of NWSSP, will set the agenda. In doing so, they will take account of the planned activity set in the annual cycle of SSPC business; any standing items agreed by the SSPC; any applicable items received from Sub-Committees and other groups as well as the priorities facing the SSPC. The SSPC Chair must ensure that all relevant matters are brought before the SSPC on a timely basis.

6.4.2 Any SSPC member may request that a matter is placed on the agenda by writing to the SSPC Chair, copied to the Committee Secretariat, at least 12 calendar days before the meeting. The request shall set out whether the item of business is proposed to be transacted in public and shall include appropriate supporting information. The Chair may, at their discretion, include items on the agenda that have been requested after the 12 day notice period if this would be beneficial to the conduct of SSPC business.

Notifying and equipping SSPC members

6.4.3 SSPC members should be sent an agenda and a complete set of supporting papers at least 10 calendar days before a formal SSPC meeting. This information may be provided to SSPC members

electronically or in paper form, in an accessible format, to the address provided, and in accordance with their stated preference. Supporting papers may, exceptionally, be provided after this time, provided that the SSPC Chair is satisfied that the SSPC's ability to consider the issues contained within the paper would not be impaired.

6.4.4 No papers should be included for decision by the SSPC unless the SSPC Chair is satisfied (subject to advice from the Committee Secretariat, as appropriate) that the information contained within it is sufficient to enable the SSPC to take a reasonable decision. Equality Integrated Impact Assessments (EqIIAs) shall be undertaken on all new or revised policies, strategies, guidance and or practice to be considered by the SSPC, and the outcome of that EqIIA shall be included within the report to the SSPC, to enable the SSPC to make an informed decision.

6.4.5 In the event that at least half of the SSPC members do not receive the agenda and papers for the meeting as set out above, the SSPC Chair must consider whether or not the SSPC would still be capable of fulfilling its role and meeting its responsibilities through the conduct of the meeting. Where the SSPC Chair determines that the meeting should go ahead, their decision, and the reason for it, shall be recorded in the minutes.

6.4.6 In the case of a meeting called by SSPC members, notice of that meeting must be signed by those members and the business conducted will be limited to that set out in the notice.

Notifying the public and others

6.4.7 Except for meetings called in accordance with SSPC Standing Order 6.4, at least 10 calendar days before each meeting of the SSPC a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed bilingually (in English and Welsh):

- at the SSPC's principal sites;
- on the SSPC's website, together with the papers supporting the public part of the agenda; as well as
- through other methods of communication as set out in the SSPC's communication strategy.

6.4.8 When providing notification of the forthcoming meeting, the SSPC shall set out when and how the agenda and the papers supporting the public part of the agenda may be accessed, in what language and in what format, e.g. as Braille, large print, easy read, etc.

6.5 Conducting Shared Services Partnership Committee Meetings

Admission of the public, the press and other observers

6.5.1 The SSPC shall encourage attendance at its formal SSPC meetings by the public and members of the press as well as officers or representatives from organisations who have an interest in the business of the SSPC. The venue for such meetings must be appropriate to facilitate easy access for attendees and translation services; and should have appropriate facilities to maximise accessibility such as an induction loop system.

6.5.2 The SSPC shall conduct as much of its formal business in public as possible. There may be circumstances where it would not be in the public interest to discuss a matter in public, e.g. business that relates to a confidential matter affecting a NWSSP officer, a patient or a procurement contract. In such cases, the Chair (advised by the NWSSP Head of Finance and Business Improvement, where appropriate) shall Annexe these issues accordingly and requires that any observers withdraw from the meeting. In doing so, the SSPC shall resolve:

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

6.5.3 In these circumstances, when the SSPC is not meeting in public session, it shall operate in private session, formally reporting any decisions taken to the next meeting of the SSPC in public session. Wherever possible, that reporting shall take place at the end of a private session, by reconvening a SSPC meeting held in public session.

6.5.4 The NWSSP Head of Finance and Business Improvement, on behalf of the SSPC Chair, shall keep under review the nature and volume of business conducted in private session to ensure such arrangements are adopted only when absolutely necessary.

6.5.5 In encouraging entry to formal SSPC meetings from members of the public and others, the SSPC shall make clear that attendees are welcomed as observers. The SSPC Chair shall take all necessary steps to ensure that the SSPC's business is conducted without interruption and disruption. In exceptional circumstances, this may include a requirement that observers leave the meeting. In doing so, the SSPC shall resolve:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the SSPC to reconvene the meeting and to complete business without the presence of the public".

6.5.6 Unless the SSPC has given prior and specific agreement, members of the public or other observers will not be allowed to record proceedings in any way other than in writing.

Addressing the SSPC, its Sub-Committees, Expert Panel or Advisory Groups

6.5.7 The SSPC shall decide what arrangements and terms and conditions are appropriate in extending an invitation to observers to attend and address any meetings of the SSPC, its Sub-Committees, expert panel or Advisory Groups, and may change, alter or vary these terms and conditions as it considers appropriate. In doing so, the SSPC will take account of its responsibility to actively encourage the engagement and, where appropriate, involvement of citizens and stakeholders in the work of the SSPC (whether directly or through the activities of bodies such as Community Health Councils) and to demonstrate openness and transparency in the conduct of business.

Chairing SSPC Meetings

6.5.8 The Chair of the SSPC will preside at any meeting of the SSPC unless they are absent for any reason (including any temporary absence or disqualification from participation on the grounds of a conflict of interest). In these circumstances the Vice Chair shall preside. If both the Chair and Vice-Chair are absent then no formal business shall take place.

6.5.9 The Chair must ensure that the meeting is handled in a manner that enables the SSPC to reach effective decisions on the matters before it. This includes ensuring that SSPC members' contributions are timely and relevant and move business along at an appropriate pace. In doing so, the SSPC must have access to appropriate advice on the conduct of the meeting through the attendance of the Head of Finance and Business Improvement. The Chair has the final say on any matter relating to the conduct of SSPC business.

Quorum

6.5.10 At least 6 voting members, at least 4 of whom are Health Board, Trust or Special Health Authority Chief Executives (or their nominated representatives) and one is either the Chair or the Vice Chair, must be present to allow any formal business to take place at an SSPC meeting. If the Managing Director of NWSSP is not present, then no formal

business should be transacted unless there is, in attendance, a properly authorised deputy for the Managing Director.

6.5.11 If a Health Board, Trust or Special Health Authority Chief Executive (or their nominated representative) or the Managing Director of NWSSP is unable to attend a SSPC meeting, then a nominated deputy may attend in their absence which should be an Executive Director of the same organisation and will formally contribute to the quorum and have delegated voting rights, provided that the Chair has agreed the nomination before the meeting.

6.5.12 The quorum must be maintained during a meeting to allow formal business to be conducted, i.e. any decisions to be made. Any SSPC member disqualified through conflict of interest from participating in the discussion on any matter and/or from voting on any resolution will no longer count towards the quorum. If this results in the quorum not being met that particular matter or resolution cannot be considered further at that meeting, and must be noted in the minutes. A member may participate in a meeting via video or teleconference where this is available.

Dealing with Motions

6.5.13 In the normal course of SSPC business items included on the agenda are subject to discussion and decisions based on consensus. Considering a motion is therefore not a routine matter and may be regarded as exceptional, e.g. where an aspect of service delivery is a cause for particular concern, a SSPC member may put forward a motion proposing that a formal review of that service area is undertaken. The Board Secretary support role will advise the Chair on the formal process for dealing with motions. No motion or amendment to a motion will be considered by the SSPC unless moved by a SSPC member and seconded by another SSPC member (including the SSPC Chair).

6.5.14 **Proposing a formal notice of Motion –** Any SSPC member wishing to propose a motion must notify the SSPC Chair in writing of the proposed motion at least 12 calendar days before a planned meeting. Exceptionally, an emergency motion may be proposed up to one hour before the fixed start of the meeting, provided that the reasons for the urgency are clearly set out. Where sufficient notice has been provided, and the SSPC Chair has determined that the proposed motion is relevant to the SSPC's business, the matter shall be included on the agenda, or, where an emergency motion has been proposed, the SSPC Chair shall declare the motion at the start of the meeting as an additional item to be included on the agenda.

6.5.15 The SSPC Chair also has the discretion to accept a motion proposed during a meeting provided that the matter is considered of sufficient importance and its inclusion would not adversely affect the conduct of SSPC business.

6.5.16 **Amendments -** Any SSPC member may propose an amendment to the motion at any time before or during a meeting and this proposal must be considered by the SSPC alongside the motion.

6.5.17 If there are a number of proposed amendments to the Motion, each amendment will be considered in turn, and if passed, the amended Motion becomes the basis on which the further amendments are considered, i.e. the substantive motion.

6.5.18 **Motions under discussion –** When a motion is under discussion, any SSPC member may propose that:

- the motion be amended;
- the meeting should be adjourned;
- the discussion should be adjourned and the meeting proceed to the next item of business;
- a SSPC member may not be heard further;
- the SSPC decides upon the motion before them;
- an ad hoc committee should be appointed to deal with a specific item of business; or
- The public, including the press, should be excluded.

6.5.19 **Rights of reply to motions –** The mover of a motion (including an amendment) shall have a right of reply at the close of any debate on the motion or the amendment immediately prior to a vote on the proposal.

6.5.20 **Withdrawal of Motion or Amendments –** A motion or an amendment to a motion, once moved and seconded, may be withdrawn by the proposer with the agreement of the seconded and the SSPC Chair.

6.5.21 **Motion to rescind a resolution –** The SSPC may not consider a motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six (6) calendar months unless the motion is supported by the (simple) majority of SSPC members.

6.5.22 A motion that has been decided upon by the SSPC cannot be proposed again within six months except by the SSPC Chair, unless the motion relates to the receipt of a report or the recommendations of a Sub-Committee/Managing Director of NWSSP to which a matter has been referred.

Voting

6.5.23 The SSPC Chair will determine whether SSPC members' decisions should be expressed orally, through a show of hands, or by secret ballot or by recorded vote. The SSPC Chair must require a secret ballot if the majority of voting SSPC members request it. Where voting on any question is conducted, a record shall be maintained. In the case of a secret ballot the decision shall record the number voting for, against or abstaining. Where a recorded vote has been used the minutes shall record the name of the individual and the way in which they voted.

6.5.24 In determining every question at a meeting, the SSPC members must take account, where relevant, of the views expressed and representations made by individuals who represent the interests of citizens in Wales. Such views may be presented to the SSPC through the Chairs of any Expert Panel, Advisory Group and/or the Community Health Council representative(s).

6.5.25 Except for decisions related to the overall funding contribution from each of the Health Boards, Trusts or Special Health Authority, the SSPC will make decisions subject to a 2/3 majority of voting. In no circumstances may an absent SSPC member (or their nominated deputy) vote by proxy. Absence is defined as being absent at the time of the vote.

6.6 Record of Proceedings

6.6.1 A record of the proceedings of formal SSPC meetings (and any other meetings of the SSPC where the SSPC members determine) shall be drawn up as 'minutes'. These minutes shall include a record of SSPC member attendance (including the SSPC Chair) together with apologies for absence, and shall be submitted for agreement at the next meeting of the SSPC, where any discussion shall be limited to matters of accuracy. Any agreed amendment to the minutes must be formally recorded.

6.6.2 Agreed minutes shall be circulated in accordance with SSPC members' wishes, and, where providing a record of a formal SSPC meeting shall be made available to the public on the NWSSP website and in hard copy or other accessible format on request, in accordance with any legislative requirements, e.g. Data Protection Act, the SSPC's Communication Strategy and Velindre's Welsh Language Scheme.

6.7 Confidentiality

6.7.1 All SSPC members, together with members of any Sub-Committee, Expert Panel or Advisory Group established by or on behalf of the SSPC

and SSPC members and/or Health Board/Trust/Special Health Authority officials must respect the confidentiality of all matters considered by the SSPC in private session or set out in documents which are not publicly available. Disclosure of any such matters may only be made with the express permission of the SSPC Chair or relevant Sub-Committee or group, as appropriate, and in accordance with any other requirements set out elsewhere, e.g. in contracts of employment, within the Standards of Behaviour Framework or legislation such as the Freedom of Information Act 2000, etc.

7 VALUES AND STANDARDS OF BEHAVIOUR

The SSPC must operate within a set of values and standards of behaviour that meets the requirements of the NHS Wales Values and Standards of Behaviour Framework. These values and standards of behaviour will apply to all those conducting business by or on behalf of the SSPC, including SSPC members, Velindre NWSSP officers and others, as appropriate. The Framework adopted by the SSPC will form part of these SOs.

7.1 Declaring and Recording Shared Services Partnership Committee Members' Interests

7.1.1 **Declaration of interests –** It is a requirement that all SSPC members should declare any personal or business interests they may have which may affect, or be perceived to affect, the conduct of their role as a SSPC member. This includes any interests that may influence or be perceived to influence their judgement in the course of conducting the SSPC's business. SSPC members must be familiar with the Values and Standards of Behaviour Framework and their statutory duties under the relevant Constitution Regulations. SSPC members must notify the SSPC of any such interests at the time of their appointment, and any further interests as they arise throughout their tenure as SSPC members.

7.1.2 SSPC members must also declare any interests held by family members or persons or bodies with which they are connected. The NWSSP Head of Finance and Business Improvement will provide advice to the SSPC Chair and the SSPC on what should be considered as an 'interest', taking account of the regulatory requirements and any further guidance, e.g. the Values and Standards of Behaviour Framework. If individual SSPC members are in any doubt about what may be considered as an interest, they should seek advice from the NWSSP Head of Finance and Business Improvement. However, the onus regarding declaration will reside with the individual SSPC member.

7.1.3 **Register of interests –** The Managing Director of NWSSP, through the NWSSP Head of Finance and Business Improvement, will ensure that a Register of Interests is established and maintained as a formal record of interests declared by all SSPC members. The register will include details of all Directorships and other relevant and material interests which have been declared by SSPC members.

7.1.4 The register will be held by the NWSSP Head of Finance and Business Improvement, and will be updated during the year, as appropriate, to record any new interests, or changes to the interests declared by SSPC members. The NWSSP Head of Finance and Business Improvement will also arrange an annual review of the register, through which SSPC members will be required to confirm the accuracy and completeness of the register relating to their own interests.

7.1.5 In line with the SSPC's commitment to openness and transparency, the NWSSP Head of Finance and Business Improvement must take reasonable steps to ensure that citizens served by the SSPC are made aware of, and have access to view the Register of Interests. This will include publication on the NWSSP website.

7.1.6 **Publication of declared interests in Annual Review –** SSPC members' directorships of companies or positions in other organisations likely or possibly seeking to do business with the NHS shall be published in each Shared Services' Annual Review.

7.2 Dealing with Members' interests during Shared Services Partnership Committee meetings

7.2.1 The SSPC Chair, advised by the NWSSP Head of Finance and Business Improvement, must ensure that the SSPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual board members must demonstrate, through their actions, that their contribution to the SSPC's decision making is based upon the best interests of the NHS in Wales. This is particularly important as there is an inherent tension in a member's role on the SSPC and as a member of the Board of a Health Board, Trust or Special Health Authority.

7.2.2 Where individual SSPC members identify an interest in relation to any aspect of SSPC business set out in the SSPC's meeting agenda, that member must declare an interest at the start of the SSPC meeting. SSPC members should seek advice from the SSPC Chair, through the NWSSP Head of Finance and Business Improvement before the start of the SSPC meeting if they are in any doubt as to whether they should declare an

interest at the meeting. All declarations of interest made at a meeting must be recorded in the SSPCs minutes.

7.2.3 It is the responsibility of the SSPC Chair, on behalf of the SSPC, to determine the action to be taken in response to a declaration of interest, taking account of any regulatory requirements or directions given by the Welsh Ministers. The range of possible actions may include determination that:

i the declaration is formally noted and recorded, but that the SSPC member should participate fully in the SSPC's discussion and decision, including voting

ii the declaration is formally noted and recorded, and the SSPC member participates fully in the SSPC's discussion, but takes no part in the SSPC's decision;

iii the declaration is formally noted and recorded, and the SSPC member takes no part in the SSPC discussion or decision;

iv the declaration is formally noted and recorded, and the SSPC member is excluded for that part of the meeting when the matter is being discussed. A SSPC member must be excluded, where that member has a direct or indirect financial interest in a matter being considered by the SSPC.

7.2.4 In extreme cases, it may be necessary for the member to reflect on whether their position as a SSPC member is compatible with an identified conflict of interest.

7.2.5 Where the SSPC Chair is the individual declaring an interest, any decision on the action to be taken shall be made by the Vice Chair, on behalf of the SSPC.

7.2.6 In all cases the decision of the SSPC Chair (or the Vice Chair in the case of an interest declared by the SSPC Chair) is binding on all SSPC members. The SSPC Chair should take advice from the NWSSP Head of Finance and Business Improvement when determining the action to take in response to declared interests; taking care to ensure their exercise of judgement is consistently applied.

7.2.7 **Members with pecuniary (financial) interests –** Where a SSPC member, or any person they are connected with[1] has any direct or indirect pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the

[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

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 Gifts[2] and Hospitality

7.5.1 The Committee will adopt the Values and Standards of Behaviour Framework Policy of Velindre University NHS Trust, which prohibits SSPC members and NWSSP officers from receiving gifts, hospitality or benefits in kind from a third party which may reasonably give rise to suspicion of conflict between their official duty and their private interest, or may reasonably be seen to compromise their personal integrity in any way.

7.5.2 Gifts, benefits or hospitality must never be solicited. Any SSPC member or NWSSP officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This

[2] The term gift refers also to any reward or benefit

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.

Annexe 1

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

This Annexe forms part of, and shall have effect as if incorporated in the Shared Services Partnership Committee Standing Orders

MODEL SCHEME OF RESERVATION AND DELEGATION OF POWERS

As set out in Standing Order 2, the SSPC - subject to any directions that may be made by the Welsh Ministers - shall make appropriate arrangements for certain functions to be carried out on its behalf so that the day to day business of the NWSSP may be carried out effectively, and in a manner that secures the achievement of the organisation's aims and objectives. The SSPC may delegate functions to:

i A Committee, e.g., Audit Committee;
ii A Sub-Committee,
iii A Joint-Committee or Joint Sub-Committee, e.g., with other Health Boards established to take forward matters relating to specialist services; and
iv Officers of NWSSP (who may, subject to the SSPC's authority, delegate further to other officers and, where appropriate, other third parties, e.g. shared/support services, through a formal scheme of delegation)

and in doing so, must set out clearly the terms and conditions upon which any delegation is being made. These terms and conditions must include a requirement that the SSPC is notified of any matters that may affect the operation and/or reputation of NWSSP.

The Board's determination of those matters that it will retain, and those that will be delegated to others are set out in the following:

- Annexe of matters reserved to SSPC;
- Scheme of delegation to Committees and others; and
- Scheme of delegation to officer.

all of which form part of the SSPC's SOs.

DECIDING WHAT TO RETAIN AND WHAT TO DELEGATE: GUIDING PRINCIPLES

The SSPC will take full account of the following principles when determining those matters that it reserves, and those which it will delegate to others to carry out on its behalf:

- Everything is retained by the SSPC unless it is specificallydelegated in accordance with the requirements set out in SOs or SFIs.
- The SSPC must retain that which it is required to retain (whether by statute or as determined by the Welsh Ministers) as well as that which it considers is essential to enable it to fulfil its role in setting the organisation's direction, equipping the organisation to deliver and ensuring achievement of its aims and objectives through effective performance management.
- Any decision made by the Board to delegate functions must be based upon an assessment of the capacity and capability of those to whom it is delegating responsibility.
- The SSPC must ensure that those to whom it has delegated powers (whether a Committee, partnership or individuals) remain equipped to deliver on those responsibilities through an ongoing programme of personal, professional and organisational development.
- The SSPC must take appropriate action to assure itself that all matters delegated are effectively carried out.
- The framework of delegation will be kept under active review and, where appropriate, will be revised to take account of organisational developments, review findings or other changes.
- Except where explicitly set out, the SSPC retains the right to decide upon any matter for which it has responsibility, even if that matter has been delegated to others.
- The SSPC may delegate authority to act, but retains overall responsibility and accountability.
- When delegating powers, the SSPC will determine whether (and the extent to which) those to whom it is delegating will, in turn, have powers to further delegate those functions to others.

HANDLING ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS: WHO DOES WHAT

The Shared Services Partnership Committee (SSPC)

The SSPC will formally agree, review and, where appropriate revise Annexes of reservation and delegation of powers in accordance with the guiding principles set out earlier.

The Managing Director

The Managing Director will propose a Scheme of Delegation to officers, setting out the functions they will perform personally and which functions will be delegated to other officers. The SSPC must formally agree this scheme.

In preparing the scheme of delegation to officers, the Managing Director will take account of:

- The guiding principles set out earlier (including any specific statutory responsibilities designated to individual roles);
- Their personal responsibility and accountability to the Chief Executive,
- NHS Wales in relation to their role as designated Accountable Officer; and
- Associated arrangements for the delegation of financial authority to equip officers to deliver on their delegated responsibilities (and set out in SFIs).

The Managing Director may re-assume any of the powers they have delegated to others at any time.

Board Secretary Governance Support/The NWSSP Head of Finance and Business Improvement

The Board Secretary Governance Support/the NWSSP Head of Finance and Business Improvement will support the SSPC in its handling of reservations and delegations by ensuring that:

- A proposed Annexe of matters reserved for decision by the SSPC is presented to the SSPC for its formal agreement;
- Effective arrangements are in place for the delegation of NWSSP's functions within the organisation and to others, as appropriate; and
- Arrangements for reservation and delegation are kept under review and presented to the SSPC, Audit Committee and Velindre Trust Board for revision and approval, as appropriate.

The Velindre University NHS Trust Audit Committee for NWSSP

The Velindre University NHS Trust Audit Committee for NWSSP will provide assurance to the SSPC and Velindre University NHS Trust Board of the effectiveness of its arrangements for handling reservations and delegations.

Individuals to who powers have been delegated will be personally responsible for:

- Equipping themselves to deliver on any matter delegated to them, through the conduct of appropriate training and development activity;and
- Exercising any powers delegated to them in a manner that accords with the Velindre University NHS Trust's values and standards of behaviour.

Where an individual does not feel that they are equipped to deliver on a matter delegated to them, they must notify the Board Secretary providing governance support to the SSPC of their concern, as soon as possible, so that an appropriate and timely decision may be made on the matter.

In the absence of an officer to whom powers have been delegated, those powers will normally be exercised by the individual to whom that officer reports, unless the SSPC has set out alternative arrangements.

SCOPE OF THESE ARRANGEMENTS FOR THE RESERVATION AND DELEGATION OF POWERS

The Scheme of Delegation to officers referred to here shows only the "top level" of delegation within NWSSP. The Scheme is to be used in conjunction with the system of control and other established procedures within NWSSP.

SECTION 1

ANNEXE OF MATTERS RESERVED TO THE SSPC[3]

SSPC		AREA	DECISIONS RESERVED TO THE SSPC
1	FULL	GENERAL	The SSPC may determine any matter for which it has statutory or delegated authority, in accordance with NWSSP SOs.
2	FULL	GENERAL	The SSPC must determine any matter that will be reserved to the whole SSPC in accordance with statutory and Welsh Government guidance.
3	FULL	OPERATING ARRANGEMENTS	Adopt the standards of governance and performance (including the quality and safety of healthcare, and the patient experience) to be met by the SSPC, including standards/requirements determined by professional bodies/others, e.g., Royal Colleges.
4	FULL	OPERATING ARRANGEMENTS	Approve, vary and amend: ▪ NWSSP SOs ; ▪ NWSSP SFIs; ▪ Annexe of matters reserved to the SSPC; ▪ Scheme of delegation to SSPC others; and ▪ Scheme of delegation to officers. In accordance with any directions set by the Welsh Ministers.

[3] Any decision to reserve a matter, and the manner in which that retained responsibility is carried out will be in accordance with any regulatory and/or Welsh Government requirements

5	FULL	OPERATING ARRANGEMENTS	Approve the SSPC Values and Standards of Behaviour Framework, including NWSSP's mission statement.
6	FULL	OPERATING ARRANGEMENTS	Approve the SSPC framework for performance management, risk and assurance.
7	FULL	OPERATING ARRANGEMENTS	Approve the introduction or discontinuance of any significant activity or operation. Any activity or operation shall be regarded as significant if the SSPC determines it so based upon its contribution/impact on the achievement of the SSPC's aims, objectives and priorities.
8	FULL	OPERATING ARRANGEMENTS	Ratify any urgent decisions taken by the Chair and the Managing Director in accordance with NWSSP Standing Order requirements.
9	FULL	OPERATING ARRANGEMENTS	Ratify in public session any instances of failure to comply with NWSSP SOs.
10	FULL	OPERATING ARRANGEMENTS	Approve procedures for dealing with complaints and incidents.
11	FULL	OPERATING ARRANGEMENTS	Approve individual compensation payments in line with NWSSP SFIs.
12	FULL	OPERATING ARRANGEMENTS	Approve individual cases for the write-off of losses or making of special payments above the limits of delegation to the Managing Director and officers.
13	FULL	OPERATING ARRANGEMENTS	Approve proposals for action on litigation on behalf of the NWSSP.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the appointment, appraisal, discipline and dismissal of the Management Team and any other SMT level appointments, e.g., the Committee Secretary.

15	FULL	ORGANISATION STRUCTURE & STAFFING	Require, receive and determine action in response to the declaration of NWSSP members' interests, in accordance with advice received, e.g. From Audit Committee.
14	FULL	ORGANISATION STRUCTURE & STAFFING	Approve, [arrange the] review, and revise the NWSSP's top level organisation structure and SSPC policies.
15	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, [arrange the] review, revise and dismiss SSPC sub-Committees, including any joint sub-Committees directly accountable to the SSPC.
16	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss the Chair and members of any sub-Committee, joint sub-Committee or Group set up by the SSPC.
17	FULL	ORGANISATION STRUCTURE & STAFFING	Appoint, equip, review and (where appropriate) dismiss individuals appointed to represent the SSPC on outside bodies and groups.
18	FULL	ORGANISATION STRUCTURE & STAFFING	Approve the terms of reference and reporting arrangements of all sub-Committees, joint sub-Committees and groups established by the SSPC.
19	FULL	STRATEGY & PLANNING	Determine the SSPCs strategic aims, objectives and priorities.
20	FULL	STRATEGY & PLANNING	Approve the SSPCs Integrated Medium Term Plan, including the balanced Medium Term Financial Plan.
21	FULL	STRATEGY & PLANNING	Approve the SSPCs Risk Management Strategy, including risk appetite, risk tolerance levels and treatment plans and managing risks in relation to public confidence.
22	FULL	STRATEGY & PLANNING	Approve the SSPCs citizen engagement and involvement strategy, including communication.

23	FULL	STRATEGY & PLANNING	Approve the SSPCs Committee's partnership and stakeholder engagement and involvement strategies.
24	FULL	STRATEGY & PLANNING	Approve NWSSP's key strategies and programmes related to: ▪ Workforce and Organisational Development ▪ Infrastructure, including IM &T, Estates and Capital (including major capital investment and disposal plans) ▪ Primary Care ▪ Communications & Engagement
25	FULL	STRATEGY & PLANNING	Approve the SSPCs budget and financial framework (including overall distribution of year end surplus/deficits including risk sharing agreements.
26	FULL	STRATEGY & PLANNING	Approve individual contracts (other than NHS contracts) above the limit delegated to the Managing Director set out in the NWSSP SFIs.
27	FULL	PERFORMANCE & ASSURANCE	Approve the SSPCs audit and assurance arrangements.
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPCs NWSSP Directors on progress and performance in the delivery of the SSPCs strategic aims, objectives and priorities and approve action required, including improvement plans.

29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPCs Sub-Committees, groups and other internal sources on the Joint Committee's performance and approve action required, including improvement plans.
30	FULL	PERFORMANCE & ASSURANCE	Receive reports on the SSPC's performance produced by external regulators and inspectors (including, e.g., WAO, HIW, etc) that raise issue or concerns impacting on the NWSSP's ability to achieve its aims and objectives and approve action required, including improvement plans, taking account of the advice of SSPC sub-Committees (as appropriate).
31	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion of the SSPC's Head of Internal Audit and approve action required, including improvement plans.
32	FULL	PERFORMANCE & ASSURANCE	Receive the annual management letter from the SSPC's external auditor and approve action required, including improvement plans.
33	FULL	PERFORMANCE & ASSURANCE	Receive the annual opinion on the SSPC's performance against the Health and Care Standards for Wales and approve action required, including improvement plans.
34	FULL	PERFORMANCE & ASSURANCE	Approval of the Risk and Assurance Framework.
35	FULL	REPORTING	Approve the SSPC's Reporting Arrangements, including reports on activity and performance locally, to citizens, partners and stakeholders and nationally to the Welsh Government.
36	FULL	REPORTING	Receive, approve and ensure the publication of SSPC reports, including its Annual Report.

SECTION 2

ANNEXE OF DELEGATION OF POWERS TO COMMITTEES AND OTHERS

Under Standing Order Section 2 it provides that the SSPC may delegate powers to SSPC Committees, Sub-Committees and others. In doing so, the SSPC has formally determined:

- the composition, terms of reference and reporting requirements in respect of any such Committees; and
- the governance arrangements, terms and conditions and reporting requirements in respect of any delegation to others;

in accordance with any regulatory requirements and any directions set by the Welsh Ministers.

Subject to Clauses within the Trust Standing Orders and to such directions as may be given by the Welsh Government, the SSPC may appoint ad-hoc committees of the NWSSP, whose membership can be wholly or partly of the Chairman and Directors of the NWSSP, or persons who are not Directors of the NWSSP.

A committee appointed under this regulation may subject to such directions as may be given by the Welsh Government or the SSPC appoint ad hoc Sub-Committees consisting wholly or partly of members of the committee (whether or not they are Directors of NWSSP) or wholly of persons who are not members of the committee (whether or not they include Directors of the NWSSP).

The Standing Orders, with appropriate alterations, apply to a committee or Sub-Committee and to a committee or Sub-Committee as they apply to the SSPC and apply to a member of such committee or sub-committee (whether or not they are a Director of the NWSSP) as it applies to a Director of the NWSSP.

The SSPC may make, vary and revoke Standing Orders relating to the quorum, proceedings and place of meetings of a committee or Sub-Committee but, this shall be carried out in accordance with the identified procedures laid down for these changes as outlined in these Standing Orders.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee Terms of Reference, and ii) Formal arrangements for the delegation of powers to others. Collectively, these documents form the SSPC's Scheme of Delegation to Committees.

The SSPC has delegated a range of its powers to the following Sub-Committees and others:

- Welsh Risk Pool Committee
- Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

Summary of matters delegated to Sub-Committees:

Sub-Committee: Welsh Risk Pool Committee **Delegated Matters:**
The Sub-Committee will: 1. To approve the payment and reimbursement of claims and impose penalties in accordance with the WRPS Claims Reimbursement Procedure. 2. To enact the risk sharing arrangements as agreed by the NWSSP. 3. To receive and consider the annual statements of account. 4. To receive and consider the annual assessment reports and to approve recommendations for any necessary action. 5. To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action. 6. To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately. 7. To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk. 8. To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis. 9. To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

Sub-Committee: Velindre University NHS Trust Audit Committee for NWSSP **Delegated Matters:**
The Committee will: 1. Approve any variation to, review annually and monitor compliance with Standing Orders and Standing Financial Instructions. 2. Review and report to the SSPC upon the adequacy of the arrangements for declaring, registering and handling interests at least annually. 3. Receive a full report of all offers of Gifts and Hospitality recorded by the NWSSP and review the adequacy of NWSSP's arrangements for dealing with offers of gifts and hospitality. 4. Advise the Velindre Trust Board on the adequacy that its assurance arrangements are operating effectively. 5. Review and approve Internal Audit Strategy, Charter, operational plan, programme of work. 6. Review effectiveness of internal audit. 7. Review policies and procedures in respect of fraud and bribery set out in the Welsh Government Directions and to receive the Counter Fraud Annual Report and Plan. 8. Approve write-off of losses or making of special payments within delegated limits determined by the Welsh Ministers. 9. Review the establishment and maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities. 10. Review the assurance gained through the development of a Risk and Assurance Framework and to consider gaps in control and gaps in assurance and report results to the Board. 11. Review the adequacy of all risk and control related disclosure statements, including the Annual Governance Statement. 12. Receive quarterly assurance of Post Payment Verification (PPV) reports.

The scope of the powers delegated, together with the requirements set by the SSPC in relation to the exercise of those powers are as set out in i) Committee terms of reference, and ii) formal arrangements for the delegation of powers to others. Collectively, these documents form the NWSSP's Scheme of Delegation to Committees.

SECTION 3

ANNEXE OF SCHEME OF DELEGATION TO NWSSP DIRECTORS AND OFFICERS

The SSPC SOs, alongside the Trust SOs and the SFIs specify certain key responsibilities of the Chief Executive Velindre University NHS Trust, the Managing Director of NWSSP, Directors, Heads of Service and other officers. The Chief Executive and Managing Director of NWSSP Job Descriptions, together with their Accountable Officer Memorandums set out their specific responsibilities, and the individual job descriptions determined for Directors and Heads of Service level posts also define in detail the specific responsibilities assigned to those post holders. These documents, together with the Annexe of additional delegations below and the associated financial delegations set out in the Velindre Trust SFIs form the basis of the Scheme of Delegation to Officers.

