Bundle Public Trust Board Meeting - Velindre University NHS Trust 25 November 2021

1.0.0 10:00 - STANDARD BUSINESS

1.1.0 Welcome and Introductions

Led by Prof Donna Mead OBE, Chair

1.2.0 Apologies

Led by Prof Donna Mead OBE, Chair

1.3.0 In Attendance

Led by Prof Donna Mead OBE, Chair

- *Vicky Morris, Independent Member (Quality & Safety)*
- *Margaret Foster, Chair of NHS Wales Shared Services Partnership*
- *Stephen Harrhy, Board Director/Chief Ambulance Service Commissioner (Agenda Item 2.1)*
- *Dr Chris Turner, Interim Chair, National Collaborative Commissioning Unit (Agenda Item 2.1)*
- *Richard Baxter, Taskforce Project Manager (Agenda Item 2.1)*

1.4.0 Declarations of Interest

Led by Prof Donna Mead OBE, Chair

2.0.0 PRESENTATIONS AND GUEST ATTENDEES

2.1.0 10:10 - Emergency Ambulance Services Committee (EASC) Update

Led by Stephen Harrhy, Board Director/Chief Ambulance Service Commissioner, Dr Chris Turner, Interim Chair, National Collaborative Commissioning Unit and Richard Baxter, Taskforce Project Manager

2.1. Velindre University NHS Trust - Annual EASC.pptx

3.0.0 CONSENT ITEMS

Led by Prof Donna Mead, Chair, OBE

3.1.0 FOR APPROVAL

3.1.1 Minutes from the Public Trust Board meeting held on the 30th September 2021

Led by Prof Donna Mead OBE, Chair

3.1.1 Draft Minutes Public Trust Board 30_09_21 FINAL.docx

3.1.2 Chair's Urgent Actions Report

Led by Prof Donna Mead OBE, Chair

3.1.2 Chairs Urgent Action Report_November 2021.docx

3.1.3 Commitment of Expenditure Exceeding Chief Executive's Limit

Led by Matthew Bunce, Executive Director of Finance

3.1.3 Public_Commitment of Expenditure November 2021.docx

3.1.3a Appendix 1_Commitment of Exependiture November 2021 (002).docx

3.1.3b Appendix 2 _ Commitment of Expenditure November 2021.docx

3.1.3c Appendix 3_NDR Commitment of Expenditure Over Chief Exec Limit CT Final.docx

3.1.3d Appendix 4_ Commitment of Expenditure_IT Refresh Programme (over 100k Expenditure) CT Final.docx

3.1.3e Appendix 5_Commitment of Expenditure - Walters UK Ltd for EW DB v0.2.docx

3.1.3f Appendix 6_Commitment of Expenditure - MOTT MACDONALDS TECHNICAL SUPPORT FOR COMPETITIVE DIALOGUE v0.2.docx

3.1.3g Appendix 7 Commitment of Expenditure.pdf

3.1.4 Revisions to NHS Wales Shared Services Partnership (NWSSP) Standing Orders

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

3.1.4a Revisions to NWSSP SOs Cover Report.docx

3.1.4b NWSSP Standing Orders for Operation of SSPC.doc

3.2.0 FOR NOTING

3.2.1 Emergency Ambulance Services Joint Committee Briefing for meeting held on 9 November 2021

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

3.2.1 Chair's EASC Summary_9Nov2021.pdf

4.0.0 10:50 - MATTERS ARISING

4.1.0 Action Log

Led by Prof Donna Mead, Chair, OBE

4.1 Public Action Log as at 30_09_21 V1.docx

5.0.0 KEY REPORTS

5.1.0 11:00 - Chairs Update

Led by Prof Donna Mead, Chair, OBE

6.1.0 Chair Update Report November 2021 Final Draft.docx

5.2.0 11:10 - CEO Update

Led by Steve Ham, Chief Executive

5.2 CEO Update Report November 2021-final.docx

6.0.0 QUALITY, SAFETY & PERFORMANCE

6.1.0 11:20 - Quality, Safety & Performance Committee Highlight Report

Led by Stephen Harries, Interim Vice-Chair/ Acting Chair of the Quality Safety & Performance Committee

• *Appendix Quality, Safety & Performance Committee Annual Report and Effectiveness Survey*

6.1a Public Quality Safety Performance Committee Highlight Report 18.11.21(v4approved).docx

6.1b Appendix 1. Annual Patient Experience Report 2020-21 AE final.docx

6.1c Appendix 2. Quality Safety Performance Committee Annual Report 2020_2021_Endorsed.pdf

6.2.0 11:30 - BREAK 11:30 - 11:40

6.3.0 11:40 - Delivering Excellence Performance Report Period September 2021

Led by Cath O'Brien, Chief Operating Officer

7.3a SEPTEMBER PMF Cover Paper TRUST BOARD NOVEMBER Final.docx

7.3b VCC Performance Report (Sep 2021) FINAL.docx

7.3c Sept. 2021 WBS PMF Report FINAL.pdf

7.3d Trust-wide WOD Performance Report - September 2021.pdf

6.4.0 12:10 - Financial Report for the Period Ended 31 October 2021 (M7)

Led by Matthew Bunce, Executive Director of Finance

7.4a Month 7 Finance Report Cover Paper - Board.docx

7.4b M7 VELINDRE NHS TRUST FINANCIAL POSITION TO OCTOBER 2021 Final.docx

6.5.0 12:15 - Velindre University NHS Trust Risk Register

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

7.5a Trust Board Public Meeting 25 Nov - Final.docx

7.5b VS 12 TRR PUBLIC PAPER.xlsx

7.5c VS 14 TRR PUBLIC PAPER.xlsx

6.6.0 12:25 - Velindre University NHS Trust Clinical Audit Report 2020/21

Led by Dr Jacinta Abraham, Executive Medical Director

7.6a Trust Clinical Audit Report 20-21-final.docx

7.6b 1 VUNHST CLINICAL AUDIT Report 2020-21.pdf

6.7.0 12:55 - BREAK 12:50 - 12:55

7.0.0 STRATEGIC DEVELOPMENT

7.1.0 13:00 - Equality Ambassadors Showcase: Religion & Belief

Led by Sarah Morley, Executive Director of Organisational Development and Workforce

8.1 Religion Equality Presentation November 2021 - Board.pptx

7.2.0 13:15 - Strategic Development Committee Highlight Report

Led by Stephen Harries, Vice Chair and Chair of the Strategic Development Committee

7.2 Public - Strategic Development Committee Highlight Report 08.11.2021 CONFIRMED.docx

7.3.0 13:25 - Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Reports for meetings held on 21 September 2021 and 25 October 2021

Led by Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee

7.3a Public - TCS Programme Scrutiny Committee Highlight Report 21_09_21.docx

7.3b PUBLIC TCS Programme Scrutiny Committee Highlight Report 25th October 2021 - TRUST BOARD - CONFIRMED.docx

7.4.0 13:35 - Transforming Cancer Services Communication & Engagement Update

Led by Lauren Fear, Director of Corporate Governance and Chief of Staff

7.4 TCS Communications & Engagement.docx

8.0.0 INTEGRATED GOVERNANCE

8.1.0 13:40 - Audit Committee Highlight Report

Led by Martin Veale, Independent Member and Chair of the Audit Committee

8.1 Public Audit Committee Highlight Report 14 10 2021-Final.docx

8.2.0 13:45 - Charitable Funds Committee Highlight Report

Led by Prof Donna Mead, Chair, OBE and Chair of the Charitable Funds Committee

8.2.0 Charitable Funds Committee Public Highlight Report FINAL.docx

8.3.0 13:50 - Blaenavon Data Centre Transition Project

Led by Stuart Morris, Chief Digital Officer

9.3 TB 2021_11_nn Public - Data Centre Transition.docx

9.0.0 13:55 - ANY OTHER BUSINESS

Prior Approval by the Chair Required

10.0.0 14:00 - DATE AND TIME OF THE NEXT MEETING

27th January 2022 at 10 am – 2.30 pm

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).

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

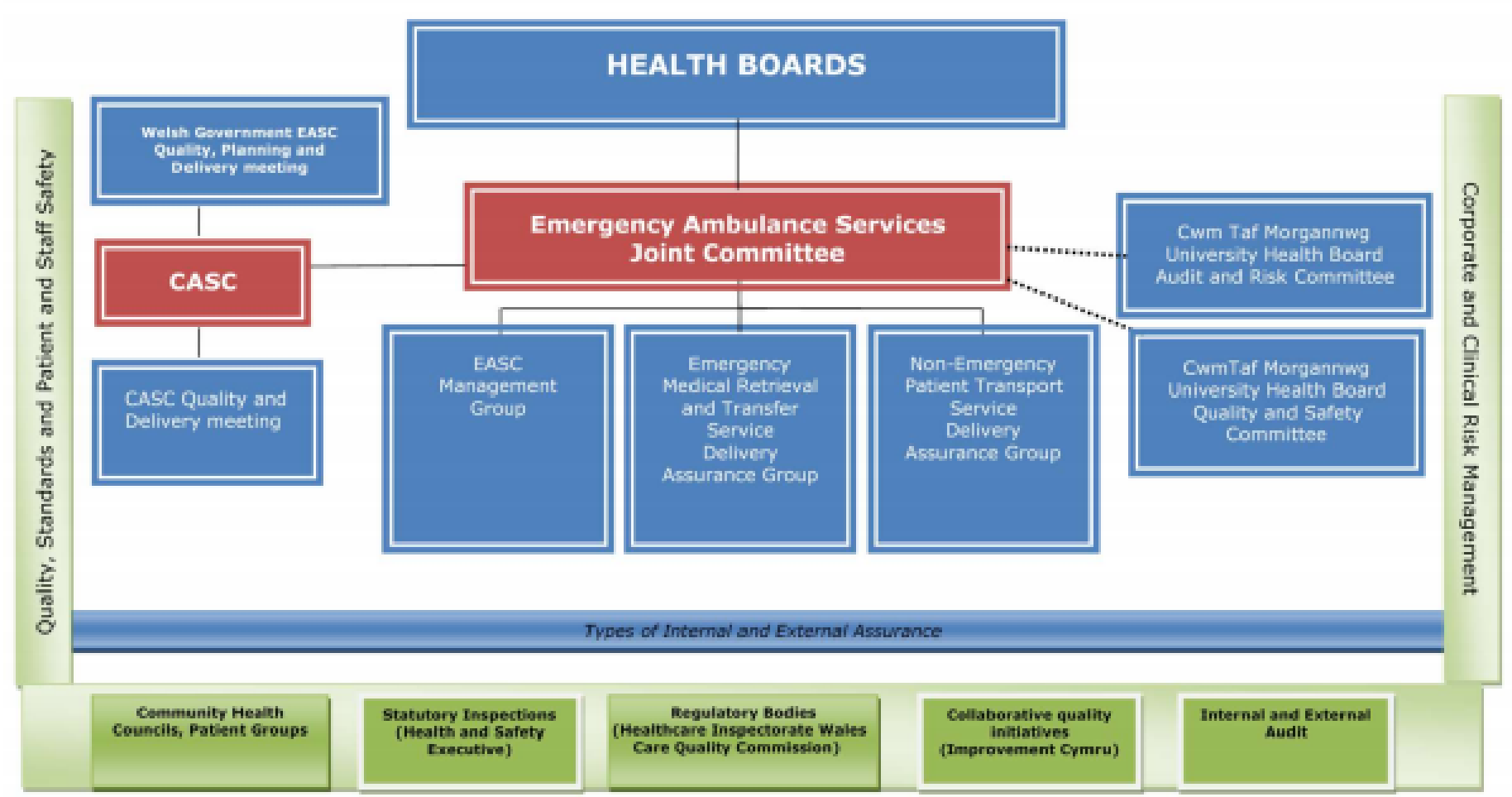
Annual EASC Update – Velindre University NHS Trust

Chris Turner - Chair Emergency Ambulance Service Committee

Stephen Harrhy - Chief Ambulance Services Commissioner

25/11/2021

Governance


HEALTH BOARDS
Welsh Government EASC Quality, Planning and Delivery meeting
Emergency Ambulance Services Joint Committee
CASC
CASC Quality and Delivery meeting
EASC Management Group
Emergency Medical Retrieval and Transfer Service Delivery Assurance Group
Non-Emergency Patient Transport Service Delivery Assurance Group
Cwm Taf Morgannwg University Health Board Audit and Risk Committee
CwmTaf Morgannwg University Health Board Quality and Safety Committee
Quality, Standards and Patient and Staff Safety
Corporate and Clinical Risk Management
Types of Internal and External Assurance
Community Health Councils, Patient Groups
Statutory Inspections (Health and Safety Executive)
Regulatory Bodies (Healthcare Inspectorate Wales Care Quality Commission)
Collaborative quality initiatives (Improvement Cymru)
Internal and External Audit

Commissioned Services

- Emergency Ambulance Services (EMS)
- Non-Emergency Patient Transport Services (NEPTS)
- Emergency Medical Retrieval and Transfer Service (EMRTS Cymru)
    - Adult Critical Care Transfer Service

Minister's Priorities

- Planning arrangements around known/predicted peaks.
- Better public messaging and education around use of services.
- Better manage patients in community – remote clinical triage or advice and guidance from senior clinicians.
- Maximise alternative community pathways or to directly refer patients to the right hospital setting.
- Develop outcomes measures for patients with time sensitive conditions.
- Develop a value-based approach to collaborative commissioning and exploring opportunities around levers for change as incentives and sanctions.
- Delivery of a more robust commissioning approach.

Taskforce – Focus Areas

In order to drive the work to realise the necessary improvements in ambulance delivery, the Minister's expectation was that the Taskforce would focus on the following areas:

1. Understanding and improving productivity.
2. Workforce, recruitment and wellbeing.
3. Digital change and technology in ambulance services.
4. Measurement for improvement.

One of the key recommendations from the Taskforce's Interim Report included the role of the Taskforce as an **external assurance body** for the delivery and enactment of a **citizen centred** vision for a modern ambulance service within a clearly defined wider health and social service system in Wales.

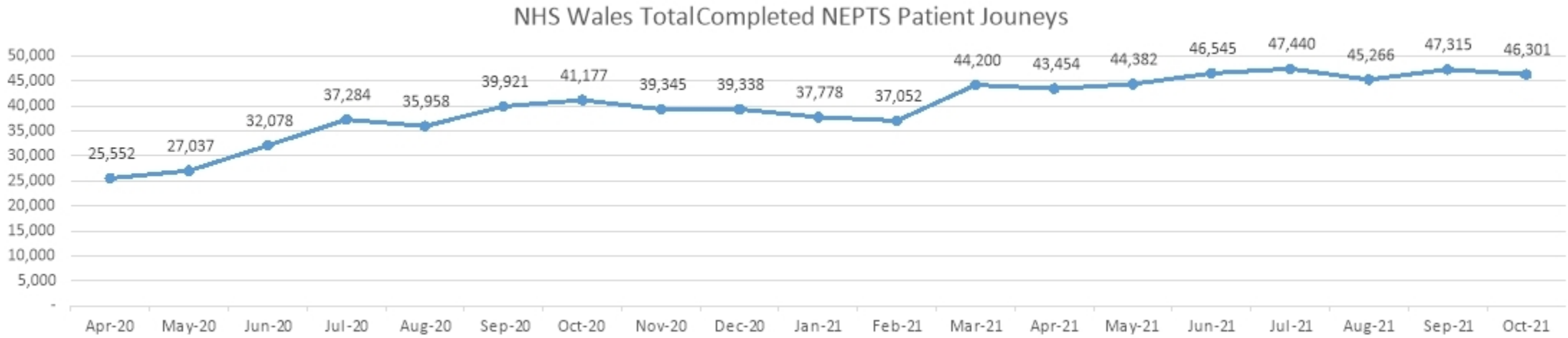
Commissioning Intentions

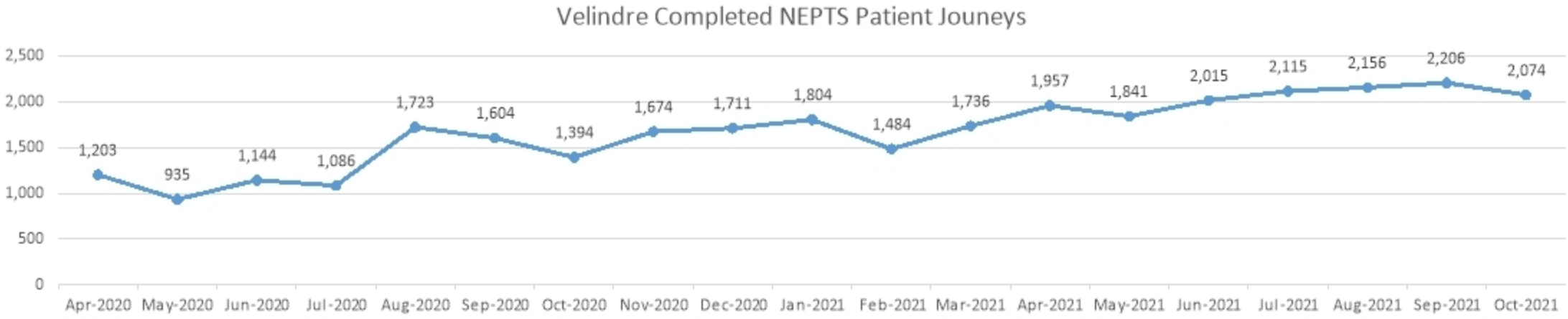
Commissioned Service	Summary of Priorities	Outcome
Emergency Ambulance Service	1. Implementation of Demand and Capacity Review specifically • Complete the closure of the relief gap • Deliver efficiencies related to rosters and post production 2. Focus on delivering improved patient and system outcomes at step 2 (Answer my call) of the ambulance care pathway. 3. Develop a value based approach to service commissioning and delivery 4. Support and enable system wide understanding and improvement.	Ensuring the minimum number of front line staff are in post Ensuring the maximum number of front line staff are available to respond to demand Ensuring that patients receive the right care at the earliest possible opportunity on their episode of care and avoid unnecessary conveyance to scene or hospital Making the best and most efficient use of the resources available Integrated and proactive management of escalation across the system
Non-Emergency Patient Transport Services (NEPTS)	1. Consolidate and build confidence in the plurality delivery model 2. Understand and mitigate demand 3. Modernise and transform capacity 4. Support system transformation	Completion of the Ministerial commitment to modernise NEPTS Reduction in overall demand and a more efficient and effective transport service for patients Increase and diversification in capacity to meet the changes in patient demand Responsive to the new emerging demands and patterns of service delivery
Emergency Medical Retrieval and Transfer Service (EMRTS)	1. Consolidate and complete the service expansion 2. Deliver a critical care transfer service for Wales	Enhancing the EMRTS 24/7 provision across Wales Providing a dedicated critical care transfer service across the whole of Wales for the first time

Funding

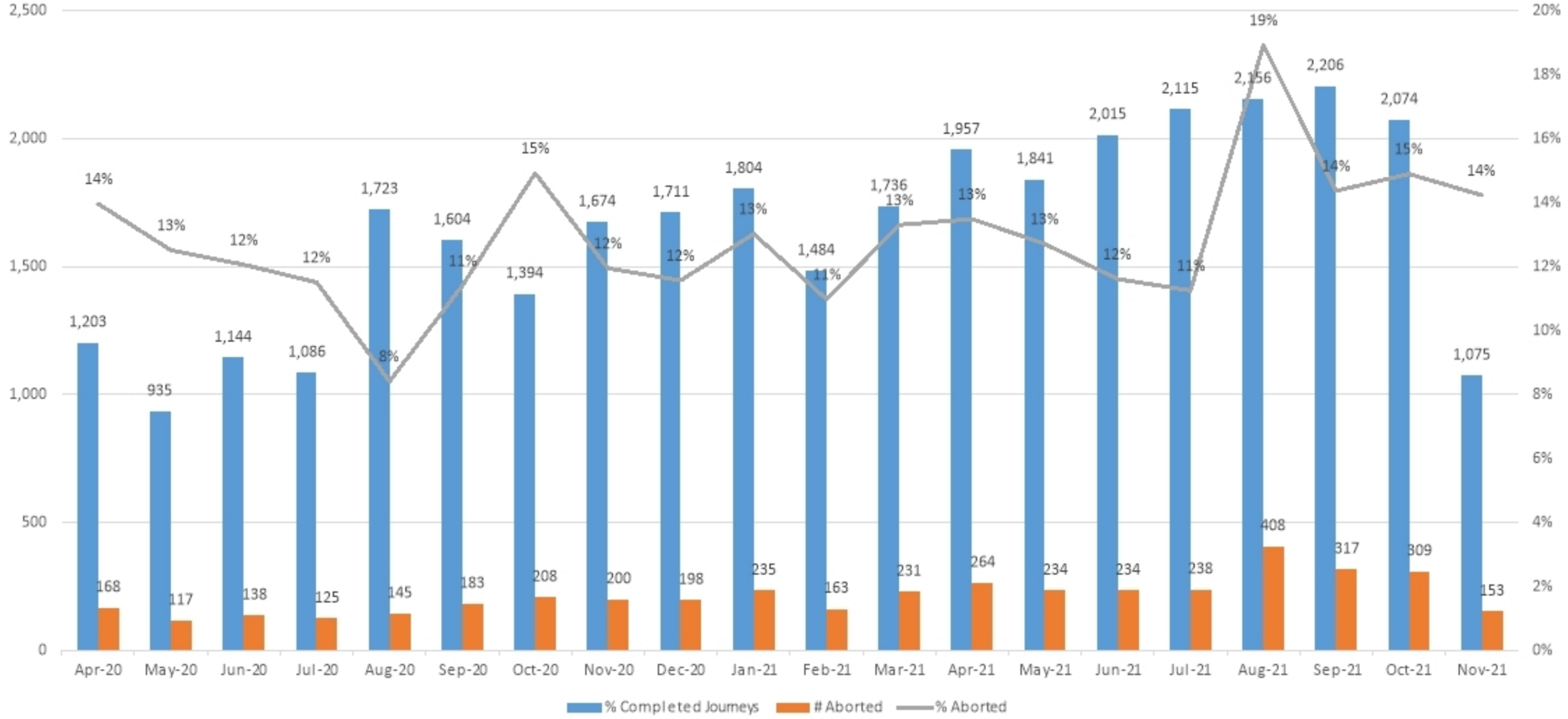
Emergency Ambulance Service Committee (2021-22 Summary)	Total £m
EAS Allocation	182.005
NEPTS Allocation	25.278
EMRTS Allocation	6.000
Ring-Fenced Commissioning Allocations	2.340
Specialist Commissioning Allocations	0.155
EASC Commissioning Funds from LHBs	215.778
EASC Team resourcing	0.610
EASC Total Funds from LHBs	216.388