Standing Orders – List of Delegated Matters

SO REF	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY
GENERAL			
	Non-compliance and variation of Standing Orders Final interpretation of Standing Orders Responsibility for providing advice to the Board on all aspects of governance/committee services	Head of Finance and Business Improvement Chair Head of Finance and Business Improvement	Board Secretary Support
CHAIR'S ACTION ON URGENT MATTERS			
SO 2.1	Use of Chair's Action and onward reporting to	Chair & Managing Director	Board Secretary Support
DELEGATION TO OFFICERS			
SO 2.3.1	Compilation of Scheme of Delegation for functions	Managing Director	Head of Finance and Business

	delegated to Managing Director for consideration and approval by the SSPC		Improvement
SO 2.3.1	Delegation of functions within Directorates/departments/localities in line with the framework established by the Managing Director and agreed by the SSPC	Directors	Directors
WORKING IN PARTNERSHIP			
SO 5.0.2	Identification and engagement with all key partners and regular review of effectiveness	Chair	Deputy Director of Finance and Corporate Services
MEETINGS			
SO 6.2	Development of the Annual Plan of SSPC Business	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Head of Finance and Business Improvement
SO 6.4	Preparation of SSPC meetings	Chair/Managing Director	
SO 6.5	Report decisions made & review NWSSP business conducted in private session	Chair	Head of Finance and Business Improvement
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Head of Finance and Business Improvement
SO 6.6	A record of proceedings of SSPC meetings	Chair (Vice Chair in Chair's absence)	Chair (Vice Chair in Chair's absence) / Head of Finance

			and Business Improvement
VALUES AND STANDARDS OF BEHAVIOUR			
SO 7.1	Establishment, maintenance and annual review of a Register of Interests declared by all SSPC members	Managing Director	Head of Finance and Business Improvement
SO 7.6	Establishment, maintenance and annual review of a Register of Gifts and Hospitality in respect of SSPC business for all SSPC members	Chair	Head of Finance and Business Improvement
SO 7.6	Establishment maintenance and annual review of a Register of Gifts and Hospitality for NWSSP Officers	Managing Director/Directors	Head of Finance and Business Improvement
SIGNING AND SEALING DOCUMENTS			
SO 8.1	Establishment, maintenance and bi-annual reporting of a Register of Sealings undertaken by the Velindre NHS Trust Board for NWSSP business	Managing Director	Head of Finance and Business Improvement

This scheme only relates to matters delegated by the Velindre Board and the SSPC to the Managing Director and Directors, together with certain other specific matters referred to in SFIs. Each Director is responsible for delegation within their department. They shall produce a scheme of delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

Annexe of Additional Delegations

Delegated matter	High level delegation	Further Delegation Allowable?	Control Documents required to be in place prior to further delegation of matters
Management of budgets	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	Financial delegations set out in Sections 4-6. Further delegations subject to authorisation matrix.
Management of cash and bank accounts	Trust Director of Finance	Yes	Authorisation matrix. Financial policies & procedures
Approval of petty cash	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Financial policies & procedures
Engagement of staff within funded establishment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Engagement of staff outside funded establishment	Managing Director of Shared Services	Nominated deputy	In absence of Director of Shared Services
Staff re-grading and awarding of incremental points	NWSSP Director of W&OD	Yes	Written authority to suitably qualified HR staff
Approval of overtime	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of annual leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of compassionate leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of maternity and paternity leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of carers leave	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures

Approval of leave without pay	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Extension of sick leave on full or ½ pay • Directors • Other staff	Managing Director of NWSSP NWSSP Directors	No Yes	Authorisation matrix. HR policies & procedures
Approval of study leave < £2k	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. HR policies & procedures
Approval of study leave > £2k	Managing Director NWSSP/ NWSSP Director of W&OD	No	
Approval of relocation costs	NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval of lease cars & phones • NWSSP Directors • Other staff	Managing Director of NWSSP NWSSP Finance Director	No No	
Approval of redundancy, early retirement and ill-health retirement	Managing Director of NWSSP	Yes	Authorisation matrix. HR policies & procedures
Dismissal of staff	Managing Director of NWSSP and NWSSP Director of W&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of NWSSP	Nominated deputy	In absence of the Managing Director of NWSSP
Approval to commission services from	Managing Director of	Yes	Authorisation matrix. Commissioning policies &

other NHS bodies	NWSSP		procedures
Approval to commission services from voluntary sector	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to commission services from private and independent providers	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Approval to enter into pooled budget arrangements under section 33 of the NHS (Wales) Act 2006	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures
Management and Control of Stocks	NWSSP Director (Head of Procurement Services)/ NWSSP Director of Finance	Yes	Authorisation matrix
Work in relation to counter fraud and corruption	Trust Director of Finance/ NWSSP Director of Finance	Yes	Authorisation matrix Fraud & Corruption policies and procedures
Authorisation of sponsorship	Managing Director of NWSSP	No	Sponsorship policies & procedures
Approval of research projects	Managing Director of NWSSP	Yes	Research policies & procedures
Management of complaints	NWSSP Director of Finance	No	Complaints policies & procedures
Provision of information to the press, public and other external enquiries	NWSSP Directors / Trust Board Secretary	Yes	Communication policies & procedures
Approval for use of charitable funds	Trust Chief Executive	Yes	Authorisation matrix. Financial policies & procedures
Approval to condemn and dispose of equipment	NWSSP Directors / Heads of Service	Yes	Authorisation matrix. Disposal policies & procedures
Approval of losses and compensation	Managing Director of	No	Within authorised limits set by WG.

(except for personal effects)	NWSSP		
Approval of compensation for staff and patients personal effects • Up to £1000 • £1,000 > £10,000 • £10,000 > £50,000 • Over £50,000	Trust Small Claims Panel Managing Director of NWSSP Approval by WG	No No No No	
Approval of clinical negligence and personal injury claims	Managing Director of NWSSP / NWSSP Director of Finance	Yes	Authorisation matrix and within limits set by WAG.
Approval of capital expenditure	Managing Director of NWSSP/ NWSSP Director of Finance	Yes	High level delegation set out in Section 4. Further delegations subject to authorisation matrix
Approval to engage external building and other professional contractors	NWSSP Director of Finance	Yes	Authorisation matrix. Capital policies & procedures.
Approval to seek professional advice and ensure the implementation of any statutory and regulatory requirements	Managing Director of NWSSP	Yes	Financial delegations set out in Section 4. Further delegations subject to authorisation matrix
The negotiation and agreement of service contracts / long term agreements	Managing Director of NWSSP& NWSSP Director of Finance	Yes	Further delegations (re: negotiation only – not agreement) to Heads of Service.

This scheme only relates to matters delegated by the SSPC to the Managing Director of NWSSP and the NWSSP Directors and Heads of Service, together with certain other specific matters referred to in SFIs. Each NWSSP Director and Head of Service is responsible for delegation within their department. They shall produce a Scheme of Delegation for matters within their department, which shall also set out how departmental budget and procedures for approval of expenditure are delegated.

SECTION 4

ANNEXE OF DELEGATION OF BUDGETARY RESPONSIBILITY

Section 5 of the Velindre University NHS Trust Standing Financial Instructions detail the requirements for Budgetary Control, including:

5.1 Budget Setting
5.2 Budgetary Delegation
5.3 Budgetary Control and Reporting

Paragraphs 5.2.1 to 5.2.4 detail the specific requirements on Budgetary Delegation. In line with 5.2.1 the Income and Expenditure budgetary responsibility for the NHS Wales Shared Services Partnership has been delegated to the Managing Director of NWSSP.

The Managing Director of NWSSP and other NWSSP Directors will, in turn, delegate budgetary responsibility to other Heads of Service and managers. The detailed Annexe of this second tier delegation will be reviewed, revised and reapproved on an annual basis by the Managing Director of NWSSP and the Senior Management Team as part of the annual Financial Strategy and Budget Setting process. Within the budgetary delegation there are delegated powers of budget virement:

- between Divisions must be approved by the Managing Director of NWSSP.
- between budgets within the same Division must be approved by the relevant Director / Heads of Service.
- between staff and non-staff within the same budget must be approved by the Budget Holder.

These delegated powers of virement, from the Managing Director of NWSSP to Heads of Service and Budget Holders, assume that the NWSSP is achieving its financial targets and can be revised, in year, by the Managing Director of NWSSP in the light of adverse financial performance. Budget virements within Divisions can be authorised by the Head of Service and Director of Finance up to the limit of £60,000.

SECTION 5

NHS WALES SHARED SERVICES PARTNERSHIP SCHEME OF BUDGETARY DELEGATION

Financial Limits (All Values exclude VAT)	Revenue	Capital	Charitable Funds	All Wales Contracts**
	£000	£000	£000	£000
Velindre:				
Trust Board	No Limit	No Limit	0	No Limit
Charitable Funds Committee	0	0	No Limit	0
NWSSP (excluding all Wales Procurement Contracts):				
Managing Director and NWSSP Chair	200	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:				
***Represents contracts where expenditure is directly incurred in respect of All Wales Contracts*				

Welsh Infected Blood Support Services Limits

Scheme Designation	Payments to Claimants (£)
Managing Director/NWSSP Chair	Over 100k
Managing Director	Up to 100k
Director of Finance and Corporate Services	Up to 80k
Deputy Director of Finance and Corporate Services	Up to 50k
Head of Function (WIBSS Manager)	Up to 10k

Corporate Areas

Scheme Designation	Area	Limits (£)
Managing Director/Director of Finance and Corporate Services	ESR Recharges	Up to 750k
Managing Director/Director of Finance and Corporate Services	Intra-NHS Invoices and Payments (included but not limited to Pharmacy rebates, NWSSP distribution)	Up to 750k

Legal & Risks Services Limits

Scheme Designation	Reimbursement of claims following Advisory Board approval (£)	WRP Managed Claims (£)
NWSSP Chair	Over 2m	Over 2m
Managing Director of NWSSP	Up to 2m	Up to 2m
Director of Finance and Corporate Services	Up to 1m	Up to 1m
Director of Legal and Risk Services and Welsh Risk Pool	Up to 500k	Up to 500k
Deputy Director of Finance and Corporate Services	Up to 100k	Up to 100k
WRP Claims Support (Head of Safety and Learning)		£20k
Note:		
All reimbursement claims are reviewed by the Advisory Board prior to approval and claims above £1m are reviewed by Welsh Government prior to the Advisory Board. *Claims above £2m will also be signed by the Managing Director of NWSSP and NWSSP Chair.		

Procurement Services Limits

Scheme Designation	*COVID Expenditure	Contracts for and on behalf of NHS Wales (£)	NWSSP Stock Requisitions and Invoices (£)	NWSSP Stock Write offs (£)
Trust Board	Over £5m			
Chair and Managing Director / Director of Finance & Corporate Services	Up to £5m			
Managing Director of NWSSP and NWSSP Chair		Over 1m	Over 2m	Over 50k
Managing Director of NWSSP		Up to 1m	Up to 100k	Up to 50k
Director of Finance and Corporate Services NWSSP		Up to 750k	Up to 60k	Up to 25k
Director of Procurement Services		Up to 750k	Up to 50k	Up to 25k
Senior Manager Procurement Services (Logistics)			Up to 25k	Up to 10k
Regional Supply Chain Manager				Up to 5k
Warehouse Manager (Bridgend/Denbigh) / Storage and Distribution Manager (IP5)				Up to 1k
Assistant Warehouse Manager (Bridgend/Denbigh) / Shift Manager (IP5)				Up to 1k
Note:				
**Limits to be reviewed again by 30 ~~June~~ September 2020*				

Existing Liabilities Scheme Limits

Scheme Designation	Damages Limit (£)
Welsh Government	1M and over
Managing Director and NWSSP Chair	Up to 1M
Managing Director	Up to 500k
Director of Finance & Corporate Services	Up to 100k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 100k
Deputy Director of Finance & Corporate Services	Up to 50k
Deputy Director of Legal and Risk Services and Welsh Risk Pool	Up to 50k
Head of Function - GMPI Team Leader	Up to 10k
Note:	
Claims and payments will be made by NWSSP and approved in line with the above scheme of delegation. Any value of damages decisions greater than £1 million will require written Welsh Government approval. All other value of claims decisions below £1million will be approved in line with the Scheme of Delegation.	

Annexe 2

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

Shared Services Partnership Committee Framework

The SSPC's governance and accountability framework comprises these SSPC SOs, incorporating Annexes of Powers reserved for the SSPC and Delegation to others, together with the following documents agreed by the SSPC.

These documents must be read in conjunction with the SSPC SOs and will have the same effect as if the details within them were incorporated within the SSPC SOs themselves:

- Standing Financial Instructions (SFIs);
- Values and Standards of Behaviour Framework;
- Risk and Assurance Framework;
- SSPC Annual Plan of Committee Business;
- Welsh Language Scheme;
- Complaints Management Protocol;
- Annual Governance Statement; and
- Annual Review,

These documents may be accessed by viewing NWSSP's website (www.nwssp.wales.nhs.uk/opendoc/326169).

NHS Wales Framework

Full, up to date details of the guidance, instructions and other documents that together make up the framework of governance, accountability and assurance for the NHS in Wales are published on the NHS Wales Governance e-Manual which can be accessed at http://www.wales.nhs.uk/governance-emanual/. Directions or guidance on specific aspects of SSPC business are also issued in hard copy, usually under cover of a Ministerial Letter.

Annexe 3

SHARED SERVICES PARTNERSHIP COMMITTEE SUB-COMMITTEE ARRANGEMENTS

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. *Welsh Risk Pool Committee - Terms of Reference*

2. *Velindre University NHS Trust Audit Committee For NHS Wales Shared Service Partnership - Terms of Reference*

1. Welsh Risk Pool Committee
Terms of Reference (September 2019)

1. Background

1.01 On 1 April 2019, the National Health Service Clinical Negligence Scheme Wales Regulations 2019 came into force. The Regulations create a Scheme for Clinical Negligence Claims in Wales and were brought into force inter alia for the management of clinical negligence claims against primary care providers in Wales, operating under sections 41, 42 and 50 of the National Health Service Wales Act 2006.

1.02 The scheme is operated by NHS Wales Shared Service Partnership (NWSSP) through Legal and Risk Services with the support of WRP using its powers as a shared service function under the Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

1.03 NWSSP has responsibility for the administration of the Welsh Risk Pool Service including the management of the Welsh Risk Pool Budget.

1.04 The aim of the WRPS budget management is to align the financial governance relating to claims and Redress cases with the corporate and quality governance agenda.

1.05 The Welsh Risk Pool Services has responsibility for reimbursement of claims over £25,000 (the £25,000 threshold does not apply to GMPI matters) and reimbursement of permitted costs and damages arising from Redress cases. It is also required to have effective processes for ensuring that NHS Wales learns from events to limit the risk of recurrence and improve the quality and safety for both patients and staff.

1.06 In line with standing orders the Committee has resolved to establish a sub-committee to be known as the Welsh Risk Pool Committee (WRPC). The WRPC is a sub-committee of the NWSSP Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Membership

2.01 The membership of the WRPC shall be determined by the NWSSPC, taking account of the balance of skills and expertise necessary to deliver the WRPC's remit and subject to any specific requirements or directions made by the Welsh Government.

2.02 The WRPC comprises of representation from senior NHS professionals from Trusts, Local Health Boards, Legal & Risk Services and the Welsh Government. The membership includes:

Chairman: Chairman of NWSSP
Members: Managing Director, NWSSP
Director Legal & Risk Services, NWSSP
Director of Finance & Corporate Services, NWSSP
Health Board or Trust Chair (1)
Health Board or Trust Chief Executive (1)
Health Board or Trust Medical Director (1)
Health Board or Trust Director of Nursing (1)
Health Board or Trust Director of Finance (1)
Health Board Director of Therapies & Health Science (1)
Health Board or Trust Chair Audit Committee Chair (1)
Health Board or Trust Board Secretary (1)
Health Board Director of Primary Care and Mental Health
Welsh Government (2)
Health Board Associate Medical Director – Primary Care
GP Advisor
In attendance:
NWSSP – WRPS Head of Finance
NWSSP - WRPS Head of Safety and Learning
WRPS Operations Team
WRPS Safety and Learning Team

2.03 Other individuals may be involved at the discretion of the Chairman (e.g. representatives from NSAGs as appropriate). The WRPC shall appoint a vice chairman from the agreed membership. The vice-chair shall deputise for the Chair in their absence for any reason.

2.04 In the event that a member of the WRPC is unable to attend a meeting he/she is required to seek a suitable person to attend on their behalf.

3. Dealing with Members' interests during meetings

3.01 The Chair, advised by the Committee Secretariat, must ensure that the WRPC's decisions on all matters brought before it are taken in an open, balanced, objective and unbiased manner. In turn, individual members must demonstrate, through their actions, that their contribution to the WRPC's decision making is based upon the best interests of the NHS in Wales.

3.02 Where individual members identify an interest in relation to any aspect of business set out in the meeting agenda, that member must declare an interest at

the start of the meeting. Members should seek advice from the Chair, through the Committee Secretariat before the start of the meeting if they are in any doubt as to whether they should declare an interest at the meeting. All declarations of interest made at a meeting must be recorded in the minutes. It is responsibility of the chair, on behalf of the Committee, to determine the action to be taken in response to the declaration of interest, this can include excluding the member, where they have a direct or indirect financial interest or participating fully in the discussion but taking no part in the WRPC decision.

4. Quorum

4.01 A quorum shall be the Chairman or Vice Chair and at least 4 other representatives, 2 of which must be officer members of shared services and 2 of which must be NHS Trust or LHB representatives.
Repeated non-attendance will be reported to the NWSSP Committee.

5. Frequency of Meetings

5.01 Meetings will be held at least 8 times per year, with additional meetings held if considered necessary.

6. Authority

6.01 The Accountable Officer for NWSSP is authorised to carry out any activity within the terms of reference and the scheme of delegation. In the normal course of WRPC business items included on the agenda are subject to discussion and decisions based on consensus. Decisions made by the Accountable Officer against that recommended by the WRPC will be reported to the NWSSP Committee and the Velindre NHS Trust Audit Committee for Shared Services.

6.02 The WRPC may, establish sub groups or task and finish groups as appropriate to address specific issues and to carry out on its behalf specific aspects of business.

7. Responsibilities of the WRPC

7.01 It is important that there is clarity between the role of the WRPC and that of the NWSSP Committee. The NWSSP Committee will have overall responsibility for overseeing the governance arrangements within WRPS and in support of this function the minutes of the WRPC will be forwarded for information and assurance including the highlighting of matters of significance.

7.02 The role of the WRPC is to:

a) Receive assurance on the management of delegations for areas of

responsibility detailed within this Terms of Reference and to report regularly to the Shared Services Partnership Committee on performance;

b) Undertake actions reserved specifically for the WRPC;
c) To provide advice and guidance to the NWSSP Accountable Officer on claims reimbursement decisions; and
d) To support and promote a learning culture within NHS Wales.

8. WRPS areas of responsibility

8.01 The main areas of responsibility for which WRPS will be held to account by the WRPC are:

- To present key financial and performance information.
- To develop an effective and efficient process including technical notes for the receipt of claims and reimbursement of monies to NHS Wales.
- To ensure that there are effective processes for the forecasting of resource requirements over the short and medium term and that there is sufficient liquidity to meet obligations.
- To ensure that the transactions of the WRPS are fully recorded and that financial accounts are produced in accordance with the timetable set by the Welsh Government.
- To undertake regular assessments of the arrangements for the management of Concerns and Claims by NHS Wales.
- To undertake regular assessments of the arrangements for the management of GMPI claims by NHS Wales.
- To undertake the assessments of high risk clinical areas as required by Chief Executives of NHS Wales Bodies.
- To develop processes for learning from events and cascading information to all NHS Wales Bodies including undertaking detailed reviews of claims and identifying trends arising from claims.
- To undertake project work as required by the WRPC.
- To develop a process for the scrutiny of claims and Redress cases presented to each WRPC to provide assurance across NHS Wales that appropriate action has been taken to reduce the risk of recurrence. This process should have regard for the number and complexity of claims being presented to ensure that sufficient consideration is given to issues arising.
- To develop an effective and efficient process for handling and responding to enquiries in relation to indemnity and reimbursement matters.

9. WRPC reserved matters

- To approve the reimbursement of claims and Redress cases and impose penalties in accordance with the Reimbursement Procedures

- To enact the risk sharing arrangements (not currently applicable to GMPI and Redress) as agreed by the NWSSP
- To receive and consider the annual statements of account
- To receive and consider the annual assessment reports and to approve recommendations for any necessary action.
- To receive and consider the outcome of claims reviews and to approve recommendations for any necessary action.
- To agree on a communication strategy across NHS Wales to ensure that learning from events is captured and communicated appropriately.
- To consider advice and guidance on matters of indemnity which are novel, contentious or expose NHS Wales to significant risk.
- To request claims reviews where the WRPC considers appropriate in order that lessons can be learnt on an All Wales basis.
- To ensure that arrangements are in place to enable the reporting of key issues and trends via the National Quality and Safety Forum.

10. Support and promote a learning culture across NHS Wales

10.1 The members of the WRPC will have collective responsibility for ensuring that the learning from events is formally considered and that a culture of improvement across NHS Wales is fostered. This will include providing advice and guidance at each meeting and where necessary taking action to address weaknesses identified, either at an individual organisational level or at a more strategic level.

11. Reporting Arrangements

11.01 Minutes shall be taken at each meeting and circulated to all members of the WRPC and to the NWSSP Committee for information.

11.02 Risk sharing arrangements will be agreed by the NWSSP Committee.

11.03 Regular financial reports on the risk sharing forecasting will be considered by the Shared Services Committee and provide to Welsh Government as and when required.

11.04 Annual presentations will be made to the groups identified by the WRPC (e.g. Chief Executives, Directors of Finance, Directors of Nursing and Medical Directors).

12. Audit Arrangements

12.01The WRPS will be subject to audit by both internal and external auditors. The external auditors of Velindre NHS Trust will ensure that there is overall audit coverage of claims management across the NHS in Wales.

13. Associated documents

- All Wales Policy on Indemnity and Insurance
- Scope of the Risk Pooling Arrangements
- WRPS Reimbursement Procedures

2. Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership - Terms of Reference July 2019

1. BACKGROUND

1.1 In May 2012, all Health Boards and Trusts approved the Standing Orders for Shared Services Partnership Committee. Section 4.0.3 of the Standing Orders (as amended 1 March 2019) states:

*"The SSPC shall establish a Sub-Committee structure that meets its own advisory and assurance needs and/or **utilise Velindre's Committee arrangements** to assist in discharging its governance responsibilities."*

These Terms of Reference set out the arrangements for utilising the Velindre University NHS Trust Audit Committee to support the discharge of those relevant functions in relation to NHS Wales Shared Services Partnership (NWSSP).

ORGANISATIONAL STRUCTURE

Velindre University NHS Trust has an interest in NWSSP on two levels:

a) The internal governance of NWSSP in relation to the host relationship; and
b) As a member of NWSSP Committee in relation to the running of national systems and services.

In 2012, it was agreed that the Velindre Audit Committee would be utilised to act on behalf of NWSSP Committee, that there would be a clear distinction between these two areas/functions and that they would be addressed separately under the Audit Committee arrangements. This 'functional split' allows for clear consideration of the issues relating specifically to the business of the nationally run systems and national services that are provided by NWSSP and avoids the boundaries between the governance considerations of the hosting relationship and the governance considerations of NWSSP being blurred.

The functional split can be illustrated overleaf:

(a) Governance (Host Relationship)	(b) Nationally Run Systems & Services
1 Velindre University NHS Trust 2 Audit Committee	Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership

The governance and issues relating to the hosting of NWSSP dealt with in **(a)** will be incorporated into the standard business of the existing Velindre University NHS Trust Audit Committee, with a specific focus on alternating Trust Audit Committee business. The assurance for the business dealt with in **(a)** will be to the Velindre University NHS Trust Board. The Chair of NWSSP Audit Committee should receive copies of the meeting papers and will be invited to attend if there is anything on the agenda which has implications for the Shared Services Partnership Committee (SSPC).

Issues relating to NWSSP nationally run systems and services **(b)** will be fed into a separate Velindre University NHS Trust Audit Committee for NWSSP operating within its own work cycle. The assurance for the business dealt with in **(b)** will be to NWSSP Chair and the NWSSP Audit Committee, via the communication routes, detailed below.

The arrangements for **(a)** above, will not be considered further within these Terms of Reference, as it is for Velindre University NHS Trust Audit Committee to determine the relevant assurance required in relation to the host relationship.

This document goes on to outline the Terms of Reference for **(b)**, above.

2. INTRODUCTION

2.1 Velindre University NHS Trust's Standing Orders provide that "*The Board may and, where directed by the Welsh Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees*".

2.2 In line with Standing Orders and NWSSP's scheme of delegation, the SSPC shall nominate, annually, a Committee to be known as the Velindre University NHS Trust Audit Committee for NWSSP. The detailed Terms of Reference and Operating Arrangements in respect of this Committee are set out below.

2.3 These Terms of Reference and Operating Arrangements are based on the model Terms of Reference, as detailed in the NHS Wales Audit Committee Handbook, June 2012.

3 PURPOSE

3.1 The purpose of the Audit Committee ("the Committee") is to:

- ***Advise*** and ***assure*** the SSPC and the Accountable Officer on whether effective arrangements are in place - through the design and operation of NWSSP's **system of assurance** - to support them in their decision taking and in discharging their accountabilities for securing the achievement of the organisation's objectives, in accordance with the standards of good governance determined for the NHS in Wales.

Where appropriate, the Committee will advise the Velindre University NHS Trust Board and SSPC as to where and how its system of assurance may be strengthened and developed further.

4 DELEGATED POWERS AND AUTHORITY

4.1 With regard to its role in providing advice to both Velindre University NHS Trust Board and the SSPC, the Audit Committee will comment specifically upon:

- The adequacy of NWSSP's strategic governance and assurance arrangements and processes for the maintenance of an effective system of good governance, risk management and internal control across the whole of the organisation's activities, designed to support the public disclosure statements that flow from the assurance processes (including the Annual Governance Statement) and providing reasonable assurance on:

  - NWSSP's ability to achieve its objectives;
  - Compliance with relevant regulatory requirements, standards, quality and service delivery requirements, other directions and requirements set by the Welsh Government and others;
  - The reliability, integrity, safety and security of the information collected and used by the organisation;
  - The efficiency, effectiveness and economic use of resources; and
  - The extent to which NWSSP safeguards and protects all of its assets, including its people.

- NWSSP's Standing Orders, and Standing Financial Instructions (including associated framework documents, as appropriate);
- The planned activity and results of Internal Audit, External Audit and the Local Counter Fraud Specialist (including Strategies, Annual Work Plans and Annual Reports);
- The adequacy of executive and management's response to issues identified by audit, inspection and other assurance activity, via

monitoring of NWSSP's Audit Action Plan;

- Proposals for accessing Internal Audit service (where appropriate);
- Anti-fraud policies, whistle-blowing processes and arrangements for special investigations as appropriate; and
- Any particular matter or issue upon which the SSPC or the Accountable Officer may seek advice.

4.2 The Audit Committee will support the SSPC with regard to its responsibilities for governance (including risk and control) by reviewing:

- All risk and control related disclosure statements (in particular the Annual Governance Statement together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances), prior to endorsement by the SSPC;
- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct and accountability requirements; and
- The policies and procedures for all work related to fraud and corruption as set out in Welsh Government Directions and as required by NHS Protect.

4.3 In carrying out this work, the Audit Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of good governance, risk management and internal control, together with indicators of their effectiveness.

4.4 This will be evidenced through the Audit Committee's use of effective governance and assurance arrangements to guide its work and that of the audit and assurance functions that report to it, and enable the Audit Committee to review and form an opinion on:

- The ***comprehensiveness*** of assurances in meeting the SSPC and the Accountable Officer's assurance needs across the whole of the organisation's activities; and
- The ***reliability and integrity*** of these assurances.

4.5 To achieve this, the Audit Committee's programme of work will be designed to provide assurance that:

- There is an effective internal audit function that meets the standards set for the provision of internal audit in the NHS in Wales and provides appropriate independent assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There is an effective Counter Fraud service that meets the standards set for the provision of counter fraud in the NHS in Wales and provides appropriate assurance to the SSPC and the Accountable Officer through the Audit Committee;
- There are effective arrangements in place to secure active, ongoing assurance from management with regard to their responsibilities and accountabilities, whether directly to the SSPC and the Accountable Officer or through the effective completion of Audit Recommendations and the Audit Committee's review of the development and drafting of the Annual Governance Statement;
- The work carried out by key sources of external assurance, in particular, but not limited to the SSPC's external auditors, is appropriately planned and co-ordinated and that the results of external assurance activity complements and informs (but does not replace) internal assurance activity;
- The work carried out by the whole range of external review bodies is brought to the attention of the SSPC and that the organisation is aware of the need to comply with related standards and recommendations of these review bodies, together with the risks of failing to comply;
- The systems for financial reporting to the SSPC, including those of budgetary control, are effective; and
- The results of audit and assurance work specific to the organisation and the implications of the findings of wider audit and assurance activity relevant to the SSPC's operations, are appropriately considered and acted upon to secure the ongoing development and improvement of the organisation's governance arrangements.

In carrying out this work, the Audit Committee will follow and implement the Audit Committee for Shared Services Annual Work Plan and will be evidenced through meeting papers, formal minutes, and highlight reports to the SSPC, Velindre Trust Board and annually, via the Annual Governance Statement, to the Velindre University NHS Trust's Chief Executive.

Authority

4.6 The Audit Committee is authorised by the SSPC to investigate or to have investigated any activity within its Terms of Reference. In doing so, the Audit Committee shall have the right to inspect any books, records or documents of NWSSP, relevant to the Audit Committee's remit and ensuring patient/client and staff confidentiality, as appropriate. It may seek relevant information from any:

- Employee (and all employees are directed to co-operate with any reasonable request made by the Audit Committee); and
- Any other Committee, Sub Committee or Group set up by the SSPC to assist it in the delivery of its functions.

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

Access

4.8 The Head of Internal Audit and the Audit Manager of External Audit shall have unrestricted and confidential access to the Chair of the Audit Committee at any time and the Chair of the Audit Committee will seek to gain reciprocal access as necessary.

4.9 The Audit Committee will meet with Internal and External Auditors and the nominated Local Counter Fraud Specialist, without the presence of officials, on at least one occasion each year.

4.10 The Chair of Audit Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

4.11 The Audit Committee may, subject to the approval of the SSPC, establish Sub Committees or Task and Finish Groups to carry out on its behalf specific aspects of Committee business. Currently, there is an established Welsh Risk Pool Committee which is a Sub Committee of the SSPC, however, there are no Sub Committees of the Audit Committee.

5 MEMBERSHIP

Members

5.1 A minimum of 3 members, comprising:

Chair	Independent member of the Board
Members	Two other independent members of the Velindre Trust Board.

The Audit Committee may also co-opt additional independent 'external' members from outside the organisation to provide specialist skills, knowledge and expertise.

The Chair of the organisation shall not be a member of the Audit Committee.

Attendees

5.2 In attendance:

NWSSP Managing Director, as Accountable Officer
NWSSP Chair
NWSSP Director of Finance & Corporate Services
NWSSP Director of Audit & Assurance
NWSSP Head of Internal Audit
NWSSP Audit Manager
NWSSP Head of Finance and Business Development
NWSSP Corporate Services Manager
Representative of Velindre University NHS Trust
Local Counter Fraud Specialist
Representative of the Auditor General for Wales
Other Executive Directors will attend as required by the Committee Chair

By invitation The Committee Chair may invite:

- any other Partnership officials; and/or
- any others from within or outside the organisation

to attend all or part of a meeting to assist it with its discussions on any particular matter.

The Velindre Chief Executive Officer should be invited to attend, where appropriate, to discuss with the Audit Committee the process for assurance that supports the Annual Governance Statement.

Secretariat

Secretary As determined by the Accountable Officer

Member Appointments

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

5.4 Members shall be appointed to hold office for a period of four years. Members may be re-appointed, up to a maximum of their term of office. During this time a member may resign or be removed by the Velindre Trust Board.

5.5 Audit Committee members' Terms and Conditions of Appointment, (including any remuneration and reimbursement) are determined on appointment by the Minister for Health and Social Services.

Support to Audit Committee Members

5.6 The NWSSP Head of Finance and Business Development and NWSSP Corporate Services Manager, on behalf of the Audit Committee Chair, shall:

- Arrange the provision of advice and support to Audit Committee members on any aspect related to the conduct of their role
- Ensure that Committee agenda and supporting papers are issued 5 working days in advance of the meeting taking place; and
- Ensure the provision of a programme of organisational development for Audit Committee members as part of the Trust's overall Organisational Development programme developed by the Velindre Executive Director of Workforce & Organisational Development.

6 AUDIT COMMITTEE MEETINGS

Quorum

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

Frequency of Meetings

6.2 Meetings shall be held no less than quarterly and otherwise as the Chair of the Audit Committee deems necessary, consistent with NWSSP's Annual Plan of Business. The External Auditor or Head of Internal Audit may

request a meeting if they consider that one is necessary.

Withdrawal of Individuals in Attendance

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

7 RELATIONSHIP & ACCOUNTABILITIES WITH THE TRUST BOARD & SSPC DELEGATED TO THE AUDIT COMMITTEE

7.1 Although the Velindre Trust Board, with the SSPC and its Sub Committees, including the Welsh Risk Pool Sub Committee, has delegated authority to the Audit Committee for the exercise of certain functions as set out within these Terms of Reference, it retains overall responsibility and accountability for ensuring the quality and safety of healthcare for its citizens through the effective governance of the organisation.

7.2 The Audit Committee is directly accountable to the Velindre Trust Board for its performance in exercising the functions set out in these Terms of Reference.

7.3 The Audit Committee, through its Chair and members, shall work closely with NWSSP and its other Sub Committees to provide advice and assurance to the SSPC by taking into account:

- Joint planning and co-ordination of the SSPC business; and
- Sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into NWSSP's overall risk and assurance arrangements. This will primarily be achieved through the discussions held at the SSPC, annually, at the end of the financial year.

7.4 The Audit Committee will consider the assurance provided through the work of the SSPC's other Committees and Sub Committees to meet its responsibilities for advising the SSPC on the adequacy of the organisation's overall system of assurance by receipt of their annual work plans.

7.5 The Audit Committee shall embed the SSPC's and Trust's corporate standards, priorities and requirements, e.g. equality and human rights, through the conduct of its business.

8 REPORTING AND ASSURANCE ARRANGEMENTS

8.1 The Audit Committee Chair shall:

- Report formally, regularly and on a timely basis to the Board, SSPC and the Accountable Officer on the Audit Committee's activities. This includes verbal updates on activity and the submission of committee minutes, and written highlight reports throughout the year;
- Bring to the Velindre University NHS Trust Board, SSPC and the Accountable Officer's specific attention any significant matters under consideration by the Audit Committee; and
- Ensure appropriate escalation arrangements are in place to alert the SSPC Chair, Managing Director (and Accountable Officer) or Chairs of other relevant Committees, of any urgent/critical matters that may affect the operation and/or reputation of the organisation.

8.2 The Audit Committee shall provide a written Annual Report to the SSPC and the Accountable Officer on its work in support of the Annual Governance Statement, specifically commenting on the adequacy of the assurance arrangements, the extent to which risk management is comprehensively embedded throughout the organisation, the integration of governance arrangements and the appropriateness of self-assessment activity against relevant standards. The report will also record the results of the Audit Committee's self-assessment and evaluation.

8.3 The Velindre Trust Board and SSPC may also require the Audit Committee Chair to report upon the Audit Committee's activities at public meetings or to community partners and other stakeholders, where this is considered appropriate, e.g. where the Audit Committee's assurance role relates to a joint or shared responsibility.