NEPTS (Activity)





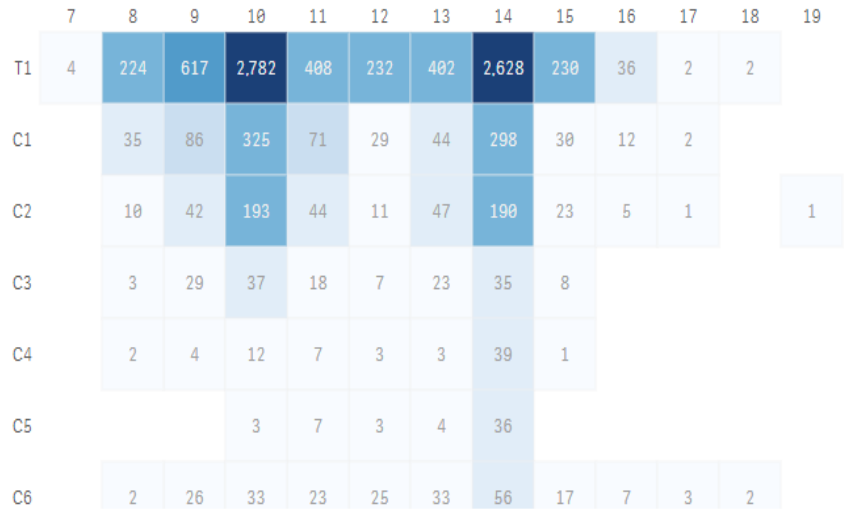
Velindre Completed vs Aborted NEPTS Patient Journeys



NEPTS Journeys – Inbound

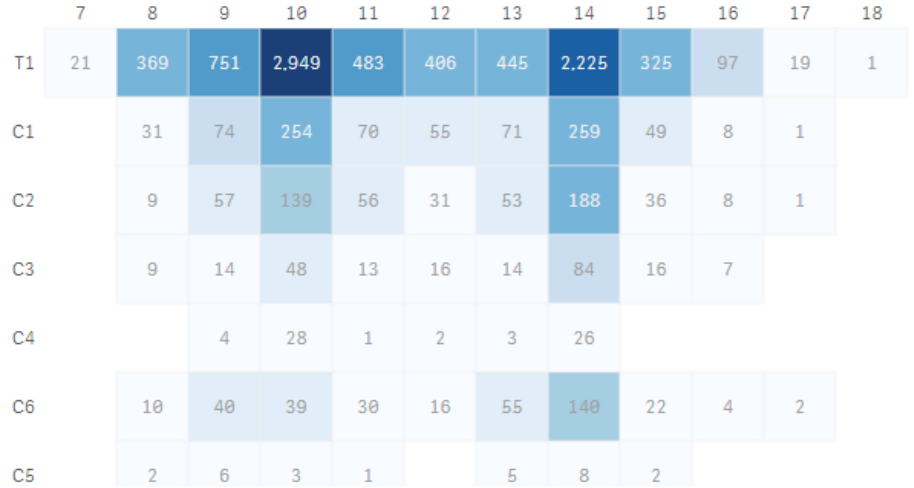
So far in 2021 there have been **10,211** journeys (9,576 in 2020) recorded on the NEPTS system to Velindre Hospital:

2020 Demand by hour by mobility



Vehicle Type	Journeys	%
Taxi	3,088	(32.6%)
Ambulance 2 Wheelchair	2,998	(31.0%)
Volunteer Car Service	1,418	(14.8%)
Ambulance Stretcher	722	(7.5%)
Ambulance Wheelchair	707	(7.5%)
Other	1,273	(6.6%)

2021 Demand by hour by mobility

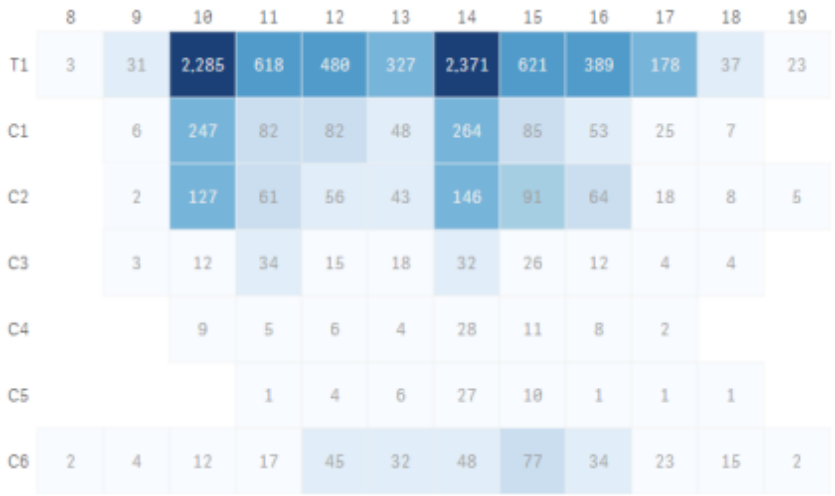


Vehicle Type	Journeys	%
Taxi	2,972	(28.9%)
Ambulance 2 Wheelchair	2,855	(28.4%)
Volunteer Car Service	2,396	(23.2%)
Ambulance Stretcher	713	(7.1%)
Ambulance Wheelchair	643	(6.3%)
Other	632	(6.1%)

NEPTS Journeys – Outbound

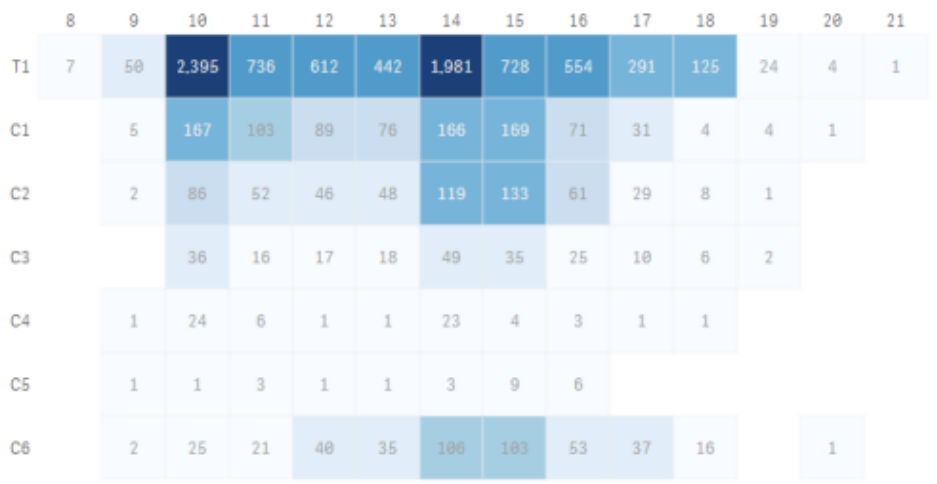
So far in 2021 there have been **10,161** journeys (9,478 in 2020) recorded on the NEPTS system from Velindre Hospital:

2020 Demand by hour by mobility



	8	9	10	11	12	13	14	15	16	17	18	19
T1	3	31	2,285	618	480	327	2,371	621	389	178	37	23
C1		6	247	82	82	48	264	85	53	25	7	
C2		2	127	61	56	43	146	91	64	18	8	5
C3		3	12	34	15	18	32	26	12	4	4	
C4			9	5	6	4	28	11	8	2		
C5				1	4	6	27	10	1	1	1	
C6	2	4	12	17	45	32	48	77	34	23	15	2

2021 Demand by hour by mobility



	8	9	10	11	12	13	14	15	16	17	18	19	20	21
T1	7	50	2,395	736	612	442	1,981	728	554	291	125	24	4	1
C1		5	167	103	89	76	166	169	71	31	4	4	1	
C2		2	86	52	46	48	119	133	61	29	8	1		
C3			36	16	17	18	49	35	25	10	6	2		
C4		1	24	6	1	1	23	4	3	1	1			
C5		1	1	3	1	1	3	9	6					
C6		2	25	21	40	35	106	103	53	37	16		1	

Vehicle Type	Journeys	%
Taxi	2,666	(27.6%)
Ambulance 2 Wheelchair	2,416	(25.4%)
Volunteer Car Service	2,132	(22.9%)
Ambulance Stretcher	971	(10.6%)
Ambulance Wheelchair	677	(7.0%)
Other	616	(6.5%)

Vehicle Type	Journeys	%
Taxi	4,556	(44.2%)
Ambulance 2 Wheelchair	1,821	(18.0%)
Volunteer Car Service	1,692	(16.9%)
Ambulance Stretcher	932	(9.4%)
Ambulance Wheelchair	532	(5.3%)
Other	2,328	(6.2%)

EMS Journeys – Inbound

So far in 2021 there have been **104** journeys (85 in 2020) recorded on the EMS system to Velindre Hospital:

Grange University Hospital	22
Llandough Hospital	1
Neville Hall Hospital	5
Prince Charles Hospital	6
Princess of Wales	3
Royal Glamorgan Hospital	26
Royal Gwent Hospital	11
University Hospital of Wales	3
Unknown	2
Ysbyty Ystrad Fawr	25

AVERAGE RESPONSE TIME
126 MINUTES (117M 2020)

AVERAGE HANDOVER DELAY TIME
0 MINUTES (0M 2020)

AVERAGE PATIENT AGE
68 YEARS (68YRS 2020)

34 journeys were completed by Emergency Ambulances (41EA 2020)

EMS Journeys – Outbound

So far in 2021 there have been **81** journeys (90 in 2020) recorded on the EMS system from Velindre Hospital to hospitals:

Grange University Hospital	11
Llandough Hospital	2
Prince Charles Hospital	1
Royal Glamorgan Hospital	5
Royal Gwent Hospital	3
University Hospital of Wales	38
Unknown	20
Ysbyty Ystrad Fawr	1

AVERAGE RESPONSE TIME
113 MINUTES (138M 2020)

AVERAGE HANDOVER DELAY TIME
27 MINUTES (50M 2020)

AVERAGE PATIENT AGE
68 YEARS (61YRS 2020)

43 journeys were completed by Emergency Ambulances (67EA 2020)

WAST – Future Ambition

*NOTE: * = indicative value*

Hear and Treat
*10% of all activity

See and Treat
*10% of all activity

See, Treat and Convey
*80% of all activity

TODAY

Hear and Treat
Hear, Treat and Refer
*50% of all activity

See and Treat
See, Treat and Refer
*30% of all activity

See, Treat And Convey
*20% of all activity

TOMORROW

Key Issues and Opportunities

- National Discharge Service
- Aborted Journeys
- Use of Taxi
- Link with WAST Strategic Plan

GIG CYMRU NHS WALES
Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Thank you for listening

Chris Turner - Chair Emergency Ambulance Service Committee

Stephen Harrhy - Chief Ambulance Services Commissioner

25/11/2021

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/LIVE STREAMED
30 SEPTEMBER 2021 @ 10.00 AM

PRESENT	
Professor Donna Mead OBE	Chair (Chair)
Stephen Harries	Interim Vice Chair
Martin Veale	Independent Member
Hilary Jones	Independent Member
Gareth Jones	Independent Member
Janet Pickles	Independent Member
Prof Donald Fraser	Independent Member
Prof Andrew Westwell	Independent Member
Steve Ham	Chief Executive
Nicola Williams	Executive Director of Nursing, AHPs & Health Scientists
Matthew Bunce	Executive Director of Finance
Dr Jacinta Abraham	Executive Medical Director
Sarah Morley	Executive Director of Organisational Development & Workforce
ATTENDEES:	
Lauren Fear	Director of Corporate Governance
Cath O'Brien MBE	Interim Chief Operating Officer
Carl James	Director of Strategic Transformation, Planning & Digital
Emma Stephens	Head of Corporate Governance
Catherine Currier	Business Support Officer, Secretariat

1.0	**STANDARD BUSINESS** Prof Donna Mead opened the meeting and welcomed everyone and advised that the Board meeting had been structured to pause at 11:00 to enable Trust Board members to join the Welsh NHS Confederation Wellbeing for Wales Lecture Series, for the Keynote Address and Keynote Speech with the First Minister and Health Minister. Following which the Public meeting of the Trust Board would reconvene at 12:30.	
1.1	**Apologies** Prof Donna Mead noted apologies from: 1. Gareth Jones, Independent Member; 2. Cath O'Brien, Interim Chief Operating Officer; 3. Dr Jacinta Abraham, Executive Medical Director, and	

	4. Professor Andrew Westwell, Independent Member, who will be intermittently attending the meeting, due to prior commitments.	
1.2	**In Attendance** Prof Donna Mead welcomed Matthew Bunce to his first Trust Board meeting, since his appointment as our new Executive Director of Finance. Prof Donna Mead also welcomed the regular attendees of the Public Trust Board and additional attendees: 1. David Cogan, Patient Liaison Representative 2. Katrina February, Audit Lead Performance, Audit Wales 3. Alan Prosser, Interim Director of Welsh Blood Service 4. Paul Wilkins, Interim Director of Velindre Cancer Centre 5. Hilary Williams, Consultant at VCC, 6. Niall Thomson, Buchan Associates 7. Philip Hodson, Deputy Director of Planning & Performance 8. Jenny Stock, Project Manager 9. Mary Swiffen-Walker, WIBSS Service Manager	
1.3	**Declarations of Interest** There were no declarations of interest for any agenda items.	
2.0	**CONSENT ITEMS**	
2.1	**FOR APPROVAL**	
2.1.1	**Minutes from the Public Trust Board meeting held on the 29 July 2021** Stephen Harries suggested for clarity the minutes regarding the Performance Report for the Velindre Cancer Centre be amended to specify that the waiting times in outpatients relates to the time a patient arrives in the Outpatient Department to the time they are seen by a Consultant, and not the time between a patient being referred to the Trust to the date of their appointment. The Trust Board **CONFIRMED** the Minutes of the meeting held on the 29 July 2021 were an accurate and true reflection, with the above amendment being made.	**Secretariat**
2.1.2	**Chair's Urgent Actions Report** The Trust Board **CONSIDERED** and **ENDORSED** the Chairs urgent action taken between the **15th July 2021 – 17th September 2021**.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Trust Board **APPROVED** the Commitment of Expenditure summarised within the report and supporting appendices.	

2.1.4	**Policies for Approval Report** The Trust Board **NOTED** the policies that have been approved since the last report received in July 2021.	
2.1.5	**Trust Seal Report** The Trust Board **APPROVED** the Trust Seal Register for the period July to September 2021.	
2.2	**FOR NOTING**	
2.2.1	**3 Year Integrated Medium Term Plan (IMTP) 2022/23 to 2025/26 – Production Timetable, Approach and Structure** The Trust Board **NOTED** the IMTP 2022/23 to 2025/26 structure, contents and production plan, based on an anticipated submission deadline of 31st January 2022.	
2.2.2	**WHSSC Joint Committee Briefings** The Trust Board **NOTED** the contents of the Welsh Health Specialised Services Joint Committee Briefing of 7 September 2021	
3.0	**STRATEGIC DEVELOPMENT**	
3.1	**South East Wales Acute Oncology Service Business Case** Prof Donna Mead commended the large volume of work involved in developing the Business Case and thanked everyone who had been involved. It was noted that each Health Board was receiving the Acute Oncology Business Case during the autumn for approval. This will allow the Business Case to be included as part of the Trust's Integrated Medium Term Plan. Dr Hilary Williams provided the Board with information and an explanation of the Acute Oncology Service and the development of the Business Case. Niall Thomson provided information on Buchan Associate's role in the development of the Business Case and outlined: • the proposed service model; • the implementation phased process, and • the benefits to the patient and the service. Niall Thomson explained the next steps for the project and progress achieved to date.	

	Prof Donna Mead thanked Dr Hilary Williams and Niall Thomson for the presentation and opened the floor to any questions/queries from the Board. Prof Donna Mead asked if the Business Case had been approved by the Cancer Collaborative Leadership Group (CCLG). Steve Ham confirmed this would be presented to the CCLG via the established Health Board governance arrangements. Steve Ham also stated that the developments outlined in the Business Case respond directly to the findings and recommendations in the Nuffield report, and will support Welsh Government's Quality Statement and their expectations for the NHS. Carl James noted in terms of the Nuffield Report, there was a core recommendation to review scheduled and acute care. It was noted the proposals and developments outlined in the Acute Oncology Business Case would help to improve the unscheduled care service for patients. Janet Pickles noted that as the outgoing Chair of the Quality, Safety & Performance Committee, it was very pleasing to see the achievement of the team in developing this Business Case and the benefits it will bring for the services we provide and for patients. Stephen Harries also offered his congratulations on this significant development and the benefits it will bring for patients. Stephen Harries commented on the potential impact on third sector partners, who support the delivery of care and asked how they had been involved in the development of the Business Case. Dr Hilary Williams confirmed McMillian supports the Acute Oncology Service throughout the UK and Wales. McMillan have recognised the pandemic has highlighted challenges for cancer patients. In addition, McMillian have made critical investments in cancer services and it was planned to continue to engage with McMillan and other cancer charities, patient experience and patient bodies. Prof Donna Mead noted there was a clear message in the Business Case to prevent avoidable admission and where admissions are necessary to reduce the number of bed days of admissions. Prof Donna Mead requested assurance on the support provided to patients during weekends i.e. the patient, who presents on a Friday morning in A&E. Dr Hilary Williams responded that the UK has been struggling with the question of whether it can provide an Acute Oncology Service 7 days a week. One of the key approaches is the upskilling and sharing of expertise with acute teams in Local Health Boards and having clear pathways. Dr Hilary Williams provided information on the on-call and weekend support available from the Trust. Niall Thomson confirmed as part of developing the service model consideration was given to the profile of admissions across the working week and there was a dip in the weekend and explained how this had been incorporated in the evaluation of service model options. Prof Donna Mead highlighted the number of Consultants with different expertise required to deliver cancer care, and queried if there are enough consultants to cover site specific cancers in supporting health	

	boards with the new model. Dr Hilary Williams provided information on the General Medical Council, who have challenged the Oncology Colleges to deliver training to enable future Oncologists to be trained in Acute Oncology Services and ensure that they are up-to-date in acute medicine. Prof Donna Mead commended the team on the attention to detail provided in the Business Case and thanked Dr Hilary Williams and Niall Thomson for their presentation today. Steve Ham echoed Prof Donna Mead's thanks and acknowledged the progress made, the benefits to patients in not being in hospital beds, and the improved patient experience this will enable. The Trust Board **APPROVED** the South East Wales Acute Oncology Business Case.	
4.0	**MATTERS ARISING**	
4.1	**Action Log** Prof Donna Mead took the Board through the action log and it was agreed that: • Item **6.6.0** VUNHST Risk Register is included in today's agenda and can be closed. • Item **8.1.0** Audit Committee Highlight Report Private Patient Debt to remain **open** until an update is received at the October Audit Committee meeting and included in the November Audit Committee Highlight Report to the Board. The Trust Board **APPROVED** the Action Log and updates captured in the meeting.	
5.0	**TRUST BOARD MEMBERS TO JOIN WELSH NHS CONFEDERATION WELLBEING FOR WALES LECTURE SERIES** The Trust Board meeting was paused at 11:00 to allow Trust Board members to join the Welsh NHS Confederation Wellbeing for Wales Lecture.	
6.0	**KEY REPORTS** Trust Board reconvened at 12:30	
6.1	**Chairs Update** Prof Donna Mead, presented the Chairs Update Report to the Board and highlighted the following: • the Trust's Annual General Meeting; • Prof Andrew Westwell's recent appointment as an Independent Member for the Trust; • the end of Janet Pickles tenure as an Independent Member for the Trust since joining us in 2012, and provided an update on the replacement recruitment process;	

	• correspondence received from the Health Minister regarding the new posts in her Department; • 150th Whole Blood Donation, which is a first for Wales. Prof Donna Mead noted that today was Janet Pickles' last Trust Board meeting, and thanked her for the tremendous contribution to the Board and for her immense skills and expertise provided to the Trust. The Trust Board also extended their thanks to Janet Pickles for her support during her tenure as an Independent Member. The Trust Board **NOTED** the content of the update report.	
6.2	**Chief Executive Officer (CEO) Update** Steve Ham presented the CEO Report and provided additional information on the following items: • the Joint Escalation and Intervention Notification received from Welsh Government; • the Joint Executive Team Meeting with Welsh Government, who had requested thanks to be passed to all staff for their hard work and contribution during the past year; • the competitive dialogue for the new hospital; • the Judicial Review, and • Matthew Bunce's appointment as Executive Director of Finance. Martin Veale requested an update on the blood collection supply issues and Mr Steve Ham responded the position was stabilising and improving. It was noted the Trust had managed the situation positively and had not been impacted by the issue. The Trust Board **NOTED** the content of the update report.	
7.0	**QUALITY, SAFETY & PERFORMANCE**	
7.1	**Wales Infected Blood Support Service (WIBSS) Annual Report** Prof Donna Mead invited Mary Swiffen-Walker to present the Wales Infected Blood Support Service (WIBBS) Annual Report. Mary Swiffen-Walker provided Board members with a brief background to the Welsh Infected Blood Support Service, the support provided to beneficiaries and their activities during the pandemic. Mary Swiffen-Walker provided information on the services interaction with the Infected Blood Inquiry and plans for the coming year. Prof Donna Mead thanked Mary Swiffen-Walker for the Annual Report and her presentation to the Board. Martin Veale asked if funding for the services was provided by Welsh Government, and this was confirmed.	

	Prof Donna Mead requested further information on the support provided by the Welsh Infected Blood Support Service and if this was replicated across the UK. Mary Swiffen-Walker explained the Welsh Infected Blood Support Service provided a bespoke service and gave further information on the services provided. It was noted other national services are looking to replicate the service provided in Wales. Janet Pickles noted her experience of claiming redress and the difficulties individuals faced and emphasised the importance of any scheme to be transparent. Prof Donna Mead thanked Mary Swiffen-Walker for her attendance at today's meeting. The Trust Board • **NOTED** the proposal for the Trust Board to receive an update in the form of subsequent Annual Reports; • **NOTED** the current Wales Infected Blood Support Service (WIBSS) Annual Report; • **AGREED** to receive an interim update from the Wales Infected Blood Support Service in approximately six months' time	
7.2	**Quality, Safety & Performance Committee Highlight Report** Stephen Harries presented the Highlight report from the Quality, Safety & Performance Committee held on 16th September 2021, which he Chaired on behalf of Janet Pickles, who was on leave. There were no items to alert to the Board, however the following key messages were highlighted for assurance and for information: • presentation of a patient story; • receipt of NHS Wales Shared Services Quality & Safety Governance Report; • an Equality update; • 15 Step Challenge Report; Prof Donna Mead also thanked Janet Pickles for her work in Chairing and supporting the development of the newly established Quality, Safety & Performance Committee. The Trust Board **NOTED** the contents of the report and actions being taken.	
7.3	**Remuneration Committee Highlight Report** Prof Donna Mead provided an update on the Extraordinary meeting of the Remuneration Committee held on the 23 September 2021 and the Standard Committee meeting of 26 August 2021. The Trust Board **NOTED** the contents of the report and actions being taken.	

7.4	**Local Partnership Forum Highlight Report** Sarah Morley presented the Trust Board with the highlight report from the Local Partnership Forum meeting held on the 1st September 2021. The following key items were highlighted: • this was Darron Dupre's (Unison Representative) last meeting. • a series of workshops were being scheduled with Trade Unions and NHS Managers to discuss developing Partnership Working. Steve Ham acknowledged the Board's thanks to Darron Dupre for his support in the Local Partnership Forum and his involvement with the Trust. Martin Veale requested an update on the Agile Working Policy, Sarah Morley confirmed a project was underway and engagement sessions were being scheduled, along with a workshop with the Executive Management Board and Senior Management Teams. The Trust Board **NOTED** the update and the actions being taken.	
7.5	**Delivering Excellence Performance Report Period July 2021** **<u>Velindre Cancer Service</u>** Paul Wilkins provided an update on the Velindre Cancer Service Performance Report and provided information on the following: • the new Clinical Oncology Strategic Targets (COST); • Radiotherapy waiting times and activity levels; • Systematic Anti-Cancer Therapy (SACT) targets, activity levels and 36 hour prescribing compliance; • times patients are waiting in Outpatients from arrival to seeing the Consultant; • therapies activity levels, and • staffing recruitment. Martin Veale noted the improvement in the how the information is presented in the Performance Report, which was a testimony to the work that had been done. Prof Donna Mead noted the Clinical Oncology Strategic Targets are currently being manually monitored and asked when the electronic system would be available. Paul Wilkins acknowledged there was no date for the implementation of an electronic system, but this was actively being progressed. Prof Donna Mead asked for this information to be provided in future reports for public reassurance. Steve Ham noted that the Clinical Oncology Strategy Targets need to be included in the Integrated Medium Term Plan (IMTP) and how this is balanced over the winter and the Trust's COVID-19 Activity Recovery Plan.	**PW/COB** **PW/COB**

	Welsh Blood Service Alan Prosser provided an update on the Welsh Blood Service Performance Report and provided information on the following: • the blood collections performance; • support provided to Scotland's NHS Service; • new bone marrow donor recruitment; • stem cell collections; • serology referrals and activity levels, and • staff sickness absence and vacancies levels. Prof Donna Mead highlighted the unsuccessful venepuncture figures and noted the spikes are mainly in the North Wales site. Alan Prosser explained this was due to the recent recruitment of new staff and local implementation actions were being undertaken. Prof Donna Mead reiterated the presentation of the performance reports had improved and were easier for members of the public to understand. **Corporate Services** Sarah Morley provided an update on Corporate Services for workforce and organisational development and provided information on the rolling absence levels and COVID-19 related absence. Prof Donna Mead asked what the Statutory & Mandatory Compliance levels were across NHS Wales. Sarah Morley stated that this was difficult to benchmark accurately although the Trust was in the top 1 or 2 and that the data in the report included hosted organisations. Prof Donna Mead noted the positive level of training achieved during the pandemic. The Board discussed the difficulty of entering data into ESR and a possible replacement system. The Trust Board **DISCUSSED** and **REVIEWED** the contents of the performance reports.	
7.6	**Financial Report Period Ended 31st July 2021 (M4)** Prof Donna Mead welcomed Matthew Bunce to the Trust Board and invited him to take the Board through the report. Matthew Bunce noted there was no material change to the previous report, due to timing of the reports and provided information on the following: • year-end position; • capital expenditure; • public payments; • COVID-19 expenditure and income, and • emergency reserve levels. Martin Veale requested information on the Trust's efficiency savings targets and Matthew Bunce provided an update on current plans. Stephen Harries asked how confident the Trust was of the impact of inflation on the Trust's finances. Matthew Bunch stated there was a confidence for this year, but it was unclear for the next financial year	

	and discussions with other Health Board Finance Directors were ongoing. Prof Donna Mead asked for the Trust Board to be kept updated, as the situation develops. The Trust Board **NOTED** the contents of the July 2021 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even.	
7.7	**VUNHST Risk Register** Lauren Fear presented the Trust's Risk Register to the Board. It was highlighted that there had been significant work undertaken since the last report and that the information reported is now aligned to the Risk Assurance Framework, which the Board had approved. Lauren Fear refreshed the Board on the Risk Register Framework and the approach taken to date. Hilary Jones highlighted the risk around Welsh Language (ID 2398) and asked for an update and target date to be added to the register. Sarah Morley confirmed the Trust has undertaken a lot of work and continues to progress activity to meet the Welsh Language Standards. Martin Veale highlighted the risk management process is continuing to be developed and refined and a comprehensive review was being undertaken. Prof Donna Mead thanked Martin Veale for his involvement and for the work of Lauren Fear and her team for their work on the review. The Trust Board: • **NOTED** the Trust Risk Register (Version 12 and Version 14), the actions status of individual risks and next steps. • **NOTED** a project plan was in place to manage the transition from Vs 12 to Vs 14 of Datix.	**SfM**
7.8	**Trust Assurance Framework** Lauren Fear took the Board through this report and explained this was the first iteration of the populated Trust Assurance Framework. It was highlighted the report sets out the development pathway to date, next steps and plans for its further development and operationalisation within the Trust. Hilary Jones thanked Lauren Fear for the work on developing the framework and noted it was a really useful document. The Trust Board: • **NOTED** the progress to date, and **DISCUSSED and REVIEWED** the first iteration of the Trust Assurance Framework. • **NOTED** the next steps in the development pathway to support full operationalisation of the Trust Assurance Framework.	

8.0	**STRATEGIC DEVELOPMENT**	
8.1	**Strategic Development Committee Highlight Report** Stephen Harries presented the highlight report of the Strategic Development Committee held on the 12 August 2021, which received: • an update on the prioritisation of CAP Investment; • presentation on overview of progress on implementing the Wellbeing Act & Future Generations Act; • a progress report against the Nuffield Report; • and a Strategy case for the AOS Business Case The Trust Board **NOTED** the contents of the report and actions being taken.	
8.2	**Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee Highlight Report** Stephen Harries provided the Trust Board with an oral update on the TCS Programme Scrutiny Sub-Committee meeting held on 21 September 2021 which received: • Finance report; • Risk register; • Programme delivery • Project delivery • Integrated Assurance Plan; • Engagement and Collaboration • Progress Report on the Nuffield Report Recommendations The Trust Board **NOTED** the oral update. A written highlight report will be received at the November Trust Board for completeness.	
8.3	**Transforming Cancer Services Communication & Engagement Update** Lauren Fear provided the Board with an update on the programme of communications and engagement since August 2021 and highlighted the following: • engagement at the start of the Competitive Dialogue for the new cancer centre; • 1st printed version of Velindre Matters, and • preparing for on-site work and engaging with the local community, in advance of any activity. Prof Donna Mead noted the large volume of work undertaken by a small team and their achievements. The Trust Board **NOTED** the report.	

8.4	**Progress Report on Quarter 1 Delivery Plan** Carl James explained this was the first progress report for the Annual Plan for 2021/22 and provided an update on the delivery of the Action Plan for Quarter 1. Prof Donna Mead was pleased to note the progress on Park Road and requested further information. Paul Wilkins highlighted the benefits for staff having a place away from their work area to take a break. It was agreed Carl James would provide a timeline for the opening of the Park Road building to the Trust Board. Carl James provided information on the infrastructure work being undertaken and how this was being funded. Prof Donna Mead asked for an update on the Plasma Derived Medicines Project and if there were set objectives in this year's Integrated Medium Term Plan. Steve Ham confirmed that written confirmation had been received that the project management could be set up for this. Alan Prosser confirmed the Minister had signed up for the UK's Memorandum of Understanding for Blood Medicines and the service were included in UK wide discussions. The Trust Board **NOTED** the report.	**CJ**
8.5	**Equality Ambassadors Showcase: Disability** Carl James provided a presentation to the Trust Board, which included information on the key issues, drivers and actions currently being undertaken and actions planned. Prof Donna Mead thanked Carl James for his presentation and for sharing his personal experiences with the Trust Board. Janet Pickles found the presentation really helpful and her experience aligned with Carl James' views and thanked him for sharing his personal experience. Martin Veale echoed Janet Pickles' comments and highlighted the Trust's support of the 'Transplant games'. Martin Veale noted the Trust's ambition to have zero tolerance of discrimination might be unachievable, as the Trust doesn't provide sign language etc. Sarah Morley informed the Board the zero tolerance, was aimed at active discrimination. The Widening Access Programme was looking at how the Trust can employ more disabled employees. It was noted this topic would be included in future Board Development Sessions. Stephen Harries thanked Carl James for his presentation and his honest reflections. Stephen Harries queried if this could be included, as part of the 15 step challenge and whether this is being included in the development and design of the new Cancer Centre. Nicola Williams responded to the 15 step challenge question and agreed this was an area to be focused on, once it was safe to involve patients and donors in this initiative. Carl James confirmed it was planned to design the building to be enable everyone to be able to access and highlighted this was an opportunity for innovation through technology.	

	Nicola Williams highlighted the need to co-produce services with all patients and donors so that this is actively achieved and work in this respect had commenced. Prof Donna Mead noted that inadvertent discrimination can take place and cited the widespread use of notices encouraging the need for physical activity which can cause embarrassment to staff and visitors who may have mobility issues and that this needs to be actively considered. Steve Ham noted the Ambassador roles were allowing the Trust to grow and develop, as an organisation. The Trust Board **NOTED** the contents of the presentation.	
8.6	**Pay Gender Gap Report** Prof Donna Mead explained the Gender Pay Gap Report was a mandatory report for Welsh Government. It was noted that due to the impact of COVID-19, the requirement for the report was temporarily suspended. Therefore the report includes data for the previous two-years. Sarah Morley took the Board through the Pay Gender Gap Report and explained the difference between Pay Equality and the Pay Gender Gap Report. The following was noted: • the report covers the whole Trust and hosted organisations; • an explanation of definitions was provided; • previous years information was included in the report and compared to this year's statistics; • the development of action plans; • provided information on bonus payments in NWSSP and mitigating actions being undertaken; and • details of Trust-wide actions plans; Martin Veale requested an update on data for the last 6 months and Sarah Morley replied the latest information showed no change and the Team are looking to ascertain Trust information only. The Trust Board **NOTED** the contents of the report, which had been submitted to Welsh Government.	
9.0	**INTEGRATED GOVERNANCE**	
9.1	**Charitable Funds Committee Highlight Report** Prof Donna Mead took the Trust Board through the highlight report of the Charitable Funds Committee held on 14th September 2021 and highlighted the following: • fundraising activity had been affected by the pandemic, although fundraising activities are now returning which is welcomed.	

	• an new interim Charity Director had been appointed (Mr Alaric Churchill); • Planning for an Annual Meeting with fundraisers was being planned for early 2022, which will provide Charity Trustees with an opportunity to meet with individual fundraisers; • a retender for the Charity's Investment Broker was being undertaken as the current contract was due to finish; • provided information on the Business Case approved; • new Ambassadors have been appointed, and • the Investment Policy was approved to strengthen the Trust ethical investment approach. Thee policy has been implemented for current investments. Stephen Harries asked if there was an opportunity to link with other charities in the retendering of the Investment Broker or to allow other charities in the future to join us to benefit from economies of scale. Martin Veale agreed to ask for this consideration to be included as part of the retender process. The Trust Board **NOTED** the contents of the report and actions being taken.	**MB**
10.0	**ANY OTHER BUSINESS** There were no further items for discussion. Prof Donna Mead thanked all attendees for their patience, whilst the Trust Board attended the First Minister and Health Minister's keynote speeches.	
11.0	**DATE AND TIME OF THE NEXT MEETING:** 25th November 2021 at 10 am – 14.30 pm.	
12.0	**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).	

TRUST BOARD

CHAIRS URGENT ACTION MATTER REPORT

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

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

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Trust Board Members – Via Email	01/10/2021	Approved
Trust Board Members – Via Email	03/11/2021	Approved

ACRONYMS	
PPE	Personal Protective Equipment
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

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

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

1.3 The Vice-Chair was invited and agreed to attend the NWSSP Financial Governance Group that has been established to oversee and scrutinise NWSSP procurement requests in response to COVID 19 PPE requirements. The Board has agreed that due to the role performed by the Vice-Chair on this group, the Vice-Chair will abstain from any approval requests sought via Chairs Urgent Action involving NWSSP procurement decisions.

1.4 This report details Chair's Urgent Action taken between the **18 September 2021** to the **15 November 2021**.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Option Appraisal / Analysis:

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

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) This action is by exception and with prior approval from the Chair. The provision to permit this urgent action is to allow for quick decisions to be made where it is not practicable to call a Board meeting and to avoid delays that could affect service delivery and quality.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Financial impact was captured within the documentation considered by the Board.

4. RECOMMENDATION

4.1 The Board is asked to **CONSIDER** and **ENDORSE** the Chairs urgent action taken between the **18 September 2021** to the **15 November 2021** as outlined in Appendix 1.

Appendix 1

The following items were dealt with by Chairs Urgent Action:

1. NHS Wales Shared Services Partnership (NWSSP) Aid to Namibia

The Trust Board were sent an email on the 1 October 2021, inviting the Board to **APPROVE** the provision of Aid to Namibia for Personal Protective Equipment (PPE) to help them with their COVID-19 response plan, and seek permission from Welsh Government to write off the value of the PPE to be donated.

Due to the urgency of this matter, it could not wait until the 25 November 2021 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Professor, Andrew Westwell, Independent Member
- Martin Veale, Independent Member
- Hilary Jones, Independent Member
- Gareth Jones, Independent Member

No objections to approval were received.

2. Commitment of Expenditure over the Chief Executive's Limit

The Trust Board were sent an email on the 3 November 2021, inviting the Board to **AUTHORISE** the Chief Executive to **APPROVE** the financial commitment to be awarded in relation to a number of COVID-19 Recovery Funding Capital Schemes and a new Apheresis Harnesses contract, and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreements where appropriate.

Due to the urgency of this matter, it could not wait until the 25 November 2021 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Stephen Harries, Independent Member
- Gareth Jones, Independent Member
- Professor Andrew Westwell, Independent Member
- Sarah Morley Executive Director of Organisational Development & Workforce

No objections to approval were received.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

TRUST BOARD

BOARD DECISIONS REQUIRED FOR COMMITMENT OF EXPENDITURE EXCEEDING £100K FOR THE PERIOD 25 November 2021 to 27 January 2022

DATE OF MEETING	25 November 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	For **APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Business Planning Group Velindre Cancer Service Senior Leadership Team ***(Appendices 1-4)***	October 2021/ November 2021	Supported
Capital Planning & Performance Group Welsh Blood Service Senior Management Team ***(Appendices 1-4)***	September / October / November 2021	Supported
TCS Programme Scrutiny Sub-Committee ***(Appendix 5)***	November 2021	Endorsed for Board Approval

TCS Programme Delivery Board & TCS Scrutiny Sub-Committee ***(Appendix 6)*** Executive Management Board ***(Appendices 1-7)***	April 2021 November 2021	Approved at TCS Programme Delivery Board and Noted by TCS Scrutiny Sub-Committee Endorsed for Board Approval

ACRONYMS	
SFIs	Standing Financial Instructions
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service

1. SITUATION/BACKGROUND

1.1 Velindre University NHS Trust (VUNHST) has a Scheme of Delegation, as set out in its Standing Orders, together with its Standing Financial Instructions (SFIs), which ensures that there are effective governance arrangements in place for the delegation of financial authority.

1.2 Financial limits apply to the commitment of expenditure. If expenditure is greater than an individual's financial limit, and is more than the limit delegated to the VUNHST Chief Executive, the planned expenditure will require VUNHST Board approval. For extensions of existing contracts in place, this only applies if the provision for extension was not included in the original approval granted by the Trust Board.

1.3 The decisions expected during the period **25 November 2021** to **27 January 2022** are highlighted in this report and are seeking approval for the Chief Executive to authorise approval outside of the Trust Board.

1.4 In line with the review of the process for Commitment of Expenditure over the Chief Executive's Limit, all reports are now received by the Executive Management Board to ensure Executive oversight and scrutiny, to provide the Board with supporting recommendations and additional assurance as required.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1 – 7** for the detailed appraisals undertaken of each of the expenditure proposals that the Trust Board is asked to **APPROVE**. The table below provides a summary of the decisions being sought from the Trust Board:

Appendix No.	**Division**	**Scheme / Contract Agreement Title**	**Period of Contract**	**Total Expected Maximum Value of Contract £ (Inc. VAT)**
Appendix 1	WBS	Apheresis Collection Systems and Consumables Contract	Start: 01/03/2022 End: 28/02/2029 Option to extend 3x12months	£2,833,096

Appendix 2	WBS	Bacterial Arm Cleansing Systems (ChloraPrep®)	Start: 31/01/2022 End: 30/01/2026 No option to extend	£231,960
Appendix 3	Corporate - Digital	NDR Infrastructure	Start: 19/01/2022 End: 19/01/27	£349,930
Appendix 4	Corporate - Digital	IT Client & Server Refresh Programme	n/a – one of purchase	£450,000
Appendix 5	TCS	Enabling Works Design and Build Contract	Start: Early 2022 End: 2023 50% (value / duration)	£10,396,003
Appendix 6	TCS	Technical Support for nVCC Competitive Dialogue	Start: Nov 2021 End: March 2023	£174,720
Appendix 7	Estates	Fire Door Replacement	Start: 01/12/2021 End: 31/03/2021	£216,000

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Due authority is being sought in advance of expenditure to ensure the compliant provision of goods/services to meet operational requirements.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	No (Include further detail below)
	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	Yes (Include further detail below)
	Further details are provided in Appendices 1-6 of this report.

4. RECOMMENDATION

4.1 The Board is requested to **AUTHROISE** the Chief Executive to APPROVE the award of contracts summarised within this paper and supporting appendices and **AUTHORISE** the Chief Executive to **APPROVE** requisitions for expenditure under the named agreement.

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	APHERESIS COLLECTION SYSTEMS AND CONSUMABLES CONTRACT
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	Monday, October 11, 2021
PREPARED BY	Rachel Evans, Michelle Evans, Rachel Morgan
SCHEME SPONSOR	Jayne Davey / Alan Prosser

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Welsh Blood Service (WBS) manufactures platelet components for transfusion to patients across Wales. Platelets are manufactured from whole blood donations and by apheresis. The method in operation at the Talbot Green donation clinic utilises the apheresis process supported currently using Terumo medical device and harness technology.

The current Apheresis Agreement for the supply of medical devices and harnesses was awarded in 2019 and ends on 28th February 2022.

To ensure continuity of service to patients in Wales, a procurement project has been active since 2019 to procure a replacement contract. This collaboration procurement between the Welsh Blood Service, the Scottish National Blood Service (SNBTS), the Northern Ireland Blood Transfusion Service, and the Ireland Blood Transfusion Service is completed.

The contract incorporates a number of apheresis devices and the consumables (harnesses and anti-coagulant) required to manufacture the platelet component.

The progress of this exercise has been delayed by the ongoing COVID-19 pandemic and uncertainty in the timelines as both the services and suppliers prioritised development in Convalescent Plasma for medical trials into the treatment of COVID-19 patients.

The procurement approach has now been agreed, Scotland National Blood Transfusion service (SNBTS) have approached the market with a Competitive Procedure with Negotiation to award a single supplier contract for 7 years with the option to extend for a further 3 x 12 months.

This paper seeks approval to renew the contract, establishing the Board authority to enter the contract with the supplier identifying and managing operational risks.						
1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/03/2022
Expected End Date of Contract	28/02/2029
Contract Extension Options **(E.g. maximum term in months)**	(1 year plus 1 year plus 1 year, possible 3 years extension beyond Feb 2029).

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**

	☐	☒
If not, please explain the reason for this in the space provided. This is business as usual that is covered under revenue expenditure.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click **here** for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
1. Do nothing • Current contract ends 28th February 2022 with no provision to extend. • The supply of platelets would rely solely on manufacturing from whole blood donations, depleting the ability to produce frozen components.

- WBS will need to initiate its own procurement exercise for the replacement contract

2. WBS to undertake its own procurement exercise for a replacement contract
    - Unlikely this could be achieved within the remaining life of the current contract
    - Increase in cost as the WBS would not be able to take advantage of the economies of scale offered by the collaboration
3. Replace the current contract (Preferred option)
    - Ensures continuity of supply of essential specialist components to patients in Wales
    - WBS is aligned to the collaborating blood services in the UK
    - Controlled increase to cost due to the scale of the collaboration
    - Purchase additional device to support business resilience

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
This procurement route has allowed for collaboration with other Blood Services, stability of the collection platform, and cumulative volumes providing economies of scale. A Competitive Procedure with Negotiation has allowed for discussion with supplier regarding how they will meet the requirements of the service.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
WBS will be unable to continue platelet manufacture using Apheresis	Manufacture all platelet components using whole blood donations and make up the shortfall by importation of components under a mutual aid agreement (at significant cost, loss of self sufficiency and reputational damage) Conduct an accelerated procurement exercise

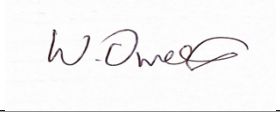
WBS will not have a contract in place for the supply of harnesses Significant increase in costs if WBS carries out a procurement exercise on its own due to weaker buying power and there is no option to further extend the current arrangements	None

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☒	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
This is a collaborative procurement process between the Welsh Blood Service, the Scottish National Blood Service (SNBTS), the Northern Ireland Blood Transfusion Service, and the Ireland Blood Transfusion Service. SNBTS have approached the market with a Competitive Procedure with Negotiation to award a single supplier contract for 7 years with the option to extend for a further 3 x 12 months. Using this procurement route has allowed for collaboration with other Blood Services, stability of the collection platform, and cumulative volumes providing economies of scale. As well as this, using a Competitive Procedure with Negotiation has allowed for discussion with supplier regarding how they will meet the requirements of the service.			