8.4 The NWSSP Head of Finance and Business Development and Corporate Services Manager, on behalf of the Partnership, shall oversee a process of regular and rigorous self-assessment and evaluation of the Audit Committee's performance and operation, including that of any Sub Committees established. In doing so, account will be taken of the requirements set out in the NHS Wales Audit Committee Handbook.

9 APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

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

- Quorum *(as per section on Committee meetings)*

- Notice of meetings
- Notifying the public of meetings
- Admission of the public, the press and other observers

10 REVIEW

10.1 These Terms of Reference and operating arrangements shall be reviewed annually by the Audit Committee with reference to the SSPC and Velindre Trust Board.

Annexe 4

ADVISORY GROUPS AND EXPERT PANELS

Terms of Reference and Operating Arrangements

This Annexe forms part of, and shall have effect as if incorporated in the SSPC Standing Orders

1. Evidence Based Procurement Board (EBPB)

1. Terms of Reference of the Evidence Based Procurement Board (EBPB) of the NHS Wales Shared Services Partnership (NWSSP) (August 2018)

1. Aims and Objectives

The Board shall be known as the 'Evidence Based Procurement Board' (EBPB), and will consist of professionals from across various disciplines within NHS Wales and appropriate research bodies, making recommendations and guidance for implementation by the Welsh NHS**.**

The EBPB advises, promotes, develops and implements value and evidence based procurement of medical technologies for NHS Wales. The group will assist with rationalisation and standardisation in line with Prudent healthcare principles, underpinned with the "*Once for Wales*" philosophy, and will assess whether NHS Wales should discard devices/technologies if they are deemed inappropriate or wasteful.

The EBPB will produce advice and guidance to support planning and decision making in Local Health Boards and Trusts.

The EBPB shall provide advice, guidance and recommendations to the Shared Services Committee and the WG Efficiency Healthcare Value & Improvement Group.

The EBPB will support NHS Wales core values through the assessment of quality and safety elements of medical technologies; using this to provide high value evidence based care whilst reducing harm. In addition, through the rationalisation and standardisation programme, the EBPB will enable reduced variation and waste. It also specifically supports the 2018 report "*A Healthier Wales: our Plan for Health and Social Care*" principles of "Higher value" (better outcomes, better experience at reduced cost, less variation and no harm) and "Evidence driven" (the use of research, knowledge and information to understand what works).

In line with the emphasis of "Value" in "*A Healthier Wales*", the EBPB will play a key role in assisting the delivery of the Value Based Health Care agenda across the NHS in Wales.

It is acknowledged that there will be some areas that will be of mutual interest to Health Technology Wales (HTW) and these will be addressed through discussion with appropriate representatives.

2. MEMBERSHIP

Membership will be endorsed by Welsh Government and made up of senior

professionals from NHS Wales and academia. The EBPB will consist of both voting and non-voting members. Membership is as follows;

- Chair - Medical Director/Assistant MD - Stephen Edwards
- NWSSP Director (SRO) - Mark Roscrow
- Finance Director - Hywel Jones
- Health Economist - Pippa Anderson
- Director of SMTL - Pete Phillips
- Health Technology Wales - Susan Myles
- Procurement Services - Andy Smallwood
- Deputy Executive Nurse Director - Jason Roberts
- Secondary Care Clinician - Paul Morgan
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician - Dr Sally Lewis
- Value Based Care/National Lead VBP - Adele Cahill
- Academic Clinician - Prof Haray
- Academia - Sam Evans
- NWSSP MD - Neil Frow

Non-voting members may be invited to attend as and when appropriate;

- Individuals co-opted for advice on specialist category areas, including Clinical networks and clinicians locally.
- Nominated experts from Evidence Research Group

Secretariat

- NHS Wales Shared Services Partnership – Procurement Services
- NHS Wales staff may request to attend as observers by writing in advance to the Chair.

Deputies

In the event of a voting member not being in attendance, an agreed named deputy should attend. The EBPB will approve deputies for all voting members of the group, (Chair excluded). A Vice Chair will be appointed in accordance with *Point 4.*

3. OFFICERS

The Chair will normally be a Medical Director/ Assistant Medical Director, appointed by the EBPB and approved by Welsh Government whose term of office shall normally be between 1-5 years. They will be eligible for re-appointment for an additional term of office, but the total period cannot exceed 10 years.
A Vice-Chair will be elected from the voting members. The Vice Chair or in their

absence, another voting member may preside over meetings in the absence of the Chair.

4. MEETINGS

The EBPB will meet a minimum of 4 times per year, and roles and responsibilities of members should be readily available to any relevant party on request.

5. DECLARATION OF INTEREST

Members MUST declare, in advance any financial and/or personal interests, to any related matter that is subject of consideration. Any declarations made and/or actions taken will be noted in the minutes.

6. VOTING

Any issues/questions should be resolved by consensus. Only voting members will have voting rights. Deputies will be eligible to vote. The Chair will not normally vote on matters however in the case of equality of votes, the Chair or person presiding as Chair will have the casting vote. Members with a conflict of interest in a specific Topic, including members who have had a significant role in the preparation of the submissions being considered, will not cast a vote for that Topic.

7. QUORUM

Quorum will be 50% of voting members.

8. VALIDITY OF PROCEEDINGS/MEMBERSHIP VACANCIES

Validity of proceedings of the EBPB is not affected by a vacancy or defect in the appointment of a member of deputy. Membership of the EBPB shall end if;

- Members resign by giving notice in writing to the Chair of the EBPB
- Absenteeism from 3 consecutive ordinary meetings; unless the EBPB is satisfied that absence is due to reasonable cause
- Ceases to belong to the body they represent
- Term of office expires

9. EVIDENCE REVIEW GROUP (ERG)

The ERG is a standing committee which reports to the EBPB. Staff from SMTL and ProcS form the core membership who will undertake the day to day workload for the ERG.

The ERG will also include experts in Health Economics and Human Factors from

Swansea University as and when required.

The ERG will liaise with other researchers and analysts as and when required, including partnering with HTW staff.

Expert Membership - The ERG will recruit expert members as and when required to provide clinical and domain-specific advice and expertise. Expert members may include Clinical experts from NHS Wales and Welsh Government National Special Advisory Groups (NSAGs).

10. POWERS OF THE EBPB

- The EBPB may require the Evidence Review Group (ERG) to convene meetings of expert advisors.
- The work and meetings of the ERG and expert advisors should be reported to the EBPB.
- The ERG should operate in an advisory role to the EBPB.
- The EBPB may seek independent advice as and when appropriate.
- The EBPB may commission external bodies to evaluate evidence in relation to products.
- The EBPB and ERG will incur the minimum necessary expenditure to enable their work to be carried out. These expenses will be considered and administered by NWSSP Shared Services Procurement Services.
- Nominated experts from the ERG may be required to attend meetings of the EBPB.

11. GOVERNANCE AND ACCOUNTABILITY

The EBPB is accountable to the NWSSP committee and will utilise NWSSP's governance structures.

12. ROLES AND RESPONSIBILITIES

- Support the rationalisation and standardisation agenda in line with prudent Healthcare principles.
- Review evaluations and evidence assessments of medical technologies.
- Develop a work programme determined by Health Boards/Trusts, Welsh Risk Pool and other stakeholders.
- Provide advice to stakeholders regarding new or innovative products for use across NHS Wales in consultation with HTW.
- Liaise with Academia on the EBPB work programme, including product development initiatives where appropriate.
- Participate in horizon scanning with other agencies such as HTW and advise on the potential impact for the NHS.

- Provide advice on clinical pathways/treatments where devices and consumables are part of the clinical process, complimenting and supporting the work of NICE.
- Receive for consideration into the work programme topics referred by WG and other key stakeholders. This will include liaison with HTW's Front Door Group.
- Liaise and engage with professional peers.
- Produce an Annual report for review by NHS Wales and Shared Services Partnership Committee.
- Consider NICE guidance and Do Not Do recommendations when developing the work programme.
- Develop mechanisms to audit adoption of the EBPB advice.

13. GROUP STRUCTURE & METHODS

A separate document is available detailing the structure and working methodology of the EBPB and other structures.

Annexe 5

Process for the Selection, Appointment and Termination of the Chair of the SSPC

This Annexe forms part of, and shall have effect as if incorporated in the SSPC SOs

The Shared Services Partnership Committee (SSPC) has the responsibility for appointing the Chair of the SSPC. Whist the appointment is not a Ministerial appointment the planned process will take account of the appointment principles outlined in the –"Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

MAIN BODY

In line with the Governance Code on Public Appointments to Public Bodies 2016 the principles of public appointments are summarised below:

A. **Ministerial responsibility** - The ultimate responsibility for appointments and thus the selection of those appointed rests with Ministers who are accountable to Parliament for their decisions and actions. Welsh Ministers are accountable to Welsh Government.

B. **Selflessness** - Ministers when making appointments should act solely in terms of the public interest.

C. **Integrity** - Ministers when making appointments must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

D. **Merit** - All public appointments should be governed by the principle of appointment on merit. This means providing Ministers with a choice of high quality candidates, drawn from a strong, diverse field, whose skills, experiences and qualities have been judged to meet the needs of the public body or statutory office in question.

E. **Openness** - Processes for making public appointments should be open and transparent.

F. **Diversity** - Public appointments should reflect the diversity of the society in which we live and appointments should be made taking account of the need to appoint boards which include a balance of skills and backgrounds.

The essential features of the process will include the following:

- A panel must be set up to oversee the appointments process;
- The panel must be chaired by an independent assessor;
- An agreed selection process, selection criteria and publicity strategy for a successful appointment;
- A panel report must be prepared, signed by the chair of the appointment panel; and
- The appointment of the successful candidate must be publicised.

It is important that all public appointees uphold the standards of conduct set out in the Committee on Standards in Public Life's Seven Principles of Public Life. The panel must satisfy itself that all candidates for appointment can meet these standards and have no conflicts of interest that would call into question their ability to perform the role.

The selection panel will comprise of the following members:

- 3 members of the SSPC; and
- NWSSP Director of Workforce and Organisational Development

The appointment process is managed by the NWSSP Director of Workforce and Organisational Development.

A suite of supporting documentation has been developed to support the process.

The job **advertisement.** It is proposed that, in line with the practice adopted by Welsh Government for all other public appoints this post is advertised on Job Wales which is the Western Mail and Daily Post on-line publication.

The candidate application **form**. The content and format very closely mirrors the application form currently used by the Welsh Government for Ministerial Public Appointments.

A **briefing pack** for candidates. This includes details of the role profile and person specification.

Governance and Risk Issues

Whist the appointment is not a Ministerial appointment, the planned process will

take account of the appointment principles outlined in the "Governance Code on Public Appointments" which came into effect on 1st January 2017 and sets out the regulatory framework for public appointments.

The appointment documentation and processes has been reviewed and agreed by the Director of Governance & Corporate Services/Board Secretary at Cwm Taf Morgannwg UHB who is a member of the SSPC; and has also been provided to the Director of Corporate Governance/Board Secretary at Velindre University NHS Trust to ensure that the appointment aligns to Velindre's governance requirements.

The selection process will be repeated following each maximum term of office for the Chair of the SSPC, or when the Chair resigns, or following removal of the Chair by termination.

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 2020, 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 National Health Service Trust Shared Services Committee (Wales) Regulations 2012.

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.

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

TRUST BOARD

CHAIR'S URGENT ACTION MATTER REPORT

DATE OF MEETING	30/7/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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 NOTING**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Item 1 • Donna Mead, Trust Chair • Carl James, Acting CEO • Gareth Jones, Independent Member • Martin Veale, Independent Member	1/7/2020	APPROVED
Item 2 • Chair, Prof Donna Mead • Mr Mark Osland, Acting CEO at the time • Mr Martin Veale, Independent Member • Ms Sarah Morley, Executive Director of WF&OD • Mrs Hilary Jones, Independent Member • Mr Stephen Harries, Independent Member	2/7/2020	APPROVED

ACRONYMS	
	Nil Identified.

1. SITUATION/BACKGROUND

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

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

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

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Committee is asked to **NOTE** the Chairs urgent action taken since the January 2020 Trust Board Meeting as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action during the 25th June – 30th July 2020.

1. NWSSP - Purchase of COVID 19 FFP3 Masks & Nitrile Gloves

The Trust Board were sent an email on the 1st July 2020, inviting the Board to **AUTHORISE** expenditure in relation to the Purchase of COVID 19 FFP3 Masks & Nitrile Gloves.

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

Recommendation Approved:

- Donna Mead, Trust Chair
- Carl James, Acting CEO
- Gareth Jones, Independent Member
- Martin Veale, Independent Member

No objections were received.

2. Quarter 2 Operational Plan to be considered under for Chairs Urgent Action

The Trust Board were sent an email on 2nd July 2020, inviting the Board to **AUTHORISE** the submission of the draft plan to Welsh Government by the submission deadline of 3rd July. This allowed the Trust the time to have a further discussion with the CHC and make final cosmetic changes.

Recommendation Approved:

- Chair, Prof Donna Mead
- Mr Mark Osland, Acting CEO at the time
- Mr Martin Veale, Independent Member
- Ms Sarah Morley, Executive Director of WF&OD
- Mrs Hilary Jones, Independent Member
- Mr Stephen Harries, Independent Member

No objections to approval received.

VELINDRE UNIVERSITY NHS TRUST

Building the Future and Delivering the Present

Key Areas of Focus for the Rest of the Year

- Developing Quarter 3, Quarter 4, and Next Year Plan
- Developing the Strategic Direction for the Trust
- Reshaping How We Work

- In the context of our initial response to COVID-19

Developing Our Operational Plans

- Key issue is uncertainty on what to plan for
- Need to be flexible and react quickly to changing circumstances
- Demand already returning to pre covid levels for services
- Need to respond to changes in our demand
  - Reinstating capacity
  - Seek out additional capacity opportunities
- However, social distancing requirements and potential for second wave need to be built into our plans and will impact
- Need to do this in partnership with our patients

Building Our Strategic Direction

- Already begun this work pre COVID now being re-invigorated to ensure that we complete this this year
- We are developing a series of plans which set out:
  - Our ambitions for blood and transplantation services for 2025
  - Our ambitions for non-surgical cancer services by 2025
  - How support services will be prioritised and aligned to support services to deliver these plans
- We are also shaping our Trust strategy long term goals for 2030
- Engaged with about 200 staff across the Trust in workshops prior to COVID
- Now re-commencing the engagement process, making use of agile and digital mechanisms
- Board will continue to be updated on the outcomes of the wider engagement process to inform the Board's decisions on the strategic direction setting over the coming months
- We also continue to work with Government and NWIS to establish the new Special Health Authority

Reshaping How We Work

- Learning from COVID response
- Beyond Business as Usual (BBAU)
  - Committee Structures and Executive Management Board
  - Trust Assurance Framework and Risk strategy and framework
  - Organisational Development programme for the Board and Executive Team
- Management Arrangements
  - Around COO
  - VCC
  - The way we work across the Trust not just structurally to continue to support an agile and responsive way of working built under our initial COVID response
  - Alongside governance arrangements
  - Development of our communications and engagement
- Building on the strong base that we already have including staff commitment, values, and behaviours

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	30/7/2020

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 Briefing on 9th July
- Integrated Governance Group on 9th July
- Board briefing on 27th August
- Session to reflect on the Covid-19 response period
- Academic Partnership Board

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Board Briefing on 9th July

2.1.1 The Chair would like to summarise the key items discussed in the Board Briefing on 9th July.

2.1.2 Firstly the Chair would like to thank Nicola Williams, Executive Director Nursing, Allied Health Professional and Health Scientists and Steve Alan from the Community Health Council for their excellent update on the Health and Social Care (Quality and Engagement) (Wales) Bill. It is planned for the Act to come into force in spring 2022 and the Board will be kept up to date on the implications and changes required for the Trust and the way in which we work with key stakeholders.

2.1.3 The Board had a discussion on the potential future direction of the Committee structure based on proposals from the Executive team. The Board agreed that they would like the opportunity to discuss the proposals at the Trust Board in September, with a view to changes agreed being implemented from October 2020. The principles driving the Board are to review our arrangements to ensure that the core functions are most effectively met in the post Covid era, in terms of; formulation of strategic direction; establishing and upholding the governance and accountability framework; Ensuring delivery of the organisation's aims/objectives through effective challenge and scrutiny of the Trust's performance; and shaping the culture of the organisation.

2.2 Integrated Governance Group on 9th July

2.2.1 The Chair would like to summarise the key items discussed at the Integrated Governance Group on 9th July. The Integrated Governance Group includes Independent Members, the CEO and Director Corporate Governance.

2.2.2 The session was focused on exploring the role of Independent Members and in particular the role of "champions." There are a number of different elements contributing to the context of this discussion, including: reflection on how the proposed change in Committee structure will impact the time Independent Members are spending in Committee meetings; the excellent feedback from the Listening and Learning Sub-Committee set up and more Independent Members wanting to have further opportunity for this style of engagement and means of assurance; new Independent Members of the Board and the need to realign responsibilities; the framework of "champion" roles has not had more fundamental review for some time and therefore the desire to ensure it effectively aligns to the strategic direction, priorities and risks for the organisation.

2.2.3 The Chair will continue to work with the Director Corporate Governance and Independent Member colleagues to develop this work in parallel to the development of proposed Committee structure changes to discuss with the Board in September Trust Board meeting.

2.3 Board briefing on 27th August

2.3.1 The Chair would like to update the Board on the planned focus for the Board briefing on 27h August

2.3.2 There will be a workshop on Risk Appetite. This will be an opportunity for Board development time on risk appetite and how it can be used most effectively in the structure and framework of strategic, risk and corporate governance frameworks. The refreshed risk appetite levels and the newly created Risk Appetite Strategy will then be coming to the Board in September for approval.

2.3.3 Further development of the capacity and demand modelling for cancer services will also be discussed with the Board in order to update on this work and how the implications for decision making and formal assurance will then be brought into the Board and Committee structure over the next period.

2.3.4 There will also be further discussion on the Board Champion role.

2.4 Session to reflect on the Covid-19 response period

2.4.1 Silver and Bronze levels of the command structure of the Covid-19 response have held sessions to review and reflect on the structures and processes in place during that period. This is to ensure any lessons learnt are acted upon and also to help build further insight on the areas which the organisation would like to ensure are built into standard ways of working. The Gold session is due to be held shortly.

2.4.2 The Chair would like to update the Board that, in agreement with the CEO, that following the Gold session, there will be an additional review held with the Board so that the whole Board can also reflect on it's role in the structure and ensure further observations and views are also captured. The Board will be updated on the plans for this session shortly.

2.5 Academic Partnership Board

2.5.1 Although there will be a highlight report later in the agenda, the Chair would like to emphasise her thanks to all partners, colleagues from outside the organisation and staff within the Trust for a very positive inaugural meeting. We were fortunate to have such a fantastic representation from our academic partners, each bringing a unique strength and area of expertise. Staff from across the Trust were able to highlight the immense progress across the research, development and innovation agendas. Ways of working together were also discussed and the progress and value this will bring to the organisation will continue to be updated to the Board.

3. IMPACT ASSESSMENT

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

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

4. RECOMMENDATION

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

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	30/7/2020

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;

- Preparing for the next phase as an organisation
- Transforming Cancer Services Programme
- Senior team update

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Preparing for the Next Phase as an Organisation

2.1.1 The Executive team have been working to ensure that the learnings from ways of working during the COVID period are captured and used to build on our plans and priorities that we had been focused on at the start of 2020. This has created a number of key themes with specific work packages associated: completion of the engagement on and communication of our Trust mission, vision and 2030 objectives; improved governance and decision making; improved people practices; enhanced digital connectivity; and the development of clear structures and ways of working.

2.1.2 The Board will continue to define and oversee the delivery of the strategic direction and priorities and changes to the organisation's culture as a result of this work.

2.2 Transforming Cancer Services (TCS) Programme

2.2.1 There will be a further update on TCS later in the meeting, including on the important work in engaging with our local community and key stakeholders on the development of plans for the new Velindre Cancer Centre. In this report, the CEO would like to draw particular attention firstly to the excellent work of the team leading and coordinating the competitive dialogue phase of the procurement of the integrated radiotherapy solution commenced. This is a pivotal procurement for the Trust in supporting the immediate and medium term provision of high quality radiotherapy services.

2.2.2 Secondly the CEO would also like to highlight the important work with one of our partner organizations, Aneurin Bevan University Health Board, to develop a radiotherapy satellite centre. It is anticipated that the Outline Business Case will be completed by October 2020 for consideration by the Trust Board and Health Board partners.

2.3 Senior team update

2.3.1 The CEO would like to congratulate Georgina Galletly on her appointment as Director Corporate Governance for Cwm Taf Morgannwg Health Board, following a 12 month secondment to the role. On behalf of the whole organisation, the CEO would like to thank Georgina for the excellent and immense contribution to the organisation during her 21 years with the Trust, including 9 years as the Board Secretary/ Director Corporate Governance. She is missed by colleagues across the Trust but we know she will remain a valued colleague for us all. The process of recruiting into the permanent position of Director Corporate Governance is now underway.

IMPACT ASSESSMENT

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

3. RECOMMENDATION

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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

HIGHLIGHT FROM THE QUALITY & SAFETY COMMITTEE

DATE OF MEETING	30th July 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, & H 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	
PPE	Personal Protective Equipment

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 20th July 2020.

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

DRAFT

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 20th July 2020.

ALERT / ESCALATE	• ***Oxygen Rich Environment – Ventilation*:** The Committee received a highlight report from the Trust's Estates Assurance Meeting. The highlight report advised that following the introduction of oxygen monitors at each bedside it had been noted that an oxygen enriched atmosphere had been picked up on the first floor ward at VCC, which is a fire hazard. This was as there is no available mechanical ventilation in this area and the cubicle door had to be left open to dissipate the oxygen. This was identified as an issue, as if patients had an infection cubicle doors cannot be left open. The Committee was informed that a Programme Business Case was being developed for the procurement of a mechanical ventilation system. The Committee felt that due to the risk there was a need to escalate the business case section that relates to the mechanical ventilation system from the overall Programme Business Case. The Committee requested an update at the August meeting that includes progress, timescales and mitigating action to taken. • ***Fire Training compliance & compartmentation risk*** – the Committee identified from the Trust's Estates Assurance Meeting the low level of compliance with fire training and the identified fire compartmentation risk. A business case has been developed to remedy these risks and the Committee were advised that there was a plan in place to address the fire training compliance. It was agreed that an update report would be provided covering both these areas at the next meeting.

ADVISE	• ***2019-20 Health & Care Standards Internal Audit Report*** – the Committee noted the Trust 2019-20 Internal Audit report that received reasonable assurance. In addition, the Committee received the ***revised Trust 2020/21 Health & Care Standards Procedure 2020/21*** developed to enhance the process that had been agreed by the Executive Management Board. The revised process increases the Divisional scrutiny of the standards to enhance ownership and includes revised arrangements for: ○ Scrutiny, sign off & action planning; ○ Standard Executive Leads and their roles; ○ Standard Divisional and Trust Operational Leads and their roles; ○ Identification of Lead Groups to monitor and assess compliance against the standards. • **Medical Education Governance Report 2019-20**: Dr Louise Hanna provided a comprehensive report on how the Trust responds to the Medical Education standards. As an overview the Trust is a popular place to work. It was identified that work is underway in relation to out of hours junior doctor support and Consultant rotas. The Committee requested further detail in the Cancer Centre report at the next meeting regarding these plans.
ASSURE	• **Clinical Audit Annual Plan 2020/21**: The Committee received the inaugural Trust Clinical Audit Annual Plan (2020/21) and would like to highlight to the Trust Board the significant progress that has been made to develop an overarching plan for both the Cancer Centre and the Welsh Blood Service and the development of audits including those related to the COVID-19 pandemic. • ***Putting Things Right Annual Report 2019-20 (attached in Appendix 1)***: The Committee received the Putting Things Right Annual Report 2019-20. The following achievements were highlighted: ○ Improved compliance against the 30 working day response timescale. The Trust achieved 78% compliance against the 30 working day response timescale which is an 15.2% increase from 2018/19 (67% compliance) ○ Development and implementation of: ▪ a revised processes for the management of complaints; ▪ a concerns investigation toolkit; ▪ Production of standardised investigation report templates.

	○ Improved ownership of concerns with management overview and onward reporting, lessons learned embedded for service improvement. • **COVID-19 'CELL' Updates:** The Committee received updates from the COVID-19 Cells, which were established to ensure the Trust is meeting COVID-19 responsibilities across key areas of the Trust. Highlights include: ○ The Quality & Safety Cell is focusing on reviewing the deferred patients; has signed off the Staff Investigation Process and the Patient investigation Process is currently out for national consultation. ○ The PPE Cell has received assurance that the Trust has increase compliance with Donning & Doffing; the Trust has reasonable stock levels and mitigation actions are being undertaken where there are potential national supply issues. ○ The Workforce Cell is being closed, as all actions have been completed and there are Trade Union representatives in the other Cells. A final report for the Cell meeting held on 14th July 2020 will be submitted to the next Quality & Safety Committee meeting.
INFORM	• **Experience of Working in the Trust During COVID-19:** The Committee received a presentation from the Psychology Service and from the Therapy services. ○ **Psychology Services:** Dr Caroline Coffey provided a presentation and highlighted the following messages: ▪ This was an unusual time as staff were experiencing the same situation as patients. ▪ There was an early recognition of the need to support staff and the pandemic provided an opportunity to meet staff and to develop a model, which could be built upon. The use of Maggies' facilities was acknowledged to be an important break-away space for staff. ▪ The need to keep clinical services running as smoothly as possible and this was done via face-to-face appointments, video calls and telephone calls depending upon the individual patient. ○ **Therapies Services:** Lisa Love-Gould provided a Youtube video (https://youtu.be/oWGeqvQNeew) and highlight report on the Therapies Team Actions during the pandemic. ▪ The Team has responded to the pandemic differently including multi-disciplinary working.

	▪ During the peak of the pandemic the team were having daily wellbeing huddles, which have now reduced to twice weekly. ▪ Clinical services have continued to be provided via face-to-face appointments, video calls and telephone calls depending upon the individual patient. • **Staff Wellbeing**: The Committee felt it was important to highlight to the Trust Board the theme of staff anxiety/stress during the COVID-19 pandemic, which crossed a number of the agenda items. The support received from Psychology services has been instrumental in maintaining staff wellbeing, along with access to the Maggies' facilities. ***The Committee feel strong that we need to continue to develop wellbeing support to staff, whilst being aware of the available space constraints in the Cancer Centre and the importance of wellbeing/break-away spaces in the new Velindre Cancer Centre.*** The Cancer centre agreed to update the Committee on agreed plans to re-provide a staff wellbeing service at the next meeting. • **Health and Social Care (Quality and Engagement) (Wales) Act 2020 –** The Committee received a slide deck providing a summary of the Health and Social Care (Quality and Engagement) (Wales) Act 2020 requirements, time scales and the next steps in relation to this for the Trust and Welsh Government.
APPENDICES	Putting Things Right 2019-20 Annual Report

4. RECOMMENDATION

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

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre

Velindre University NHS Trust

Putting Things Right

Annual Report

2019/2020

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

Contents

1. Introduction

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 a strong reputation across the United Kingdom, Europe and internationally for the services we provide.

We have two main divisions: Velindre Cancer Centre (which provides specialist tertiary non-surgical cancer centre) and the Welsh Blood Service (which is responsible for the provision of blood and blood products to NHS Wales). In addition, the Trust is 'Host' to a number of external organisations namely;

- NHS Wales Informatics Service (NWIS)
- NHS Wales Shared Services Partnership (NWSSP)
- Health Technology Wales (HTW)

The management arrangements for organisations hosted by the Trust are direct to the Welsh Government, and therefore, our hosted organisations have not been included in this report.

The Trust places 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. Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving all complaints and incidents in accordance with the NHS (Concerns, Complaints and Redress Arrangements) (Wales), which apply to all Welsh NHS bodies, providing NHS funded care, commonly known as **Putting Things Right** (PTR).

The Velindre University NHS Trust Putting Things Right Annual Report 2019-20 summarises how the Trust and its two divisions has managed concerns (complaints, claims and serious incidents) during the period of the 1st April 2019 and the 31st March 2020. This includes: how the Trust has developed its systems and process for the effective investigation and management of concerns; engaged with and responded to patients / donors and their families during these processes; and ensured that changes have been made and lessons learnt and disseminated following investigations.

2. Putting Things Right - Definitions

The Putting Things Regulations refer to the term "concern" which means any complaint, claim or reported patient safety incident (about NHS treatment or services). For the purpose of this report, the following definitions will be used when describing our concerns activity.

The Putting Things Right annual report will be presented under the above definitions.

3. Trust arrangements for managing concerns

The Trust's Chief Executive, Steve Ham has ultimate overall responsibility for all concerns (complaints, redress, claims and serious incidents), however has delegated this responsibility to the Executive Director of Nursing, Allied Health Professionals and Health Scientists (Jayne Elias, Interim Executive Director of Nursing & Service Improvement (1st April 2020 - 26th August 2020 / Nicola Williams, Executive Director of Nursing, AHPs & Health Scientists from 27th August 2020 who is accountable for setting the systems and processes to ensure the Trust meets its Putting Things Right Regulatory requirements.

Under the Regulations, an Independent Member should be identified who will be responsible for keeping an overview on how processes are operating at a local level. Jan Pickles was the Trust Independent Member for maintaining the strategic oversight of the NHS Concerns, Complaints & Redress Arrangements.

The Trust Quality & Safety Manager, Lisa Heydon is the Designated Senior Investigations Manager, and is responsible for overseeing the handling and consideration of all concerns across the Trust. The Quality & Safety Manager is supported by a Concerns Team comprising a Complaints Manager and a Claims Manager, and by Quality & Safety leads within the two divisions.

The way in which we manage managing concerns (complaints, redress, claims and serious incidents) is based upon a number of key principles; we will

- Adopt a consistent approach for investigating concerns which is proportionate to the issue raised.
- Ensure that the person raising the concern is properly and appropriately supported, for example, through access to advocacy support at all stages of the process, both from Community Health Council (CHC) advocates and more specialist advocacy services where needed.
- Provide an acknowledgement within 2 working days of the concern being raised, and will aim to respond to all concerns within 30 working days.
- Deal with all concerns openly and honestly.
- Provide a detailed response including clarity about next steps, and an offer to meet to discuss the findings of our investigation.
- Ensure decisions relating to Redress are clearly explained.
- Demonstrate that learning and improvements have resulted from the process; and

The following sections provide an overview of the way in which we have managed and responded to complaints, redress, claims and serious incidents.

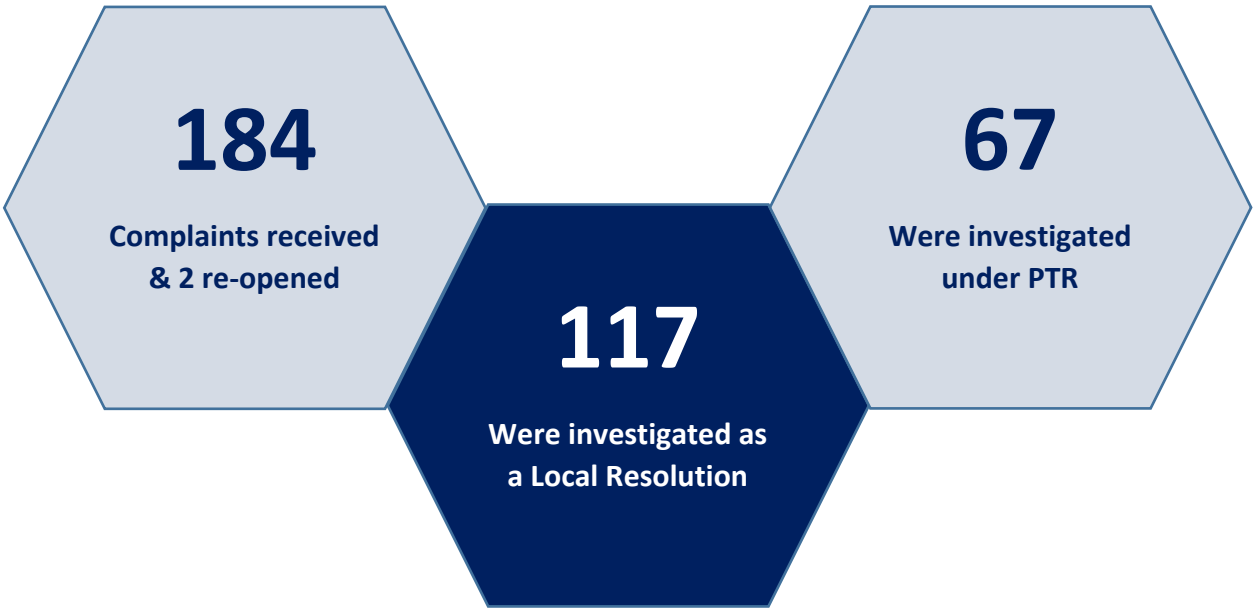
4. COMPLAINTS

How we have responded to complaints

Complaints are received via a number of routes including verbal, social media, formally in writing and through our websites. When a complaint does not require a comprehensive investigation we aim to resolve these complaints by the end of the following working day. These complaints are called '*Local Resolutions*', and do not need to be formally considered under the Putting Things Right Regulations (PTR).

Where it has not been possible to resolve a complaint within this timescale, or where an in-depth investigation is required, the complaint is managed under the Putting Things Right Regulations.

Complaints received between the 1st April 2019 – 31st March 2020



Where a complaint is investigated under PTR, an acknowledgment should be provided within 2 working days. We achieved **95% compliance** against this requirement.

Re-opened Complaints

During the period, two complaints that had been previously investigated were re-opened. On both occasions, we were able to successfully resolve the outstanding matters, and no further issues were raised. As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response to complainants, and to date, have not had any further re-opened complaints.

The Welsh Government requires Health Bodies within Wales to thoroughly investigate all complaints, and for 75% of all complaints to be resolved and a response produced within 30 working days of receipt. Where this cannot be achieved, a response should be provided within 6 months.

During the year we investigated and responded to **82** complaints under PTR.

78% of concerns were responded to within 30 working days

This is an increase of **15%** from 2018/19

Three complaints were responded to outside of the 6 month timescale. Whilst these complaints were complex and required a detailed investigation, delays also occurred due to the complaint manager post being vacant for a period of time. We have since reviewed our complaint processes and trained more staff to undertake investigations to ensure these delays do not occur in the future.

For those investigations that required longer than 30 working days to investigate, our concerns team contacted the person raising the complaint, prior to the 30 day timescale, to explain the reason for the delay and agree a revised date.

Public Service Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the person raising the complaint, the matter can be referred to the Public Service Ombudsman for Wales (PSOW). During this reporting period, four complaints were referred to the PSOW for investigation - one of the complaints was subsequently not upheld, and the other three investigations are still on-going.

How we have improved the way we manage complaints

We Listened

All complainants were contacted whenever possible by the concerns team to offer an apology and to fully discus the nature of their concerns.

We Improved Response Timescales

Improvements have been made in the 30 day response timescales, with 78% of complainants receiving a response within 30 working.

We delivered a More Efficient Complaints Process

The Trust complaints process was reviewed and a number of improved complaint management procedures have been implemented.

We appointed a Donor Experience Manager

A Donor Experience Manager was appointed in 2019, to manage concerns relating to the Welsh Blood Service with a view to improving the services provided to the donor.

We Acknowledged Complaints Promptly

During the period 95 % of complaints were acknowledged within 2 working days.

We undertook Quality Investigations resulting in a reduced number of re-opened complaints

A concerns investigation framework was developed improving the structure of investigations, and identifying potential delays earlier in the process.

We Improved our Technology

The electronic system for managing complaints (DATIX) was upgraded in January 2020, providing enhanced functionality for the Trust to identify complaint themes and trends and improve learning. Informal verbal complaints will also now be captured on this system.

We Actively Monitored our Performance

Holding weekly review meetings has improved the monitoring of all active complaints, serious incidents and claims.

We continue to work in partnership with other organisation across Wales to investigate and resolve complaints. We work closely with the Community Health Council in Wales as part of the advocacy services they provide for people who want to raise a concern about NHS care and/or treatment. All of our complaint acknowledgement letters provide information on the advocacy support available from the Community Health Council.

A number of complaints investigated during the year also related to services provided by other health bodies. Where this occurred, investigations were undertaken jointly with the relevant health body to ensure a single, co-ordinated complaint response.

What have our complaints told us?

All our complaints are categorised in accordance with all-Wales categories that have been determined by the Welsh Government. This ensures that themes and trends can be identified across NHS Wales and learning can be shared on a national basis.

Within the **Velindre Cancer Centre**, the highest number of complaints investigated under PTR related to clinical assessments and communication. These include complaints relating to the timeliness of treatment, the diagnosis of conditions, and the lack of a 'joined up' approach with other care providers.

The highest percentage of complaints resolved as an Early Resolution related to clinical services and communication. These include patients who had not received a timely response to appointment or treatment queries, and patients who were unhappy with explanations provided in relation to their care.

Within the **Welsh Blood Service**, the highest number of complaints investigated under PTR and those resolved as an Early Resolution related to appointments where donors had not been accommodated at donation clinics. These included donors unable to book appointments, donors who were unable to be accommodated at a walk in blood donation session and donors who were unhappy with the donation process.

Themes from the complaints we investigated and responded to are summarised on the next few pages.

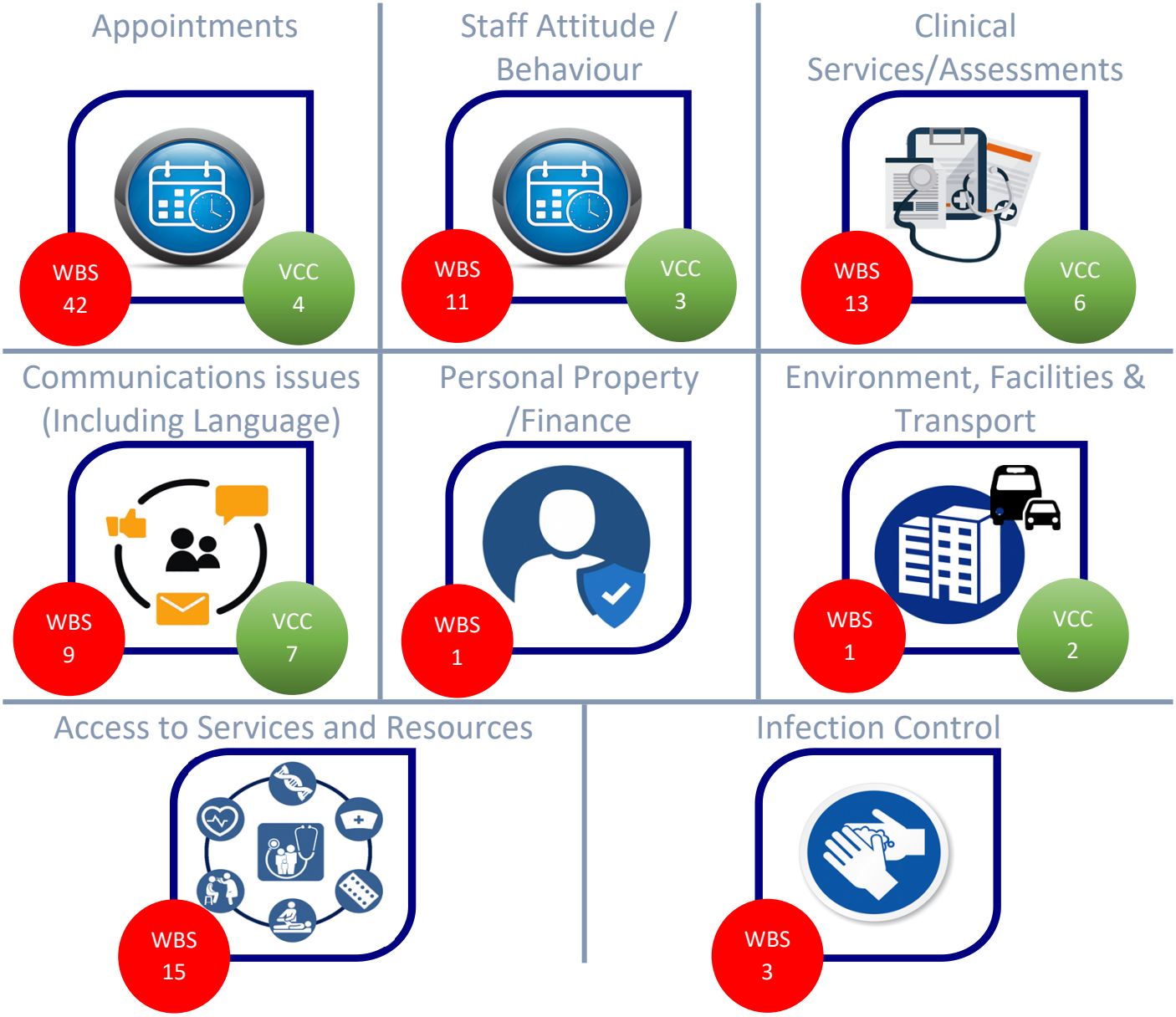
Themes from Putting Things Right complaints

(Welsh Blood Service **WBS**; & Velindre Cancer Centre **VCC**)

Appointments WBS 9	Staff Attitude / Behaviour WBS 2 VCC 2	Clinical Services/Assessments WBS 9 VCC 27
Communications issues (Including Language) WBS 1 VCC 16	Equality WBS 1	Environment, Facilities & Transport WBS 2
Infection Control WBS 1	Record Keeping WBS 1	Monitoring and Observations VCC 3
Access to Services and Resources WBS 6	Test and Investigation VCC 1	Patient Care VCC 1

Themes from Early Resolution complaints

(Welsh Blood Service **WBS** & Velindre Cancer Centre **VCC**)



Complaints relating to the Welsh Language

The Trust received three complaints in 2019-20 in relation to the provision of services in the medium of Welsh, which were investigated under the Regulations. All Welsh Language complaints were investigated with support from our Welsh Language Officer, and the learning points have been incorporated into our Welsh Language action plan for 2020-2021.

Learning from complaints

An important part of the management of complaints is to ensure that lessons are learnt, and actions taken as a result of any identified failings in services or care. We have a range of processes in place to share learning from complaints, including: team meetings, newsletters and clinical audits. These arrangements were further strengthened in 2019 when the Trust established a Shared Listening and Learning Committee. The following spotlight on learning provides examples of how we developed our services during 2019/20 using learning from the complaints.

We implemented a new procedure for booking follow-up outpatient appointments

In response to complaints raised to the Cancer Centre regarding the way in which follow up appointments are arranged, we undertook a review of the management of the outpatient appointment booking system. As a result of this review, a new procedure was implemented for the booking of follow up appointments – this mitigated the risk of appointments being requested by the Clinician, but not being booked onto the appointments system. The Medical Records Manager is monitoring the effectiveness of the new process.

We worked with staff to improve the way we communicate clinical information

Complaints investigated during 2019/20 identified themes in relation to the way treatment options are discussed with patients and families, and how terminology may not always be understood. To improve the way in which we discuss clinical information, we have worked with our clinical teams within the Cancer Centre to re-emphasize the importance of clear and concise communication with patients and family members, along with the importance of clear documentation and record keeping. We have also undertaken a review of some of our patient information leaflets to ensure that they are clear and easy to understand. We will continue to deliver communication training throughout 2020/21, and will utilize the feedback received from patients and families to aid with learning.

We produced a guidance document for the completion of the medical cause on the death certificate

The loss of a loved one is an extremely difficult time for families, and at all times the Cancer Centre aims to act with compassion and sensitivity. A complaint was received regarding an error with the completion of a death certificate and immediate action was taken to resolve the error and to put measures in place to avoid a similar event happening again. The Cancer Centre developed and issued a guidance document for medical staff for the completion of the 'medical cause of death' certificate. This guidance is also now being provided to all new doctors on induction.

We improved the information on the Welsh Blood Service website to make it easier to book appointments to donate blood

The Welsh Blood Service website has since been updated to provide information about blood donation clinics and on how to make appointments. The Welsh Blood Service has also continued to develop its web based customer portal to enable donors to book their own appointment to donate blood. In 20/ 21, the donor web portal and smartphone app will be further developed in order to improve access and information for donors, and to enable direct communication with donors.

*We **undertook a pilot to improve the consent process for blood donation"***

Concerns were received by the Welsh Blood Service relating to the blood donation process, which also include pain during donation and bruising. A new 'Before you donate' leaflet was created with details the risks associated with donation, and ensures that Donors are able to make a fully informed decision to proceed. This leaflet has been extensively piloted in 8 Donation clinics. Constructive feedback has been received regarding the new 'Before you Donate' leaflet, and this will be further revised and implemented into service in 2020/21.

Experience & Feedback

Feedback is received through a number of sources and provides an opportunity to learn from the experience of our donors and patients. Improvements have been made during the year as a result of feedback on our services.

Feedback from Donors		Action Taken
Donors raised feedback in relation to reduced clinic availability in North Wales	→	Recruitment was undertaken for additional staff to increase clinic capacity
The removal of the ability to book next donation appointment when at clinic	→	Communication was provided to donors explaining the rationale for changes in the blood collection appointment system
Clinical Letters were being issued without sender information	→	The clinical letter was amended to include sender information
Comments were received in relation to staff attitude when donors could not be accommodated at donation clinics	→	Customer care training was delivered to all collections staff across Wales
The Website information about travel risk (West Nile Virus) was out of date due to frequency of country update	→	The information was improved by providing a direct link to live updates
Lack of updates to donors if there are clinic delays	→	Collection Teams now inform the Donorr Contact Centre of any delays so donors can be informed
Feedback was received with regards to the high levels of single use plastics on clinic	→	A Sustainability group formed and a number of items were replaced and waste segregation/ recycling pilots were introduced

The Cancer Centre also has processes in place to review patient feedback on an on-going basis, and wherever possible, suggestions are acted upon to improve the patient experience. Feedback on actions taken is displayed via patient information boards located at prominent locations across the Cancer Centre. Examples of action taken in relation to feedback include;

well done

Sut wnaethom ni
How did we do

Compliments

Patients, relatives, carers and donors contact us to let us know about the good care and service they have received. Compliments are received via social media, verbally and many thank you messages and cards are received by our teams on a day to day basis.

We appreciate the time taken by patients, relatives, carers and donors to let us know how good their experience of our service and care has been. The individuals and teams involved in the care and service provided are pleased and encouraged by such feedback. Examples have included:

‘Appointments my husband had on May 28th run to time…unusual in our experience. Staff were comforting and very friendly, felt at ease’.

‘Very welcoming, very helpful, when I asked for info. Successful donation. Lovely biscuits!! Thank you a very pleasant experience’.

‘Velindre is unique all staff are fantastic nothing is too much trouble they always smile and greet everyone, your recruitment is obviously spot on’.

‘All staff are amazing and really put me at ease. They went above and beyond for myself and my family’.

‘Very professional, made to feel very relaxed and made to feel very much appreciated for giving up my time today for my donation’

‘Appointments have been on time. Staff always happy and helpful. Coming to Velindre has not been as traumatic as we expected. The experience so far have been very positive, not like visiting other hospitals in Wales’.

‘Fantastic as always everyone is so welcoming and never failed to put me at ease. I'll sing your praises all day long’.

‘Staff are so calm and in control - you feel safe when you walk into the unit because you know they are going to look after you. Thank you’.

‘Excellent experience! Booked appointment for 11:20, on time, questionnaire very quick and efficient. Friendly staff. Best thing now - the way sessions are booked further in advance so it is so much easier to plan future attendance’.

5. REDRESS

Under the National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (section 25-33), there is a requirement for an NHS organisation to consider Redress in situations where a patient may have been harmed, and that harm was caused by an NHS provider in Wales. When a breach of duty and harm has been caused, a qualifying liability will be established. This means that the Trust is liable and will be responsible for taking steps to put things right by offering a remedial resolution under the Putting Things Right processes. The Redress remedies are:

- An explanation
- A written apology
- A report on the action(s) which has, or will be taken to prevent similar cases occurring
- An offer to provide care or treatment
- An offer of financial compensation - maximum threshold for damages settlement of £25,000
- Or an offer of both treatment and financial compensation

The offer of redress is subject to the individual forgoing the right to pursue civil proceedings.

Where the investigation of a concern concludes there has been a breach of duty, the case is presented to the Trust Putting Things Right Redress Panel. The Panel are required to consider whether redress applies in situations where a patient may have been harmed, and whether the harm was caused during / by care provided by the Trust.

During 2019/20, the Trust considered four Redress matters. One Redress matter was concluded in July 2019 with an award of damages compensation. The further three Redress matters have not yet been concluded, and will be reported in the Trust Putting Things Right Annual Report 2020/21.

4

6. CLAIMS

Clinical Negligence and Personal Injury claims are managed by the Trust Claims Manager, and legal advice is provided by NHS Wales Shared Services Partnership, Legal & Risk Services.

At the end of March 2020, there were 12 open claims.

Claim Type	New Claims received between	Pre-Existing Claims	Claims Closed	Total Claims handled
Clinical Negligence	3	3	0	6
Personal Injury	2	3	3	8
Product Liability	1	0	0	1

Learning from closed claims

During the year 2 personal injury claims were closed and 1 personal injury claim was withdrawn. Learning has been identified from the closed claims:

Closed claim 1 *- Following a fall in the Cancer Centre car park, improvements have been made to the inspection and monitoring of external areas of the Cancer Centre. This includes annual inspections of all external areas of the Cancer Centre, the development of action plans following site audits/inspections, and a programme of ongoing monitoring of the site is now in place.*

Closed claim 2 – As a result of a fall on wet ground, visual spot checks have been carried out at across the Cancer Centre by the Operational Team to ensure that 'wet floor' signage is in use and that the floors are safe.

7. SERIOUS INCIDENTS

Learning from Serious Incidents

Welsh NHS bodies are required to report all serious patient safety incidents to the Welsh Government. Serious incidents will occur when care has not been delivered to the required standard, and has resulted in serious harm. Serious Incidents should be fully investigated within 60 working days, and learning needs be identified to avoid a similar situation occurring.

Avoidable Healthcare Acquired Pressure Ulcers	➢ Twice daily audits of documentation ➢ Pocket guides provided to staff to aid the assessment of a patient's skin integrity ➢ A Pressure area care focus day was held for staff ➢ Targeted individual & group training was undertaken ➢ A Pressure Ulcer Scrutiny Panel was established ➢ Tissue Viability Nurse appointed Pressure Ulcer incidents have since reduced
Misreporting of scan results	Incorrect reporting of 2 scans ➢ A new Radiologist was appointed in July 2019 ➢ More frequent discrepancy audits were implemented ➢ Robust Discrepancy Panel meetings established ➢ Process for ensuring learning from any discrepancies was implemented
Management of a patient fall in an outreach clinic	Patient fall in outreach clinic in another Health Board: ➢ Cancer Centre falls prevention group re-established to support the inclusion of the falls prevention policy in outreach clinics ➢ A post falls training programme was developed and delivered for all relevant staff including those staff working in outreach clinics ➢ Falls risk assessment introduced to the out-patient setting ➢ Governance arrangements for incidents at outreach clinics refined and disseminated to staff

8. Looking Forward to 2020/2021

During 2020-21, the Trust will continue to strengthen its processes for responding to concerns, and we will;

- **Increase the number of complaints responded to within 30 working days**

  The Trust Concerns Team will continue to develop the complaints investigation toolkit with an aim of reducing delays within the investigation.

- **Implement an electronic system which will be accessible to all staff to record verbal complaints**

  Our electronic system for recording complaints will be configured for staff to report verbal complaints. This will improve the way we manage verbal complaints and will ensure complaints are escalated to the most appropriate person to resolve. Developing our electronic system will also improve the identification of themes or trends to support learning.

- **Make training available to all staff on the management of complaints and concerns**

  A training plan will be delivered and implemented to ensure that all staff receive training in the management of complaints. A number of training options will be provided, including: classroom sessions, e-learning and digital solutions. The Trust induction programme will also be expanded to ensure that all new staff receive training on the management of complaints and concerns within the first few weeks of joining the organsiation.

- **Roll out an electronic form for staff to record compliments**

  It is equally important to know what we are doing well, and we will implement an electronic tool for staff to record any compliments / plaudits received in their department. This will enable us to share good news across the organisation, and to triangulate compliments with complaints information.

- **Improve our Welsh language service for the handling of complaints**

  We are committed to providing an equal service for our Welsh speaking population, and our email address for reporting a complaint will be provided bilingually. Our concerns team will work with the Trust Welsh Language Officer to identify ways of improving our Welsh language provision for the management of complaints.

9. Further Information

This report will be published on the Trust's Internet Site and can be accessed via the following link:

www.**velindre**-tr.wales.**nhs**.uk/ - 'publications'.

It is suggested that the Annual Quality Statement (AQS) is read in conjunction with this report as that statement provides an opportunity to advise the public in greater detail on the progress being made across a wide range of service areas. The AQS will also be published on the Trust's Internet Site via the following link:

www.**velindre**-tr.wales.**nhs**.uk/ - 'publications'.

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

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	25/6/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	16/6/2020	ENDORSED FOR APPROVAL

1. SITUATION/BACKGROUND

The Trust Risk Register was reviewed by the Board in full in the June meeting. Given the Trust Boards are currently meeting monthly, rather than bi-monthly, it was agreed by the Chair that this July report can be an exception report to highlight any significant changes. The full Trust Risk Register will then be received in the September meeting.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 New risk assessments

There have been no new risks proposed for inclusion on the Trust Risk Register during the period.

2.2 Proposed changing to the scoring of risk assessments

There is one risk that the Board is asking to approve an increase in score from 8 to 12. Please see appendix 1.

- 14860: Brexit - Disruption, delays or inability to provide full range of treatments and services if the government fails to achieve a withdrawal agreement when the UK leaves the EU.

As further context for this risk, there was a briefing, facilitated by the Welsh NHS Confederation, in early July from Welsh Government's Health and Social Services (HSS) Leadership Group. This group had met for the first time since March 2020 to discuss readiness arrangements for the UK exiting the EU Transition Period on 31 December 2020.

During the meeting the risk to the NHS and social care was discussed and it was suggested that the profile of Brexit as an issue on NHS organisations Risk Registers should be updated if necessary as it may have been removed due to Brexit developments and other risks, including responding to COVID-19.

However, to note that the Brexit risk on the Trust Risk Register has remained under assessment each month and had not been placed in the recovery plan.

The Briefing went on to update that preparations for leaving the Transition Period will be fundamentally different than other times during the planning process. Prime Minister Boris Johnson and European Commission President Ursula von der Leyen agreed on 15 June not to extend the Transition Period. This means that unless a Free Trade Agreement is brought to the European Council meeting on 15-16 October to be ratified by Member States, the UK will leave the EU on World Trade Organization (WTO) terms at the end of the calendar year.

Regardless if the UK ends the Transition Period on WTO terms or with a Free Trade Agreement with the EU, as of January 2021 there will be fundamental differences on how trade, medicines, immigration etc. will operate.

Boards of organisations across the NHS have therefore been asked to review Brexit risk assessment in this context.

2.3 Closed risks

There have been no risks proposed for closure on the Trust Risk Register during the period.

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

The Trust Board is asked to **APPROVE** the change to the score of risk 14860 relating to Brexit.

Risk Domain: Performance & Service Sustainability **Risk Ref: 14860**	**Director Lead:** Director Strategic Transformations **Assuring Committee:** Planning & Performance Committee	
Risk: Brexit– Disruption, delays or inability to provide full range of treatments and services if the government fails to achieve a withdrawal agreement when the UK leaves the EU.	**Date Added to Register:** 17/10/18	**Date Last Reviewed:** 21/07/2020

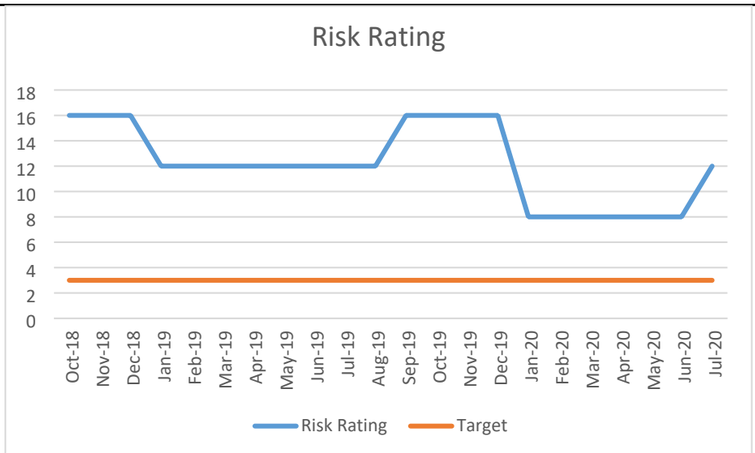
Risk Rating

(impact x likelihood)

Initial	4x4	16
Current	**4x3**	**12**
Target	3x1	**3**

Risk Appetite:

Nil



Rationale for current score	Rationale for target score	Groups reviewed risk during period
On 23/01/2020, The UK's EU Withdrawal bill became law. The UK officially left the EU on 31/01/2020. An 11-month transition phase will run to 31/12/2020. This risk position and impact will be reviewed throughout the transition period, as and when the key milestones are reached. In line with NHS Confed/WG, the Trust is being asked to consider the risk in light of a parallel impact of Covid-19 pandemic. The current risk position has increased on consideration of the following:- - The final month for Britain to request an extension of its transition period beyond 2020 has now past (June 2020). A Trade Deal agreement must be in place by November 26th 2020. - Additionally, there is increased concern around the supply chain for PPE due to the Covid-19 pandemic. Contingency arrangements to minimise the effects of disruption will be maintained for the immediate future & reviewed and revised following consultation with WG recommendations.	Risk appetite is Nil and the Trust objective would be to maintain services at the level pre Brexit.	EMB 21/07/2020

What controls have we put in place for the risk:

Corporate

1. Workforce planning - Staff supported to apply for settled status. The Home Office is currently continuing its engagement with employers to shape the future immigration system which will be in place for the recruitment of European Economic Area (EEA) and non-EEA citizens from 1 January 2021. The risks identified for a no-deal Brexit have recently been revised in light of COVID-19 as at 30th June 2020.
2. The UK Government is putting in place plans to ensure the supply of medical devices and clinical consumables.
3. The current OJEU legislation of fairness, transparency and equal treatment will prevail. The engagement with EU entities will largely depend on the content of any trade agreements that are negotiated with the EU.
4. All Wales procurement services provided by NWSSP for NHS Wales via contingency stock warehouse (IP5).
5. Management action plan being redrafted to reflect current understanding of risk profile.

What actions should we take:

Action	Lead	Date
Monitor and review position within Velindre UNHS Trust BC meetings include updates from COVID-19 cells, Track & Trace, PPE, Social Distancing, Workforce and Quality & Safety.	Chief Operating Officer, Directors VCC & WBS	On-going
Continued engagement in UK groups.	Directors VCC & WBS	On-going
Continued engagement with NWSSP & NWIS.	Director Finance & Directors VCC & WBS	On-going
Continue to review political situation regarding likelihood of a 'No Deal'.	Chief Operating Officer	On-going
Future Engagement with Welsh Government to determine funding support of financial consequences that cannot be met from within existing allocations, identified through Velindre UNHS Trust monitoring.	Director Finance	On-going

6. Many fixed price agreements in place across the divisions for key services/ equipment. 7. Contingency exercises planning events have taken in place for WBS, VCC, NWIS and NWSSP. 8. Website launched with internal / external information for patients/donors/partners and staff on issues related to Brexit. Continuing to update as new developments surface. 9. A separate risk assessment has been undertaken to consider the specific issues around the provision of Personal Protective Equipment (PPE) in light of COVID-19 and Brexit. The international PPE market and supply into the UK could be impacted by Brexit, but only for European based manufacture which does not make up the bulk of manufacturing. Mitigated by daily stock monitoring, critical stock uplifted and mutual aid from LHBs and Trusts. 10. A separate risk assessment is underway on the Transforming Cancer Services (TCS) programme and project risk revision post COVID-19 and Brexit. 11. Public Contract Regulations in place. 12. Financial consequences at an organisation and national level are monitored at Directors of Finance regular meetings, to determine any funding flows above planned inflationary levels. **VCC** 13. Divisional risk assessments undertaken and regularly reviewed. The VCC risk assessment has been reviewed in light of the anticipated increase in demand due to the impact of first peak of COVID-19 which is anticipated to be in the Autumn of 2020. 14. Review of critical supplier lists within service division completed. 15. Work ongoing on supply chain at VCC. 16. Undertake/review departmental Business Impact Analysis to identify key risk areas within Service division completed. 17. Services have identified range of contacts with EU suppliers and assessed delivery confidence. **WBS** 18. Divisional risk assessments undertaken and regularly reviewed. The WBS risk assessment has been reviewed to consider impact post COVID-19. 19. Memorandum of Understanding (MOU) with UK & Ireland Blood establishments (extended to include consumables and blood components). 20. Joint Professional Advisory Committee will consider derogations to Regulations if critical blood supply chain issues arise. 21. Human Tissue Authority (HTA) produced statutory instrument for import and export of tissues and cells. 22. Review of critical supplier lists within service division completed. 23. Maximised critical inventory stock 24. Review contracts and discuss critical impact points with individual suppliers and contractors. 25. Review of critical equipment maintenance programmes. 26. Undertake/review departmental Business Impact Analysis to identify key risk areas within Service division completed. 27. Services have identified range of contacts with EU suppliers and assessed delivery confidence.	

Additional Comments:
1. VCC and WBS have completed full risk assessments; under regular review as more information becomes available.
2. The hosted organisations have completed risk assessments & provided assurance that these are under regular review as more information becomes available.
3. Regular meetings of the VUNHST Business Continuity &Emergency Preparedness Group and engagement in national groups continues.

Appendix 1

Risk Appetite Levels

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

Risk Matrix

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

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

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

TRUST BOARD

DELIVERING EXCELLENCE PERFORMANCE REPORT

DATE OF MEETING	30/07/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Phil Hodson, Assistant Director of Planning
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath Obrien, Interim Chief Operating Officer

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board*	21st July 2020	ENDORSED

ACRONYMS	
IMTP	Integrated Medium Term Plan
PADR	Performance Appraisal and Development Review

VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

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

1.2 The attached reports describe performance through to the end of June 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 has been operating 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. There is a complex demand relationship between the number of patients referred during the first quarter of the year with changes in referral patterns and adaptations to treatment pathways.

This is notable for radiotherapy where the changes of treatment intention for patients from SACT to radiotherapy has impacted on the demand profile. This, together with the capacity impact of operating within a COVID 19 environment with additional infection control measures and social distancing have led to decreases in compliance with treatment targets.

An over 500% increase in SACT referrals for patients in late March and the change to radiotherapy for the treatment plans for these patients have been a factor in this performance.

The decision to accept the referrals and to change the treatment modality in order to treat the majority of these patients with radiotherapy was taken in line with the clinical principles established under the leadership of the Trust's Medical Director and approved by the Trust Board. These principles acknowledge the issue of patient and staff safety as paramount and the decision to accept these referrals was representative of the Trust's commitment to offer all possible support to regional cancer services. It was also in keeping with the current advice of the Royal College of Radiologists (RCR). None of these patients breached the tier 1 target for 1st definitive treatment.

The June data for breaches has improved over the proceeding months. Radical Radiotherapy within 28 days 94% with 10 breaches from 162 treated. Palliative Radiotherapy within 14 days 92% with 10 breaches from 120 treated. Breaches were as a result of reduced Covid related capacity and changes of intent from radical to palliative treatment.

2.2.2 Velindre acquired healthcare associated infections (page 17)

There was one case of E.coli reported in June.
A root cause analysis was conducted and appropriate learning disseminated.

2.2.3 % of patients with NEWS score ≥3 that receive all 6 elements in required timeframe (page 18)

1 of 9 patients did not receive all 6 elements of the sepsis bundle in the required timeframe. The patient did not go on to receive a diagnosis of sepsis and suffered no other harm. The remedial action is to review out of hour's process.

2.3 Welsh Blood Service

Supply of all blood components to meet demand has been sustained in difficult operating environment. 1220 new donors attended a donation session in June with 1076 of these proceeding to give a full donation. This was a 447 increase in new donors bled vs June 2019.

2.3.1 Stem Cell Donation (page 4)

The WBMDR has continued to take stem cell donations throughout the pandemic period, supporting stem cell transplant across the world. Changes were made to the process to enable safe delivery.

2.3.2 Incidents closed within 30 days (page 5)

There was a reduction in performance in May and June as a result of operational pressures. A risk based approach made sure all immediate actions required were taken.

2.3.3 Critical Findings and adverse events (page 6)

MHRA audit

In June, the MHRA undertook a desktop audit exercise which had been postponed from an anticipated full audit visit earlier in the year due to COVID pandemic. There was one major non-conformance noted. An action plan is being developed in conjunction with the MHRA and WBS colleagues to address the non-conformities. This is being reported via the Quality and Safety Committee.

Two serious adverse events were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in May. These have been reviewed and preventative actions have been put in place.

2.3.4 Whole Blood Efficiency and Manufacturing and Production Efficiency and Platelet Waste (page 8 and 9)

There has been an overall reduced demand due to service changes in LHBs, although demand rose slightly in June. 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, changes in hospital demand and the successful introduction of partial Ambient Overnight Hold Model (AONH), resulting in increased resource requirements. These changes account for whole blood efficiency and manufacturing and production efficiency showing as below target for the month of May and June. This is likely to continue whilst COVID is present within the community

Platelet stocks production targets have been altered to reduce waste but ensure ability to need to maintain stock against the uncertainty of demand with services changes from the pandemic.

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: • 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.

Velindre Cancer Centre Monthly Report

Canolfan Ganser Felindre
Velindre Cancer Centre

At a Glance Highlights - June 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

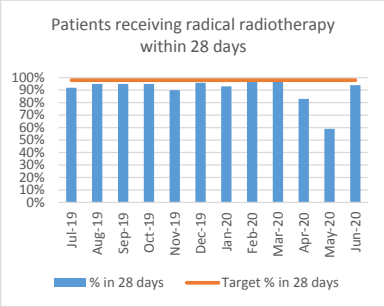
6 KPIs improved relative to the previous month's performance.