6.3 What is the approximate timeline for procurement?
As this is a joint procurement, the tender was issued by SNBTS in December 2020 and returned by suppliers in January 2021. Evaluation of the responses has resulted in a successful supplier being recommended. Following ratification of this decision via the required governance structure, the aim is to publish the award in November 2021, in preparation for the planned contract commencement of March 2022.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Wyn Owens (Head of Sourcing – Medical & Clinical)
Signature:	
Date:	12/10/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)** £2,833k
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

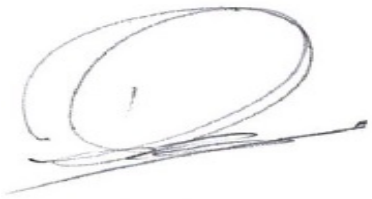
PROFILE OF EXPENDITURE

Qption - Equipment Rental (5 devices) and Consumables (2,850)	**Year 1**	**Year 2**	**Year 3**	**Total (7 years)**	**Year 8**	**Year 9**	**Year 10**	**Total (7 years, plus 1, plus 1, plus 1)**
Capital Outlay								
Annualised Capital/Leasing/Rental Cost (Incl VAT) (5 devices)	£16,500	£16,500	£16,500	**£115,500**	£16,500	£16,500	£16,500	**£165,000**
Maintenance (Excl VAT) (5 devices)	£7,000	£7,000	£7,000	**£49,000**	£7,000	£7,000	£7,000	**£70,000**
Interface (Incl VAT)	£9,876	£9,876	£9,876	**£ 69,132**	£9,876	£ 9,876	£9,876	**£ 98,760**
Consumables (Incl VAT)	£249,934	£249,934	£249,934	**£1,749,535**	£249,934	£249,934	£249,934	**£2,499,336**
Total Annualised Cost	**£283,310**	**£283,310**	**£283,310**	**£1,983,167**	**£283,310**	**£283,310**	**£283,310**	**£2,833,096**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	At the point of award, a change will be recorded and iHUB (Innovation hub) resource will be assigned to support the project through implementation. Following implementation, the operational team will monitor performance using the contact performance indicators and governance arrangements to WBS Senior Management Team (SMT).

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	ALAN PROSSER
Signature:	
Service Area:	WELSH BLOOD SERVICE
Date:	12.10.21

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
CPPG	14.10.2021
Divisional Senior Management Team	13.10.2021
Executive Management Board	01.11.2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	Bacterial Arm Cleansing Systems (ChloraPrep®)
DIVISION / HOST ORGANISATION	Welsh Blood Service
DATE PREPARED	24th September 2021
PREPARED BY	Sally Gronow, Senior Operations Manager
SCHEME SPONSOR	Jayne Davey, Interim Blood Supply Chain Lead

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Bacterial Arm Cleansing Systems consist of an antibacterial substance in a pre-prepared swab applicator. They are used by WBS Collection Teams to cleanse the site of the donor's arm prior to inserting the blood donation cannula.

WBS purchase these swabs under an NHSBT agreement. By utilising this route to market, WBS have been able to access more competitive pricing, resulting from the greater commercial opportunity generated by the aggregate spend of NHSBT and WBS.

The only product range - in individual applicator form and containing the required 2% chlorhexidine gluconate in 70% isopropyl alcohol formulation - currently licenced by the MHRA is ChloraPrep®.

Welsh Blood Service's existing agreement ended on 23rd October 2021. The new contract (subject to Trust Board approval) is due to commence on 31st January 2022. Consumable have been purchased to support the contract interim period. Orders will be placed under the new contract (should it be approved) that allow for lead in delivery time to ensure continuity of supply under the new contract.

There is a significant cost saving in the replacement contract, generated by a volume resizing of antibacterial substance from 1.5ml to 1.0ml per applicator. The replacement substance volume continues to provide effective cleansing to the cannulation site, which is specified as a 10cm x 10cm area.

Produce prices:

Produce description	Produce code	Product per case	List price per case	List Price per Device
Existing ChloraPrep® 1.5 ml Applicator (coverage area 10 cm x 13 cm)	260407i	100	£55.00 plus VAT	£0.55 plus VAT
Replacement ChloraPrep® 1.0 ml Applicator (coverage area 10 cm x 10 cm)	270480	240	£76.80	£0.32 Excl VAT

Year of usage	Chloraprep usage	Net Issue Value
2019	1134	£84,131.19
2020	832	£55,616.70
2021 to date (12.10.21)	699	£36,575.00

The current contract estimated to be £260,000 over the four years of the agreement

Based on present usage and applying a 10% contingency in usage growth per annum, the following table provides forecast cost and volume.

Profile Assumption	**Months**	**Monthly Units**	**Annual Units**	**Annual Price**
Baseline Monthly		**10,000**		**Unit Price £0.32**
Feb 22 to Mar 22	2	10,000	20,000	£ 6,400.00
Apr 22 to Mar 23	12	11,000	132,000	£ 42,240.00
Apr 23 to Mar 24	12	12,100	145,200	£ 46,464.00
Apr 24 to Mar 25	12	13,310	159,720	£ 51,110.40
Apr 25 to Jan 26	10	14,641	146,410	£46,851.20
	48		**603,330**	**£193,065.60**
Assume up to 10% Growth per Annum				

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☐	Contract Extension	☐	Contract Renewal	☒

1.2 Period of contract including extension options:	
Expected Start Date of Contract	31/01/2022
Expected End Date of Contract	30/01/2026
Contract Extension Options **(E.g., maximum term in months)**	None

2. STRATEGIC FIT (*Host Organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognized as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognized leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development, and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM-TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.		

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation, and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a Centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☐	Integration	☐	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e., 'do nothing'

3.1 Please state alternative options considered and reasons for declining

As the market in the UK is limited to one supplier there is no advantage to having traditional award criteria; however, the evaluation will still comprise a multi-stage pass/ fail process as summarised below:

- STAGE1: Tender responses will be checked to ensure that they have been completed correctly and all necessary information has been provided.
- STAGE2: Responses to the mandatory and discretionary grounds for exclusion will then be reviewed (and evaluated if self-cleaning information has been submitted).
- STAGE3: Responses to the financial and economic information (or Authority obtained Credit Safe report) will then be assessed to ensure there is no concern in fulfilling the requirements of the contract.
- STAGE4: Responses to the specification will then be assessed to ensure all mandatory requirements can be complied with.
- STAGE5: A negotiation will then ensue to ensure agreement is reached on the essential terms (e.g., price) and deliverables under the contract. NOTE: The negotiation strategy will be drafted before the tender is issued and finalised prior to the 'Deadline for the submission of tender responses', in order to ensure that NHSBT is in the strongest position to negotiate with the supplier.

It was not envisaged that any validation would be required prior to the 'Notification of award to tenderers', as validation would only be necessary if Insight Health Limited did not offer the current ChloraPrep® 1 ml applicator.

1. Preferred option – contract Renewal – this will allow the service to continue with no changes to current practice.

2. Contract Expiry with no replacement – loss of current supply with no replacement would result in WBS being unable to produce blood products, risk of reputational damage to WBS and potential risk to life if blood supply to hospitals is not maintained.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Option 1 is preferred • No change in the chloroprep solution formulation except the amount needed for cleaning of the 2-inch square per donation to 1ml. • Reduced wastage by eliminating cleansing of a larger surface areas than is needed to meet infection prevention requirements. • Service continuity with as little disruption to our current way of collecting donations ensuring the safety of blood products is maintained. • No validation required • Continuation of economy of scale cost benefit

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
Infection risks to blood products	SOP to be updated to reflect change in chloroprep swab to 1ml with no change in the pre donation of cleaning 2inch square. The plan to monitor this change is to send a box of 10 swabs to each team (7 teams in total) during the training phase to obtain some baseline data and then send a further box of swabs to each team post implementation to evaluate the performance. once the chloroprep are in routine use. The results for all teams will be analyzed pre and post introduction.
Training	Preparation of training package and lesson plan for all collection teams to be commenced week of 2nd January 2022.
End of current contract 17/10/2021 – disruption to supply.	An order was placed under the existing contract on 13th October 2021 to the supplier for 3 pallets of 1.5ml chloroprep, this equates to 14,400 applicators (box of 100 x 48 boxes x 3 pallets) to ensure service continuity during the interim contract period. There is an immediate risk to blood supply if the contract is not agreed and in place by 31st January 2022.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.	
Competition	**Single source**
3 Quotes ☐	Single Quotation Action ☐
Formal Tender Exercise ☐	Single Tender Action ☐
Mini competition ☐	Direct call off Framework ☐
Find a Tender ☒ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐
Click here for link to Procurement Manual for additional guidance	
6.2 Please outline the procurement strategy	
A formal procurement Find a Tender exercise has been carried out by England Blood Services (NHSBT) on behalf of all UK Blood services, this included WBS's requirement for a 4 year period. **Contract to be awarded once internal governance is completed.**	
6.3 What is the approximate timeline for procurement?	
6 months timeline completed in July 2021	

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	01/11/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)**	**Including VAT (£k)** **£232k**
The nature of spend	**Capital** ☐	**Revenue** ☒
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below:		

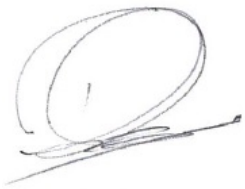
PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £k**	**Year 2 (exc. VAT) £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Consumables	6.4	42.4	46.5	98	193.3	232
Overall Total	6.4	42.4	46.5	98	193.3	232

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g., PRINCE 2	Not applicable

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Alan Prosser
Signature:	
Service Area:	Collections
Date:	10/11/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Capital Planning and Performance Group	29/10/2021
Divisional Senior Management Team	29/10/2021
Executive Management Board	01/11/2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	NATIONAL DATA RESOURCE INFRASTRUCTURE
DIVISION / HOST ORGANISATION	Corporate - Digital
DATE PREPARED	03/11/2021
PREPARED BY	Emma Powell
SCHEME SPONSOR	Cath O'Brien/Matthew Bunce

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The National Data Resource (NDR) is a 10 year transformative national programme which Welsh Government has committed to that is intended to enhance and integrate local data stores into a federated, 'system of systems' national architecture to enable better interoperability and data sharing across Health Boards and Trusts in Wales.

We need to "establish a national data resource which allows large scale information to be shared securely and appropriately" Welsh Government - A Healthier Wales: our Plan for Health and Social Care

"…the NDR will support the enhancement of local data stores (comprising both TDS [Transactional Data Store] and ADS [Aggregate Data Store] components) to ensure they can liberate local data, making it easier to submit to the national data store and enable health and care organisations to directly share data in relation to their citizens between them." -NDR PBC June 2019

To enable this approach, the National Data Resource (NDR) provided each Trust and Health Board with funding for 2 WTE post, which have been appointed. Along with a capital/revenue budget of £500K to be spent over 3 years. This was in recognition that the resources and Infrastructure within the Health Boards and Trusts would not enable the NDR objectives to be met and the programme needed to support this.

Velindre Trusts 1st year allocation was rolled over into year 2 and 3. Velindre initially had recruitment issues which enabled the NDR to utilise the recruitment underspend to fund KPMG to

review the current and future technical resources needed to support this work. The direction and choice of the technology has been delegated to the NDR and local IT teams to decide the most appropriate technical option – that can be integrated and supported locally – to deliver on the NDR strategic objectives.

To ensure the correct approach was taken, Velindre has engaged in a yearlong audit with KPMG, Digital Services and VCC & WBS BI teams to review the current state of the BI infrastructure and advise on requirements for future technologies to enable the NDR integration and development. KPMG's current infrastructure report highlighted that the current BI infrastructure would not be scalable or able to support the NDR integration. KPMG did not make any recommendation on specific vendors, it did review and score an array of on-premise, hybrid and cloud native deployment options and provides guidance on key high level architecture designs.

Using the key recommendations proposed by KPMG, the local NDR, VCC BI, WBS BI and IT infrastructure teams have been engaged in ongoing discussions to research and score a number of different solutions for the Trust. These options included a range of on-premise, cloud native, hybrid and cloud native solutions – both propriety and open-source on-premise solution. The review took into account cost, current skills within the trust and workload requirements. The three overall options included: cloud native, open source on-premise & cloud hybrid platforms and on-premise platforms that enabled the transition to cloud native.

Following the review of the technology options Dell's VxRails is the preferred solution due to:

- Review of Welsh NHS organisation and their NDR technology highlighted that VxRails was being used by two organisations and being considered in a third. Due to this and the below VxRails is the preferred platform.
- Knowledge and skills throughout Wales on the VxRails platform, VxRails platform has already been procured and deployed in Cwm Taf Morgannwg by their local NDR & IT team. Engagement sessions to learn about its adoption have been undertaken.
- Currently the BI and NDR are not in a position to transfer directly to cloud due to the need to redesign and develop the architecture, current workload pressures and skills within the NDR and BI teams. In addition, there is a large recurring revenue cost associated with Cloud for which there is no funding solution. VxRails enables Cloud readiness and easy transition in the future.
- It offers market leading support for containerisation which will enable the adoption of Microsoft's SQL Server Big Data Cluster technology. This is the future direction for MS SQL Server and offers a number of key benefits including licensing, big data tooling, performance and resilience
- Provides capability for a hybrid model which integrates cloud services to our local on-premise infrastructure and network.

- VxRails would enable the 'stepping stone' approach to future cloud adoption. This will enable the upskill on tools like HDFS, Databricks / Delta data lakes, Apache Spark, Kubernetes on premise without the revenue overheads of running these services in the cloud or the immediate resource implication.
- Integrates into current IT and BI infrastructure allowing speed of deployment with familiar technologies and services.
- Integrates with the current IT infrastructure (Dell) and can be supported with the current knowledge and skills base in the IT infrastructure team and wider NHS Digital teams.
- Jointly engineered technology between DELL and VMWARE leveraging existing architecture products

The purchase of the VxRails is £350,000 capital expenditure the remaining £150,000 will be utilised next financial year for the licensing of the platform due to the delivery timescales for VxRail. **There will be a recurring revenue licensing cost pressure of approx. £50,000.** Licensing requirements may vary dependent on the use of the product and the cores used, this will be less in the first couple of years and will be constantly reviewed to ensure efficiency and requirements are kept to a minimum.

The purchase of VxRails has been approved by the NDR programme for the Trustwide purchase and use. In addition, there are ongoing discussions with the NDR Programme regarding recurring funding for licenses etc. associated with the technical solutions to deliver the NDR Strategic Objectives.

This is a Trust wide purchase to provide infrastructure for the NDR, VCC BI and WBS BI.

KPMG provided indicative costs that enabled comparable costs for the different options. This was based on replacing the current BI requirement and data volumes. This did not include an LDR environment for the NDR, the data volumes/storage that would be needed or an always available model which was recognised as required.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	19/01/2022
Expected End Date of Contract	19/01/2027
Contract Extension Options	N/A

(E.g. maximum term in months)	

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☐
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☒
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐
If not, please explain the reason for this in the space provided. This is in the BI and NDR agreed work programme for the last 2 years and vision for the future to support the delivery of the Trust information needs and to enable a data driven organization and evidence based decisions. It was also part of the recruitment and job descriptions of the 2 NDR posts.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☒
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☒	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining

Option 1 – Do Nothing - Discounted
KMPG review advises that the Do Nothing will not support the integration of the NDR and enable the NDR objectives to be met.

This option will not enable the integrate into the NDR and provide Whole System patient/donor pathways. Whole System Pathways will enable the evaluation of the benefit and Value of the service to the patient/donor by integrating the whole patient/donor journey along with their reported experiences and outcomes (PREMS & PROMS) reporting in both Velindre and the wider NHS organisations. This is key to Value Based Healthcare, services redesign based on the patient/donor needs, capacity and demand planning based on whole system change.

The current infrastructure does not have the disk space, big data capabilities and back up solutions that are needed.

Currently the BI infrastructure is being used more and more for operational reporting and business continuity, this means that the current server needs to be always available which is not currently supported.

Option 2 – Cloud Based Technology- Discounted

- *No sufficient Nationally Agreed IG framework for assuring the use of cloud technology and storage of patient/donor data 'off-site' within the NDR Programme. This would need to be a locally approved IG framework for cloud use.*
- *Insufficient skills in the BI and local infrastructure teams to support it. Unintended costs can be incurred without diligent control of resources and architecture due to the 'pay as you go' operational cost model.*
- *'Vendor lock-in' – switching to another vendor could result in signification outbound data costs.*
-
- *It would require a significant redesign of current data warehouse and extraction methods, given current workloads and resources this would impact current priorities.*
- *Additional overheads would be incurred by the IT infrastructure team when linking the cloud services to local network. (For example, DHCW is currently procuring express route cabling to manage this).*

- *KPMG Options for the indicative comparable costs (not the full specification required) for Cloud*
    - *An estimated £90k p.a.*
    - *one-off staffing & training revenue costs of £220k.*
    - *Estimated 5 year costs £674k - £135k p.a.*

Option 3 – Hybrid on-premise & open source cloud providers, such as OpenStack

- *Representative for Canonical, an Ubuntu OpenStack provider, advised that it would be the wrong choice for the Trust's size and the skills required to manage it would be hard to find and harder to retain.*
- *Most of the licensing benefit existed from adopting a 'bare metal' deployment, without a managed provider, however:*
    - *There isn't currently sufficient infrastructure knowledge in-house to support this deployment and the IT teams would be solely responsible for the installation and configuration of the servers, putting a significant pressure on IT resources.*
    - *There isn't currently sufficient knowledge to operate the 'cloud' software.*
    - *Limited warranty and assurance options.*
- *This approach is better suited to big data, open-source workloads and wouldn't integrate as well with current Microsoft SQL workloads.*
- *It would require further work and expenditure to integrate with current local infrastructure and network.*

- *KPMG Options for the indicative comparable costs (not the full specification required) for Cloud*
    - *The annual licensing costs would be higher at an estimated £73k p.a. + one-off staffing & training revenue costs of £222k.*

○ *Capital costs £242k* ○ *Estimated 5 year cost £826k - £165k p.a.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Option 4 – On Premises solution that enables cloud ready • *Review of Welsh NHS organisation and their NDR technology highlighted that VxRails was being used by two organisations and being considered in a third. Due to this and the below VxRails is the preferred platform.* • *VxRails platform has already been procured and deployed in Cwm Taf Morgannwg – by their local NDR & IT team. Engagement sessions to learn about its adoption have been undertaken.* • *It offers market leading support for containerisation which will enable the adoption of Microsoft's SQL Server Big Data Cluster technology. This is the future direction for MS SQL Server and offers a number of key benefits including licensing, big data tooling, performance and resilience* • *Provides capability for a hybrid model which integrates cloud services to our local on-premise infrastructure and network.* • *VxRails would enable the 'stepping stone' approach to future cloud adoption. This will enable the upskill on tools like HDFS, Databricks / Delta data lakes, Apache Spark, Kubernetes on premise without the revenue overheads of running these services in the cloud or the immediate resource implication.* • *Integrates into current IT and BI infrastructure allowing speed of deployment with familiar technologies and services.* • *Integrates with the current IT infrastructure (Dell) and can be supported with the current knowledge and skills base in the IT infrastructure team and wider NHS Digital teams.* • *Jointly engineered technology between DELL and VMWARE leveraging existing architecture products* • *Expanding the backup options to integrate with our current DELL backup solution to accommodate expanding workloads.* • *KPMG Options for the indicative comparable costs (not the full specification required) for Cloud* ○ *The annual licensing costs would be lower at an estimated £32k p.a. depending on use & no. cores + one-off staffing revenue costs of £192k.* ○ *Capital cost £283k* ○ *Estimated 5 year cost £634k - £127k p.a.- lowest annual cost*

- *VxRails comparison*
  - *Capital costs £250k, plus £40k backup solutions*
  - ***Annual licensing of approximately £50k (dependent on core use, less in first few years)***
  - *5 year cost £540k- £108k p.a. (no installation cost as included in the price ,excl VAT)*

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
Unable to support the NDR programme and strategic objectives. Withdraw of funding to support the NDR infrastructure and possible funding of resources employed by the Trust due to non-delivery of the NDR objectives. Unable to provide whole system pathway information to support Value Based Healthcare, service redesign, whole system capacity and demand planning, advance analytics, machine learning and AI, along with the Trust Information requirements.	Continue with the current infrastructure and with the current level of availability to support VCC, WBS and Velindre Trust information requirements. This however, would not meet the growing demand for information and patient/donor pathway requirements and would only provide minimal achievements of the NDR objectives. There will be limited expansion of the data or whole system pathway analysis

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒

Find a Tender ☐ (replaces OJEU Public Contract regulations 2015 still apply)	All Wales contract ☐
Click here for link to Procurement Manual for additional guidance	
6.2 Please outline the procurement strategy	
NPS Framework IT Products and Services (ii) NPS-ICT-0094 – 19 – Lot 2	
6.3 What is the approximate time line for procurement?	
6-8 working weeks	

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	16/11/21

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£)** **£291,608.19**	**Including VAT (£)** **£349,929.83**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		

If you have selected 'Other' – please provide further details below:

The funding and purchase of VxRails has been approved by the NDR Programme and monies are available for the Trust to draw down to purchase the software. Funding letter attached. Below is the email confirmation.

From: Stephen Twiddy (DHCW - National Data Resource) <Stephen.Twiddy@wales.nhs.uk>
Sent: 29 October 2021 15:13
To: Emma Powell (Velindre - Head of Information) <Emma.Powell@wales.nhs.uk>
Cc: Rebecca Cook (DHCW - Information Services) <Rebecca.Cook2@wales.nhs.uk>; Mark Cox (DHCW - Finance & Business Assurance) <Mark.Cox@wales.nhs.uk>; Sian Williams (DHCW - Finance & Business Assurance) <Sian.Williams25@wales.nhs.uk>
Subject: NDR Capital Funding for Velindre VXRAILS Purchase
Importance: High

Hi Emma,

Following on from our previous discussions around NDR Capital to support the VXRAILS purchase in VCC I'm pleased to confirm that we're able to support this for you subject to the attached Funding letter being signed. Could you please arrange for this to be signed off and returned to me by the end of next week. I've been advised that you can take this email as authorisation to start procurement in the interim as timescales are tight and once the funding letter is signed we can arrange for the funding to be transferred from Welsh Government.

If you have any queries please feel free to contact me.