4 KPIs fell below the previous month's performance.

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

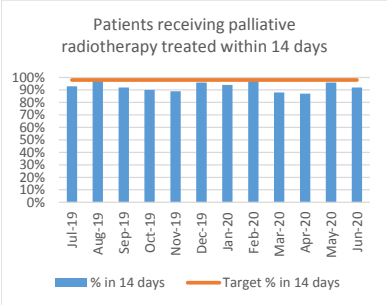
Equitable and Timely Access to Services - Radiotherapy

Jun-20



Last month

Target Not Achieved



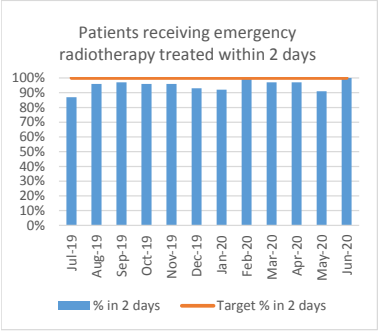
Last month

Target Not Achieved

Target: 98%	**SMT lead: Radiotherapy Services Manager**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion dat**
No patient who failed to begin treatment in June 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).	A1: A major programme of work in radiotherapy and medical physics instigated in response to performance issues and the findings of an external review.	E1: To begin in July 2020
Demand for radiotherapy services has fallen with 320 new patient referrals received in June. In light of the COVID pandemic, a number of clinical staff are unable to provide patient facing care. Such changes have reduced available linac capacity and impaired the service's overall flexibility. .	A2: Formal monthly performance review to be introduced with VCC senior management team to focus on performance, capcity , finance, workforce, etc..	A2: July 2020
162 patients were referred for treatment with radical intent. 10 did not begin treatment within 28-days (performance rate of 94%). a number of breaches were due to the need for a rescan, or COVID related. Of these 10 patients: • 4 began treatment within 35 days • 4 began treatment within 40 days • 1 began treatment within 50 days • 1 began treatment within 78 days	A3: VCC performance team with business intelligence support and service input to implement system for the monitoring of whole patient pathway in radiotherapy.	E3: To begin in July 2020
	A4: Weekly waiting times and patient tracker meetings to be reinstituted.	E4: Complete
120 patients were referred for treatment with palliative intent. 10 did not begin treatment within 14-days (performance rate of 92%). A number of these breaches were due to change on intent from radical to palliative. Of these 10 patients • 7 began treatment within 21 days • 3 began treatment within 28 days	A5: Radiotherapy and medical physics to identify individual roles responsible for waiting list management.	E5: Complete
	A6: Radiotherapy Management Group (RMG) to be specifically tasked with supporting implementation of the Single Cancer Pathway (SCP).	E6: July 2020

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

Jun-20

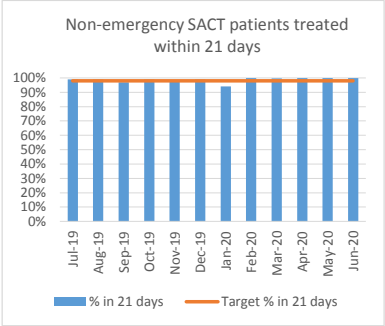


Last month

Target Achieved

Target: 98%	SMT lead: Radiotherapy Services Manager	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
45 patients were referred for emergency treatment. Of these, all patients were treated within 2-days (performance 100%).	A1: Weekly waiting times and patient tracker meetings to be reinstituted. A2: Radiotherapy and medical physics to identify individual roles responsible for waiting list management.	E1: Complete E2: Complete

Equitable and Timely Access to Services - Non-Emergency Systemic Anti-Cancer Therapy (SACT) Jun-20

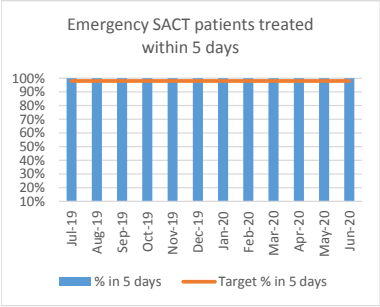


Last month

Target Achieved

Target: 98%	SMT lead: Chief Pharmacist	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion d**
All patients referred began treatment within 21-days. 217 new patients began treatment in month. Referrals have fallen in comparison to earlier months in light of the COVID-19 pandemic. The SACT service has repatriated all services delivered in an outreach context. With effect from April, all SACT delivery is being undertaken at VCC. This represents ongoing strong performance however, demand for SACT services prior to the advent of the COVID-19 pandemic was in the region of 10% higher than at the same point in 2019. As such, it is recognised that a robust operational plan which addresses likely future demand is required. 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 increase this issue may become acute.	A1: The SACT Strategic Group to commission an operational plan to ensure safe, sustainable delivery of the service in the recovery phase and long-term. A2: The SACT service is developing a plan in response to the COVID-19 pandemic which will ensure the availability of sufficient capacity and a robust operating model during the course of the pandemic. A3: Weekly waiting times and patient tracker meetings to be reinstituted. A4: SACT service to identify individual roles responsible for waiting list management.	E1: July 2020 E2: Complete E3: Complete E4: Complete

Equitable and Timely Access to Services - Emergency Systemic Anti-Cancer Therapy (SACT) Jun-20



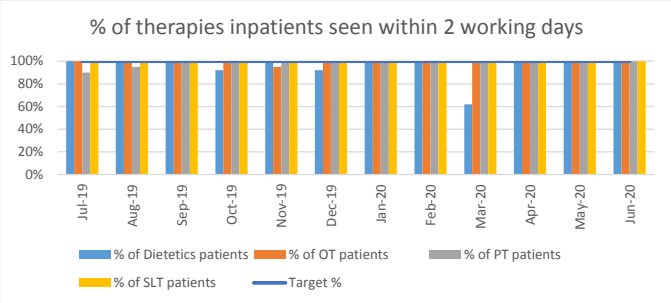
Last month

Target Achieved

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

Equitable and Timely Access to Services - Therapies (Inpatients)

Jun-20



Dietetics - last month
OT - last month
PT - last month
SLT - last month

Target: 100%

Reason for performance:

All inpatients were seen within target.

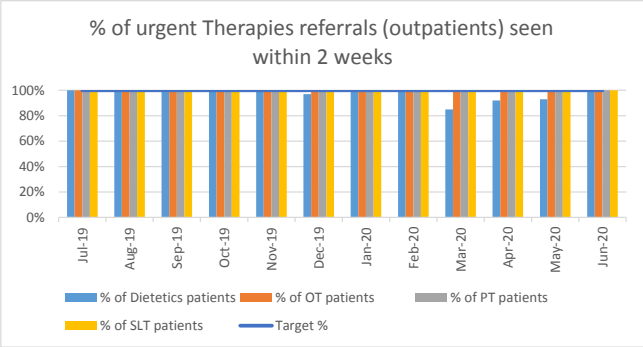
Routine, face to face, outpatient appointment were suspended with effect from the 16th March as part of the Trust's response to the COVID-19 pandemic.

SMT lead: Therapies Manager

Actions being taken to improve performance:	**Expected completion**
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. 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: Commencing June 2020

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

Jun-20



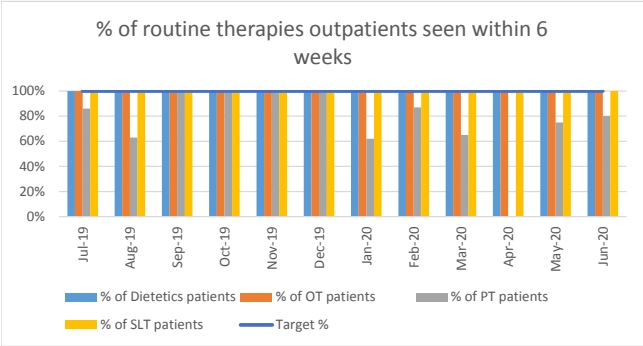
Dietetics - last month
OT - last month
PT - last month
SLT - last month

Target: 100%
Reason for performance:
.All patients were seen within the two week target. 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**
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.	E3: Commencing June 2020

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

Jun-20



Dietetics - last month
OT - last month
PT - last month
SLT - last month

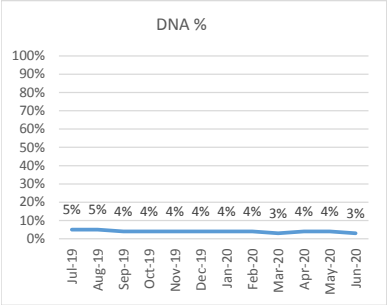
Target: 100%
Reason for performance:
3 physiotherapy patients were not seen within the 6-week target (all have received treatment). This was due the COVID-19 response and the suspension of routine outpatient activity. Routine, face-to-face, outpatient appointments were suspended with effect from the 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.	E3: Commencing June 2020

Equitable and Timely Access to Services - Outpatient Waiting Times

Jun-20

Target: <20 minutes	**SMT lead: Head of Nursing**	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion date:**
More than 40% of Outpatient activity was conducted virtually in June. 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. 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. 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.	A1: Detailed plans to be developed and implemented to allow the Outpatient activity to re-start in outreach contexts. A2: Weekly waiting times and patient tracker meetings to be reinstituted. A3: Outpatient department to identify individual roles responsible for waiting list management.	E1: Plans fully implemented by September 2020. E2: Complete E3: Complete



Last month

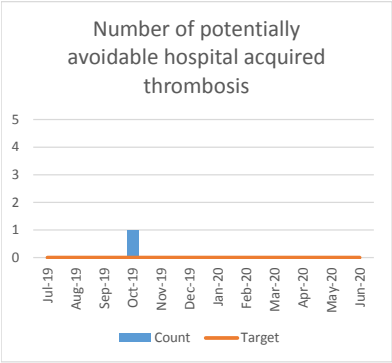
Target Achieved

Outpatients - Did Not Attend (DNA) Rates

Jun-20

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

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

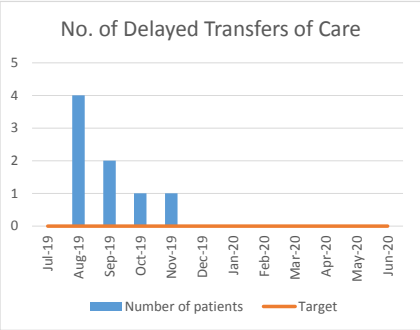


Last month

Target Achieved

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

Safe and Reliable Services - Delayed Transfers of Care (DToC's) Jun-20



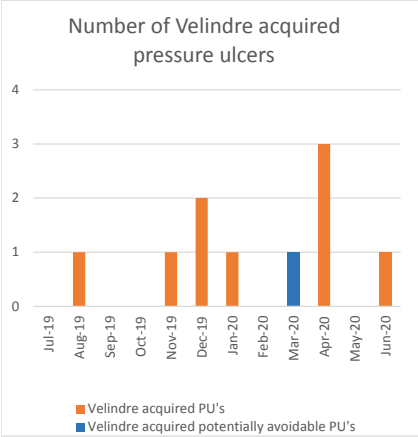
Last month

Target Achieved

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 June 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

Jun-20

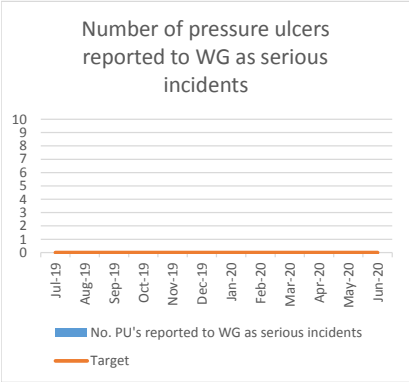


Last month

Target Not Achieved

Target: zero pressure ulcers	SMT lead: Head of Nursing	
Reason for performance:	**Actions being taken to improve performance:**	**completion date:**
Risk assessment was completed and the patient was deemed at risk of developing pressure damage. Appropriate equipment and a prevention plan put in place. Reviewed by Tissue Viability nurse who concluded that there were 2 unstageable pressure ulcers. Patient was nursed on pressure redistributing support surface and repose cushion with regular repositioning and sitting in the chair limited to three one hour periods in any 24 hours.	The Pressure Ulcer Scrutiny Panel is responsible for monitoring the implementation of any agreed actions or recommendations. A1: A full investigation was undertaken. The pressure damage was considered to be unavoidable.	E1: Complete

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



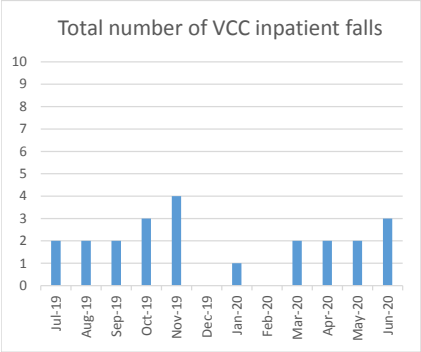
Last month

Target Achieved

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

Safe and Reliable Services - Falls

Jun-20



Last month

Target Not Achieved

	SMT lead: Head of Nursing	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion**
Falls – There were three falls during June 2020 (one patient had two falls). No injuries were reported. Following investigation falls were deemed unavoidable. Patients had been risk assessed and all appropriate action was taken prior to the falls.	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. A2: Contribute to development of all-Wales standardised falls prevention care plan. A3: A full investigation of both falls reported in June was conducted. Appropriate learning has been disseminated.	E1: Activity on hold due to requirements of pandemic response. E2: Activity on hold due to requirements of emergency response. E3: Complete

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

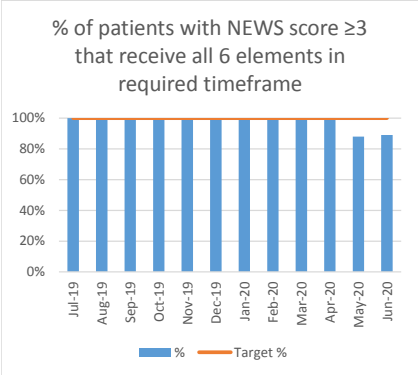
Target: 0 infections	SMT lead: Clinical Director	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion**
One case of E.coli was reported in June.	A1: A root cause analysis was conducted and appropriate learning disseminated.	E1: Complete

Last month ↓ ☒ Target Not Achieved

Annual figures for Velindre-acquired infections:

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

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

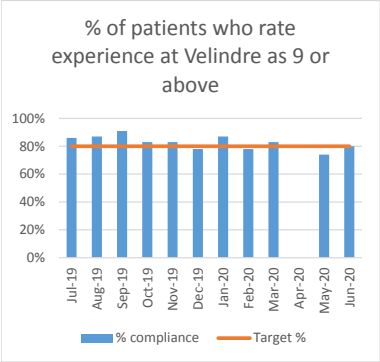


Last month

Target Not Achieved

Target: 100%	SMT lead: Clinical Director	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion**
Of a total of 122 patients who atended the acute assessment unit during June, 9 patients met the criteria for sepsis 6 care bundle. 1 patient did not receive all 6 elements of the sepsis bundle in the required timeframe. The patient did not go on to receive a diagnosis of sepsis and suffered no other harm.	The treatment of acutely unwell patients and unscheduled care is under review at a strategic and operational level. A1: Nursing teams to revisit process with a particular focus on the development of robust processes for the delivery of out of hours care (outside the assessment unit's operational hours).	E1: July 2020

Jun-20



Last month

Target Achieved

Target: 80%	SMT lead: Director of Operations	
Reason for performance:	**Actions being taken to improve performance:**	**Expected completion**
In response to the COVID-19 pandemic, staff were redeployed in April and patient experience data was not collated. Patient experience data began to be collated again in May. Patients returning lower scores in June in relation to their experience of treatment at VCC commented on several themes, including: • Social distancing in the Outpatient Department • Communication issues • Discomfort due to high temperatures during warmer weather.	A1: All patients who were contactable (ie not anonymous) contacted to discuss concerns further. 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. A3: Proposal to increase patient and visitor car parking space on VCC site.	E1: Business as usual E2: Activity on hold due to requirements of emergency response. E3: Activity on hold due to requirements of emergency response.

First Class Patient Experience - VCC Concerns

Jun-20

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.

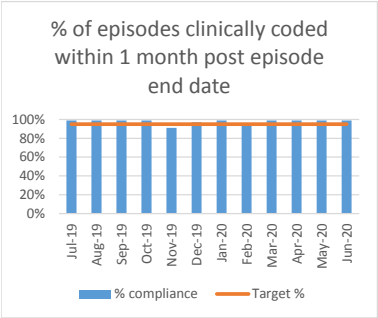
Themes included:

1. Communication issues.
2. Environment / facilities - extremes of tempreture / not able to use fans due to risk of infection.

Type of concern	No.
Early resolution	3
PTR (formal concern)	2
Claims	0

Information - Clinical Coding

Jun-20



Last month

Target Achieved

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

VCC Measures Glossary

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

VCC Measures Glossary - Cont.

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

Welsh Blood Service Monthly Report

June 2020

Gwasanaeth Gwaed Cymru
Welsh Blood Service

All clinical demand was met with overall stock position of red cells was 2809 at the end of June .

Whole blood collection efficiency is below the target for the fourth consecutive month as a consqeuence 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.

Manufacturing efficiency was 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.

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

All stock groups were maintained above 3 days.
All demand for red cells was met
All clinical demand for platelets was met.
Platlelet expiry remained high in June, this is due to continued production of pooled platlelets to maintain stocks againts the uncertainty of platelet demand. Platelet demand remained low in June.
81% of quality incidents closed within the required 30 days. This is just below the target position.

No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in June.
MHRA undertook a remote desktop inspection of the WBS Quality Management System w/c 15th June. There was one major non-conformance noted, consisting of 20 points relating to Change Control, Deviations (incidents) and CAPA (corrective and preventive action)

Overall donor satisfaction continued to exceed target position at 97%.

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

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

11 Key Performance Indicators were down on the previous month's performance, however 6 achieved target.

The 4 Performance Indicators reported on a quarterly basis achieved target

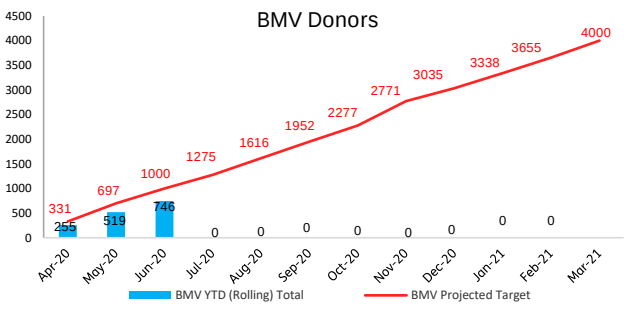
Reference Table

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

Monthly Reporting

Equitable and Timely Access to Services

Jun-20



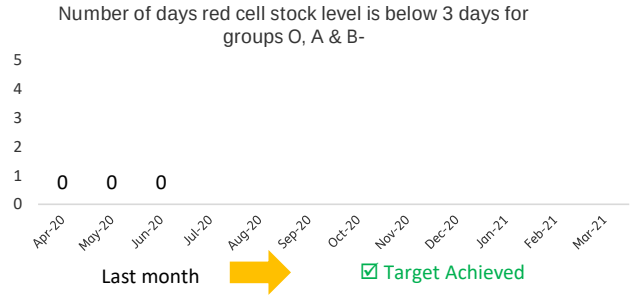
Last month

☒ Target Not Achieved

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 227 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in June. Recruitment was down on the required levels as the Service is currently unable to host sessions at the venues that typically deliver high numbers of bone marrow recruits. However, the 227 in June represents an increase of 32 donors vs the same month last year, despite there being considerably fewer opportunites for donors to donate due to Covid-19.	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 ake forward recruitment of non blood donors

Safe and Reliable Service

Jun-20



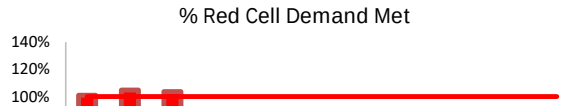
Last month

☑ Target Achieved

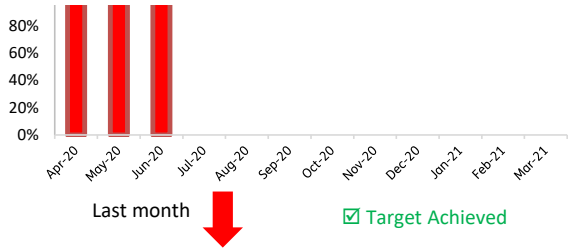
Monthly Target: 0	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
All stock groups were maintained above 3 days. Stock levels are robust. Effective collaboration between the Collections and Laboratory teams within the Supply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

Safe and Reliable service

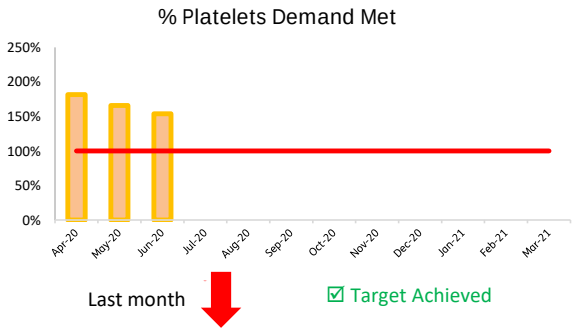
Jun-20



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



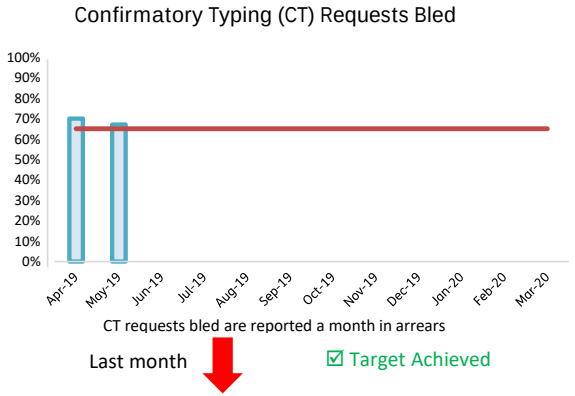
All demand for red cells was met. Stock levels remain robust across the blood groups. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs.	Daily Resilience meetings are held in a collaboration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



Safe and Reliable service

Jun-20

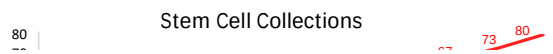
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs. Over supply verus demand due to inablity to forecast demand during COVID	Work has also been initiated to review the WBS Platelet Production Strategy that will facilitate optimum supply chain management aligned with a wider programme of work in response to the recently revised SaBTO guidance on plasma production.	TBC Currently on hold due to other priorities as a result of COVID



Safe and Reliable service

Jun-20

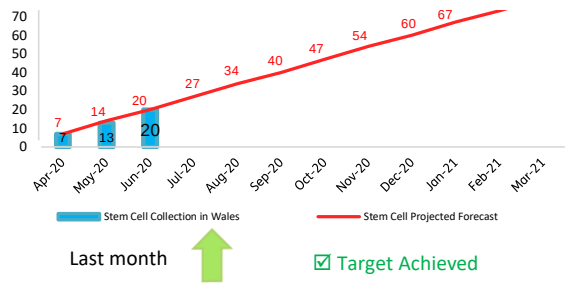
Monthly Target: 65%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The number of CT requests for May was 15: -10 donors were bled (67%) (0 cancellation) - 100% of samples were bled within 7 days - 100% of requests were completed within 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

Jun-20

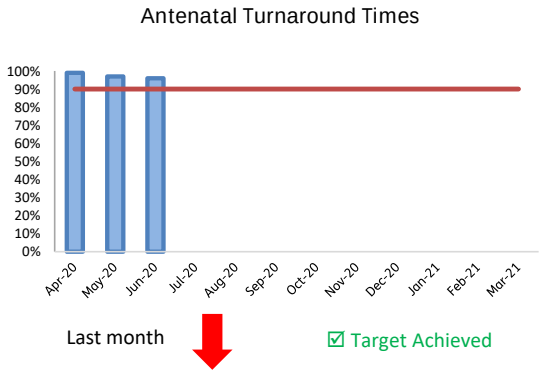
Annual Target: 80	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



There were 7 Stem Cell Collections in June with YTD collections on target position. Plus 2 x PBL collections 4 x Cancellations at work up stage, 1 x failed medical	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

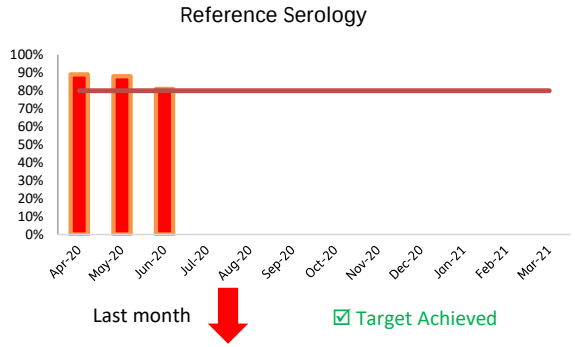
Jun-20



Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for routine Antenatal tests in June remained above target at 96%. Continued monitoring and active management is in place.	Continuation of existing processes which are maintaining high performance against current target.	Business as Usual

Safe and Reliable service

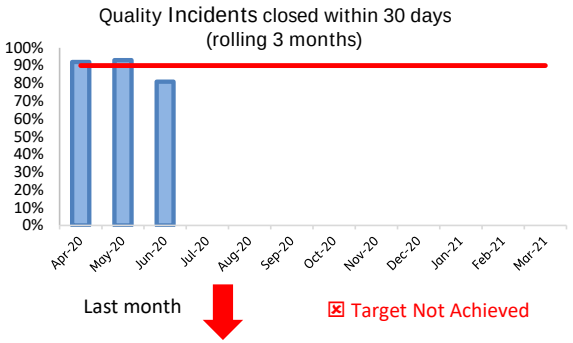
Jun-20



Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround times for specialist referrals in June above target at 81%. Workload returning to 'near normal' (150 referrals in June 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.	March 2021

Safe and Reliable service

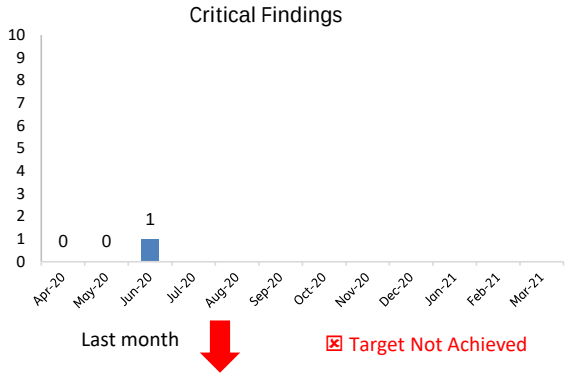
Jun-20



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Performance in June is below the target position, with 81% of quality incidents closed within the required 30 days. This indicates a 12% decline in performance. The number of incidents reported in the three month rolling period has remained the same (73 reports); 14 reports were not closed within this period, compared with 5 in the previous reporting period.	The agreed SMT action plan will remain in place to ensure that the improved performance is sustained.	Continue with close monitoring and feedback issues to SMT huddle weekly.

Safe and Reliable service

Jun-20



Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
MHRA undertook a remote desktop inspection of the WBS Quality Management System w/c 15th June. There was one major non-conformance noted, consisting of 20 points relating to Change Control, Deviations (incidents) and CAPA (corrective and preventive action).	An action plan is being drawn up to address each point in detail, with longer term actions being included to prevent a recurrence and address broader themes.	Action deadlines are to be agreed by the responsible Person and Head of Quality Assurrance & Regulatory Compliance, with endorsement by SMT. Action plan to be submitted to MHRA by Friday 17th July, for review and approval by MHRA. QA Systems staff will work in partenrship with WBS colleagues to address the non-conformities and excute long-term preventive action.

Safe and Reliable service

Jun-20

Incidents Reported to Regulator/Licensing

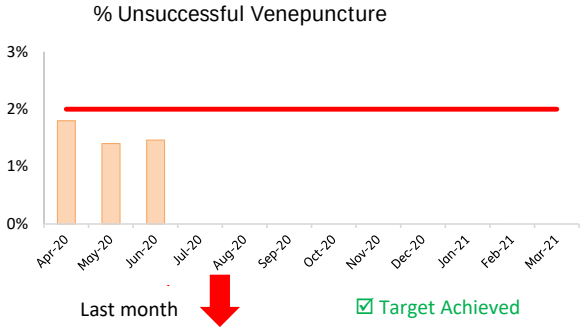
Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When

No Serious Adverse Events (SAE) were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) in June.	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 Regulaory Assurance & Governance group and a request made to further explore one aspect of the investigation. MHRA have been informed that the investigation has been extended. Confirmation report to be submitted on completion of extended investigation.	October 2020

Spending Every Pound Well

Jun-20

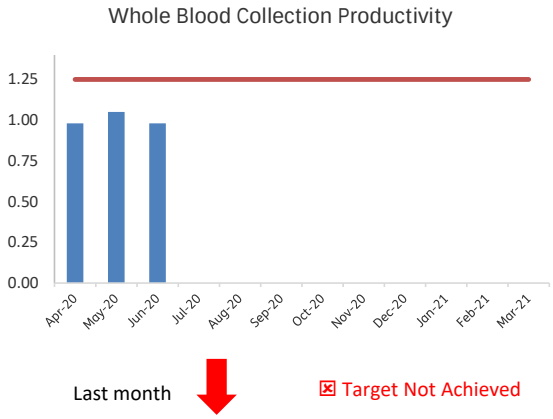
Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Part Bag rate for June 2020 remains within the 3.0% tolerance at 2.42% of donors who donated.	Ongoing work to maintain the part bag rate under tolerance threshold include (but is not limited to) the following: - Ongoing cycle of Points Of Care Audit	Business as Usual
The overall Part Bag figure gives general reassurance that this is not an area of concern.	- Review of Audit findings and implementation of associated action plans	Business as Usual
The value of the breakdown of this data into 'targeted' and 'other' should be reviewed going forward.	- Task and Finish groups with clinical teams with trend of exceedance tolerance levels to determine and implement service improvement projects	Business as Usual
	The factors that comprise the 'reasons for part bags' will continue to be monitored on an individual team and collective basis.	Business as Usual



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

Spending Every Pound Well

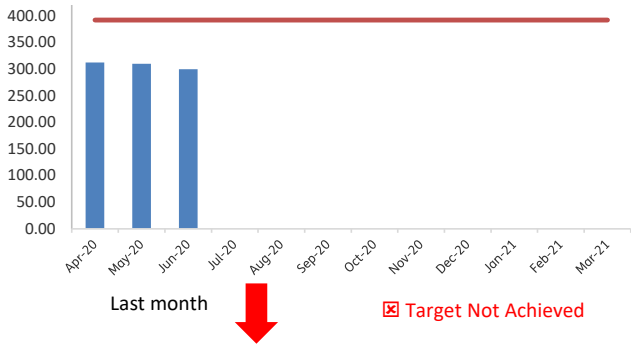
Jun-20



Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Collection efficiency is below the target of 1.25 for the third 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 resource 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. The Blood Supply Chain 2020 Programme is under review and it is anticipated it will recommence early Autumn 2020	December 2020

Spending Every Pound Well

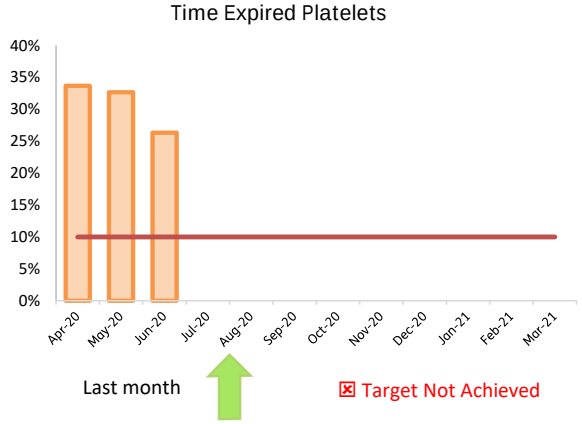
Monthy Target 392	SMT Lead: Trcaey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When



Production effciency continues to remain below the target. The principle influences on this are lower collctions and increased staffing reflecting changes in service provision and hospital demand during COVID. This include recriutment 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	December 2020

Spending Every Pound Well

Jun-20



Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platlelet expiry remained high in June, this is due to continued production of pooled platlelets to maintain stocks againts the uncertainty of platelet demand. Platelet demand remained low in June. Production targets have been reduced for pooled platelets	Keep platelet issues under review and consider reduction in production. Work has been initiated to review the WBS Platelet Production Strategy to enable a Prudent Supply Chain and reduce the potential for waste in the system. This will include working with hospitals via the Blood Health Team and the Transfusion Laboratory Managers forum. As part of this work the WBS will also be reviewing the impact of the recent revised guidance by the Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) on vCJD. The WBS will commence an incremental 12 month transition to increase domestic plasma acquisition. An update to be provided at the end of March 2020.	See above project on hold due to other priorities.