Regards,

Stephen

Stephen Twiddy
Reolwr Prosiect| Project Manager
Adnodd Data Cenedlaethol | National Data Resource
Ffôn/Tel: 02920 50 2853 | stephen.twiddy@wales.nhs.uk
5 Castlebridge, Cowbridge Road East, Cardiff CF11 9BB

https://digitalhealth.wales/national-data-resource

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £	Year 2 (exc. VAT) £	Year 3 (exc. VAT) £	Total Future Years (exc. VAT) £	Total (exc.VAT) £	Total (inc. VAT) £
Capital					**£291,608.19**	**£349,929.83**
Overall Total					**£291,608.19**	**£349,929.83**

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*Project management through the NDR Programme. Oversight via Operational Services Delivery Directorate D&D group*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Matthew Bunce
Signature:	
Service Area:	Finance
Date:	16th November 2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	NDR Programme Board 29/10/2021
Divisional Senior Management Team	Trust Wide purchase
Executive Management Board	22/11/2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	IT Client & Server Refresh Programme
DIVISION / HOST ORGANISATION	Corporate - Digital
DATE PREPARED	Tuesday 15th November 2021
PREPARED BY	David Mason-Hawes – Head of Digital Delivery
SCHEME SPONSOR	Stuart Morris – Chief Digital Officer

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

A digital procurement to secure additional IT equipment / infrastructure (laptops, desktop PCs, peripherals etc.). The investment is required to replace existing 'end of life' (out of warranty) equipment – part of the annual IT 'refresh' programme for Trust IT equipment. The replacement of these 'end of life' devices ensures Trust staff are able to work using equipment that meets our minimum standards of service provision, as well as ensuring the Trust can access appropriate technical support from the supplier in the event of the equipment developing a fault.

The requirements of the procurement have been reviewed in alignment with the current risk register for Digital Services. The total planned investment is set out in further detail below.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☐	Contract Renewal	☐

1.2 Period of contract including extension options:

Expected Start Date of Contract	n/a – one of purchase All equipment supplied with 5 year warranty

Expected End Date of Contract	n/a – one of purchase All equipment supplied with 5 year warranty
Contract Extension Options **(E.g. maximum term in months)**	n/a

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☒

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☐	☒
If not, please explain the reason for this in the space provided. This is business as usual capital procurement activity.		
2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.		

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☒
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☒	Involvement	☒

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Do Nothing – discounted. The annual refresh of Trust IT equipment is a core part of the service provided to Trust staff by the Digital Services team – any failure to proceed would result in a significant proportion of the IT equipment in use across the Trust being out of warranty. This would likely lead to a gradual decline in overall performance as staff would be working with ageing equipment. Furthermore, the funding allocation (£450,000) for this spending has been granted by Welsh Government – the Trust is expected to ensure these monies are spent before financial year end.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Non-Quantifiable • IT equipment in use across the Trust is under warranty • Staff have access to current, supported equipment • Reduced risk of individual and/or wider service disruptions due to failing, end of life equipment • Maintain staff morale through the ongoing provision of the latest equipment to staff

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Requirement to return £450,000 to Welsh Government • Risk of individual and/or wider service disruptions due to failing, end of life equipment	None

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
NPS Framework IT Products and Services (ii) NPS-ICT-0094 – 19 – Lot 2 With lengthening lead times and raw material prices increasing a swiftly executed competition is recommended.			
6.3 What is the approximate timeline for procurement?			
Aim to complete all procurement activity, including delivery of all equipment, by 31st March 2022. There is a global supply chain issue for IT equipment due to COVID-19. As such, suppliers are advising on ensuring all orders are placed prior to Christmas so as to ensure delivery before financial year end.			

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	16/11/21

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** £375,000	**Including VAT (£k)** £450,000
The nature of spend	**Capital** ☒	**Revenue** ☐

How is the scheme to be funded? Please mark with a (x) as relevant.

Existing budgets	☐
Additional Welsh Government funding	☒
Other	☐

If you have selected 'Other' – please provide further details below:

Additional funding has been provided by Welsh Government to cover the full costs associated with these requirements.

7. FINANCIAL ANALYSIS

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
IT equipment - Laptops - Desktop PCs - All in One PCs - Monitors - Peripherals	£375k	-	-	-	£375k	£450k
Overall Total	£375k	-	-	-	£450k	£450k

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? e.g. PRINCE 2	n/a

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.

Lead Director Name:	Matthew Bunce
Signature:	MBunce
Service Area:	Finance
Date:	16th November 2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	Date of Approval:
CPPG	16/11/2021
Divisional Senior Management Team	Trust Wide purchase
Executive Management Board	22/11/2021

Host Organisations	Date of Approval:
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	WALTERS UK LTD – ENABLING WORKS DESIGN AND BUILD CONTRACT
DIVISION / HOST ORGANISATION	TRANSFORMING CANCER SERVICES
DATE PREPARED	NOVEMBER 2021
PREPARED BY	Hannah Moscrop, Project Manager
SCHEME SPONSOR	MARK ASH, ASSISTANT PROJECT DIRECTOR

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

This contract is to deliver the Works Packages for the Enabling Works:

- Works Package 1 - nVCC primary access bridge, and temporary and permanent haul road (TCAR1), together with landscape, environmental, ecological and habitat management and mitigation works;
- Works Package 3 - works within Lady Cory Field and the surrounding footpaths and Coryton Railway Station;
- Works Package 4 - construction of temporary haul road (TCAR2);
- Works Package 5 - provision of site drainage and installation of major utilities.

The procurement was undertaken via a competition through the South East Wales Highways Framework, as agreed with NWSSP Procurement Team, and approved through the Trust's internal governance.

A report detailing this procurement and award process has been endorsed by the EW Project Board and TCS Programme Delivery Board in November 2021. It is awaiting endorsement by the TC Scrutiny Sub-Committee in November 2021, and will be presented at the Trust Board on 25th November 2021.

This contract will not be awarded until the Welsh Government has approved the Enabling Works Full Business Case (EW FBC) and released the appropriate funding as a result.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension (new contract for existing supplier)	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	Early 2022
Expected End Date of Contract	2023
Contract Extension Options **(E.g. maximum term in months)**	50% (value / duration)

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
As part of supporting the nVCC Project.	☒	☐

If not, please explain the reason for this in the space provided.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Option 1 – Do nothing – If the Enabling Works Design and Build work is not undertaken, there will not be a prepared site on which to build the nVCC – therefore the nVCC opening date will be delayed by a considerable length of time - over 12 months as a minimum.

A re-procurement of the D&B contractor, or amending the nVCC procurement to include the D&B work would result in considerable time, resource and cost implications in relation to the nVCC – incurring negative impacts on care and service delivery to patients. **Option 2 – award the contract with Walters UK Ltd (recommended)** – this would ensure that the Project is able to progress according the Project Plan, and in accordance with Welsh Government approval of the EW FBC. **Other options considered but not taken forward:** It was considered that the nVCC Contractor could undertake the Enabling Works site preparation and access works, however it has been previously agreed to undertake the Enabling Works separately in order to de-risk the MIM nVCC Procurement as much as possible.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Undertaking the Enabling Works with the preferred contractor, to time, will ensure that a 'shovel ready' site is provided to the nVCC contractor – thereby de-risking the nVCC Project, and ensuring a shorter timeline from nVCC contract award to nVCC opening for patients.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
Not proceeding presents risks in relating to the EW and nVCC Project timelines and costs, which will impact on patient care and service delivery.	The Project has sought NWSSP Procurement advice and support for this procurement and the procurement route. The Project has discussed with the preferred contractor and confirmed their ability and capacity to deliver the required support. The Project has undertaken considerable preparatory work with its Professional Advisers prior to, during and following this procurement process.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☒	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
Competition via the South East Wales Highways Framework.

6.3 What is the approximate time line for procurement?
The Project has identified its preferred supplier, and will be in a position to award the contract on the approval by the Welsh Government of the EW FBC. This is anticipated in December 2021 or January 2022.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	18/11/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£)** **£8,663,336**	**Including VAT (£)** **£10,396,003**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

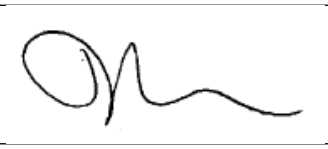
EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £k**	**Year 2 (exc. VAT) £k**	**Year 3 (exc. VAT) £k**	**Total Future Years (exc. VAT) £k**	**Total (exc.VAT) £k**	**Total (inc. VAT) £k**
Welsh Government Enabling Works Funding	800	7,863		0	8,663	10,396
Overall Total	800	7,863		0	8,663	10,396

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The advisor work is being overseen in line with the NEC contract management procedure. The advisor will be monitored at monthly contract management meetings.

	In addition to this, the Enabling Project is managed by PRINCE2 methodology.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	David Powell
Signature:	
Service Area:	TCS
Date:	18/11/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	N/A
Divisional Senior Management Team	N/A
Executive Management Board	22/11/2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	MOTT MACDONALDS TECHNICAL SUPPORT FOR NVCC COMPETITIVE DIALOGUE
DIVISION / HOST ORGANISATION	TRANSFORMING CANCER SERVICES
DATE PREPARED	NOVEMBER 2021
PREPARED BY	Hannah Moscrop, Project Manager
SCHEME SPONSOR	MARK ASH, ASSISTANT PROJECT DIRECTOR

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

In December 2019, it was agreed that the nVCC Project would target areas of expertise to strengthen the TA support for the competitive dialogue.

The Project required technical advice in the areas of FM, Energy, Design and Acoustics Engineering, BIM and Sustainability / Net Zero Consultancy.

Mott MacDonald have previously supported the Project in these areas, and have been an integral part of drafting the Procurement Documentation underpinning the nVCC Competitive Dialogue procurement.

Their expertise and excellent work to date ensures a consistency of approach, quality of advice, and value for money for the Project.

The procurement route – Direct Award via NHS SBS Construction Consultancy Services 2 Framework has been agreed with NWSSP Procurement Team.

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension (new contract for existing supplier)	☐	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	November 2021
Expected End Date of Contract	March 2023
Contract Extension Options **(E.g. maximum term in months)**	

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☐
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan? As part of supporting the nVCC Project.	**Yes** ☒	**No** ☐
If not, please explain the reason for this in the space provided.		

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☒
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☐
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☐

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED Please mark with a (x) in the box the relevant principles for this scheme. Click **here** for more information									
Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
Option 1 – Do nothing – If the technical support is not obtained promptly, then the Project will be unable to undertake Competitive Dialogue with the appropriate technical support, which risks the quality of the end product – the nVCC. This risks the quality of care and delivery we are able to provide to patients, and may also lead to delays or safety concerns in relation to the final nVCC build. **Option 2 – award the contract with Mott MacDonald (recommended)** – this would ensure that the Project has the appropriate technical support to run the competitive dialogue process in an effective manner, with a realistic ambition to receive quality tenders and a procure the nVCC which meets our ambitions. **Other options considered but not taken forward:**

As part of this process, it was considered whether another advisor could be contracted to undertake this work. This was explored but not taken forward because the Trust is currently under time limitations with regards to the procurement timetable for the nVCC. As Mott MacDonald have been used for previous work in this area and have already been procured, it would be time efficient to not undertaken a competition for the work. We feel this satisfies our value for money requirements, as there is no lead-in or prep time needed, and our quality requirements – as we have been happy with the work undertaken for us by Motts in this area previously.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Awarding the contract of Mott Macdonald as a Trust advisor will help to ensure that the nVCC Competitive Dialogue process proceeds with the relevant technical adviser support, and therefore de-risks potential delay or quality issues which may otherwise arise. By awarding the contract to the advisors that undertook the work to be updated, the Project is saving time and financial resources and ensuring continuity of Project expertise.

5. RISKS & MITIGATION

5.1 Please state risks of not proceeding with the scheme	**5.2 Please state any mitigation to reduce the risk if the scheme is not approved**
Not proceeding presents risks in the quality of the Competitive Dialogue process, the quality of the final tenders submitted, and the quality of the final nVCC commissioned and built. This may impact on patient care and service delivery, as well as delays to the Project timelines.	The Project has sought NWSSP Procurement advice and support for this procurement and the procurement route. The Project has discussed with the Technical Advisers and confirmed their ability and capacity to deliver the required support.

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☐	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☒
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐

Click here for link to Procurement Manual for additional guidance

6.2 Please outline the procurement strategy
Direct Award via the SBS Construction Consultancy Services 2 Framework.

6.3 What is the approximate time line for procurement?
If approved by the Trust Board then it is intended that the procurement can be completed by the end of November 2021.

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Christine Thorne
Signature:	
Date:	18/11/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£145.6k**	**Including VAT (£k)** **£174.7k**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☒ Additional Welsh Government funding ☐ Other ☐		
If you have selected 'Other' – please provide further details below: Velindre Cancer Centre's discretionary capital allocation.		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £**	**Year 2 (exc. VAT) £**	**Year 3 (exc. VAT) £**	**Total Future Years (exc. VAT) £**	**Total (exc.VAT) £**	**Total (inc. VAT) £**
Construction Consultancy Services / Professional Fess	£17,129.41	£102,776.47	£25,694.12	0	£145,600	£174,720
Overall Total	£17,129.41	£102,776.47	£25,694.12	0	£145,600	£174,720

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The advisor work is being overseen in line with the SBS contract management procedure. The advisor is monitored at monthly contract management meetings. In addition to this, the nVCC and Enabling Projects are managed by PRINCE2 methodology.

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	David Powell
Signature:	
Service Area:	TCS
Date:	18/11/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	N/A
Divisional Senior Management Team	N/A
Executive Management Board	22/11/2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

COMMITMENT OF EXPENDITURE EXCEEDING CHIEF EXECUTIVE'S LIMIT / BUSINESS JUSTIFICATION

SCHEME TITLE	VELINDRE TRUST - FIRE DOOR REPLACEMENT
DIVISION / HOST ORGANISATION	Corporate Estates, Environment and Capital
DATE PREPARED	19/11/2021
PREPARED BY	Jason Hoskins Assistant Director Estates, Environment and Capital
SCHEME SPONSOR	Carl James Director of Strategic Transformation, Planning, and Digital

All Divisional proposals must be consistent with the strategic and operational plans of Velindre University NHS Trust.

1. DESCRIPTION OF GOODS / SERVICES / WORKS

- **Replacement of Fire doors Trust wide:**

  - Assessment of the Trust Estates has highlighted a number of issues that present a risk from a fire safety perspective.
  - A business case has been presented to Welsh Government outlining funding requirements to address concerns raised
  - Welsh Government have endorsed the proposal providing £1.1M of funding staged over a number of years in support rectification of the identified issues
  - An external consultancy firm was commissioned to carry out an assessment of the condition of fire doors across the trust which has informed the approach adopted by the Trust
  - A work package to address issues that exist across the Trust relating to Fire Doors has been compiled in preparation to go to tender.
  - Rough Order costs associated with scope of works to replace fire doors at VCC and WBS is anticipated to cost £190K
  - The works outlined in the documentation is to supply and fix new fire doors to replace those found to be in a poor condition following external survey
  - All works have been reviewed and signed off internally by the Trust Fire Safety Manager, and external consultant

1.1 Nature of contract: Please indicate with a (x) in the relevant box	First time	☒	Contract Extension	☒	Contract Renewal	☐

1.2 Period of contract including extension options:	
Expected Start Date of Contract	01/12/2021
Expected End Date of Contract	31/03/2021
Contract Extension Options **(E.g. maximum term in months)**	

2. STRATEGIC FIT (*Host organisations are not required to complete Section 2)*

2.1 OUR STRATEGIC PILLARS This scheme should relate to at least one of the Trust's five strategic pillars. Please mark with a (x) in the box the relevant pillars for this scheme.	
Goal 1: Be recognised as a pioneer in blood and transplantations services across Europe.	☒
Goal 2: Be a recognised leader in specialist cancer services in Europe.	☒
Goal 3: Be recognised as a leader in stated priority areas of research, development and innovation.	☐
Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all.	☐
Goal 5: An exemplar of sustainability that supports global well-being and social value.	☐

2.2 INTEGRATED MEDIUM TERM PLAN		
Is this scheme included in the Trust Integrated Medium Term Plan?	**Yes**	**No**
	☒	☐

This scheme has been identified as part of the Estates Compliance Capital works 2021 – 2023. Funding has been secured through Welsh Government.

2.3 SHAPING OUR FUTURE WELLBEING OBJECTIVES This scheme should relate to at least one of the Trust's wellbeing objectives. Please mark with a (x) in the box the relevant objectives for this scheme.	
Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways.	☐
Improve the health and well-being of families across Wales by striving to care for the needs of the whole person.	☐
Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery.	☒
Deliver bold solutions to the environmental challenges posed by our activities.	☐
Bring communities and generations together through involvement in the planning and delivery of our services.	☐
Demonstrate respect for the diverse cultural heritage of modern Wales.	☐
Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovations whilst also making a lasting contribution to global well-being.	☒

FIVE WAYS OF WORKING (SUSTAINABLE DEVELOPMENT PRINCIPLES) CONSIDERED

Please mark with a (x) in the box the relevant principles for this scheme.

Click **here** for more information

Prevention	☐	Long Term	☒	Integration	☐	Collaboration	☐	Involvement	☐

3. OPTIONS CONSIDERED

Include 'business as usual' i.e. 'do nothing'

3.1 Please state alternative options considered and reasons for declining
There are limited options available with the exception of *Option 1 - Do Nothing – presents ongoing H&S risks associated with the non-compliance – Fire Safety legislation and H&S legislation breach* *Option 2 - Supply and install new fire door to replace existing doors that are beyond economic repair, In doing so making the Trust compliant with WHTM and H&S Legislation* *Preferred Option – This options provides a compliant solution reducing risk of fire to life and limb, and property. Underpinned by a full assessment of each door listed for replacement.*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
• Provides a fully auditable compliant solution to asset level including update of the Trust Fire Safety Management documentation, and Bolster system allowing ongoing management of each asset. • Removes all identified risk presented by fire doors listed as requiring attention detailed within the commissioned survey and provides a benchmark for future management.

5. RISKS & MITIGATION

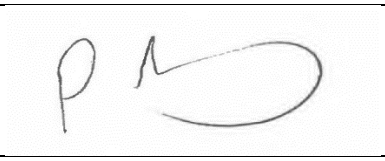
5.1 Please state risks of not proceeding with the scheme	5.2 Please state any mitigation to reduce the risk if the scheme is not approved
• Non compliance with WHTM firecode • Non compliance with H&S Legislation • Non compliance with building documentation - The Fire Strategy for buildings	• Risks cannot be fully mitigated

6. PROCUREMENT ROUTE

6.1 How is the contract being procured? Please mark with a (x) as relevant.			
Competition		**Single source**	
3 Quotes	☐	Single Quotation Action	☐
Formal Tender Exercise	☒	Single Tender Action	☐
Mini competition	☐	Direct call off Framework	☐
Find a Tender (replaces OJEU Public Contract regulations 2015 still apply)	☐	All Wales contract	☐
Click here for link to Procurement Manual for additional guidance			

6.2 Please outline the procurement strategy
Formal procurement exercise to be undertaken via issue of specification through Marketplace.
6.3 What is the approximate time line for procurement?
6 weeks

6.4 PROCUREMENT ROUTE APPROVAL

The Head of Procurement / Delegated Authority has approved the preferred procurement route	
Head of Procurement Name:	Pp Paul Thomas
Signature:	
Date:	19/11/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£180k**	**Including VAT (£k)** **£216k**
The nature of spend	**Capital** ☒	**Revenue** ☐
How is the scheme to be funded? Please mark with a (x) as relevant. Existing budgets ☐ Additional Welsh Government funding ☒ Other ☐		
If you have selected 'Other' – please provide further details below:		

PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Fire Door Replacement	£180k				£180k	£216k
Overall Total	£180k				£180k	£216k

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*This project will be managed against organisational SFI's and the estates project management process.*

9. DIRECTOR/SPONSOR DECLARATION OF COMPLIANCE

The Lead Director, by providing email confirmation, to seek Board approval is making a declaration that all procurement procedures, standing orders and standing financial instructions requirements have been appropriately discharged and observed and that where relevant, appropriate advice and confirmation has been obtained to that effect. Procurement Services retain this confirmation electronically in the tender file.	
Lead Director Name:	Jason Hoskins
Signature:	*J.D.Hoskins*
Service Area:	Estates, Environment and Capital
Date:	19/11/2021

10. APPROVALS RECEIVED

List and include date of approvals received in support of this scheme.

Divisions	**Date of Approval:**
Business Planning Group or local equivalent	N/A
Divisional Senior Management Team	N/A
Executive Management Board	22/01/2021

Host Organisations	**Date of Approval:**
NWSSP / NHS Wales Shared Services Partnership Committee	N/A
HTW – Senior Management Team	N/A

TRUST BOARD

REVISIONS TO NHS WALES SHARED SERVICES PARTNERSHIP STANDING ORDERS

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item.

PREPARED BY	Peter Stephenson, Head of Finance & Business Development, NWSSP
PRESENTED BY	(Please Include Name and Title)
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Shared Services Partnership Committee	18/11/2021	ENDORSED FOR APPROVAL

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership
SSPC	Shared Services Partnership Committee

1. SITUATION/BACKGROUND

1.1 To ensure effective, robust, and up to date governance arrangements are in place for the Shared Services Partnership Committee (SSPC), the Standing Orders are reviewed on at least an annual basis and were last updated in May 2021, being endorsed by the SSPC and approved at Velindre University NHS Trust Board. Amendments have been made to the document since its last publication date and a summary of the amendments proposed are set out below.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The following amendments are proposed for the Standing Orders:

Page(s)	Amendment
72	The removal of the increased temporary financial limits for COVID-19 expenditure with effect from 30 September 2021.
14, 70,	Change in job title for the previous Deputy Director of Finance to the Director of Planning, Performance, and Informatics.
69	Additional authority for the Director of Planning, Performance, and Informatics for general expenditure (£50k Limit).
3, 7, 14,	The recognition of Digital Health & Care Wales as the twelfth NHS organisation in Wales.
Various	The change in title of the Senior Leadership Team to the Senior Leadership Group.
16, 100, 101,	The removal of the temporary wording of the tenure of the Chair which had previously been amended to include the provisions of Regulation 3 of the National Health Service (Temporary Disapplication of Tenure of Office) (Wales) (Coronavirus) Regulations 2020.
14, 25, 29, 64, 65, 69,	The change in job title of the Director of Workforce and Organisational Development to the Director of People and Organisational Development.
30	The inclusion of reference to the Welsh Language Standards.
69	The deletion of reference to Charitable Funds in the Scheme of Delegation as this is not applicable to NWSSP.
Various	Correction of some minor grammatical errors.

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 Trust Board are asked to **APPROVE** the amendments to standing orders set out above.