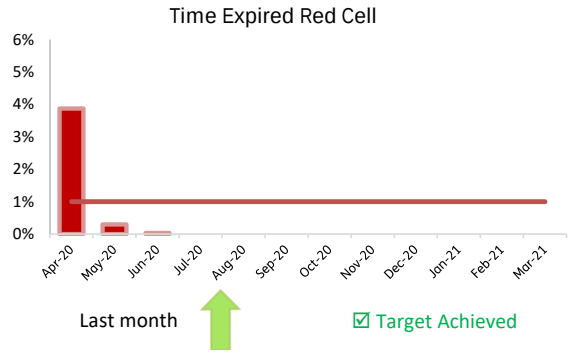
Spending Every Pound Well

Jun-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
The controllable red cell losses were : Incorrect Storage : 5 Operator (Blood Press) : 1 Performance is within specified parameters	Local reporting and manangement of incidents where they occur for monitoring of losses and lessons learnt.	Business as Usual

Spending Every Pound Well

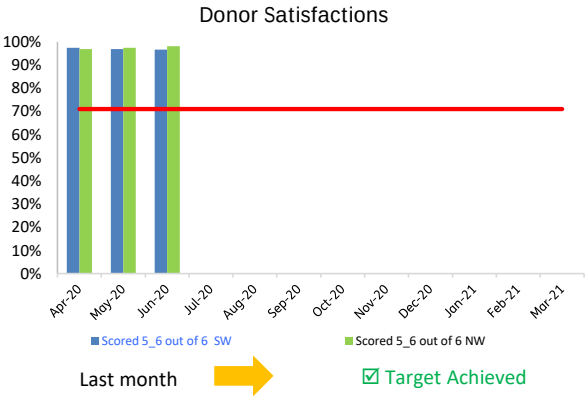
Jun-20



Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Time expired red cells are below the target of 1%. Issuing practice has changed to issue oldest units first (rather than a range of shelf life) due to change in demand from hospitals as a result of COVID (high wastage is due to reduced demand from hospitlas as a result of COVID).	A review of a number of multifactorial contributory factors is underway in order to determine root cause of increased time expiry and any learning to inform future demand planning arrangements	September 2020

First Class Donor Experience

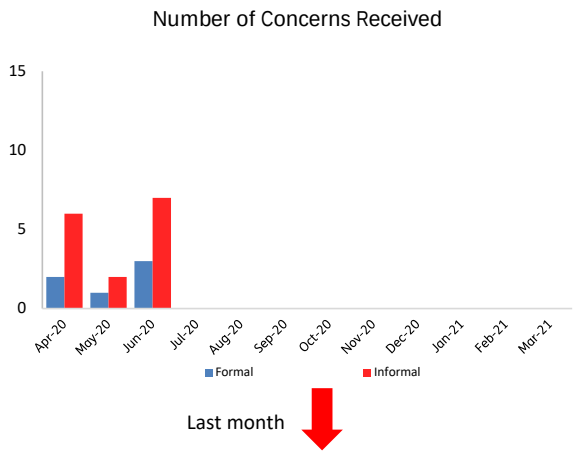
Jun-20



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 97.1%. In total there were 1,255 respondents who shared their donation experience, 331 were from North Wales and 920 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.	September 2020

First Class Donor Experience

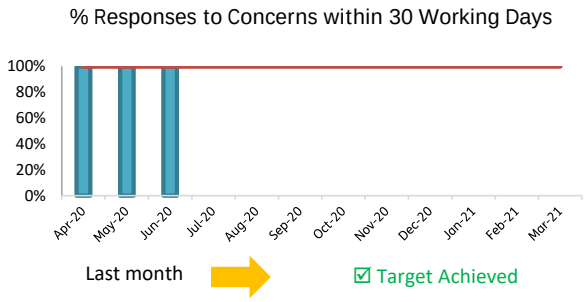
Jun-20



Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In June 2020 a total of 7203 donors were registered at clinic. A total of 10 concerns (0.001%) were reported within this period with 7 being managed as early resolution (ER) within 2 working days and 3 managed as a Formal Concern, within 30 days. Reasons for concerns during this period including: - Inavailability of donation appointment within chosen geographical area due to altered service provision as a result of COVID19 - Eligibility criteria preventing donor from donating - Donor concerned regarding COVID19 management on clinic	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.	Business as usual

First Class Donor Experience

Jun-20



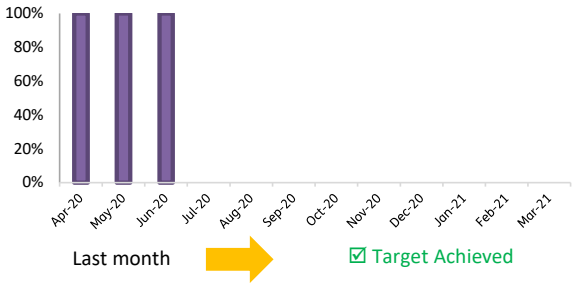
Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
100 % compliance- All formal written responses were completed within the required 30 working day timescale.	Continue to monitor 30 day response compliance.	Business as Usual

First Class Donor Experience

Jun-20

% Concerns Acknowledged within 2 Working Days

Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



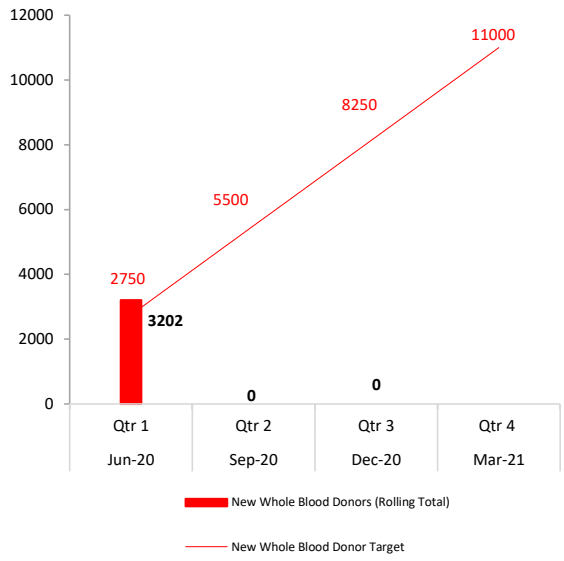
100% compliance- All concerns were acknowledged within 2 working days of receipt.	Continue to closely monitor concern management timescales reinforced within training package	Business as Usual

Quarterly Reporting

Equitable and Timely Access to Services Jun-20

New Whole Blood Donors

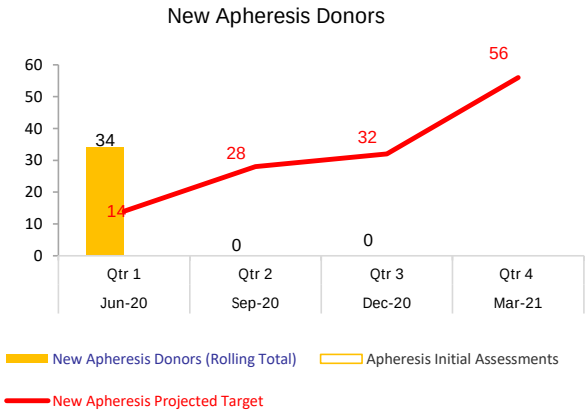
Quarterly Target: 2750	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



☑ Target Achieved

1220 new donors attended a donation session in June with 1076 of these proceeding to give a full donation. This was a 447 increase in new donors bled vs June 2019. 3202 new donors gave completed donations in the quarter, a 50% increase on the same quarter of last year - despite there being considerably fewer opportunities to donate during the period. 17% of all donations in the quarter came from new donors, compared to 10% of the total collections in the corresponding period of 2019 - a hugely positive result. It is suspected that the rise in new donors is a result of increased donor availability during lockdown (as work and social comitments have been removed) and of an added focus across society to contribute to the NHS in the battle against Covid-19. The engagement and communications team have delivered a range of high impact communications to partners through social media and the press, driving new donors into our clinics.		Business as Usual

Jun-20



☑ Target Achieved

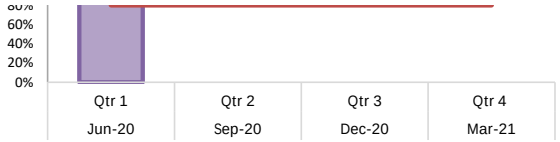
Quarterly Target: 14	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 14 new apheresis donors in June 2020, taking the total number of new apheresis donors in the quarter to 34, a 143% increase on target.	Continue to recruit new apheresis donors.	Business as Usual

Safe and Reliable service

Turnaround Times (Deceased Donor Typing/Crossmatching)

Jun-20

Quarterly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When



☑ Target Achieved

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 restrictions on eligibility to donate	Continued monitoring and active management is in place.	TBC delayed due to COVID but will form part of the Collection Centre review

Safe and Reliable service

Jun-20

Anti D & -c Quantitation

☑ Target Achieved

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Workforce Monthly Report

June 2020

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR and Statutory and Mandatory training
- A 12 monthly trend report for Sickness, PADR and Statutory and Mandatory training with narrative to explain the data

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Jun-20	May-20	
PADR	59.89	62.28	85%
Sickness	5.17	5.11	3.54%
S&M Compliance	81.74	81.83	

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	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	66.04	67.62	66.02	66.67	66.99	73.53	79.00	73.00	71.88	65.35	59.80	51.46	43.93
Research, Development & Innovation	48.78	50.00	41.86	36.96	32.50	32.50	33.33	86.49	87.50	83.72	71.43	72.50	69.77
Transforming Cancer Services	33.33	33.33	23.08	23.08	7.69	61.54	84.62	84.62	78.57	64.29	69.23	69.23	75.00
Velindre Cancer Centre	78.96	78.80	77.79	75.58	72.31	73.46	74.31	70.49	69.66	68.68	64.78	60.26	58.52
Welsh Blood Service	83.00	86.52	87.00	86.04	84.92	85.43	85.68	85.75	84.75	78.00	73.57	67.25	64.94
Velindre Organisations	77.72	79.02	77.97	76.29	73.99	75.94	77.09	76.38	75.43	71.89	67.51	62.28	59.89
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)	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	81.47	80.17	80.17	76.81	76.42	76.89	77.11	77.04	76.47	74.21	72.36	70.73	68.94
Research, Development & Innovation	63.06	61.25	61.57	60.59	60.20	61.04	59.58	68.57	74.00	74.51	75.10	75.92	76.27
Transforming Cancer Services	72.50	71.67	70.77	72.31	70.00	69.23	80.00	82.31	77.50	77.65	74.38	69.41	65.29
Velindre Cancer Centre	74.89	76.54	75.93	75.47	75.55	76.62	77.05	78.10	79.11	78.16	77.94	77.76	77.62
Welsh Blood Service	93.90	93.49	92.37	90.90	91.22	90.96	91.88	90.85	90.68	92.26	92.87	93.27	93.79
Velindre Organisations	81.16	81.79	81.02	79.94	80.00	80.60	81.15	81.75	82.30	82.08	82.00	81.83	81.74

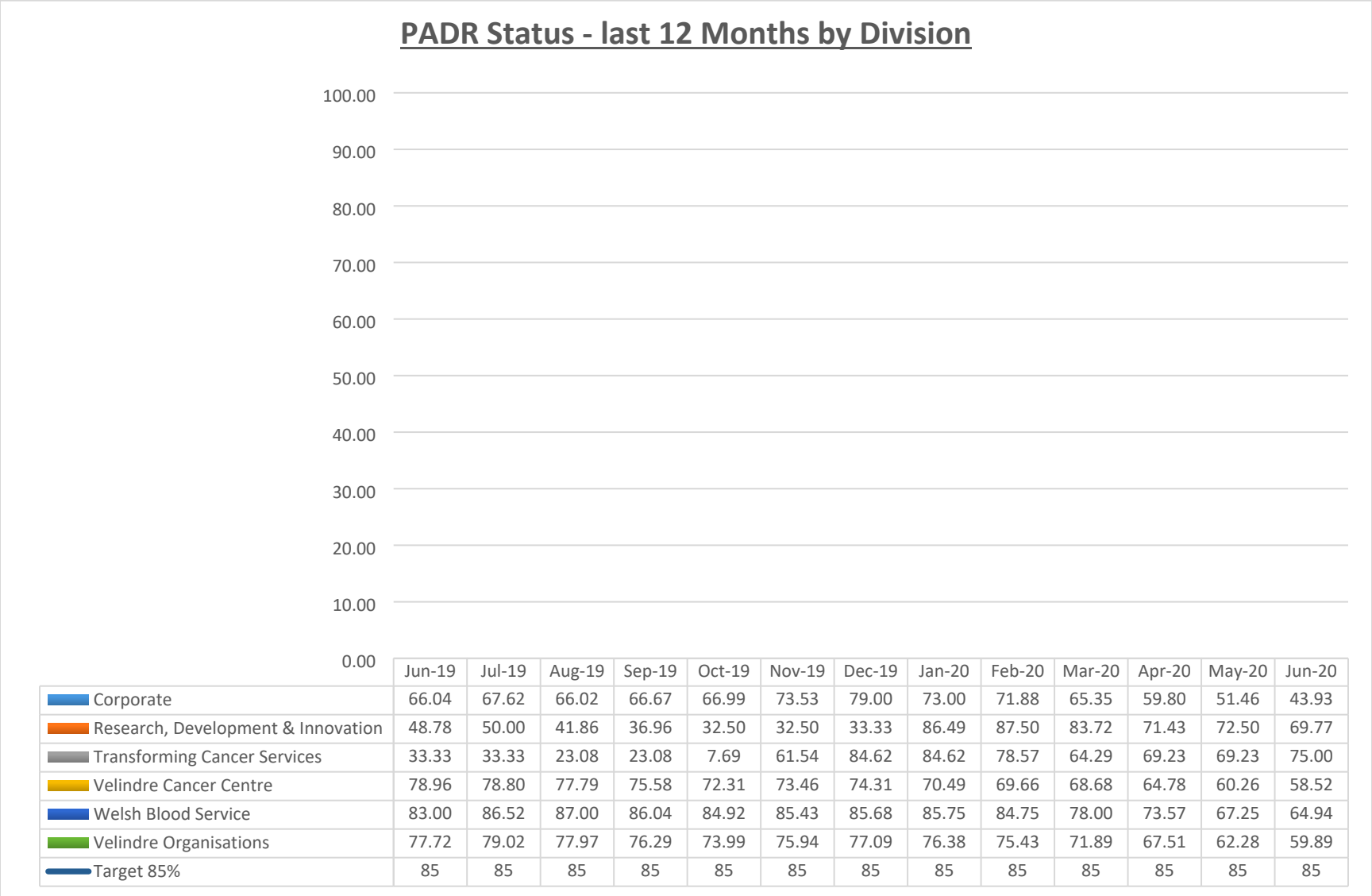
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above	

Sickness	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	4.25	4.44	4.48	4.65	4.79	4.93	4.92	4.84	4.70	4.78	4.94	5.00	5.10
Research, Development & Innovation	2.76	2.66	3.12	3.44	3.54	3.42	3.91	4.07	4.02	4.16	4.36	4.68	5.01
Transforming Cancer Services	10.92	11.52	11.28	10.02	8.57	7.17	5.77	4.90	4.17	3.91	3.99	3.81	3.69
Velindre Cancer Centre	4.42	4.20	4.09	4.01	4.02	4.05	4.15	4.25	4.30	4.61	5.04	5.22	5.40
Welsh Blood Service	5.02	4.91	4.78	4.79	4.79	4.77	4.78	4.72	4.80	4.96	5.09	5.05	4.86
Velindre Organisations	4.64	4.50	4.40	4.36	4.37	4.37	4.43	4.45	4.48	4.72	5.01	5.11	5.17
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	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	N/A	0.12	0.06	0.00	0.39	0.13	0.19	0.94	0.90	0.68	0.24	0.02	0.11
Research, Development & Innovation	N/A	0.00	0.22	0.00	0.65	0.20	0.00	0.00	1.73	2.41	0.58	1.22	0.00
Transforming Cancer Services	N/A	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	N/A	0.30	0.15	0.37	0.34	0.38	0.35	0.30	0.40	0.42	0.54	0.46	0.36
Welsh Blood Service	N/A	0.48	0.36	0.27	0.21	0.61	0.43	0.55	0.82	0.72	0.82	0.50	0.50
Velindre Organisations	N/A	0.33	0.21	0.29	0.31	0.42	0.34	0.42	0.62	0.60	0.59	0.45	0.36

Monthly Special Leave Absence % Special Leave Covid Related	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.04	2.51	1.69	1.63
Research, Development & Innovation	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	6.18	5.04	3.46	3.42
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	0.00	0.06	3.79	5.60	4.14	3.42
Welsh Blood Service	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.98	4.00	3.13	3.13
Velindre Organisations	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.04	3.01	4.73	3.52	3.12

PADR – The Figures



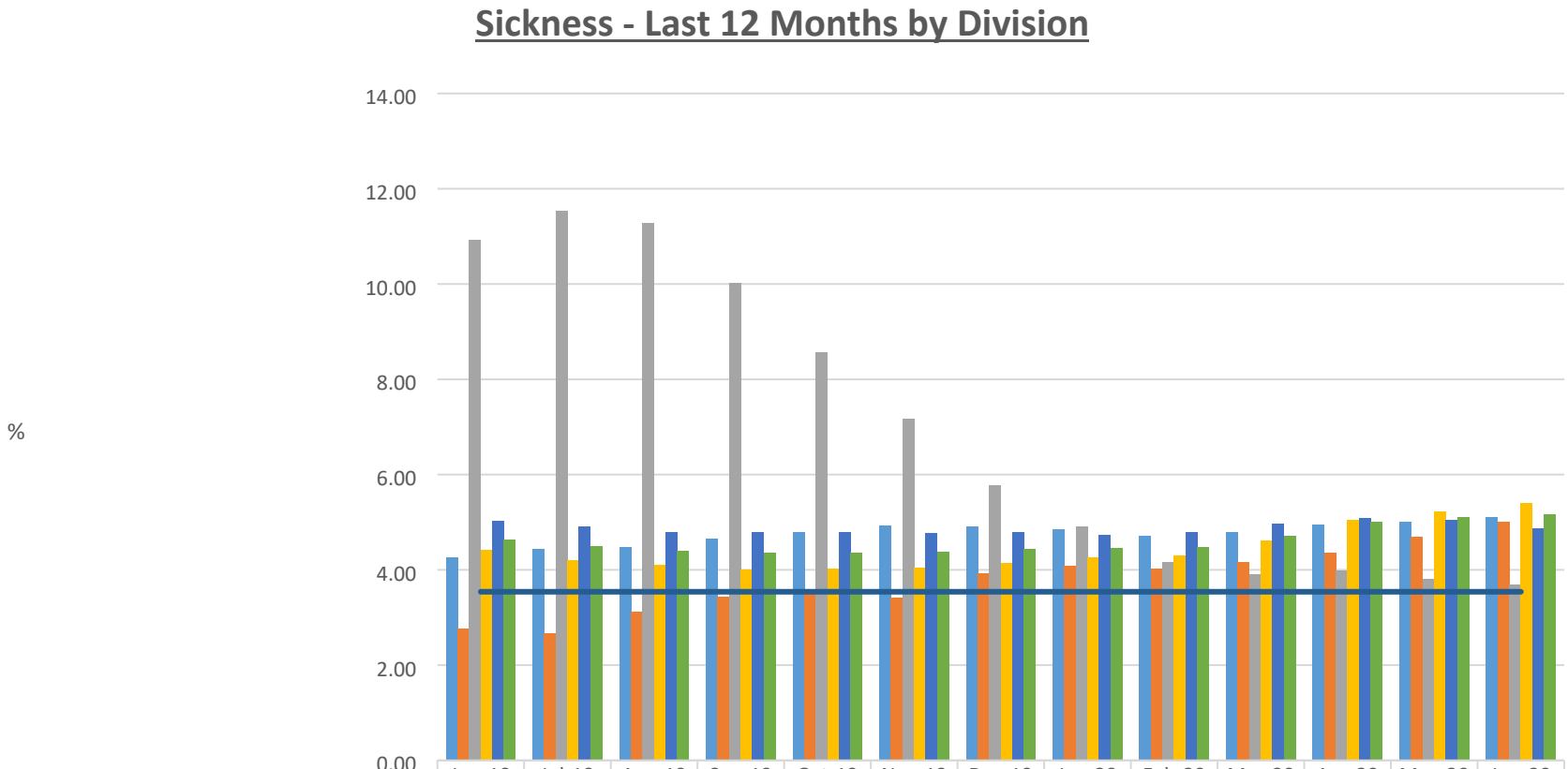
	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	66.04	67.62	66.02	66.67	66.99	73.53	79.00	73.00	71.88	65.35	59.80	51.46	43.93
Research, Development & Innovation	48.78	50.00	41.86	36.96	32.50	32.50	33.33	86.49	87.50	83.72	71.43	72.50	69.77
Transforming Cancer Services	33.33	33.33	23.08	23.08	7.69	61.54	84.62	84.62	78.57	64.29	69.23	69.23	75.00
Velindre Cancer Centre	78.96	78.80	77.79	75.58	72.31	73.46	74.31	70.49	69.66	68.68	64.78	60.26	58.52
Welsh Blood Service	83.00	86.52	87.00	86.04	84.92	85.43	85.68	85.75	84.75	78.00	73.57	67.25	64.94
Velindre Organisations	77.72	79.02	77.97	76.29	73.99	75.94	77.09	76.38	75.43	71.89	67.51	62.28	59.89
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

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

		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	Ongoing development of report to benchmark in NHS Wales and UK wide

Sickness Data – The Figures



	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Corporate	4.25	4.44	4.48	4.65	4.79	4.93	4.92	4.84	4.70	4.78	4.94	5.00	5.10
Research, Development & Innovation	2.76	2.66	3.12	3.44	3.54	3.42	3.91	4.07	4.02	4.16	4.36	4.68	5.01
Transforming Cancer Services	10.92	11.52	11.28	10.02	8.57	7.17	5.77	4.90	4.17	3.91	3.99	3.81	3.69
Velindre Cancer Centre	4.42	4.20	4.09	4.01	4.02	4.05	4.15	4.25	4.30	4.61	5.04	5.22	5.40
Welsh Blood Service	5.02	4.91	4.78	4.79	4.79	4.77	4.78	4.72	4.80	4.96	5.09	5.05	4.86
Velindre Organisations	4.64	4.50	4.40	4.36	4.37	4.37	4.43	4.45	4.48	4.72	5.01	5.11	5.17
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

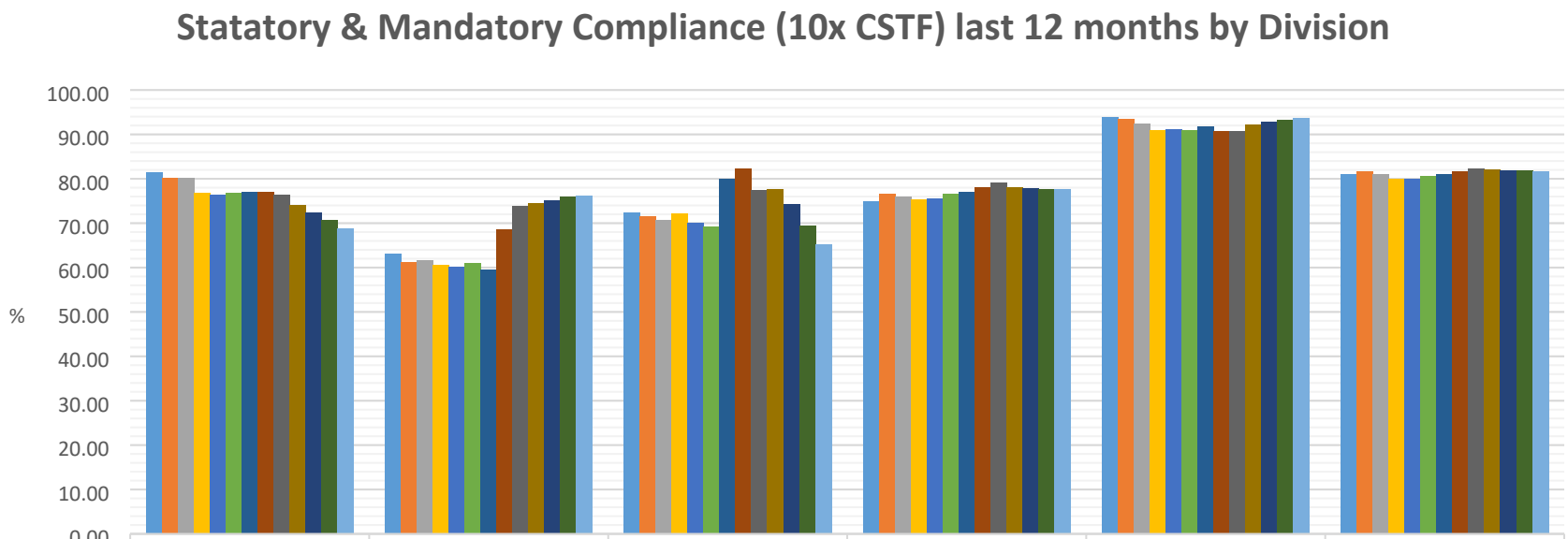
Sickness – The Narrative

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

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

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

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Jun-19	81.47	63.06	72.50	74.89	93.90	81.16
Jul-19	80.17	61.25	71.67	76.54	93.49	81.79
Aug-19	80.17	61.57	70.77	75.93	92.37	81.02
Sep-19	76.81	60.59	72.31	75.47	90.90	79.94
Oct-19	76.42	60.20	70.00	75.55	91.22	80.00
Nov-19	76.89	61.04	69.23	76.62	90.96	80.60
Dec-19	77.11	59.58	80.00	77.05	91.88	81.15
Jan-20	77.04	68.57	82.31	78.10	90.85	81.75
Feb-20	76.47	74.00	77.50	79.11	90.68	82.30
Mar-20	74.21	74.51	77.65	78.16	92.26	82.08
Apr-20	72.36	75.10	74.38	77.94	92.87	82.00
May-20	70.73	75.92	69.41	77.76	93.27	81.83
Jun-20	68.94	76.27	65.29	77.62	93.79	81.74

Statutory and Mandatory Figures – The Narrative

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

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

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

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 30TH JUNE 2020 (M3)

DATE OF MEETING	30/07/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager
PRESENTED BY	Mark Osland, Executive Director of Finance & Informatics
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance & Informatics

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	

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

1. SITUATION/BACKGROUND

1.1 See attached report

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 See attached report

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust financial position at the end of June 2020 is an overspend of £13k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

4.1 Trust Board is asked to **NOTE** the contents of the June 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 positon as at the end of June attached as appendix 1.

Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JUNE 2020/21

TRUST BOARD MEETING

30 JULY 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.

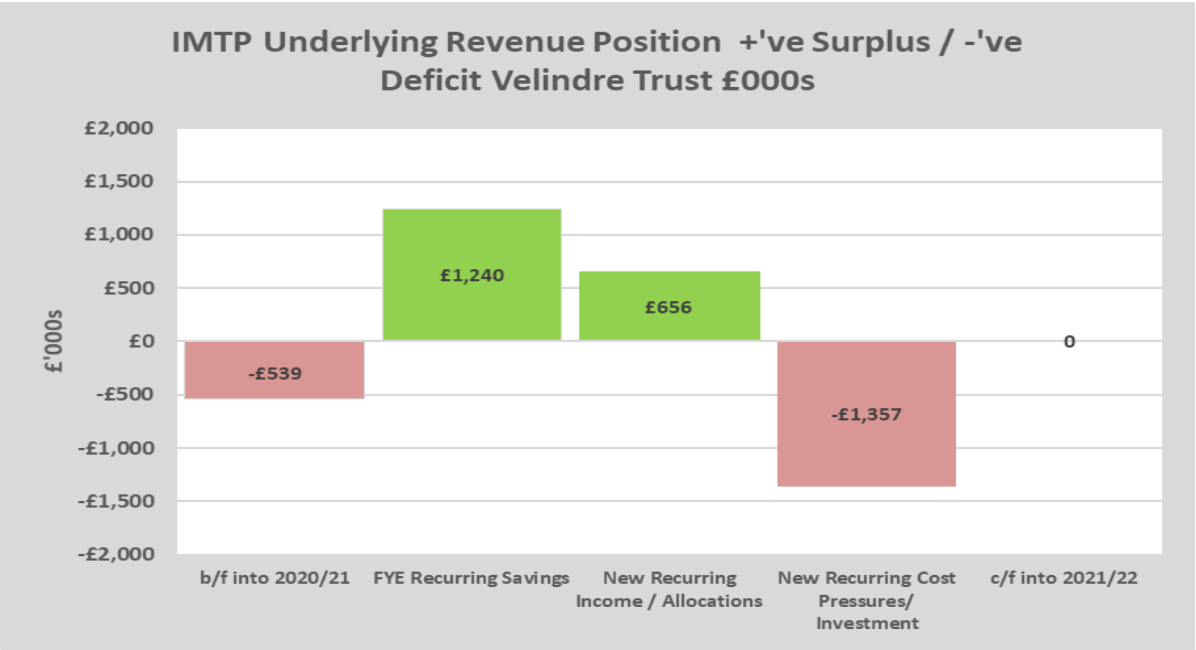
2. Background / Context

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	1,240	656	- 1,357	-

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	(16)	(13)	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1,428	2,028	4,992
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.9	96.8	95.0

Performance against Planned Savings

Efficiency Savings /	Variance	(2)	(139)	0

Revenue

The Trust has reported a **£(16)k** in-month overspend for June '20, with a cumulative position of **£(13)k** overspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at June 2020 is currently **£4,992k** for 2020-21. This represents all Wales Capital funding of £2,653, Discretionary funding of £1,850k and funding for Covid-19 of £489k.

The current cumulative spend against the programme as at the end of June is **£2,028k**, (which includes £961k of Covid-19 expenditure) with a forecasted spend of **£4,992k** to match the current CEL.

PSPP (Excluding Hosted Organisations)

During June '20 the Trust (core) achieved a compliance level of **97.9%** (May '20: 98.4%) of Non-NHS supplier invoices paid within the 30 day target, which gives a cumulative compliance figure of **96.8%** to the end of June 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, £(139)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		
£(13,173) Overspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(36,593)	(36,354)	(239)	(143,983)	(143,983)	0
Pay	16,028	15,982	46	63,674	63,674	0
Non Pay	20,565	20,385	180	80,309	80,309	0
Total	**(0)**	**13**	(13)	**0**	**0**	0

The overall position against the profiled revenue budget to the end of June is an overspend of £(13)k, with a significant underachievement against income offset by an underspend in both Pay and 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		
	£(239)k Underachievement			Breakeven		
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	16,598	16,598	0	70,000	70,000	0
Nice/ High Cost Drugs	9,274	9,274	0	34,902	34,902	0
WBS Wholesale Blood Products	2,486	2,490	4	12,887	12,887	0
WBS WTAIL & Blood Components	790	762	(27)	2,993	2,993	0
Home Care Drugs	138	173	35	575	575	0
Private Patient	396	350	(47)	1,880	1,880	0
VCC Activity Income	383	383	0	1,734	1,734	0
RD&I*	821	763	(57)	3,884	3,884	0
Radiation Protection	182	175	(6)	736	736	0
Staff Recharges	458	386	(72)	1,701	1,701	0
One Wales Palliative and EOL Care	2,687	2,687	0	4,447	4,447	0
Velindre Charity	647	570	(77)	2,630	2,630	0
Other Charity	265	278	14	956	956	0
Other Operating Income	1,469	1,463	(6)	4,658	4,658	0
Total	**36,593**	**36,354**	(239)	**143,983**	**143,983**	0

*RD&I full year budget includes £917k of Velindre Charity income.

The Trust has reported a cumulative year to date underachievement of **£(239)k** on Income.

- RD&I £(57)k and Welsh Transplantation and Immunogenetics Laboratory (WTAIL) £(27)k are lower than planned due to under activity.
- Private Patients £(47)k – The Trust has already lost 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. Whilst the impact of this year is not as severe as initially expected the total risk to the Trust for 2020/21 is still estimated at circa £(150)k.
- Staff recharges are underachieving by £(72)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 £(77)k due to vacancies within the service which are not being recharged to the Charity.

4.2 Pay Analysis by Staff Group

	Cumulative £46k Underspent			Year End Forecast Breakeven		
STAFF GROUP	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
ADD PROF SCIENTIFIC AND TECHNICAL	564	554	10	2,325	2,325	0
ADDITIONAL CLINICAL SERVICES	1,579	1,496	83	6,251	6,251	0
ADMINISTRATIVE & CLERICAL	5,175	4,890	286	20,151	20,151	0
ALLIED HEALTH PROFESSIONALS	1,543	1,759	(217)	6,145	6,145	0
ESTATES AND ANCILLIARY	489	520	(31)	1,880	1,880	0
HEALTHCARE SCIENTISTS	1,953	1,831	123	7,821	7,821	0
MEDICAL AND DENTAL	2,793	2,731	61	11,076	11,076	0
NURSING	2,341	2,185	156	9,450	9,450	0
STUDENTS	18	18	(0)	18	18	0
SAVINGS & VACANCY FACTOR TARGET*	(425)	0	(425)	(1,442)	(1,442)	0
Total	**16,028**	**15,982**	46	**63,674**	**63,674**	0

* Full year budget - VCC Vacancy Factor £450k, Savings £350k, WBS Vacancy Factor £450k, Savings £72k, R&D Vacancy Factor £120k

The Trust has reported a cumulative year to date position underspend of **£46k** on Pay.

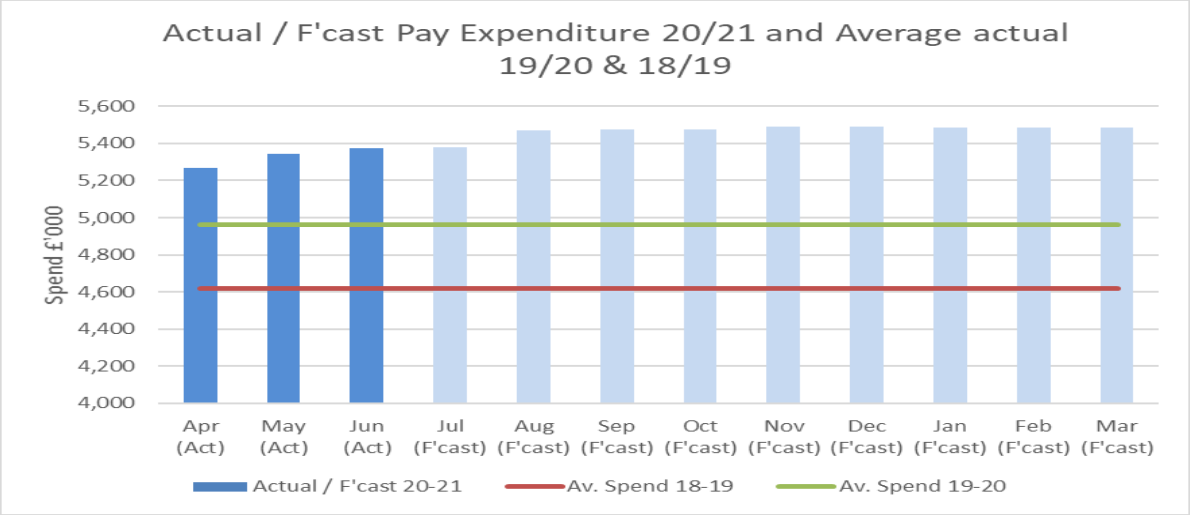
Included within the various staff group expenditure values showing within the above table, the total Agency spend for June was £196k (May £224k), giving a cumulative year to date spend of **£645k** and a forecasted spend of circa **£1,822k.** Of these totals the year to date spend on agency directly related to Covid-19 is £63k and forecasted spend is circa £254k.

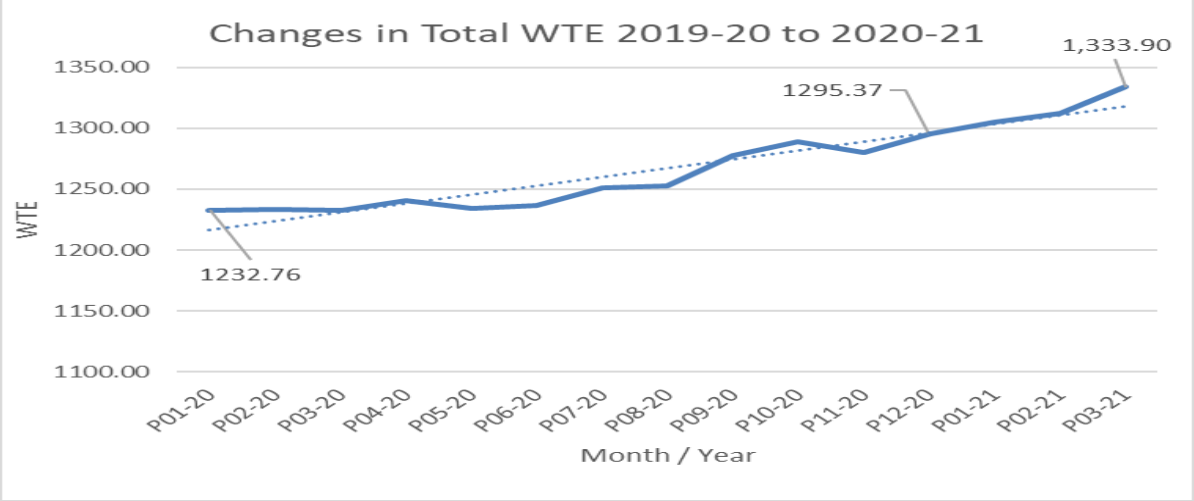
- Current vacancies against underspending staff groups are Clinical Services (4.51 wte), Admin & Clerical (11.08 wte), Healthcare Scientists (15.69 wte), Medical & Dental (14.34 wte), Nursing (22.84 wte).
- Allied Health Professionals are experiencing an over spend of £(217)k which is due to the use of agency in Radiotherapy and Medical Physics to cover the additional capacity.
- The underachievement of £(425)k that is being reflected against the divisional savings and vacancy factor target is being achieved through underspends across numerous staffing groups, as illustrated in the above table.