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 ~~June~~November 2021)

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 two Special Health Authority~~y~~ies within NHS Wales, that defines the obligations of the ~~eleven~~12 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 Development, NWSSP (acting Board Secretary for the SSPC) will be able to provide further advice and guidance on any aspect of the SOs or the wider governance arrangements for the SSPC. Further information on governance in the NHS in Wales may be accessed at: http://www.wales.nhs.uk/governance-emanual/standing-orders

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Section: A – Introduction

Statutory Framework

i) Velindre University National Health Service Trust (Velindre) is a statutory body that came into existence on 1st December 1993 under the **Velindre National Health Service Trust (Establishment) Order 1993 (1993/2838)** (the Establishment Order).

ii) The Velindre University NHS Trust Shared Services Partnership Committee (to be known as the SSPC for operational purposes) was established under the **Velindre National Health Service Trust Shared Services Committee (Wales) Regulations 2012 (2012/1261 (W.156))** (the Shared Services Regulations). The Shared Services Regulations define Shared Services at regulation 2 and the functions of the SSPC at regulation 4. The SSPC functions are subject to variations to those functions agreed from time to time by the SSPC**.** The SSPC is hosted by Velindre on behalf of each of the seven Health Boards, three Trusts and two Special Health Authoritiesy 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.

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 Development, 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 Development 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

xxi) 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 Development, 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

xxii) 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.

xxiii) 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

xxiv) 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

xxv) 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.

xxvi) 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 Leadership Group ~~Management Team~~ (SLG~~MT~~) 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 1~~2~~4 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 Planning, Performance and Information~~Finance and Corporate Services~~, NWSSP Director of People~~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 Development, 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 Leadership Group~~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 Leadership Group (SLG)

1.3.12 The Managing Director of NWSSP will lead a SLG to deliver the SSPC's annual Business Plan. The SLG 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 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 Authoritiesy. 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 Development 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 SLG 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:

- 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~~People and Organisational Development.

together with the following:

- General Managers/Divisional Managers; and
- ~~Workforce~~People 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 NWSSP's~~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 NWSSP~~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 Leadership Group~~Management Team~~ may determine that designated S~~M~~TLG members or NWSSP staff shall be in attendance at LPF meetings. The LPF's Chair may also request the attendance of SLG~~MT~~ members or ~~Trust~~NWSSP staff, subject to the agreement of the Chair.

4.11.3 The S~~M~~TLG shall determine the arrangements for any joint meetings between the S~~M~~TLG 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 People~~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 Development who is responsible for the overall planning and co-ordination of the programme of SLG~~MT~~ 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 SLG~~MT~~ 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 and Standards; 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 Development, 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 Development, 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 Development. 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 Development 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

Development. 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 Development, 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 Development, 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 Development 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 Development 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 Development, 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 Development 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 Development 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

[1] In the case of persons who are married to each other or in a civil partnership with each other or who are living together as if married or civil partners, the interest of one person shall, if known to the other, be deemed for the purpose of this Standing Order to be also an interest of the other

pecuniary interest in any matter being considered by the SSPC including a contract or proposed contract, that member must not take part in the consideration or discussion of that matter or vote on any question related to it. The SSPC may determine that the SSPC member concerned shall be excluded from that part of the meeting.

7.2.8 The Membership Regulations define 'direct' and 'indirect' pecuniary interests and these definitions always apply when determining whether a member has an interest. These SSPC SOs must be interpreted in accordance with these definitions.

7.2.9 **Members with Professional Interests –** During the conduct of a SSPC meeting, an individual SSPC member may establish a clear conflict of interest between their role as a SSPC member and that of their professional role outside of the SSPC. In any such circumstance, the SSPC shall take action that is proportionate to the nature of the conflict, taking account of the advice provided by the NWSSP Head of Finance and Business Development.

7.3 Dealing with Officers' Interests

7.3.1 The SSPC must ensure that the NWSSP Head of Finance and Business Development, 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.

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

7.5.2 Gifts, benefits or hospitality must never be solicited. Any SSPC member or NWSSP officer who is offered a gift, benefit or hospitality which may or may be seen to compromise their position must refuse to accept it. This may in certain circumstances also include a gift, benefit or hospitality offered to a family member of a SSPC member or NWSSP officer. Compliance with the Velindre University NHS Trust Standards of Behaviour Framework is mandatory for all Trust employees.

7.5.3 In determining whether any offer of a gift or hospitality should be accepted, an individual must make an active assessment of the circumstances within which the offer is being made, seeking advice from the NWSSP Head of Finance and Business Development 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 Development, 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 Development, 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 Development 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 SSPC's 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 Development 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 Audit Wales 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 Development, 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 Development

The Board Secretary Governance Support/the NWSSP Head of Finance and Business Development 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 University NHS 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 SLG~~MT~~ 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: ▪ People~~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 SSPC's audit and assurance arrangements.
28	FULL	PERFORMANCE & ASSURANCE	Receive reports from the SSPC's NWSSP Directors on progress and performance in the delivery of the SSPC's strategic aims, objectives and priorities and approve action required, including improvement plans.

29	FULL	PERFORMANCE & ASSURANCE	Receive assurance reports from the SSPC's 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~~Audit Wales, 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 Development Chair Head of Finance and Business Development	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		Development
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 Development
SO 6.3	Call meetings of the SSPC	Chair/Managing Director	Head of Finance and Business Development
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 Development
SO 6.5	Chair SSPC meetings & associated responsibilities	Chair	Head of Finance and Business Development
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 Development

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 Development
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 Development
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 Development
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 Development

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 ~~WP~~&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 ~~WP~~&OD	Yes	Authorisation matrix. HR policies & procedures
Approval to procure goods and services within budget	NWSSP Directors / Heads of Service	Yes	Standing financial instructions. Authorisation matrix. Procurement & finance policies & procedures.
Approval to procure goods and services outside of budget that would result in a budgetary overspend	Managing Director of NWSSP	Nominated deputy	In absence of the Managing Director of NWSSP
Approval to commission services from other NHS bodies	Managing Director of NWSSP	Yes	Authorisation matrix. Commissioning policies & procedures

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

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 People~~Workforce~~ and Organisational Development	50	50	~~N/A~~	N/A
Director of Planning, Performance and Informatics	50	50		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
Other Senior Finance Staff	5	0	~~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~~Planning, Performance and Informatics	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 £1m
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 & Risk and Welsh Risk Pool Services Limits

Scheme Designation	Reimbursement of claims and redress cases following WRPC approval (£)	WRP Managed Claims (£)	
		(£)	(actions)
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	Agree settlement and make admissions
Deputy Director of Legal & Risk and Welsh Risk Pool	Up to £250k	Up to £250k	Agree settlement and make admissions
Deputy Director of Finance and Corporate Services	Up to 250k	Up to £250k	
Head of Safety and Learning	Up to 100k	£20k	
Note:			
All cases submitted for reimbursement are reviewed by a Learning Advisory Panel and the Welsh Risk Pool Committee prior to approval. Approval of Lessons Learned in cases where payments will exceed £1m are delegated by Welsh Government to the Welsh Risk Pool Committee. Payments above £1m are approved by Welsh Government prior to the Welsh Risk Pool Committee. Claims above £2m will 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
Assistant Directors of Procurement			Up to £25k	Up to £10k
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 September 2021~~ ***Contracts for and on behalf of NHS Wales > £1m require prior approval from Welsh Government*				

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

KEY GUIDANCE, INSTRUCTIONS AND OTHER RELATED DOCUMENTS

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

Shared Services Partnership Committee Framework

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

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

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

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

NHS Wales Framework

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

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 April 2021

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.

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, should there be 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
- NWSSP Director (SRO)
- Finance Director
- Health Economist
- Director of SMTL
- Health Technology Wales
- Procurement Services
- Deputy Executive Nurse Director
- Secondary Care Clinician
- National Clinical Lead for Prudent & Value Based Care/Primary Care Senior Clinician
- Value Based Care/National Lead VBP
- Academic Clinician
- Academia
- NWSSP MD

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 wais a member of the SSPC; and has also been provided to the Director of Corporate Governance/Board Secretary at Velindre University NHS Trust to ensure that the appointment aligns to Velindre's governance requirements.

The selection process will be repeated following each maximum term of office for the Chair of the SSPC, or when the Chair resigns, or following removal of the Chair by termination.

Reappointment and Tenure

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

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

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

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

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

~~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

Pwyllgor Gwasanaethau Ambiwlans Brys
Emergency Ambulance Services Committee

Reporting Committee	**Emergency Ambulance Services Committee**
Chaired by	Chris Turner
Lead Executive Directors	Health Board Chief Executives
Author and contact details.	Gwenan.roberts@wales.nhs.uk
Date of last meeting	9 November 2021

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

An electronic link to the papers considered by the EAS Joint Committee is provided via the following link: https://easc.nhs.wales/the-committee/meetings-and-papers/

Chris Turner (Chair), welcomed Members to the virtual meeting (using the Microsoft Teams platform) of the Emergency Ambulance Services Committee.

MINUTES

The minutes of the EASC meetings which took place on 7 September 2021 were approved.

PERFORMANCE REPORT

The EASC Performance Report was introduced and it was explained that this would become the first standing agenda item at each meeting of the EASC Joint Committee. The Committee noted:

- The clear deterioration in the 95th percentile call answering time but were re-assured around WAST recruitment to resolve this
- The volume of incidents resolved by 'hear and treat' is improving, noting that recent investment in both staff and technology should support further improvements in this as well as providing more granular data on the outcomes for patients and the impact on the wider system
- The increased response times for red and amber incidents, with particular concern around the Amber median and 95th percentile for both categories

The main focus of the discussion centred on the growing level of handover delays at hospital sites in Wales and it was recognised that over 18,000 hours were lost in October, which was an increase of 4,000 hours on September. Members had previously committed to delivering a maximum of a 150 hours lost a day, or circa 5,000 hours a month. The system has lost over 5,000 hours so far in November (at 9th November).

It is recognised that many of the solutions to the handover issue are not at the front door of the hospital and information was shared relating to patients medically fit for discharge. We also recognised that, as a committee charged with the provision of emergency ambulance services, we must draw a line at the level of handover hours we are prepared to tolerate.

We noted that a solution to mitigating the impact of handover delays could not be solely via WAST employing additional staff and delivering efficiencies that they have previously committed to.

As a joint committee we agreed to the following deliverables as the start point of our commitment to reducing handover delays:

- No ambulance handover will take more than 4 hours
- We will reduce the average lost time per arrival by 25% from the October 2021 level at each site (from 72 minute to 54 minutes at an all Wales level)

It was agreed that further work will need to be done locally with clinical teams to deliver this and also that there would need to be a consideration of the organisational implication for failure to achieve this requirement.
We recognised that the scale of this challenge would vary by site, and the EASC team agreed to work closely with Morriston, GUH and YGC, in particular, to support the improvements needed.
There was broad agreement that this requirement must be included in the wider system escalation plans that are in development and that we would have further discussions on this at the next NHS Leadership Board, as well as continuing discussions with COO's, Medical Directors and Directors of Nursing.

Members **RESOLVED** to: **NOTE** the report.

Chair's NOTE: A note of this item and the agreed deliverables, was circulated to members within 48 hours of the meeting and comments requested.

CHIEF AMBULANCE SERVICES COMMISSIONER'S (CASC) REPORT

Stephen Harrhy presented an update on the following areas:

- **Non-Emergency Patient Transport Services** (NEPTS) – services at Cwm Taf Morgannwg University Health Board (CTMUHB) have now transferred to the Welsh Ambulance Services NHS Trust (WAST) in line with all other health boards in Wales. It was also noted that additional funding has also been secured from WG to support additional capacity within NEPTS for the remainder of this year.
- The **EASC Action Plan** details the key milestones as we work towards agreeing the vision of a modern high-performing emergency ambulance service, monthly performance meetings will now be held with Welsh Government officials.
- The new **Commissioning for Value Framework** was presented at the recent EASC Management Group meeting with the key principle of moving from a framework that reflects the an ambulance service where patients are predominantly conveyed to hospital to a framework that reflects the development of ambulance services in Wales and the extended offer already made including 'hear and treat' and 'see and treat' services. This framework will now be refined in line with the discussions held with stakeholders, working with WAST colleagues as we work to sign off via EASC ahead of 1 April 2022 implementation.
- An update was provided on the process of engagement undertaken during 2021 as part of the **commissioning intentions process**, including agreement of the commissioning cycle, a more timely and collaborative approach to development of next year's commissioning intentions including the receipt of feedback from organisations regarding the development of that these intentions. These commissioning intentions identify the strategic priorities as agreed by Health Boards and are not intended to include all work streams that will be undertaken by commissioned services during the period.

- The **Commissioner Ambulance Availability Taskforce** met in September and focussed on the future clinical workforce, the digital future of WAST and the revised commissioning for value framework that is being progressed.
- A proposed **system escalation process** has been developed for Health Boards to work alongside the WAST Clinical Safety Plan, enabling clinical and operational leaders within organisations to respond to areas of greatest clinical risk. This process involves an integrated approach that requires collaboration and response across health and social care and is supported by local operational delivery units. Engagement with relevant peer and stakeholder groups is currently being undertaken and the plan is being revised in response to these discussions.
- The **Adult Critical Care Transfer Service** (ACCTS) has now gone live in both North and South Wales. The team recently presented at the Welsh Government Critical Care Summit and Health Board critical care colleagues noted the significant impact already made.

PROVIDER ISSUES

Jason Killens, Chief Executive at the Welsh Ambulance Services NHS Trust (WAST) gave an overview of key matters including:

- CoVID-19 and the impact of CoVID-19 is having a severe impact on WAST, in particular, very high EMS demand, high roster abstractions, high handover lost hours and social distancing on NEPTS transport
- WAST is at maximum escalation and expects to remain so for the foreseeable future and has stood up its' Pandemic Plan structures again
- There were 586 12 hour and over patient waits in Sep-21 (the third highest recorded), 48 patient safety incidents were referred to health boards under the Appendix B arrangements) over the last three months and 17 WAST SAIs were reported to Welsh Government
- The Red 8 minute 65% target has been missed for the last 14 months, with significant health board variation (almost 65% of Red incidents were responded to in 9 minutes)
- WAST remains concerned at the number of hours lost outside EDs, with 14,402 hours lost in Sep-21
- WAST continues to seek to efficiencies, in particular, the pan-Wales EMS Response roster review (temporarily paused) and modernising working practices (negotiations re-started with TU partners in Sep-21), in particular, PPLHs return to base meal breaks
- The ePCR programme is in delivery phase with initial go live in Nov-21.

FOCUS ON – UPDATE ON DEMAND AND CAPACITY

The 'Focus On' session provided the context in terms of the demand and capacity reviews previously undertaken and how the wider system environment has changed. The key areas of improvement that have already been delivered and a number of updated assumptions that will be included within the updated modelling were noted.

Members noted the next steps in WAST's transformation journey aligned to the key principles of additional capacity, improved efficiency and demand management and the progress made against each of these areas to date including:

- recruitment
- increased 'hear and treat' rate and
- the work that has commenced on realigning rosters with demand

Members noted:

- the significant uplift in the number and proportion of red calls
- an increase in sickness levels and abstractions
- increased handover hours lost
- deteriorating response times leading to significant patient harm
- short term actions that include additional capacity (St John Ambulance, military and fire and rescue support), demand management (additional clinicians and mental health staff to increase the clinical support desk) and increased efficiency (working with TU partners to look at modernisation in key areas)

The next steps were noted to include a strategic outcome case to be developed by early December to start to realise the strategic ambition for the transformation of services, this will include recruitment deliverability, fleet and estates, capital and revenue, benefits and risks.

DRAFT FINANCIAL PLAN

Following the operational discussions regarding additionality held earlier in the meeting, a first draft financial plan was also presented to ensure early sight of the financial requirements for 2022-23. It was agreed that engagement would now be undertaken with appropriate peer groups including finance and planning to ensure inclusion in IMTPs and taken through the EASC Management Group. Members discussed the information within the report and noted that a final draft would be presented for ratification at the January meeting of the committee.

Members **RESOLVED** to: **NOTE** the draft financial plan.

FINANCE REPORT

The EASC Finance Report was received. Members approved the current financial position and forecast year-end.

Members **RESOLVED** to: **APPROVE** and **NOTE** the report.

EASC SUB GROUPS

The confirmed minutes were received and approved for the EASC Management Group – 26 August 2021, the NEPTS Delivery Assurance Group – 10 August 2021 and the EMRTS Delivery Assurance Group – 15 June 2021.

EASC GOVERNANCE INCLUDING THE RISK REGISTER

The EASC Governance report was received. Members noted that the Risk Register had been reviewed by the EASC Team and two risks had been increased, namely the performance against the target for the Red and Amber categories.

Members **RESOLVED** to:

- **APPROVE** the risk register

Key risks and issues/matters of concern and any mitigating actions

- CoVID-19 and the impact of CoVID-19 is having a severe impact on WAST, in particular, very high EMS demand, high roster abstractions, high handover lost hours and social distancing on NEPTS transport
- WAST is at maximum escalation and expects to remain so for the foreseeable future and has stood up its' Pandemic Plan structures again

• Handover delays continue to increase with the number of hours lost outside EDs standing at 14,402 hours lost in Sep-21 • The Red 8 minute 65% target has been missed for the last 14 months, with significant health board variation (almost 65% of Red incidents were responded to in 9 minutes)				
Matters requiring Board level consideration and/or approval				
• Standing Orders would be forwarded as soon as documentation finalised				
Forward Work Programme				
Considered and agreed by the Committee.				
Committee minutes submitted	Yes	√	No	
Date of next meeting	**18 January 2022**			

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM PUBLIC TRUST BOARD MEETINGS
UPDATED as at 30 September 2021

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
29.07.2021 PUBLIC TRUST BOARD				
8.1.0	**Audit Committee Highlight Report:** Private Patients Debts to be a standing item on the Committee Highlight Report.	**OPEN**	**MO/MB**	**Update 11/11/2021** Next Audit Committee is scheduled for 14 October 2021 with the Highlight Report to be presented at the November Trust Board.
30.09.2021 PUBLIC TRUST BOARD				
2.1.1	**Minutes from the Public Trust Board meeting held on the 29 July 2021**: Minutes of the previous meeting to be amended to specify that the waiting times referred to in the Velindre Cancer Centre Performance Report relate to the time a patient arrives in the Outpatient Department to the time they are seen by a Consultant, and not the time between a patient being referred to the Trust to the date of their appointment.	**CLOSED**	**CC**	Minutes from the 29 July 2021 meetings have been amended.
7.1	**Wales Infected Blood Support Service (WIBSS) Annual Report:** The Trust Board Cycle of Business to be updated to include the receipt of the WIBSS Annual Report yearly.	**CLOSED**	**LF**	Added to the Trust Board Cycle of Business.
7.1	**Wales Infected Blood Support Service (WIBSS) Annual Report:** An interim WIBSS report to be received by the Trust Board in approximately six months' time.	**CLOSED**	**LF**	Added to the Trust Board Cycle of Business.
7.5	**Delivering Excellence Performance Report Period July 2021: Velindre Cancer Centre**: The Trust Board requested information on the development of an	**OPEN**	**COB**	**Update 29/10/21 -** Information around the electronic data system will

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
	electronic data collection system for Clinical Oncology Strategic Targets (COST) is included in future Performance Reports.			be included in the October PMF report. This item will be closed once the October 2021 PMF report is received at the January 2022 Trust Board.
7.5	**Delivering Excellence Performance Report Period July 2021: Velindre Cancer Centre**: The achievement of Clinical Oncology Strategic Targets (COST) to be included in the IMTP.	**CLOSED**	**COB**	**Update 29/101/21** - This has been included as part of the IMTP capacity challenge.
7.7	**VUNHST Risk Register:** A target date to be included on the register for the Welsh Language Standards Risk (ID 2398).	**CLOSED**	**SFM**	Risk register has been updated.
8.2	**Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Report**: Highlight report from the Sub-Committee on 21 September to be provided to the November Trust Board, as oral update provided.	**CLOSED**	**LF**	Included in November Trust Board papers.
8.4	**Progress Report on Quarter 1 Delivery Plan:** Mr Carl James to provide a timelines for the opening of the Park Road building to the Trust Board.	**CLOSED**	**CJ**	**Update 11/11/21:** The 19 Park Road building is available at short term notice. The specification for works is out to procurement currently. The scheme is due to be finished by March/April 2022.
9.1	**Charitable Funds Committee Highlight Report:** Consideration to be given to linking with other charities in the retendering process of the Investment Broker or to allow other charities in the future to join us to benefit from economies of scale.	**CLOSED**	**MB**	This matter has been discussed with the Chair of the Investment Performance Review Sub Committee and has agreed that as investment strategies differ across organisations and timings

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
				do not align this was not a viable option.

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Catherine Currier, Business Support Officer & Lauren Fear, Director of Corporate Governance & Chief of Staff
PRESENTED BY	Professor Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
CDRL	Component Development Research Laboratory
AHP	Allied Health Professional
RCN	Royal College of Nursing
IMTP	Integrated Medium Term Plan

1. SITUATION/BACKGROUND

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

1.2 Issues addressed in this report cover the following:

- Board Briefing Sessions
- Component Development Research Laboratory Launch
- Armistice Day 11th November 2021
- Macmillan Professionals Excellence Award 2021
- BBC Programme 'Dom Delivered..'
- Director of Wales Cancer Research Centre
- Nursing, Allied Health Professional (AHP) & Clinical/Healthcare Scientists Research Celebration Event
- Royal College of Nursing (RCN) Nurse of the Year Award
- Young Ambassadors Presentation
- Chair's Full Year Appraisal Review

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Board Briefing Sessions

2.1.1 The Chair would like to summarise matters discussed at the recent Board Briefing sessions. At the session held on 24th August 2021 the Board received updates on:

- the Trust's responsibilities under Putting Things Right process;
- an update on the Quality Bill and the Trust's implementation plans including the Quality & Safety Framework;
- received a presentation from Mr Len Richards, Chief Executive and Mrs Abigail Harris, Executive Director of Planning for Cardiff & Vale University Health Board on 'Shaping our Future Hospitals' development plan.

At the Board Briefing Session on 26th October the Board received:

- a presentation from Dr Chris Jones, Chairman, Mrs Alex Howells, Chief Executive Officer, Professor Pushpinder Mangat (Executive Medical Director) and Mrs Lisa Llewellyn, Executive Director of Nursing & Health Professionals of Health Education and Improvement Wales (HEIW) on their key strategic programme and developments; a follow on meeting has been arranged between the CEO's of the Trust and HEIW to consider how we closely align HEIW's work with our own transformation programmes.

- a presentation from Legal and Risk on work being undertaken to support the Trust's planning arrangements for a Public Inquiry into the COVID pandemic and a Terms of Reference for a Public Inquiry Internal Co-Ordination Group which has been developed;
- a presentation on the Board's cyber security responsibilities;
- an update on the development of the Trust's Integrated Medium Term Plan (IMTP);
- an update on the NHS Wales Blood Health Plan and the impact of a recently published Welsh Health Circular on the service;
- an update on the Infected Blood Inquiry, and
- an update on the key developments on the Trust's Organisational Design and Development.

2.1.2 **Component Development Research Laboratory (CDRL) Launch**

The Chair is pleased to inform the Trust Board that the Welsh Blood Service launched the Component Development Research Laboratory (CDRL) on 11th October 2021. The event consisted of a mix of live segments and pre-recorded videos.

The event was opened by the Head of Quality Assurance, Peter Richardson, and the Head of the CDRL, Chloe George. The launch provided an opportunity:

- to meet the team;
- to understand the Service' interest in cold platelet storage;
- to understand the work on optimising the storage and function of platelets;
- future plans, and
- to undertake a virtual laboratory tour.

A recording of the event is available at www.welsh-blood.org.uk/cdrl-launch

2.1.3 **Armistice Day 11th November 2021**

The Chair and Commanding Officer of 203 (Wales) Field Hospital led the Armistice Service at Velindre Cancer Service. They were joined by 203 (Wales) Field Hospital and Velindre Cancer Centre Staff. The service was carried out with great dignity and inspired a spirit of remembrance. Wreaths were laid and the last post and reveille was played by Alex James from the fundraising team. A two minute silence was also held at the Welsh Blood Service offices and Trust Headquarters.

2.1.4 **Macmillan Professionals Excellence Award 2021**

The excellent work of the Cancer Centre has been recognised by a nomination and shortlisting for the Therapy Assessment Unit Team for the Macmillan Professionals Excellence Award. The Therapy Assessment Unit Team were the only nominations from Wales.

2.1.5 **BBC Programme 'Dom Delivered..'**

The Chair would like to inform the Board that the Welsh Blood Service has been involved in a feature length documentary, which showcased the work of WBS and the blood donation process. During the programme Dominic "Dom" Littlewood follows a blood donation journey from the donor leaving home to the delivery of a blood pack to a hospital. Filming took place just over a year ago and staff from the Welsh Blood Service spent two days filming with the presenter. The programme is available at wbs-intranet.cymru.nhs.uk/welshbloodservice/dom-delivered/.

2.1.6 **Director of Wales Cancer Research Centre**

The Chair is delighted to inform the Board that Dr Mererid Evans, Consultant Oncologist has been appointed as the new Director of the Wales Cancer Research Centre. Dr Evans will continue to lead the research component of Velindre Futures.

2.1.7 **Nursing, Allied Health Professional (AHP) & Clinical/Healthcare Scientists Research Celebration Event**

On the 12th October 2021, the Trust held a Nursing, AHP and Clinical/Healthcare Scientists Research Celebration Event. The event was held virtually and attended by over 60 people from a variety of health disciplines. Professor Bridge Johnson, Clinical Professor at University of Glasgow and NHS Greater Glasgow and Clyde, as Guest Speaker spoke about the importance and impact of simple ideas. This was followed by presentations on research undertaken by staff.

2.1.8 **Royal College of Nursing (RCN) Nurse of the Year Award**

The Trust has for a number of years sponsored the RCN Nurse of the Year Award. This year's event held on 10th November 2021 was held virtually and attended by both the Chair, Chief Executive and Executive Director of Nursing, AHPs and Health Scientists. The Trust is delighted and proud to record that Diane Rees (Velindre Cancer Centre) was the winner of the health care support worker category. The Trust was once again pleased to be the sponsor the Nurse of the Year category award which was announced and presented by the Trust.

2.1.9 **Young Ambassadors Presentation**

In recognition of the hard work and importance of the contribution made by young Ambassadors a Presentation event was held on 15th November 2021 in SupaJump. The event was attended by Sam Warburton, Charity Ambassador, who presented a medal to each of the young Ambassadors. The Chair took the opportunity of speaking at the event highlighting the amazing contribution of these individuals and their impact on the Trust. The event concluded with the Ambassadors having free reign of the trampoline park.

2.1.10 **Chair's Full Year Appraisal Review**

The Chair has received a letter from the Minister following her Full Year Appraisal Review for the period 2020/21. The review focussed on progress in respect of the following key areas:

- oversight and scrutiny of Quarter 3/4 plans and delivery of essential services;
- oversight and scrutiny of regional and partnership working;
- arrangements in place to ensure quality of care and prevention of nosocomial infections;
- oversight of the Board with regard to technology and digital innovation, ensuring momentum is maintained whilst evaluating benefits to service users and organisation;
- leadership provided to the organisations workforce, and
- consider the Four Harms from COVID-19.

The Minister has confirmed that all objectives for the year have been met. The Chair would like to thank and acknowledge the considerable work and support from the Executive Leadership Team and Trust Officers in enabling us to get to this position, over what has been another highly successful year in the most extraordinary of times.

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
	If more than one Healthcare Standard applies please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4.0 RECOMMENDATION

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	25/10/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Lauren Fear, 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.

ACRONYMS	
CHC	Community Health Council

1. SITUATION/BACKGROUND

This reports provides information to the Board from the Chief Executive.

Issues addressed in this report cover the following;

- Application for Judicial Review
- COVID/Flu Vaccinations
- Chief Operating Officer
- Velindre Cancer Centre Enhance Garden and Increased Biodiversity
- 'Meet and Greet' with Radiotherapy Staff, Velindre Cancer Centre
- Team Wales Event
- Health Education Improvement Wales

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Application for Judicial Review

Last week, Mr Justice Eyre reviewed the original September 2021 High Court decision to refuse an application seeking permission to review the Welsh Government's decision to approve the Outline Business Case (OBC) for the new Velindre Cancer Centre.

He has decided to uphold the original September order and so the application bought by the claimant has been dismissed and permission for a review of the Welsh Government's approval of the OBC has been refused.

2.2 COVID/Flu Vaccinations

The Trust's Immunisation programme commenced in October 2021 and is providing both the COVID booster and seasonal Influenza vaccinations for all eligible Trust staff (as per the Joint Committee on Vaccination and Immunisation - JCVI criteria).

Several clinics have been held at both the Cancer Centre and the Welsh Blood Service, and staff have been offered the opportunity to receive the COVID booster and Influenza vaccinations at the same time (as per JCVI recommendation) or separately should they wish.

The Trust is not participating in the national mass population vaccination programme, and all patients and donors will receive their vaccinations via their local Health Boards. The Team at VUNHST have been working with the Welsh Government Vaccination Team and the Vaccination Leads at the local Health Boards to ensure that the patients at the Cancer Centre who are immuno-compromised are prioritised for their COVID booster / 3rd primary dose vaccine.

Following the completion of the Trust's vaccination programme at the end of November, the total data and percentage vaccination uptake will be reported via EMB and the Quality, Safety and Performance Committee

2.3 Chief Operating Officer

The Chief Executive Officer is pleased to announce that Mrs Cath O'Brien has been appointed as Chief Operating Officer. Cath has been covering this role on an interim basis since February 2019 following six years as the Director of the Welsh Blood Service. Cath's breadth and depth of experience working with staff across both Welsh Blood Service, Velindre Cancer Centre and the wider NHS and Government will benefit us all as we work together to deliver our ambitions.

2.4 Velindre Cancer Centre Enhance Garden and Increased Biodiversity

The Chief Executive Officer is delighted to inform the Board that the Cancer Centre has been working with Crown Gardens to increase the biodiversity across the Trust sites and in the patient's garden including introducing new flowers and scented planting to develop areas of tranquility and serenity. This work forms part of the Trust's programme to reduce noise and air pollution across sites. The Chief Executive Officer would like to thank all involved and the team at Crown Gardens.

2.5 Visit to Radiotherapy in Velindre Cancer Centre

As part of a programme to visit areas across the Trust, the Chief Executive Officer met with Radiotherapy Staff on 29th October 2021. Due to the current pandemic

situation it was decided the not to undertake a tour of the department. The Chief Executive Officer enjoyed meeting with various members of the department and speaking to them about their roles within the Trust and has taken forward the issues they raised with the senior team in the Cancer Centre. The Chief Executive Officer would like to thank all involved and for their engagement and commitment.

2.6 Team Wales Event

Welsh Government have reinstated their Team Wales Event, which is attended by Health Boards from across Wales. The first meeting was held on 11th November 2021 and focused on innovation in the NHS. Each organisation was invited to share examples and Cath O'Brien, Chief Operating Officer, presented on behalf of the Trust innovations in our model for assessment, ambulatory care and Patient Support units merged to increase same day unscheduled and emergency care without admission and increase range of tumour site patients supported.

2.7 Health Education Improvement Wales (HEIW)

Following the recent discussion at our Board Development session the Chief Executive has met with his counterpart in HEIW to agree that they would become a strategic partner in terms of taking forward the development programmes around the cancer service.

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 Chief Executive.

TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	25th November 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Kyle Page, Business Support Officer
PRESENTED BY	Stephen Harries, Interim vice Chair and Acting Chair of the Quality, Safety & Performance Committee
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	
MHRA	Medicines and Healthcare products Regulatory Agency
COSC	Clinical Oncology Sub-Committee Stretch Targets
NHSBT	NHS Blood & Transplant
NEWS	National Early Warning Score (Sepsis)

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Quality, Safety & Performance Committee at its meeting held on the 18th November 2021.

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

2. BACKGROUND

The Quality, Safety and Performance Committee meets on a bi-monthly basis and provides an opportunity to triangulate information and data in respect of quality, safety, finance, workforce, performance and digital. The Committee in this format had been meeting for a year and it was recognised that it is continuing to mature alongside the ongoing development of reporting formats and additional assurance mechanisms.

3. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the Public meeting of the Quality, Safety & Performance Committee held on the 18th November 2021.

There was an emerging area of triangulation evident through the reports received by the Committee that related to the overall impact on service delivery of COVID related staff absenteeism, overall sickness levels, social distancing and COVID safe measures and increasing demand. These elements are emerging within the Welsh Blood Service and SACT services at Velindre Cancer Centre but have to date been mitigated through additional staffing allocation as part of recovery plans. However, within Radiotherapy services these issues have been exacerbated by the fragility of some of the Linear Accelerators resulting in breakdowns (being addressed through the replacement programme) and the provision of radiotherapy services is an emerging area of concern.

ALERT / ESCALATE	**Velindre Cancer Centre Divisional Performance Report – Radiotherapy** As detailed above the Committee received a detailed analysis of the current position in relation to Velindre Cancer Center's ability to meet radiotherapy delivery standards impacting on the Trusts ability to meet the COSC (Clinical Oncology Sub-Committee Stretch) targets for scheduled, urgent scheduled and emergency patients (all reporting on the performance scorecard as red). The Committee were advised of all the enhanced business continuity measures that were in place in order to mitigate the risks as far as possible and to ensure service delivery. There is close daily monitoring underway and the situation is being managed through a Silver

	Command infrastructure. The Board will receive additional detailed analysis via the Chief Operating Officer in respect of this matter.
ADVISE	**Highlight Report from the Trust-wide Infection Prevention & Control Management Group** The Trust-wide Infection Prevention & Control Report was discussed, which contained three areas for alerting and escalating: • The delay in undertaking the Velindre Cancer Centre theatre decontamination refurbishment due to procurement issues. The procurement is being actively managed by the Estates Team, but a date to commence the work is awaited; • The lack of a clear plan to address the inadequate staff changing facilities resulting in insufficient space for social distancing and inadequate locker facilities, creating COVID-19 transmission risk. The Cancer Centre Senior Management Team has undertaken a full risk assessment and continues to work on the development of a resolution plan; and • Environmental audits across Velindre Cancer Centre identified a number of estates actions to reduce infection transmission risks such as general decoration and replacement flooring. Each of these are currently being risk assessed and costs quantified by the Estates Team so that a resolution plan can be implemented. The report also detailed the overall ongoing reduction in Healthcare acquired infections and highlighted that there had not been any COVID related transmission incidences in the last six months. The Committee commended the operational delivery teams for this. The Committee **NOTED** the report and the items for escalation. **Welsh Blood Service Donor Improvement Story** Committee members had received and viewed in advance of the meeting a video by Andrew Harris, Interim Head of Donor Engagement at the Welsh Blood Service, outlining the measures currently being implemented to prevent donors who may be unable to donate (as do not meet the stringent requirements) being able to book onto a donation session online. These improvements will prevent potential donors having a wasted journey if unable to donate, avoid disruption to clinics, and free up appointments to eligible donors ensuring the best

possible experience for donors.

The Committee commended this work and outlined this demonstrated the wholescale changes the service was making after actively listening to feedback from donors.

Medical Engagement Survey

The Committee received a detailed presentation that outlined the key findings from the Medical Engagement Scale survey undertaken between December 2020 and May 2021. This was a national survey that the Trust took an active role in and was undertaken to assess the position post-pandemic, measuring levels of engagement of medical staff within their organisations against key items on the Medical Engagement Scale so that emerging themes could be identified. Overall the number of medical staff who completed the survey had increased considerably (46 completed) from the previous survey (2016) and the Trust benchmarked favourably across NHS Wales in relation to levels of engagement. Although there was an overall reduction in levels of engagement since the previous survey.

The Committee were ADVISED that that work was already underway to further explore the themes that had emerged and that a number of events have been planned within a short space of time.

Velindre Cancer Centre Performance Report

The Velindre Cancer Centre report provided an update on performance against key performance metrics for the period until the end of September 2021. Considerable discussion took place in relation to this Report. The Committee recognised the work that was underway to redevelop the Performance Framework (due for completion by March 2022) and recognised the limitations of the current report format. It was identified that, until this time, there should be a robust cover paper that provides appropriate explanation and assurances in respect of areas where performance has deteriorated or is not at the required level. The following areas were particularly highlighted:

- Sustained unprecedented pressure on provision of services across all services, compounded by ongoing high levels of staff absences (some COVID related). Considerable effort is being made to ensure that services are being maintained and that demand is met. Despite these issues, at present, SACT waiting

times remain on target.

- Inpatient Falls – Two falls had been received (one deemed avoidable / one unavoidable). The narrative requires further contextualisation. It was noted that overall the number of falls was very low and explanations are required of why a fall may have been deemed unavoidable. The revised metric will also include repeat falls. A review of the falls scrutiny process will be undertaken by the Senior Nurse, Professional Standards.
- Outpatient (30 minute) waiting times – The work being undertaken to improve compliance with this standard was discussed and in some instances was linked with patients receiving blood tests and needing to await results on the same day as their appointment as this was their preference.
- Sepsis Bundle Compliance– It was noted that the overall low numbers was skewing the 75% compliance as three of four patients meeting the criteria for a Sepsis Screen had received all elements of the sepsis bundle within the required hour. The fourth patient came to no harm and there was a documentation issue with one of the bundle elements.
- Breast (new patient referrals) – It was identified that the red reporting status of this measure was a direct result of the reduction in breast screening that had been undertaken nationally during the early phases of the COVID pandemic. As a result the breast service was now experiencing unprecedented spikes in referrals which is impacting clinical services.
- Healthcare Acquired Pressure Ulcers – Enhanced clarification required in relation to avoidable versus unavoidable pressure ulcers. An independent review of the Cancer Centre Pressure Ulcer scrutiny process has been commissioned as an additional layer of assurance.

RD&I Sub-Committee Highlight Report

The Research, Development and Innovation Sub-Committee Highlight Report was discussed which included the following two items for alert / escalation:

- The ongoing difficulty in undertaking research in some clinical areas due to capacity issues. The Committee noted this poses a risk in terms of diminishing research and retention of staff and were ASSURED that strategic discussions will be undertaken through the Executive Management Board to identify potential solutions.

	• The ongoing challenges in relation to effective communication of research, development and innovation outputs due to the lack of a dedicated resource. The Committee noted and were ASSURED that a communication plan has been initiated to support more effective communication of research, development and innovation activity.
ASSURE	**Velindre Quality & Safety Committee for NHS Wales Shared Services (CIVAS@IP5)** The NHS Wales Shared Services Quality & Safety Governance Report was discussed. The Committee were advised that CIVAS@IP5 (a Shared Services delivered medicines preparation service) had been inspected by the Medicines and Healthcare products Regulatory Agency (MHRA) against Good Distribution Practice on 6th September 2021. The inspection report had been received identifying no critical or major service deficiencies. The Committee were ASSURED that all action points identified had been completed. Full compliance against the framework of standards legally required as an MHRA "Specials" and Wholesale Dealer licence holder has since been confirmed and a renewed medicines licence has been received. **Trust Risk Report** The Committee discussed the Trust Risk Report that summarised all risks scoring 12 or greater. The Committee were advised that the work to refine and enhance the Trust risk register is ongoing and has been a significant piece of work. The Committee were ASSURED that additional narrative would be included in future reports outlining actions being taken to reduce or eliminate these risks. **Welsh Blood Service Divisional Performance Report** The Committee received a detailed Welsh Blood Service Performance report that provided an overview of performance against key quality, safety, regulatory and performance metrics for the period June 2021 to September 2021. The following areas were highlighted: • Supply of all blood components to meet NHS Wales demand continues to be sustained despite the difficult operating environment and ongoing challenges presented by the pandemic in relation to staff absenteeism and social distancing

affecting the capacity of blood collection venues. The Welsh Blood Service also continues to support when it can to the other UK services as they are currently frequently requesting mutual aid. The positive impact that the recruitment of a fourth collections team had on the service being able to meet demand was recognised;

- An increase in sickness has been observed for the first time which has a potential to impact on the ability of the service to meet demand. Assurance was provided that all appropriate actions were being taken to manage sickness in line with NHS Wales policies and procedures;
- An increase in 'Did Not Attend' (DNA) rates for the service had been experienced the reasons for this are being explored;
- Assurance that all actions to meet the recommendations from the 15 step challenge visit undertaken in a donation clinic on the 17th June 2021 had been undertaken was provided.

The Committee **NOTED** the comprehensive report and commended the Welsh Blood Service Team for all it is doing to ensure that the service continues to meet the demand across NHS Wales for blood and blood products.

Welsh Blood Service Apheresis Clinic 15 Step Challenge Report

The Committee received the summary report from the 15 Step Challenge visit undertaken by an Independent Member, Executive Director and Business Support Officer within the Apheresis Clinic of Welsh Blood Service on the 5th October 2021. The review was extremely positive with exemplar feedback from donors. A small number of recommendations were made that included reviewing whether travel expenses for donors could be reimbursed as well as strengthening the inclusivity of services.

Workforce and Organisational Development Performance Report

The Workforce and Organisational Development Performance Report was received and discussed. The following was noted:

- Sickness absence to 15th November 2021 stands at 5.41%.
- COVID-related absence – 10 staff currently absent, with 14 staff on COVID-related special leave (12 within Velindre Cancer Centre – a number of whom are in the same team).

The Committee received ASSURANCE that the primary focus would now be to address sickness / absence levels, in particular addressing the fragility of smaller, more specialist teams. Additionally, work is being undertaken across divisions to support staff currently attending work in terms of morale, exhaustion, etc, via the employee assistance programme, accessible by all staff.

It was also noted that a large scale recruitment campaign is underway in a number of clinical areas.

Digital Service Operational Report

The Digital Service Operational Report was discussed and the following advised:

- September / October had seen a number of significant system upgrades, in particular:
    - The introduction of WellSky, replacing the outdated IT system within the Pharmacy department, aligning the Trust with the rest of Wales;
    - A number of changes into the WBS ePROGESA system, supporting the new 'FAIR' regulations for blood donation;
    - An upgrade to the Synapse solution, used by VCC Radiology to review and report radiology images.
    - Rollout of the 'Civica' patient experience platform into VCC.
- A series of outages had been experienced within Velindre Cancer Centre and reported through appropriate channels. The Committee received ASSURANCE that all outages had generally occurred out of hours with zero to minimal impact to patients and services.

Financial Report

The Trust Financial Report, outlining the financial position and performance for the period to the end of September 2021 (with additional verbal update for October 2021) was discussed. The Committee noted that there are no major variances on revenue and capital budget and that formal confirmation had been received that all COVID-19 related funding requirements would be received from Welsh Government.

Annual Estates Update

The Annual Estates update was discussed, in particular the significant increase in gas consumption in the Welsh Blood Service during April 2020. The Committee were advised that this increase was a result of changes made to the ventilation plant due to the Covid-19 situation and received ASSURANCE that a review had been undertaken and appropriate adjustments have been made to the control moving forward.

Quarter 2 Putting Things Right Report

The Quarter 2 Putting Things Right Report was discussed and the following highlighted:

- The top three themes in relation to complaints remain communication, attitude and behaviour, and clinical treatment. The Committee were advised that a deep dive analysis is underway in relation to clinical areas concerned so that training can be targeted. A review will be presented to the January 2022 Committee, and;
- The compliance with responding to formal complaints within 30 working days had reduced during the quarter had reduced to 67%. The Committee were advised that this reduction had been due to frequent changes in complaint personnel and were advised that a revised concerns management and oversight process was now in place and that it was anticipated that the compliance would rapidly improve and that a year end position of greater than the Welsh Government target of 75% would be achieved.

Health and Care Standards Self-Assessment Action / Improvement Plan

The Health and Care Standards report was received, advising of the increase in frequency of reviews / self-assessments from annually to quarterly. This has been welcomed by teams despite the pressures posed by the Covid-19 pandemic.

The Committee received ASSURANCE that good progress has been made to date in relation to the improvement action plan. In addition to the increase in frequency of assessments, the internal audit team will also undertake an independent review of a sample of self-assessments.

Highlight Report from the Trust-wide Safeguarding & Public Protection Group

The Highlight Report from the Trust-wide Safeguarding & Public Protection Group was discussed, alerting the Committee to the following:

- Safeguarding training compliance remains below the target of 95% in most areas - a training needs analysis is currently underway to facilitate more accurate reporting and improved compliance;
- There has been a delay in the production nationally of the consultation Code of Practice for the pending new Liberty Protection Safeguards legislation which may leave the Trust ill-prepared to be able to effectively meet the required legislative changes. All possible preparation is underway but detailed plans cannot be developed without the document.
- The Trust does not currently have provision for tier 2 dementia training, however the Committee was ASSURED that a potential agreement with Cardiff & Vale was under development that would more than adequately meet this requirement.

The Committee also NOTED the revised Terms of reference and name of the Group to widen its remit to cover vulnerable adults and older persons. The new title was the Safeguarding and Vulnerable Adult Management Group.

Patient / Donor Experience 2020-2021 Annual Report

The Patient / Donor Experience 2020-2021 Annual Report was discussed (attached in ***Appendix 1***). The following areas were highlighted by the Committee:

- Despite the COVID-19 pandemic and short notice changes to services, the teams across both divisions have actively engaged with patients and donors, seeking greater feedback on our services, increasingly via digital means (due to restrictions imposed on traditional means by the pandemic).
- Patient and donor feedback has, overall remained positive. However, some feedback linked to those emerging in Concerns relating to communication, staff attitude and behaviour and treatment.