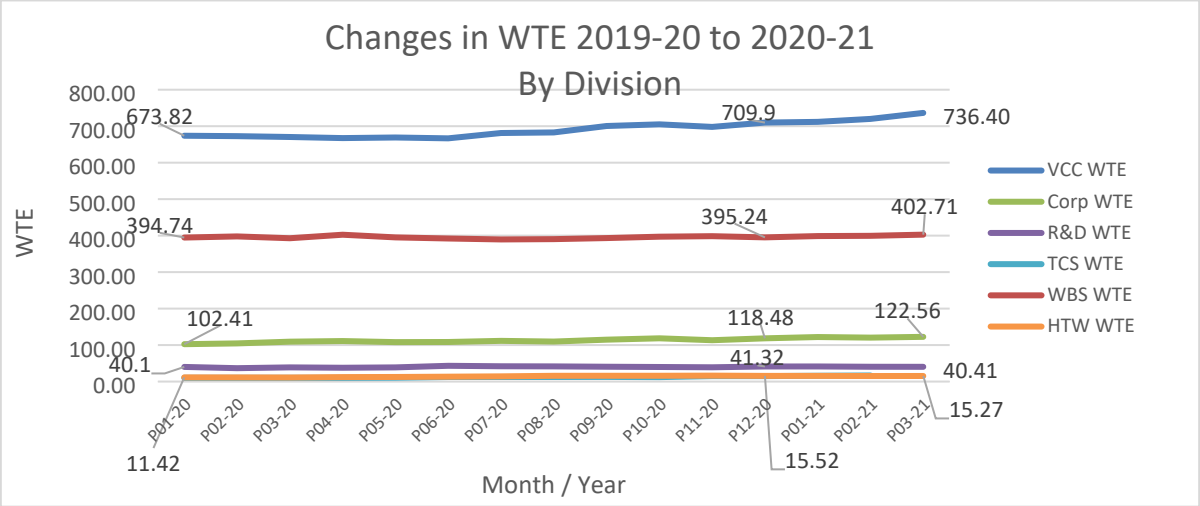
Pay Spend Trends (Run Rate)

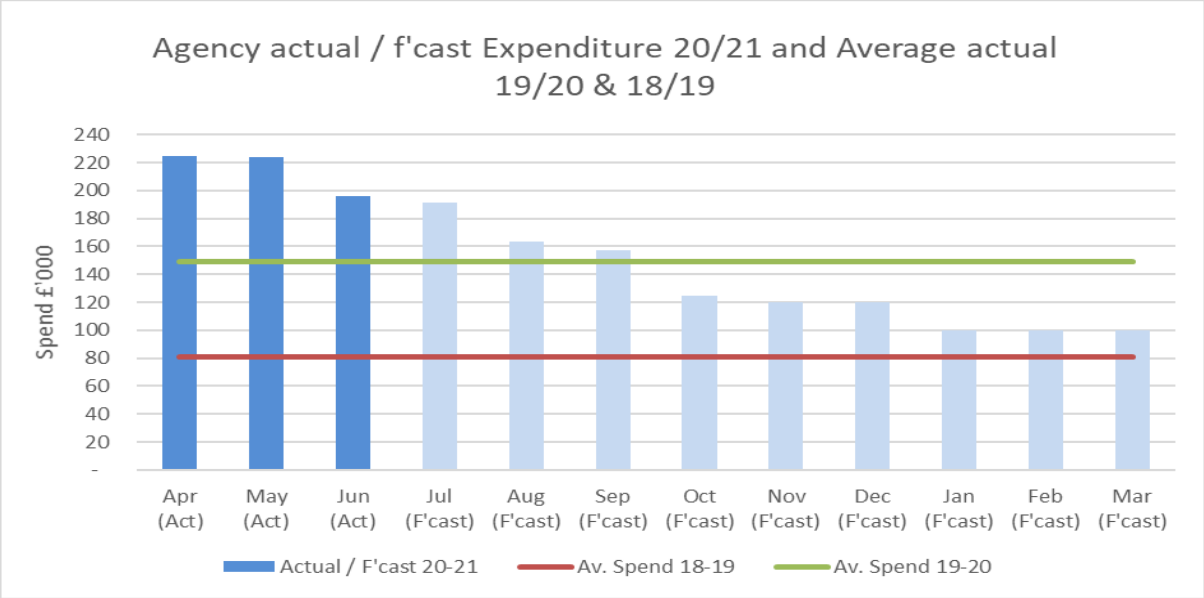
The pay spend for 19-20 was 12% above av. pay 18-19. 3% can be attributed to the pay award. 1.3% (£822k in total) relates to an increase in use of agency staff, and 6.3% the Increase in pension award which was accounted for in month 12. The remaining difference is a result of the additional staff recruited since the end of March'19 (c63wte).

The pay spend for 20-21(excluding the 6.3% increase in pension) is circa 7.4% above av. pay in 2019-20. 3% can be accounted for by the pay award, 2.8% 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 (c38wte), and pay costs associated with Covid-19.









4.3 Non Pay Analysis

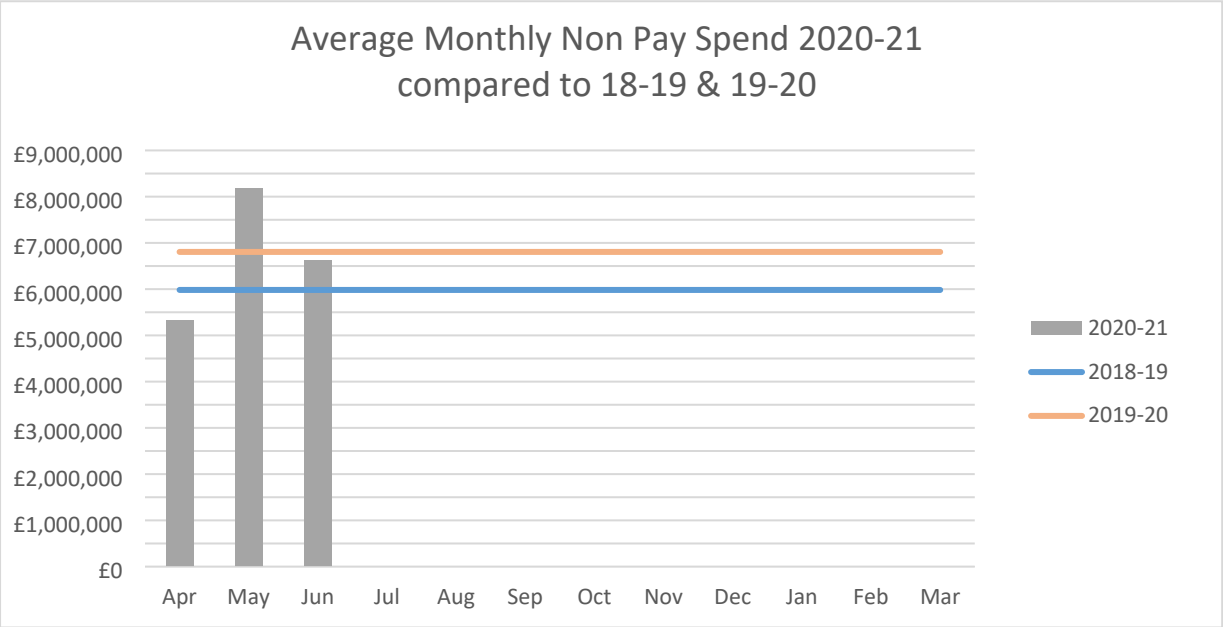
	Cumulative £180k Underspent			Year End Forecast Breakeven		
Income Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Nice & High Cost Drugs	9,116	9,116	0	34,366	34,366	0
Blood Wholesaling	2,505	2,502	3	12,961	12,961	0
Depreciation	1,604	1,604	0	6,416	6,416	0
Clinical Services & Supplies	1,203	1,186	17	5,281	5,281	0
Facilities Management	236	258	(23)	784	784	0
Maintenance & Repairs	720	706	14	2,844	2,844	0
General & PP Drugs	657	524	133	2,572	2,572	0
Utilities/ Rent /Rates	547	559	(12)	2,191	2,191	0
General Services & Supplies	336	217	119	1,073	1,073	0
Blood Components	360	330	30	1,653	1,653	0
Transport	252	237	15	1,044	1,044	0
Printing / Stationary / Postage	191	164	27	815	815	0
Computer Maintenance & Supplies	170	235	(65)	679	679	0
Travel & Subsistence	104	61	43	566	566	0
Equipment & Consumables	85	100	(15)	253	253	0
Education & Development	65	35	30	313	313	0
NHS SLA	23	29	(5)	299	299	0
Audit Fees	74	69	5	279	279	0
Telecoms	44	72	(28)	174	174	0
One Wales End of Life Care	2,373	2,373	0	3,193	3,193	0
General Reserves / Savings Target	(99)	9	(107)	2,553	2,553	0
Total	**20,565**	**20,385**	180	**80,309**	**80,309**	0

The Trust has reported a cumulative year to date position of **£180k** underspend on Non-Pay.

- General drugs is underspending by £133k as at the end of June due to low activity.
- General Services and Supplies is underspending by £119k, however the majority £95k relates to the budget alignment in R&D which will be corrected in month 4.
- Computer Maintenance & Supplies is over spending by £(65)k, with £(24)k a direct result of Covid-19, and the rest being front loaded expenditure for 2020/21 maintenance contracts.

- General Reserves / Savings Target is currently reporting an overspend of £(107)k due to non-achievement of savings related to Covid-19.

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 M3 has currently remained static at c£6.7m.



*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 Actual (£'000)	Full Year Forecast (£'000)
Pay	257	2,438
Non Pay	499	5,150
Reduction of non pay costs due to reduced elective activity	(130)	(250)
Non Delivery of Finalised (M1) Savings	138	700
Total	**764**	**8,038**

The total year to date net additional expenditure on activity directly related to Covid-19 is £764k. This incorporates actual gross expenditure of £756k, plus non delivery of savings of £138k, offset by a reduction in activity costs of £130k.

The full year net additional forecast cost amounts to £8,038k. Included within this forecast is expenditure of £1,153k relating 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 2020-21. Consequently the current unfunded forecast revenue expenditure directly associated with Covid 19 is £6,885k.

The total forecast cost of £8,038k has significantly increased from previous forecasts, primarily due to the inclusion of estimated costs to provide additional capacity to meet an expected increase in demand later this year.

Drivers for Creating 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 3 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 **£4.6m** 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.

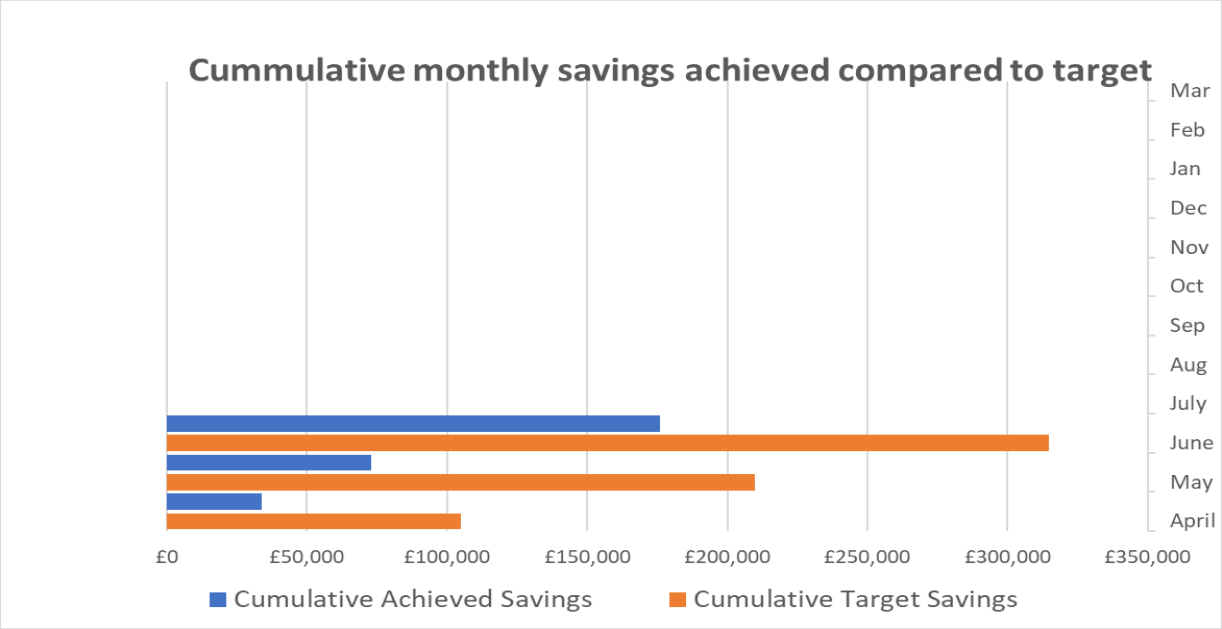
Within the identified savings, £650 of the schemes are now RAG rated as green, £200k are RAG rated amber, and £550k have turned red in response to Covid-19. A significant proportion of the savings were expected to be delivered through service redesign and workforce rationalisation, which has been impossible 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, £(139)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 turning amber (£150k) with the likelihood of achievement being very low. 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	214	35	(179)	300	(550)
			93%		91%	
WBS TOTAL SAVINGS	450	76	71	(5)	300	(150)
			99%		105%	
CORPORATE TOTAL SAVINGS	100	25	25	0	100	0
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	1,400	315	131	(184)	700	(700)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	0	0	45	45	0	0
ANTICPATED WG COVID FUNDING FOR LOSS OF SAVINGS			0	0	700	700
TRUST TOTAL SAVINGS	1,400	315	176	(139)	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	14	0	(14)	0	(50)
Premium of Agency Staffing	Red	150	38	0	(38)	0	(150)
Supportive Structures	Red	150	38	0	(38)	0	(150)
Procurement National and Local Value Plan	Amber	50	13	0	(13)	38	(12)
Non Pay targeted Savings	Green	84	21	21	0	84	0
Non Recurrent Gains - Stock Management	Green	100	25	20	(5)	100	0
Review of Staffing	Green	116	30	30	0	116	0
Changes in Staffing Establishment	Green	100	25	25	0	100	0
Total Income Generation		**800**	202	96	(107)	438	(362)
Income Generation							
Productivity Gains	Red	200	50	0	(50)	0	(200)
Maximising Meds@Home opportunities	Green	50	13	35	23	63	13
Medicines Management (Secondary Care)	Green	100	25	0	(25)	100	(0)
Maximum income opportunities	Green	100	25	0	(25)	100	(0)
Increased Sale of Products	Amber	150	0	0	0	0	(150)
Total Income Generation		**600**	113	35	(77)	263	(337)
TRUST ADDITIONAL NON-RECURRENT SAVINGS		0	0	45	45	0	0
ANTICPATED WG COVID FUNDING FOR LOSS OF SAVINGS				0	0	700	700
Trust Total Savings		1,400	315	176	(139)	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 available funding is shown below:-

	Recurring £k	Non Recurring £k
Unallocated Budget	**181**	**68**

Emergency Reserve		**522**

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

Covid-19 (High)

Overview Of Key Risks & Opportunities	FORECAST YEAR END	
Risks (negative values)	£'000	Likelihood
Covoid 19: Expenditure incurred funding not received from WG	(6,185)	High
Covoid 19: Savings Slippage	(700)	High
Private Patient Income	(150)	Medium
Further Opportunities (positive values)		
Additional in Year Vacancy Factor	150	Medium

The total forecasted expenditure on Covid-19 is £8,038k. This includes £2,438k of pay costs, £5,150k of non-pay costs, £(250)k of cost reduction, and £700k of slippage expected on delivery of savings.

Of the £8,038k forecast Covid-19 revenue expenditure, £1,153k relates to the All wales Convalescent Plasma service which Welsh Government has agreed to fund which reduces the risk on operational expenditure to £6,185.

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.

At this point no agreement has been reached on the arrangements from 1 October 2020.

Due to the complexities and uncertainties around forecasting future activity levels and contracting arrangements we are currently planning on a neutral impact regarding our Marginal activity income.

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 £150k.

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 @ M3 £000s	Forecast Year End Spend £000s	Year End Variance £000s
All Wales Capital Programme						
Transforming Cancer Services	0	495	0	(495)	4,238	(4,238)
TCS - Radiotherapy Procurement Solution	548	114	0	434	548	0
IT - WPAS (CANISC replacement phase 2)	0	220	0	(220)	892	(892)
VCC CT Sim Replacement x2	1,957	221	735	1,001	1,957	0
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	1,051	822	780	7,783	(5,130)
Covid-19						
COVID-19 WBS Plasmapheresis	397	207	0	190	397	0
COVID-19 Digital Devices	92	0	0	92	92	0
COVID-19 Other		754	0	(754)	968	(968)
Total Covid-19	489	961	0	(472)	1,457	(968)
Discretionary Capital	1,850	45	72	1,733	1,850	0
Sub Total	4,992	2,057	894	2,041	11,090	(6,098)
Charitable Funded Capital Scheme	45	0	0	45	45	0
TOTAL	**5,037**	**2,057**	**894**	**2,086**	**11,135**	**(6,098)**

The approved Capital Expenditure Limit (CEL) as at June 2020 was £4,992k for 2020-21 (excl Charity). This includes All Wales Capital funding of £2,653k, Covid-19 funding to date of £489k, 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. Whilst we await WG approval of the business cases we have submitted an interim request for funding of £1.1m for the period April 2020 to September 2020.

This has not yet been approved as the primary focus of the WG capital team is to deal with capital issues associated with Covid-19. 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.

Covid-19

The Trust is forecasting to spend £1,457k (£961k to end of June) on Covid-19 related capital expenditure. A submission was made to WG on the 5th June requesting funding to support these costs. The Trust has since received confirmation of funding from WG for the Digital Devices £92k, and the Convalescent Plasma Collection Devices £397k. The Trust has been asked to submit a further updated return to WG on the 17th July, and we are hopeful for a response on funding from WG following this.

WPAS

Funding of £892k for WPAS has been agreed and will be transferred from NWIS in 2020/21.

Major Schemes in Development

- VCC – PBC (compliance and safety issues prior to opening of the new hospital)
- Fire Safety – c **£1.25m**
- Ventilation – **c £2m**
- WBS PBC – Mechanical / Electrical infrastructure – c **£21m over 4 years**

Performance to date

The actual cumulative expenditure to June 2020 on the All Wales Capital Programme schemes was £1,052k, this is broken down between spend on the TCS Programme £495k, TCS Radiotherapy Procurement Solution £114k, WPAS £220k, and CT SIM Replacement £221k.

The year to date spend related to Covid-19 is £961k.

There has been little movement on the Discretionary capital funding programme with the current uncertainty around covid-19 and funding for the TCS programme. The Capital planning group has however allocated £100k to both VCC and WBS, and £179k 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 both Covid-19 and the TCS programme.

Year-end Forecast Spend

The year-end forecasted outturn is currently expected to be managed to a breakeven positon.

Risks associated with the Capital Programme

Significant capital requirements identified across the Trust

- Unlikely to be 100% successful with bids to the All Wales Programme
- Currently using Discretionary funds to support the TCS programme
- Expenditure directly related to Covid-19 estimated to be circa £968k. Reimbursement not guaranteed.
- 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 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 30th June '20 and forecast closing balance as at 31st March '21.

Non -Current Assets

The **Increase of £6,044k** from 1st April to 30th June 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 £28,045k** from 1st April to 30th June 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 Covoid-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.

	Opening Balance Beginning of Apr 20	Closing Balance End of Jun-20	Movement from 1st April to Jun-20	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	129,552	135,596	6,044	129,552
Intangible assets	17,645	17,645	0	17,645
Trade and other receivables	861,947	861,947	0	861,947
Other financial assets				
Non-Current Assets sub total	1,009,144	1,015,188	6,044	1,009,144
Current Assets				
Inventories	13,134	41,179	28,045	13,134
Trade and other receivables	415,297	493,583	78,286	415,297
Other financial assets				
Cash and cash equivalents	18,227	42,145	23,918	18,227
Non-current assets classified as held for sale				
Current Assets sub total	446,658	576,906	130,248	446,658
TOTAL ASSETS	1,455,802	1,592,094	136,292	1,455,802
Current Liabilities				
Trade and other payables	(166,041)	(743,493)	(577,452)	(166,041)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(273,929)	167,354	441,283	(273,929)
Current Liabilities sub total	(439,970)	(576,139)	(136,169)	(439,970)
NET ASSETS LESS CURRENT LIABILITIES	1,015,832	1,015,955	123	1,015,832
Non-Current Liabilities				
Trade and other payables				
Borrowings				
Other financial liabilities				
Provisions	(862,084)	(862,084)	0	(862,084)
Non-Current Liabilities sub total	(862,084)	(862,084)	0	(862,084)
TOTAL ASSETS EMPLOYED	153,748	153,871	123	153,748
FINANCED BY:				
Taxpayers' Equity				
PDC	112,984	113,119	135	112,984
Retained earnings	12,432	12,419	(13)	12,432
Revaluation reserve	28,333	28,333	(0)	28,333
Other reserve				
Total Taxpayers' Equity	153,749	153,871	122	153,749

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.

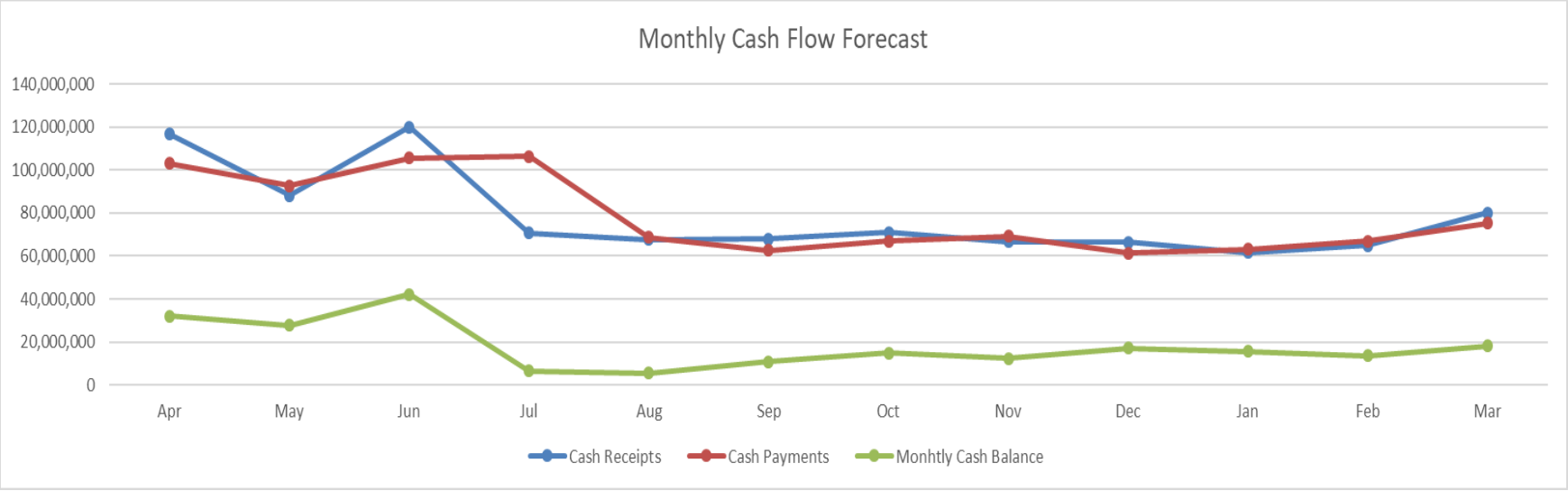
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products have been purchased by WBS, to provide resilience for NHS Wales due to the precarious decision around Brexit.

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 Covod-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 are 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	28,900	23,008	22,005	27,115	23,800	25,800	24,000	33,025	39,800	315,037
2	**WG Income**	93,193	44,297	70,821	39,850	42,820	44,100	42,018	41,003	38,670	35,670	29,850	38,140	560,432
3	**Short Term Loans**													0
4	**PDC**	149												149
5	**Interest Receivable**	3	4	0	4	4	4	4	4	4	4	4	4	43
6	**Sale of Assets**													0
7	**Other**	3,162	17,499	28,494	2,025	1,875	1,950	1,950	1,875	1,875	2,000	2,000	2,025	66,730
8	**TOTAL RECEIPTS**	**116,869**	**88,184**	**120,154**	**70,779**	**67,707**	**68,059**	**71,087**	**66,682**	**66,349**	**61,674**	**64,879**	**79,969**	**942,391**
	PAYMENTS													
9	**Salaries and Wages**	15,946	15,958	16,323	16,275	18,429	19,346	19,636	20,029	20,098	20,184	22,493	22,558	227,275
10	**Non pay items**	84,539	75,671	88,129	88,801	49,175	42,690	39,310	48,190	39,999	41,274	42,800	45,625	686,204
11	**Short Term Loan Repayment**													0
12	**PDC Repayment**												5,111	5,111
14	**Capital Payment**	2,551	1,004	1,167	1,400	1,100	700	980	1,100	1,400	1,800	1,600	2,000	16,802
15	**Other items**							7,000						7,000
16	**TOTAL PAYMENTS**	**103,036**	**92,633**	**105,619**	**106,476**	**68,704**	**62,736**	**66,926**	**69,319**	**61,497**	**63,258**	**66,893**	**75,294**	**942,392**
17	**Net cash inflow/outflow**	13,832	(4,450)	14,535	(35,697)	(997)	5,323	4,161	(2,637)	4,852	(1,584)	(2,014)	4,675	
18	**Balance b/f**	18,227	32,059	27,610	42,145	6,448	5,451	10,774	14,935	12,298	17,150	15,566	13,552	
19	**Balance c/f**	32,059	27,610	42,145	6,448	5,451	10,774	14,935	12,298	17,150	15,566	13,552	18,227	



DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Variance £000
VCC	8,534	8,689	(155)	34,432	34,432	0
RD&I	(16)	(59)	42	(473)	(473)	0
WBS	4,809	4,724	85	21,176	21,176	0
Sub-Total Divisions	**13,327**	**13,355**	**(28)**	**55,136**	**55,136**	**0**
Corporate Services Directorates	1,433	1,420	15	5,680	5,680	0
Delegated Budget Position	**14,760**	**14,774**	**(13)**	**60,816**	**60,816**	**0**
TCS	134	134	(0)	537	537	0
Health Technology Wales	0	(0)	0	0	0	0
Non recurrent measures to achieve financial breakeven	0	0	0	0	0	0
Trust Position	**14,894**	**14,908**	**(13)**	**61,352**	**61,352**	**0**

VCC

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**12,639**	**12,505**	**(134)**	**47,927**	**47,927**	**0**
Expenditure						
Staff	9,128	9,280	(152)	36,452	36,452	**0**
Non Staff	12,044	11,914	131	45,907	45,907	**0**
Sub Total	**21,173**	**21,194**	**(21)**	**82,359**	**82,359**	**0**
Total	**8,534**	**8,689**	**(155)**	**34,432**	**34,432**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre at the end of June 2020 was an overspend of **£(155)k** representing 0.19% of the division's annual budget.

Income at month 3 was **£(134)k** under achieved, this primarily relates to non-achievement of the Income savings target of £(134)k, Private patient income is also under achieving as noted earlier, along with canteen takings being down due to reduced activity in the hospital, and the closure of

the gift shop in response to Covid-19. 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 **£(152)K** overspent as at month 2. The major factor contributing to the overspend is the cost of agency which totals £(418)k as at the end of June, 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 partly offsetting the agency costs.

Non Pay Expenditure at month 2 was **£164k** 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, Physics Management TPS maintenance, and the non-achievement of savings plans.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**3,602**	**3,562**	**(40)**	**16,810**	**16,810**	**0**
Expenditure						
Staff	4,099	4,002	97	16,239	16,239	**0**
Non Staff	4,312	4,285	27	21,747	21,747	**0**
Sub Total	**8,411**	**8,286**	**125**	**37,987**	**37,987**	**0**
Total	**4,809**	**4,724**	**85**	**21,176**	**21,176**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of June 2020 was an under spend of **£85k** representing 0.22% of the division's annual budget.

Income underachievement to date is **£(40)k**, Plasma sales, and Bone Marrow, activity are lower than planned due to Covid-19 suppressed activity. There is also a risk of under achievement on Renal income due to reduced activity, which does not currently form part of the position (£51k to June).

Staffing underspend continues to be high with a **£97k** under spend reported to June, which is above the divisions vacancy factor target. Vacancies remain significant as unable to introduce meaningful recruitment due to Covid-19.

Non Pay underspend of **£27k** is largely due to reduced costs from suppressed activity, Underspend on collections services, Laboratory Services, and WTAIL, General Service (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	**2,707**	**2,699**	**(7)**	**4,263**	**4,263**	**0**
Expenditure						
Staff	1,788	1,766	22	6,904	6,904	**0**
Non Staff	2,352	2,353	(1)	3,038	3,038	**0**
Sub Total	**4,140**	**4,119**	**21**	**9,943**	**9,942**	**0**
Total	**1,433**	**1,420**	**15**	**5,680**	**5,679**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services Division at the end of June 2020 was an under spend of **£15k** representing 0.15% of the division's annual budget.

Income underachievement of £(7)k due to fall in interest rate resulting in drop in bank interest received.

Staff is underspent by £22k. This is largely due to 2 vacancies in the Estates Team (one filled in May, one due to be filled this month) and the Deputy Director of Nursing post being vacant.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**821**	**763**	**(57)**	**3,884**	**3,884**	**0**
Expenditure						
Staff	699	618	81	2,767	2,767	**0**
Non Staff	106	87	19	643	643	**0**
Sub Total	**804**	**705**	**100**	**3,411**	**3,411**	**0**
Total	**(16)**	**(59)**	**42**	**(473)**	**(473)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of June 2020 was an under spend of **£42k** representing 1.24% of the total divisional budget.

The under achievement of **£(57)k** on income, is due to underperformance on projects which is offset by underspends within staff and non-staff.

Half of the **£81k** underspend on staff is due to fully funded projects, which therefore have no impact on bottom line. The remaining underspend is due to vacancies.

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	134	135	(1)	536	536	**0**
Non Staff	0	(1)	1	0	0	**0**
Sub Total	**134**	**134**	**(0)**	**537**	**536**	**0**
Total	**134**	**134**	**(0)**	**537**	**536**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of June 2020 was **Breakeven.**

A small overspend on staff **£(1)k** was offset by a small underspend in non-staff **£1k**.

HTW

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**226**	**226**	**0**	**1,100**	**1,100**	**0**
Expenditure						
Staff	179	181	(2)	777	777	**0**
Non Staff	47	45	2	323	323	**0**
Sub Total	**226**	**226**	**0**	**1,101**	**1,100**	**0**
Total	**0**	**(0)**	**0**	**0**	**0**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of June 2020 was **Breakeven.**

There is no variance on income and a small overspend of **£(2)k** on staff was offset by a small underspend on non-staff £2k.

TCS PROGRAMME FINANCIAL REPORT FOR 2020-21

JUNE 2020

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 03 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, namely the nVCC Project and Enabling Works Project, amounting to a cumulative value to date is £17.321m and revenue funding of £2.163m. The total cumulative expenditure as at the end of March 2020 was £17.321m for Capital and £2.682m 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 A capital funding request of c£1.141m has been submitted to Welsh Government for the Enabling Works and nVCC Projects form April 2020 to September 2020 inclusive.

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** *WG Capital Funding* Capital funding from WG to be confirmed *Revenue Funding* 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

Description	Funding	
	Capital	Revenue
Project 6 – Service Delivery, Transformation and Transition		
No capital funding requirement at present	£nil	
Allocation from funding provided from Commissioners for 2020-21 to cover direct clinical/management support and PMO		£0.180m
Funding transferred from the Trusts core revenue budget toward the costs of the Project Director post		£0.067m
Funding transferred from Velindre Cancer Centre toward the costs for the Project Manager post		£0.049m
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 30TH JUNE 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

Description	Current Month			Financial Year		
	Budget to Jun-20	Spend to Jun-20	Variance to Jun-20	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
CAPITAL						
PAY						
nVCC Project and Enabling Works Project Staff	0	207,875	-207,875	0	1,132,478	-1,132,478
Other Project Staff	0	29,549	-29,549	0	118,195	-118,195
NON-PAY - PROJECTS						
nVCC Project Delivery	0	5,946	-5,946	0	88,979	-88,979
Project 1 - Enabling Works	0	144,016	-144,016	0	2,310,462	-2,310,462
Project 2 - New Velindre Cancer Centre	0	107,763	-107,763	0	587,627	-587,627
Project 3 - Radiotherapy Procurement Solution	112,750	113,994	-1,244	548,000	548,000	0
CAPITAL TOTAL	**112,750**	**609,143**	**-496,393**	**548,000**	**4,785,740**	**-4,237,740**
REVENUE						
PAY						
Programme Management Office	60,000	60,534	-534	240,000	243,661	-3,661
Service Change Team	73,898	74,153	-255	295,591	295,591	0
NON-PAY						
nVCC Project Delivery	0	6,149	-6,149	0	30,030	-30,030
REVENUE TOTAL	**133,898**	**140,836**	**-6,939**	**535,591**	**569,282**	**-33,692**
TCS PROGRAMME TOTAL	**246,648**	**749,979**	**-503,332**	**1,083,591**	**5,355,023**	**-4,271,432**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 30TH JUNE 2020

CAPITAL SPEND

WG Funded Staffing

5.1 An in year **spend of £0.208m** for posts funded by WG reflects the current 'interim' posts, with a **forecast spend of £1.132m** for the year. The budget is to be confirmed.

Other Project Staff

5.2 There is an in-year **spend of £0.030m** to date against a nil budget for project staff not funded by WG, with a **forecast spend of £0.118m** for the year. There is no budget for this spend.

Project Delivery Costs

5.3 There is a capital cost of **c£6k** 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 **£0.089m**, with the budget is to be confirmed.

Project 1 – Enabling Works for nVCC

5.4 There is an in-year capital spend of **£0.144m**, with a forecast spend for the year of **£2.310m**. The budget is to be confirmed.

Work package	Spend to 30th June 2020
Planning (inc TCAR & Asda)	£0.012m
Master Planning & Feasibility Study	£nil
Asda Undertakings	£0.030m
Enabling Works - Design & Employers Requirements	£0.113m
Enabling Works – Works	£nil
Miscellaneous works	-£0.011m

Project 2 – nVCC

5.5 There is an in-year capital spend of **£0.108m**, with a forecast spend for the year of **£0.588m**. The budget is to be confirmed.

Work package	Spend to 30th June 2020
Project Agreement (PA)	£0.050m
Procurement Documents (PD)	£0.044m
Competitive Dialogue Preparedness	£0.014m
Land Transfer	£nil
Competitive Dialogue - PQQ & Dialogue	£nil
Miscellaneous works	£nil

Project 3 – Equipment and Digital

5.6 There is an in-year spend of **£0.114m** for the Integrated Radiotherapy Solutions Procurement Project against a budget of **£0.113m**. The slight underspend is due to a delay in meetings and workshops taking place due to COVID-19 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 **£0.061m** against a budget of **£0.060m**. There is a forecast outturn of **£0.244m** against a budget **£0.240m** for the financial year 2020-21. This forecast overspend of c£4k is due to some of the costs for the Director of Commercial & Strategic Partnerships being borne by the PMO from April 2020. There are no non pay costs identified by the PMO at present.

Projects 1 and 2 Delivery Costs

5.8 There is a revenue delivery cost for the nVCC and Enabling Works Projects of **£6k** to date. This includes rates and other office 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 **£0.074m** against a budget the same. The project is forecast to break even for the year against a budget of **£0.296m**. There are no non pay costs identified by the Project at present.

6. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
RELATED HEALTHCARE STANDARD	Staff and Resources
	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.

7. RECOMMENDATION

7.1 The TCS Programme Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2020-21 as at 30th June 2020.

TRUST BOARD

COMMUNICATIONS AND ENGAGEMENT UPDATE FOR THE TRANSFORMING CANCER SERVICES PROGRAMME

DATE OF MEETING	30/07/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Non Gwilym, Assistant Director Communications and Engagement
PRESENTED BY	Lauren Fear, Director Corporate Governance
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director Corporate Governance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Transforming Cancer Services Programme Scrutiny Committee	28/7/2020	Proposed for NOTING (Committee not yet sat when papers published)

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 This paper has been prepared to provide the Trust Board with an update on Transforming Cancer Services communications and engagement activity since June 2020.

1.2 The Board is requested to **NOTE** the contents of the report including the immediate priorities and agree the recommendations.

1.3 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 communities of interest.

1.4 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

Mainstream programme communications is delivered under the Velindre Cancer Centre brand and channels.

1.5 Programme communications and engagement was paused in March 2020 following the outbreak of COVID-19 which resulted in Cardiff City Council (the Council) suspending the consideration and determination of planning applications.

1.6 The Council's planning process resumed in June.

.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Since June 2020, programme communications and engagement have focused on supporting two projects: the new Velindre Cancer Centre enabling works project and the Outreach Project.

The Outreach project

2.2 The focus of the Outreach project is the delivery of systemic anti-cancer therapies, outpatient and services in the local community and at home for the south East Wales Area. Specifically, it delivers on the programme's ambition to maximise patient treatment choice, regional collaboration and a focus on patient outcomes.

2.3 A communications and engagement strategy was considered and approved by the project board on 30 June. The project stakeholders have different levels of knowledge, interest and influence in the wider programme and the Outreach project specifically.

2.4 The strategy sets the following goals for patient & stakeholder engagement and communication:

- Ensure robust and meaningful patient, public, and staff engagement to frame the options and support decisions on the preferred model.
- Supporting the development and communication of the Project's vision among all stakeholders including consultation with the Community Health Councils and Commissioning Health Boards.
- Secure the support of key stakeholders in accordance with the stakeholder strategy and communications plan.

2.5 The Board also adopted a project narrative that reinforces the wider programme narrative and messages - *Velindre futures: treating more, living longer, closer to home*. It incorporates five key messages:

- Wales has some of the lowest cancer survival rates in the western world
- Velindre is preparing to treat more patients and help more people live longer with cancer
- Patient needs are at the heart of our service development
- We are committed to treating more patients closer to home and making better use of technology to support them
- Velindre is working across south east Wales to treat cancer and support cancer patients.

2.6 Content and key messages will also refer to the project benefits as captured by the project board. They are:

- Less time travelling and to fewer locations
- Easier and improved access to services
- Better knowledge/ alignment within local cancer services
- Increased resilience in services
- Additional service capacity
- Increased opportunity to participate in clinical trials
- Fewer patients admitted to hospital
- Patients able to receive care within the home and remain independent.

2.7 Finally, content will highlight the project's commitment to delivering in accordance with the six dimensions of Quality namely safe, effective, patient-centred, timely, efficient and equitable health services.

2.8 The Communications and Engagement strategy will have two phases – phase one is the project consultation phase and the second phase will focus on the delivery of excellent patient and stakeholder information to explain phase 1 outcomes i.e. the agreed changes to service delivery (rationale, how it will affect patient experience). The strategy adopted by the Board is focused on phase 1 and the objectives are:

- Informing stakeholders – to establish effective ways to inform project stakeholders about project developments (proposals, decisions) and opportunities for engagement.

- Involving stakeholders – creating innovative ways for stakeholders to get involved with the project's development with a focus on encouraging consultation responses.
- Empowering patient voice – creating new ways for patients and carers to engage with the project's development making suggestions and testing assumptions on an ongoing basis.
- Effective collaboration – work closely with the project team to ensure that we are exploiting the use of communications and engagement to manage our relationship with our stakeholders.

New Velindre Cancer Centre enabling works project

2.9 A communication and engagement strategy was agreed by the Trust Board in December 2019 to support the submission of planning applications for two access roads to the new Velindre Cancer Centre – the main access via Asda and an extension in time of a temporary construction access road through Whitchurch Hospital.

2.10 The strategy objective is to gain the support of City Cardiff Council planning officers and committee members to approve the two related planning applications.

2.11 The Board agreed a high level narrative for the project built around three messages:

- The current 60 year old cancer centre does not have the facilities or space for the future;
- The new centre will treat more patients' cancers and help people live longer with cancer; and
- The new centre will support international research and development into cancer treatment.

2.12 For the Asda access, there are two supporting messages:

- The access will be more convenient for the majority of patients and staff who travel to the hospital from across South East Wales, not just Cardiff; and
- The access will substantially reduce the traffic congestion caused by people driving through Whitchurch to the existing cancer centre.

2.13 For the temporary construction road, there are three supporting messages:

- The extension in time will help us open the new Velindre Cancer Centre ten months earlier, in 2024;
- The extension in time will save between £5 million and £11.5 million of public money; and
- By using three access roads for construction we will reduce disruption for people shopping at Asda

2.14 In February, the Trust announced draft plans for the two planning applications. We were obliged to run a formal pre-planning consultation on the Asda application but opted to consult on both.

2.15 Members of the Project Team met with community groups and individuals to explain the plans. A leaflet was delivered to every household in the area, the media was briefed and reported on Trust plans; and the Trust used its online channels to promote six drop-in sessions at Whitchurch Rugby Club. Three of the sessions were held and were attended by about 40 local residents who were able to see detailed plans and ask questions about the new cancer centre.

2.16 The final three drop-in sessions were cancelled when the Welsh Government announced measures to manage the coronavirus pandemic. Cardiff Council then stopped processing new planning applications so, in April, the Trust agreed to defer submission of our two applications.

2.17 During lockdown, a campaign to 'save the northern meadows' organised and grew, bolstered by some local residents 'discovering' the site for the first time and by some influencers expanding its reach beyond Whitchurch. A lot of misinformation was circulating.

2.18 By June, when Cardiff Council started processing planning applications again and when the Trust was ready to submit its two applications, the communications context was very different.

2.19 The Project Team adopted a new 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 a range of 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.

2.20 Additional support has been brought in to deliver the plan and a Communications Coordination Group has been set up, including Board membership, to review and coordinate action.

2.21 Implementation of the plan has so far involved:

- Regular communications with staff by newsletter and an open meeting for all staff to attend
- A series of meetings and follow-up meetings with community groups and leaders – explaining our proposals and how they have been adapted since the pre-planning consultation period and listening to concerns and new issues.
- Two meetings open to the public – one to explain our green vision and ambitions and the other, with the MyWhitchurch Facebook Group, to answer any questions. The meetings were widely promoted but the number of people attending was low.
- Press releases announcing the planning applications and the green vision and ambitions documents; as well as responses to media enquires prompted by opponents. Coverage has been centred more on opponents' arguments since June.

- Daily posts on Velindre Cancer Centre social media channels. 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. However, there is evidence of greater support in reactions to our post and a reluctance to engage with the arguments by some supporters.
- Contact with staff, charity patrons and patient leaders to generate more active support – by posting on social media, filming videos, writing to the press or writing in support of our planning applications.
- Development of a leaflet to be delivered to every household in the area.

2.22 By 22 July, in relation to the Trust's Asda planning application, the council had received 487 objections and 110 letters of support. For the temporary construction access road, the council had received 592 objections and 229 letters of support.

Priorities

2.23 For the next two months, our priorities will be:

- continued engagement with the local community and stakeholders about the nVCC project and enabling works planning applications by face-to-face engagement, social media updates and other communications action;
- establishing regular opportunities to raise awareness among key stakeholders about programme developments;
- reviewing how we keep staff informed about nVCC project updates and enable them to advocate on behalf of the project;
- raising awareness among Community Health Council representatives of the programme projects and opportunities for them to influence their development, specifically creating opportunities for public engagement;
- establishing an implementation plan for Outreach project communications and engagement in collaboration with LHB engagement leads
- working with ABU LHB engagement lead to develop a strategy to support the Radiotherapy Satellite project.

3.0 IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.

RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
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.
	Support across a range of service delivery areas will be required to support staff and managers through changes

4.0 RECOMMENDATION

4.1The Board are requested to:

- **NOTE** the individual project updates.
- Consider and approve the immediate priorities for programme communications.

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE ACADEMIC BOARD

DATE OF MEETING	30th July 2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Rebecca Goode, Corporate Governance Manager
PRESENTED BY	Prof Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing

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 Inaugural Academic Partnership Board Meeting at its meeting on the 22th July 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	**N/A**
ADVISE	**N/A**
ASSURE	Prof Donna Mead, Chair, confirmed that this was the inaugural meeting of the Academic Partnership Board with representation from Cardiff Metropolitan University, Swansea University, University of South Wales, University of Wales Trinity St David and Welsh Government – each bringing a unique strength and area of expertise to the Group. The Terms of Reference (ToR) were discussed and an action taken to broaden and strengthen the remit around 'Improvement and Quality' and the ToR were **APPROVED** subject to that change. **Updates were received as follows:** • **Triennial Review of the Trust's University Health Board Status** – update by Lauren Fear, Interim Director of Corporate Governance – which explained the process and next steps around the Triennial review and that a Task & Finish group will be set-up to take this work forward. • **Inter-disciplinary Cancer Care and update on Professor of Nursing -** Update by Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Scientists – outlined the collaborative approach with Cardiff University and the plans for a Professor of Nursing and a Research Fellow to build on the current research activity across the Trust in Nursing, Therapies and Allied Health Professionals.

- **Update on Velindre University NHS Trust: Who We Are and Opportunities -** Update by Dr Jacinta Abraham, Executive Medical Director and Lead for Research, Development & Innovation (RD&I) – outlined the opportunities across the Trust for all disciplines and opportunities for widening the breadth of studies that the Trust could participate in. Dr Jacinta also took the opportunity to mention the plans for the new Cancer Centre and the perfect timing to work collaboratively on the concepts for the new facility.

- **RD&I Strategy – Research Horizon Scanning -** Update by Mark Briggs, Head of Cell & Gene Therapy Strategy and Sarah Townsend, Head of R&D – outlined some of the RD&I work that is currently in place and the plans ahead. Mr Briggs briefed the Group on the unique opportunities to be explored with Welsh Blood Service (WBS) which is a national service and the opportunities with the Cancer Cente. Mrs Townsend updated the Group on the commercial studies currently open.

- **PHD Students (KESS) & Undergraduate Students: Sustainability Research and Transforming Cancer Services in South East Wales (TCS) Opportunities** – Updates by Mark Briggs, Head of Cell & Gene Therapy Strategy and David Powell, Project Director (TCS) – outlined the opportunities to support staff development and innovation through KESS studentships. The Trusts aspirations to broaden the scope to include innovation, green and the sustainability agenda and the plan is to develop a 'Programme of Projects' to discuss with partners going forward.

- **Place Making and Digital Opportunities –** Led by Stuart Morris, Associate Director of Informatics – briefed the Group on the vision for the South East Wales Region and the aspirations for a 'digital first' philosophy in the design and delivery of new services to promote mobile, flexible, patient and donor centred services and workforce models of delivery.

Vision for Centre for Learning - Dr Mick Button, Consultant Oncologist/Medical Education Lead – summarised for the Group the vision for the 'Centre for Learning' and the importance of the education, training, research, service improvement, audit, innovation, patient involvement and professional development of staff. Dr Button highlighted the value of these activities, the alignment as a University Trust and also the opportunities to collaboratively to work with our NHS, Academic and Industry partners. The board was informed that a similar model is in place in Newcastle and arrangements are now in hand to learn from this.

INFORM	Mrs Nicola Williams led the discussions on the Programme of work ahead and proposed that the next session should be about learning from University colleagues. The agreed approach was as follows: 1. Next Session in early Autumn – presentations/updates from University Partners in a Conversational format. 2. Once a year 'All together Academic Partnership Board' Meeting to discuss the business of the Group 3. Individual University / Velindre University NHS Trust meetings to develop a more focused approach with universities around their strengths and expertise and to facilitate further partnership working The Chair confirmed that this was an excellent approach and that individual meetings are more productive and would benefit both partners more in terms of networking and collaboration. Note: Apologies were received from Cardiff University on this occasion.
APPENDICES	Academic Partnership Board Meeting Terms of Reference v4 attached

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

ACADEMIC PARTNERSHIP BOARD

Terms of Reference & Operating Arrangements

DRAFT

Version:	Draft version 4.0
Date of Draft:	23rd July 2020
Date Agreed:	
Review Date:	

1. INTRODUCTION

1.1 The Trust's Establishment (Amendment) Order, 2018 no.887 (W.176) established Velindre NHS Trust as Velindre University NHS Trust. This development acknowledges the Trust as *'…having a significant teaching commitment by virtue of paragraph 5(3)(b) of Schedule 3 to the National Health Service (Wales) Act 2006'.*

1.2 The Trust is committed, by way of holding University Status, to ensure one of the Non-Executive Directors (Independent Members) is appointed from Cardiff University.

1.3 The Trust has made a commitment to recognise the importance of partnership working across all academic partners and has established an **Academic Partnership Board** to support these partnerships and hereby sets out the formal terms of reference and operating arrangements.

1.4 The Academic Partnership Board will provide a formal mechanism whereby a strategic approach will be taken to steer future operational collaboration with academic partners. The collaboration, overseen by the Academic Partnership Board should be of mutual benefit and support in order to promote the health, wellbeing, education and economic regeneration to the benefit of the Trust's service users and the wider population of Wales.

1.5 The collaboration will be driven by a shared commitment to ensure excellent health, medical care, research, innovation, wellbeing and health care education. The parties recognise that there are synergies between them that will allow the development and promotion of the Trust's University status and provide positive opportunities for collaboration which potentially exceed the traditional University Hospital model.

1.6 The Academic Partnership Board will operate in accordance with the following principles:

- Quality Improvement, enhancing patient safety and experience is at the centre
- Commitment to facilitate discussion
- Create an environment to identify, support and allow collaboration to flourish
- Realise opportunities in partnership working to enhance;
  - education, research and development across all disciplines (including engineering, maths, business, medicine, health sciences and biosciences);
  - translating research and learning into practice;
  - continuing professional development (CPD);
  - audit;
  - innovation and commercialisation;
  - modernisation and service improvement including technological developments;

- international bench-marking;
- wealth creation;
- funding and grant capture; and
- workforce modernisation/reconfiguration and training/education for newly emergent roles

2. PURPOSE

2.1 The Partnership Board is responsible for strategic collaboration between Velindre University NHS Trust and academic partners to provide and strengthen quality, safety and patient / donor experience and to gain an international reputation for excellence and innovation. In particular the purpose of the Academic Partnership Board is to:

- Ensure that the Memorandum of Understanding between the parties to which these Terms of Reference form an Annex, is fully enacted to support the services provided by the Trust achieve the highest standards of health, clinical care, research, innovation and health care education and training.

- Promote collaborative efforts to improve the health, wellbeing, education and wealth of patients, service users and the population.

- Review the strategic aims and objectives of each of the partners and where those aims and objectives appear to be usefully aligned, to optimise the benefits to patient care and health care service delivery through an inclusive and supportive approach.

- Accelerate the translation of discoveries to drive improvements in quality and productivity.

- Become a national and international exemplar for effective strategic, research and operational collaboration between the local health service and its partner universities.

- Provide a broad horizon-scanning function in those areas of activity for which the Academic Partnership Board has responsibility.

- Foster a forward-looking organisational culture across all partners which:

  a) promotes quality improvement across all activities;
  b) is rich in educational activities and staff development opportunities;
  c) helps attract and retain the very best staff, including internationally leading clinical academics;
  d) facilitates research grant capture by clinicians and academics and the translation of research findings into practice;
  e) encourages innovation and modernisation;
  f) encourages multi-disciplinary work and access to new and emergent fields of research and evidence based practice;

g) builds capacity for translational research that allows all parties to compete at an international level;
h) integrates education, research and practice that looks beyond targets and entrenched ways of working, fostering a culture of learning and innovation;
i) facilitates wealth and economic growth in the region and beyond;
j) Supports the capture and analysis of the service user experience;
k) Develops health informatics opportunities to achieve their potential;
l) Supports strategic planned lines of enquiry enabling knowledge creation.

- Receive assurance that projects in which the parties are currently collaborating have appropriate agreements which detail the projects and clearly reflect the responsibilities of the parties. Depending on the nature of the projects the risk to the parties should be understood and the appropriate mitigated action taken.

- The work of the Board will focus on healthcare professional education and training, continuing professional development, scholarly enquiry and research, audit and evaluation.

3. ROLE

3.1 The Partnership Board will;

- Explore opportunities for the further development of collaborative activities/research opportunities between the members of the partnership - especially in relation to clinical services, research, teaching, innovation and improvement, providing advice thereon to appropriate decision- making bodies;

- Advise on matters relating to resources for existing or potential collaborative activity;

- Build on existing work in developing opportunities for widening access and increasing participation in health and social care education amongst local communities;

- Explore opportunities for the development of collaborative activities in relation to research and to promote and plan for synergy in research;

- Maximise the benefits of shared resources and expertise;

- Monitor and facilitate the delivery of all aspects of undergraduate teaching and postgraduate training as delivered by the members of the partnership;

- Promote excellence in education and training to develop a workforce with the capability and commitment to transform healthcare;

- Build capacity for translational research across the integrated patient pathway that allows the University Trust to compete at an international level;

- Promote an outward-facing culture eager to build external links nationally and internationally with other clinical, academic and industrial partners;

- Establish systems to recognise and reward innovation in education, research and practice, sharing best practice for stakeholders to learn from each other and facilitating the promotion of NHS clinicians to academic titles and academics to honorary clinical titles;

- Establish specific task and finish groups, as necessary, to take forward any relevant initiatives;

- Agree a forward work programme annually.

4. MEMBERSHIP

4.1 Membership of the Academic Partnership Board will include:

- Chair, Velindre University NHS Trust (**CHAIR**)
- Cardiff University Nominated Representative
- Cardiff Metropolitan University Nominated Representative
- Swansea University Nominated Representative
- University of South Wales Nominated Representative
- University of Wales Trinity St David Nominated Representative
- Welsh Government Representative
- NHS Wales Informatics Service Nominated Representative (NWIS)
- Health Technology Wales Nominated Representative (HTW)
- Executive Medical Director
- Executive Director of Nursing, Allied Health Professions & Health Sciences, Velindre University NHS Trust
- Chief Operating Officer, Velindre University NHS Trust
- Executive Director of OD & Workforce / Assistant, Velindre University NHS Trust
- Clinical Director Lead for Education, Velindre University NHS Trust
- Clinical Director Lead for Research and Innovation, Velindre University NHS Trust
- Independent Board Member (in addition to the Chair), Velindre University NHS Trust
- Director of Corporate Governance, Velindre University NHS Trust
  - Transforming Cancer Services, Director, Velindre University NHS Trust
  - Velindre University NHS Trust Senior Manager in RD&I Partnership Engagements

DRAFT

4.2 Co-option:

The Academic Partnership Board may co-opt other members to attend as required to meet work plan and agenda requirements.

4.3 Secretariat/Meeting support

Velindre University NHS Trust Executive PA Team will provide secretarial support to the Academic Partnership Board.

Operational Meeting Support will be provided by Velindre University NHS Trust's Senior Manager in RD&I Partnership Engagement.

Executive Leadership for the Academic Partnership Board will be provided by the Executive Director of Nursing, AHPs and Health Scientists and supported by the Medical Director.

4.4 Quorum

There should be at least: one Independent Member/Chair of Velindre University NHS Trust, one Executive Director of Velindre University NHS Trust, and two of the academic partner organisations listed in the membership section above for a meeting to go ahead.

Members are asked to identify a nominated deputy who can attend and represent member/organisation in the event of member being able to attend. It is essential the nominated deputy has full decision making capacity.

4.5 Withdrawal of individuals in attendance

The Chair of the Academic Partnership Board 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. MEETINGS

5.1 In order to support Academic Partnership Board Members Velindre University NHS Trust Executive function will:

- ensure the provision of secretariat support for meetings, including that the appropriate notice of a meeting of the Board is given, accompanied by an agenda and copies of any papers to be discussed at the meeting;
- ensure that the Academic Partnership Board receives the information it needs on a timely basis;
- facilitate effective reporting to the respective organisation(s);

- oversee a process of regular and rigorous self-assessment and evaluation of the Academic Partnership Board's performance and operation.

5.3 Meeting Management

Draft meeting notes and action log will be sent out to members within 10 days of a meeting being held.

Meeting agenda and papers will be sent to members at least 10 days before a meeting.

5.4 Frequency of meetings

Meetings shall be held at a maximum of bi-annually, and supplemented by annual partnership meetings between Velindre University NHS Trust and each partner University.

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

6.1 The Academic Partnership Board, through its Chair and members, shall work closely with the Velindre Trust Board and academic partners through the:

- joint planning and co-ordination of Trust business; and,
- appropriate sharing of information

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

6.2 The Academic Partnership Board will consider the assurance provided through the work of the Board's other Committees and sub Committees to meet its responsibilities for advising the Trust Board on the adequacy of the Trust's overall system of assurance by receipt of their annual work plans.

6.3 The Academic Partnership Board shall embed the Trust's corporate standards, priorities and requirements, e.g. equality and human rights through the conduct of its business.

7. REPORTING ARRANGEMENTS

7.1 Velindre University NHS Trust

The Chair of the Academic Partnership Board will be required to report upon the activities at public meetings of the University Trust or to community partners and other stakeholders, where this is considered appropriate. This will be through a highlight report.

Formal reporting within Velindre University NHS Trust will be via Executive Management Board, Quality & Safety Group and ultimately the Trust Board.

7.2 **Universities/Organisations External to Velindre Trust**

Academic/External Partners will be responsible for reporting through Academic Partnership Board activities and outcomes through appropriate structures within their respective organisations.

8. REVIEW

The Academic Partnership Board Terms of Reference and operating arrangements shall be agreed by the Academic Partnership Board Members and by the Trust Board and will be reviewed annually.

DRAFT

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE AUDIT COMMITTEE

DATE OF MEETING	30/07/2020

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Claire Bowden, Head of Financial Operations
PRESENTED BY	Martin Veale, Independent Member
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
EMB	Executive Management Board
GDPR	General Data Protection Regulation
IA	Internal Audit
NWIS	NHS Wales Informatics Service
WHEPPMA	Welsh Hospital Electronic Prescribing, Pharmacy & Medicines Administration

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Audit Committee at its meeting on the 9th July 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	**Audit Action Tracker** The Committee received the document which showed actions completed since the last meeting, and those which had now become overdue. Some action owners had requested extensions to deadlines which the Committee agreed, and where no updates had been provided or extensions requested, the Committee identified revised dates they felt would be appropriate from the information available to them. The Chair and Committee Members expressed disappointment where updates had not been received. The Executive Director of Finance committed to pursuing those where they had not been received.
ADVISE	**NWIS** The Committee received the usual suite of reports from NWIS and expressed some concerns regarding the quality of some of the information which was noted by NWIS representatives. The level of detail included in the NWIS Risk Register was requested to be increased and more comparable with the level of detail in the Trust's Risk Register. A verbal update from the Director of Finance in NWIS and from a representative from Welsh Government regarding the plans for NWIS to become a Special Health Authority was provided and the Committee asked for this to become a standing agenda item. The Committee received three Internal Audit reports for NWIS as follows: • Supplier Management – limited assurance • GDPR – limited assurance • WHEPPMA project – reasonable assurance The Committee expressed concerns that some actions were due to be completed later than they would expect and requested updates on some prior to their next meeting in October 2020. They also expressed concern that some of the responses to the recommendations contained in the two limited assurance reports were not sufficiently focused, and asked for them to be rewritten and the reports reissued. The Committee also asked to be made aware of any limited assurance IA reports when they became available rather than have first sight of them via

	Audit Committee meeting papers – this related to all such reports, not just those relating to NWIS. **Internal Audit** The Committee received an Internal Audit report on Workforce Planning that had received a limited assurance rating and discussed this with the Executive Director of Workforce & Organisational Development who joined the meeting for this item. The Committee was content with the proposed actions set out in the report. **COVID-19 – Corporate Governance Arrangements Update** The Interim Director of Corporate Governance provided the Committee with an update on these arrangements, and the Committee endorsed approval.
ASSURE	**Trust Risk Register** The Interim Director of Corporate Governance presented the Trust Risk Register, noting that it had the same content as the one the Trust Board had received on 25 June 2020 due to meeting scheduling. The Committee were given a comprehensive overview of the new documents, with a new template currently being considered by the EMB. **Internal Audit Programme** The Committee received the IA **Progress Report** and were informed that the following reports that have been finalised during the period (in addition to the Workforce Planning report commented on in the 'advise' section of this report): • Fire Safety (additional testing) • Velindre Capital Systems – Financial Safeguarding – reasonable assurance • Health and Care standards – reasonable assurance.
INFORM	**Counter Fraud** Reports for both May and July 2020 were received by the Committee and deferred at the request of the Chair due to the number of papers presented at the meeting. The Committee received and approved the Annual Report presented by the Local Counter Fraud Specialist, and also the Workplan for 2020/2021. The Committee asked for a paper to be brought to the October 2020 meeting updating them on the impact of the objectives.

	Other Business The Committee also received written or verbal reports under the following agenda items: • Audit Committee Annual Plan • Guide for Audit and Risk Committees on Financial Reporting and Management during COVID-19 • Thematic Assessment Fraud Threats to the NHS from COVID-19 • Audit Wales & Internal Audit Update • Losses & Write offs for the period ending 30th June 2020 • Procurement Compliance Report
APPENDICES	**NOT APPLICABLE**

GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

PUBLIC TRUST BOARD

ASSURANCE REPORT FROM THE CHAIR OF THE VELINDRE UNIVERSITY NHS TRUST AUDIT COMMITTEE FOR NHS WALES SHARED SERVICES PARTNERSHIP

Meeting Date:	30 July 2020
Author:	Roxann Davies, Corporate Services Manager, NHS Wales Shared Services Partnership
Sponsoring Executive Director:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust
Report Presented by:	Lauren Fear, Interim Director of Corporate Governance, Velindre University NHS Trust

Trust Resolution to: (please tick) ☑							
APPROVE:		**REVIEW:**		**INFORM:**	☑	**ASSURE:**	☑
Recommendation:	For the Board to review and **NOTE**.						

This report supports the following Trust objectives as set out in the Integrated Medium Term Plan: (please tick) ☑	
Equitable and timely services	☑
Providing evidence based care and research which is clinically effective	
Supporting our staff to excel	
Safe and reliable services	☑
First class patient/donor experience	
Spending every pound well	☑
Acronyms:	
NWSSP – NHS Wales Shared Services Partnership SSPC – Shared Services Partnership Committee SMT – Senior Management Team	NHAIS – National Health Application and Infrastructure Services PPE – Personal Protective Equipment
Executive Summary:	
This paper has been prepared to provide the Velindre Trust Board with details of the key issues considered by the Velindre University NHS Trust Audit Committee for NHS Wales Shared Services Partnership, at its meeting on 30 June 2020. The Board is requested to **NOTE** the contents of the report and actions being taken. Key assurances and highlights from the meeting are reported overleaf:	

ALERT	No matters to alert/escalate.
ADVISE	No matters to advise.
ASSURE	**Governance and Assurance Matters During COVID-19 Pandemic** The Committee received a comprehensive verbal update from the NWSSP Director of Finance and Corporate Services in relation to the handling of COVID-19 matters and the impact on the organisation. This provided an insight into and highlighted the importance of the challenging and complex work undertaken by NWSSP staff, ranging from Procurement going above and beyond to source, acquire and deliver PPE for frontline care, Informatics migrating 1500 staff to Microsoft Office365 and delivery of our business critical services to ensure NHS Wales staff were recruited and paid, as well as continuing payments to suppliers, contractors, GPs and opticians. A number of groups were established to provide oversight and assurance at this time, namely the SMT Planning and Response Group, an IT Update Group and the Building Managers Group. The safeguarding of staff has been the No.1 priority with enhanced measures at all sites to comply with social distancing measures and reduce risk. The Planning and Response Group has been recently stood down, and the Adapt and Future Change Group had been tasked with learning lessons from COVID-19 and looking at how we revolutionise the way we work. We have also formalised an Agile Working Group, with representatives from all services across the organisation. A Staff Peer Support Network has been set up, and development of local Risk Assessments and Site Plans, to include guidance such as Site Information, Managing Remotely and Returning to Work Toolkits, have received positive feedback. The Communications Team have also been keeping staff updated on a daily basis and the SMT and Trade Union Representatives had recorded video messages to staff. In addition, a staff survey had been launched, which received a very high response rate of 87% across the organisation. There were two surveys released; one for those working at home and one for those working on site. The outcomes of the survey were very positive. Going forward, it was highlighted that a big challenge would be availability of capital due to COVID-19. The Committee formally noted and recognised how helpful and flexible the Velindre Trust Board have been in adapting to the exceptional circumstances and turning around NWSSP requests rapidly, in order to assist in obtaining vital equipment. In addition, the Committee receives a further report in relation to NWSSP financial expenditure that highlighted the changes to governance arrangements, as a result of COVID-19, including the changes made to the delegated limits for urgent COVID-19 expenditure and the establishment of a Finance and Governance Committee to monitor the overarching contracts and ensure due diligence for robust and complex arrangements, chaired by the Director of Audit and Assurance Services. Further, the NWSSP COVID-19 advance payment log for purchases and checklist was tabled at the Committee, which included a detailed breakdown of updates on goods received, to include planned delivery schedules, as informed by Procurement. The Committee received the COVID-19 Risk Register for review, which detailed one red risk relating to total quantum for funding and addressing COVID-19 and seven amber risks, which were related to areas such as procurement of PPE, staff safety and well-being, business continuity for essential services and strategic plans for field hospital sites.
ASSURE	**Governance, Risk and Assurance** Governance Matters - The Committee received the Governance Matters paper, which detailed the contracting activity from January 2020, to date and highlighted that there had been no departure from the Standing Orders. In relation to contracting activity, during the reporting period, there had been 21 contracts let for NWSSP, and 62 contracts let for NHS Wales, of which 8 were at briefing stage, 42 at ratification and 12 were extensions. It was noted no declarations were made as to gifts, hospitality or sponsorship since the last meeting and there had been no limited or no assurance audit reports. Where contracting activity related to the procurement of goods relating to COVID-19, these had been recorded centrally and each had been subject to robust governance and due diligence processes, which required a separate file note to be held. Audit Tracking - In relation to the tracking of audit recommendations, there were 202 recommendations, of which 187 were implemented, 14 were not yet due, and one had a proposed a revised deadline of 30/09/2020, for Committee approval. This recommendation related to cyber

	security and this was delayed in implementation due to the impact of COVID-19. The Committee were content to approve the revised deadline proposed. Corporate Risk - The Corporate Risk Register highlighted two existing red risks, six amber risks, three yellow risks and zero green risks, in the Risks for Action section of the Register. There remained one yellow risk in the Risks for Monitoring section of the Register and the Committee was reminded that the Register is reviewed at each SSPC, Audit Committee and Formal SMT meeting. The existing two red risks were summarised as follows and the Committee was informed that these long-standing risks had been progressed and would come off the Register in the coming months: • The Northern Ireland model procured to replace the NHAIS system fails to deliver the anticipated benefits within required timescales impacting the ability to pay GPs; and • NHS Digital were withdrawing the Ophthalmics Payment service from the end of September 2020. In addition, the Committee also received a comprehensive Assurance Mapping exercise and an updated in relation to the Audit Committee Effectiveness Survey, which were both items provided annually.
ASSURE	**Internal Audit** The Committee received a comprehensive update from Internal Audit and in addition to the Position Statement, which highlighted progress of the 2019/20 Internal Audit Plan, together with an overview of other activity undertaken since the previous meeting. In addition, the Committee received the following reports for consideration: • Budgetary Control Internal Audit Report Achieved reasonable assurance, with two low priority recommendations for action and did not identify any issues that would be classified as a weakness in the system control or design. • Payroll Services Internal Audit Report Achieved reasonable assurance, with one high, five medium and 1 low priority recommendations for action, which identified two issues that were classified as weaknesses in the system control or design and five issues for the operation of the system control or design. In addition, the Committee received the Internal Audit Operational Plan for 2020-21. NWSSP SMT had reviewed and endorsed the Operational Plan and the Committee were content to approve the Internal Audit Operational Plan for 2020-21 and Chair noted that the Plan would be subject to change throughout the year, which would be brought back to Committee for approval. Finally, the Committee received the sixth annual Quality Assurance and Improvement Plan, setting out the approach for 2020/21, demonstrating compliance with the Internal Audit Standards and measuring quality through capturing feedback. The report was formally noted by the Committee and will be shared with the NHS Wales Board Secretaries. SC confirmed he would be working with a sub-group of Board Secretaries on KPIs, linked into more systematic assessment of recommendation tracking and what the impact of these has been. The following was also highlighted: • Reviewing audit files to look at what has been done, comparing similarities and best practice; • The usage of the treasury audit quality framework, for example, sharing outputs and governance reviews; • KPIs, insofar as the programme was interrupted, but sufficient work was completed; and • Audit Wales review was yet to take place, but the feedback received to date was positive.
ASSURE	**External Audit** Audit Wales presented a detailed Position Statement which set out an update as to current and planned audit work, together with the Auditor General's planned programme of topical publications, related studies, good practice, and national events that may be of interest to the Committee. Whilst the majority of planned audit work for NWSSP was complete, there was a need for the Nationally Hosted NHS IT Systems and Management Letter audits to be rescheduled later in 2020. There were no significant issues of concern to report to the Committee. Further, Audit Wales'

	representative brought to the Committee's attention the letter written to all Chief Executives on 30/04/2020, providing an update as to the audit programme, for information.
ASSURE	**Counter Fraud** The Committee received a comprehensive Position Statement summarising the recent Counter Fraud work carried out to date, which was accompanied by thematic guidance arising in relation to COVID-19. In addition, the Committee received the Counter Fraud Annual Report for 2019-20 and Self-Review Submission Tool, which both demonstrated positive progress within NWSSP for the reporting period. The Committee also received the Counter Fraud Work Plan for 2020-21, which was approved.
INFORM	The following items were received for Committee information: • Review of Shared Services Partnership Committee Standing Orders; and • Audit Committee Forward Plan 2020-21.