- Concerns raised around treatment predominantly related to changes to service provision as a result of the COVID-19 pandemic.

The Committee received ASSURANCE that both Divisions are taking action to review all feedback received and take appropriate improvement actions. It was noted that the roll out of the electronic patient / donor experience software will facilitate a much higher volume of feedback, and in real time.

Quality, Safety & Performance Committee Annual Report 2020/21 (including Committee Effectiveness Survey Findings)

The Committee received the first Annual report for the Quality, Safety & Performance Committee (attached in ***Appendix 2***) which summarises the key areas of business activity undertaken by the Committee in its first year of operation. The report also incorporated the findings from the Quality, Safety & Performance Committee first Annual Effectiveness Survey, designed to assess its performance together with any opportunities for continuous improvement.

The Committee noted that a recurring theme running throughout the report relates to the Committee's pivotal role in collating information under one umbrella in a more integrated way to allow for more effective triangulation, together with the key areas of focus for the coming year as the Committee continues to mature and further develop.

The Committee was ASSURED that this year's survey findings would be used as a rolling benchmark for year on year reporting. It was agreed that clarification would be provided to distinguish between responses from members and attendees, and that additional detail would be added to demonstrate that the Committee is attended by representatives from a number of external organisations that represent the patient viewpoint and regulatory input.

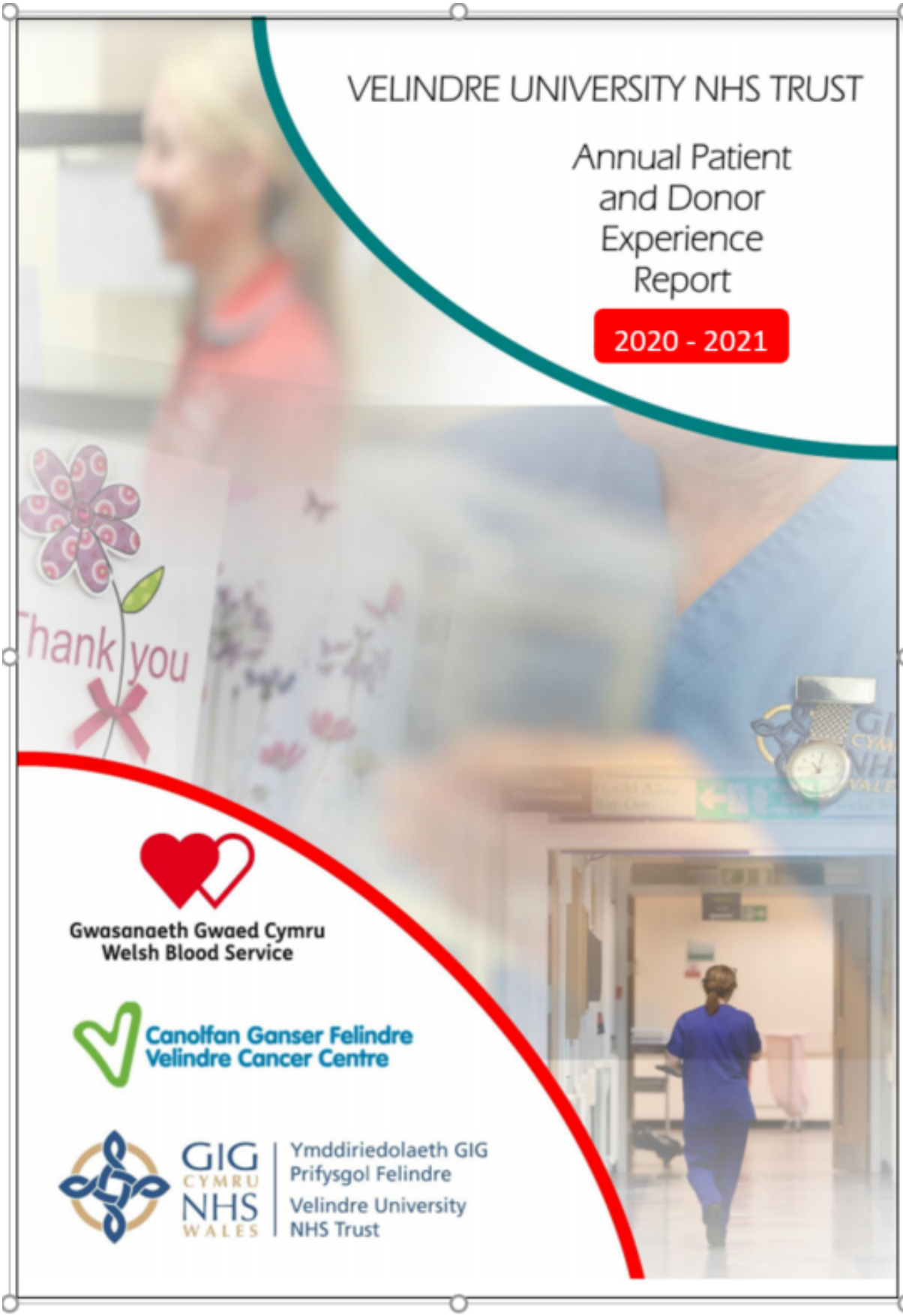
The revised Committee work plan was also received and APPROVED.

The Quality, Safety & Performance Committee **ENDORSED** for **BOARD APPROVAL** the Quality, Safety & Performance Committee Annual Report for 2020-2021.

INFORM	There were no items identified to inform the Board.
APPENDICES	***Appendix 1:*** Patient / Donor Experience 2020-2021 Annual Report ***Appendix 2***: Velindre University NHS Trust Quality, Safety & Performance Committee Annual Report 2020-2021

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the Quality, Safety & Performance Committee held on the 18th November 2021.


VELINDRE UNIVERSITY NHS TRUST
Annual Patient and Donor Experience Report
2020 - 2021
Thank you
Gwasanaeth Gwaed Cymru
Welsh Blood Service
Canolfan Ganser Felindre
Velindre Cancer Centre
GIG CYMRU NHS WALES
Ymddiriedolaeth GIG
Prifysgol Felindre
Velindre University
NHS Trust

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1.0 EXECUTIVE SUMMARY

Velindre University NHS Trust is committed to ensuring that patients and donors are at the heart of everything we do, striving to ensure that all of our patients and donors receive positive care and service experiences.

This report covers the period from the 1st April 2020 to the 31st March 2021 and details how we have engaged with patients and donors to seek their feedback, what their feedback has shown us, and how we have utilised the feedback to shape and improve our services.

During the reporting period, we witnessed the worst global pandemic in modern times with COVID-19 radically changing the traditional ways in which the Trust delivered care to our patients and donors. The COVID-19 Pandemic also provided us with the added challenge of continuing to encourage and obtain patient and donor feedback when traditional feedback mechanisms were not as accessible as they had previously been (in particular due to reduced face to face attendances at the Cancer Centre as part of the COVID-19 risk reduction measures in place nationally). Nonetheless, this also provided the Trust with the opportunity to explore 'doing things differently', and in particular, seeking greater donor and patient feedback digitally. We have during this year been implementing the 'Once for Wales' Patient Feedback system: 'CIVICA' so that we can capture real time experience feedback on mass.

The Trust strives to ensure that patients and donors are at the heart of everything that it does, and is grateful for the continued levels of assistance, encouragement and feedback that is received from our patients, donors, staff, partners and supporters.

2.0 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.

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

Providing blood, bone marrow, haematopoietic stem cell and transplant laboratory services, and immunogenetics services across Wales.

Providing non-surgical tertiary oncology and palliative care services to the population of south-east Wales, and highly specialist cancer services for patients from other regions of Wales

Canolfan Ganser Felindre
Velindre Cancer Centre

2020 – 2021 Context

The activity and number of patients and donors treated and cared for by our services continued to increase during 2020 – 2021 (as anticipated). The added challenge over the past year was to work to ensure that our patients and donors continued to have a good experience of their care, despite the frequent and rapid changes in services that needed to be made to ensure patient and donor safety during the COVID-19 Pandemic.

During 2020 – 2021, the Trust remained as committed as ever to ensuring that every patient and donor had an excellent experience, and that feedback was actively sought. However, the COVID-19 pandemic necessitated the need to adopt different pathways and mechanisms to engage, encourage and obtain feedback from our patients and donors. Adopting more digital ways of receiving feedback provided us with ability to continue to monitor patient and donor experiences during the COVID-19 Pandemic, and enabled us to continue to learn and adapt our services following the feedback received.

The greater digital feedback received during this time also afforded us with the opportunity to receive more 'real time' supportive messages from our patients and donors. The ability to receive and share such positive and caring feedback amongst our staff in 'real time' was enormously beneficial in boosting the morale of our staff during what was a very challenging period for them.

The Trust remains indebted to its patients and donors for their support during this time. An example of some of the messages received is shown below:

The Trust continues to have a strong governance framework regarding the monitoring of our patient and donor feedback, including a review of qualitative and quantitative data (including patient / donor stories) at the following forums:

- *Shared Listening & Learning Committee*
- *Quality, Safety and Performance Committee*
- *Executive Management Board*
- *Trust Board*

This is being further strengthened with the phased implementation of the CIVICA digital patient and donor feedback system which commenced in Quarter 4 of 2020.

This report is the second overarching annual patient and donor experience report that the Trust has produced. It provides an overview of how we seek and monitor patient / donor experience, our patient / donor satisfaction scores, the actions that we have undertaken as a result of patient / donor feedback, and how we engage with our patients /donors.

3.0 CAPTURING PATIENT AND DONOR FEEDBACK

The Trust continues to have a number of different mechanisms to encourage and obtain patient and donor feedback. This has been further enhanced over the past year due to the COVID-19 Pandemic, and there has been a shift to a greater emphasis on Digital feedback mechanisms. This was particularly important as our more traditional method of hard paper copies of patient surveys was removed due to Infection Prevention and Control reasons.

3.1 Velindre Cancer Centre: patient and carer feedback mechanisms in place:

- Online digital surveys linked to social media messaging
- Social media channels were a valuable source of feedback including comments, stories and check-ins
- Provision of a snapshot survey to enable a faster way for patients to share their thoughts, containing just three of the core validated questions
- 'How Did We Do' business cards that patients could pick up and take away as a reminder about how and where to complete the online surveys
- Quickly identifying issues and concerns raised to enable learning to be captured and changes to be made

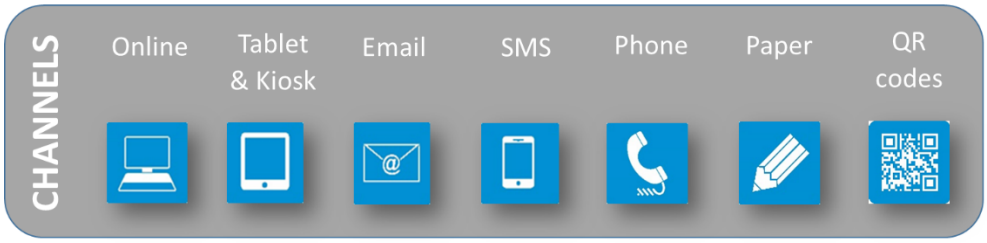
3.2 Welsh Blood Service: Donor feedback mechanisms in place:

Feedback	Format	Detail
On session	Paper feedback forms	At each donation session, sealable English and Welsh paper feedback forms are made available. Every response is read by the Donor Experience Manager and escalated if necessary.
On session and post-donation	Donor adverse events	Occasionally donors can experience an adverse event as a result of donating blood, i.e. bruising, discomfort or feeling light headed. A report is completed on session and followed up by the Clinic Nurse or for more complex incidents the Specialist Nurse for Donor Care/Medical Consultant.
Post-donation	Concerns procedure	An easily accessible process for our donors to report when things go wrong, these are handled in line with 'Putting Things Right' guidelines. Concerns are forwarded to the relevant departments who discuss the concern with donors to identify possible improvements.
	Contact centre and social media	Donors can provide feedback through our social media channels which are operated during typical office hours or call 0800 252 266. Feedback is forwarded to the relevant teams or escalated if necessary.
	Donor awards	Each year we host around 12 award evenings where senior management sit amongst donors and gather qualitative feedback.
	Digital survey	Each donor session attendee is invited to complete a digital survey via email based on their experience at session. A monthly report is generated and shared at a monthly departmental meeting.

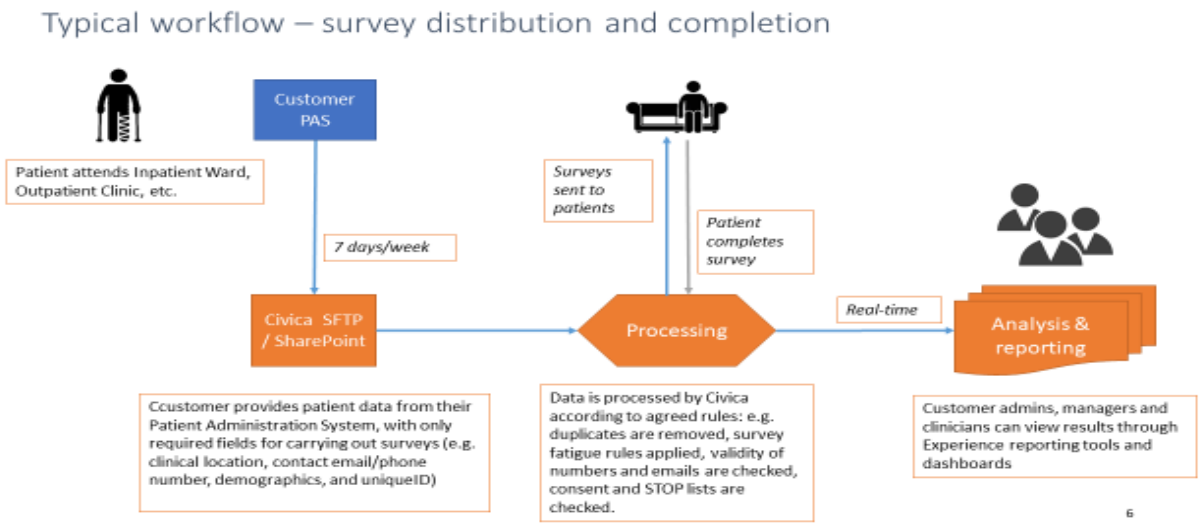
3.3 Recent and Future developments in strengthening Feedback Mechanisms

Our key focus is to ensure that patients and donors can provide feedback in an easy, simple and straightforward way. We have been working on implementing a new feedback system (called CIVICA) that will provide patients and donors with a wider choice of channels to use to provide their feedback. This will include: including

online, paper, phone, SMS and email.



The diagram below demonstrates how the CIVICA system can be used in order that 'real time' insights into patient and donor feedback can be received and reviewed. This will enable rapid actions to be taken to address any areas of concern.

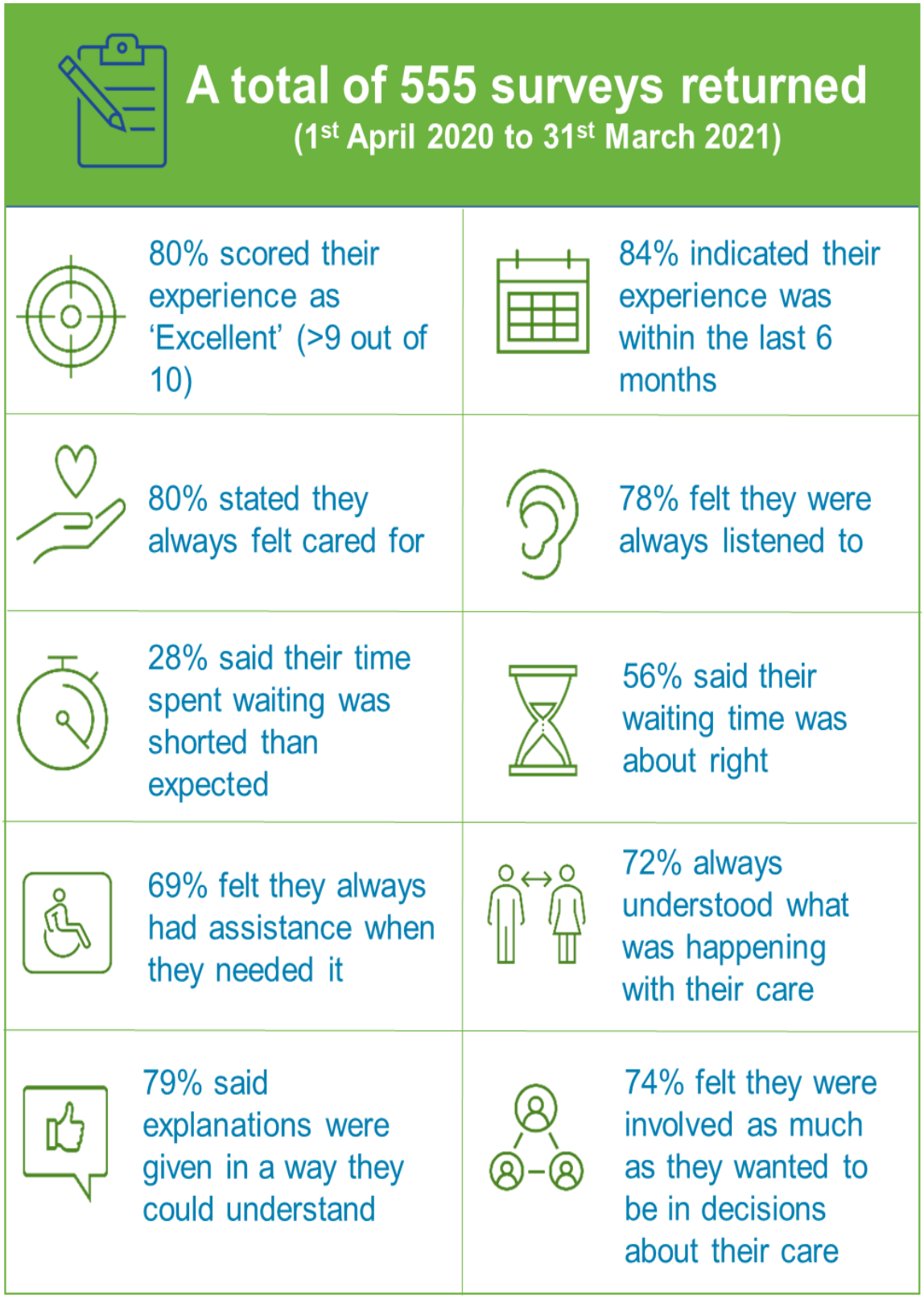


The further phased roll out of the CIVICA system at the Cancer Centre and within the Welsh Blood Service will progress during 2021 – 2022.

4.0 VELINDRE CANCER CENTRE PATIENT SATISFACTION RESULTS

Due to the global COVID-19 pandemic, all the formal patient experience surveys were undertaken and feedback captured via Digital mechanisms. As a result of this, there was a reduction in the number of respondents in comparison with recent previous years, this is an issue mirrored across all healthcare organisations in 2020 – 2021.

4.1 Patient and Carer Satisfaction Results

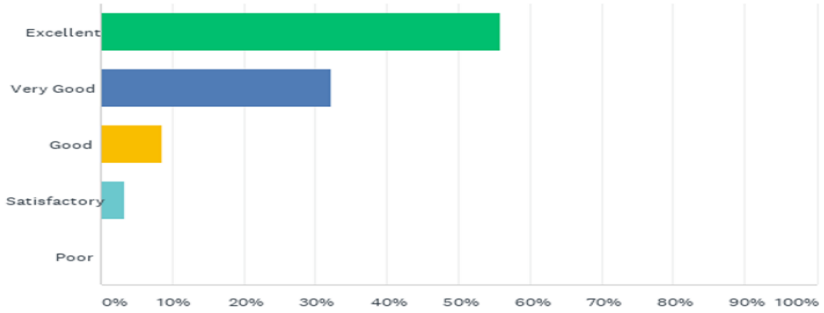


Due to the COVID-19 Pandemic, and in line with national COVID-19 risk reduction meaures, many of our routine out-patient appointments were converted to ‘virtual clinics’. They were undertaken either via Video or Telephone. This was an initial challenge for us and for our patients as this had not been routinely done before.

It was therefore important for us to target obtaining feedback from patients attending the ‘virtual’clinics in order that we could assess the satisfaction response, and to rapidly learn and make adustments to our service. A selection of results from the survey are shown over the next 1-2 pages.

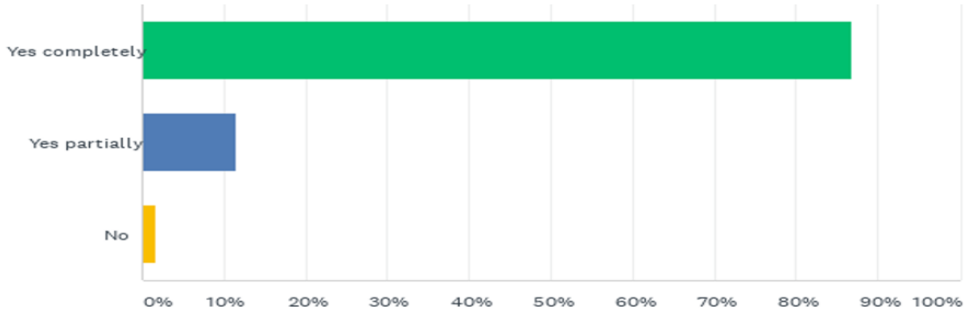
Q2: What was your experience of the call quality (audio and / or video)?

Answered: 59 Skipped: 2



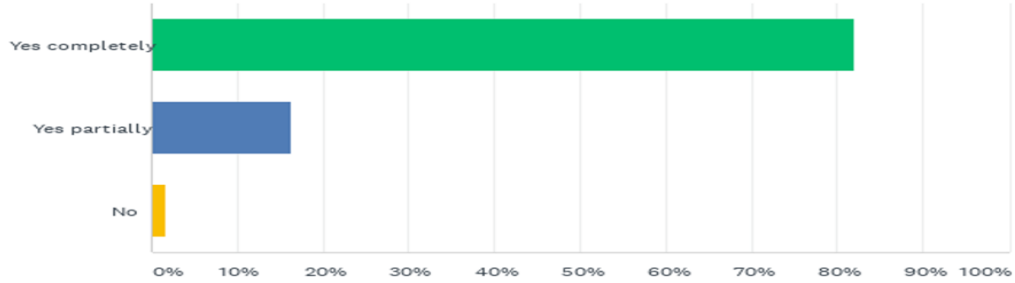
Q6: Were things explained to you fully and in a way you could understand?

Answered: 61 Skipped: 0



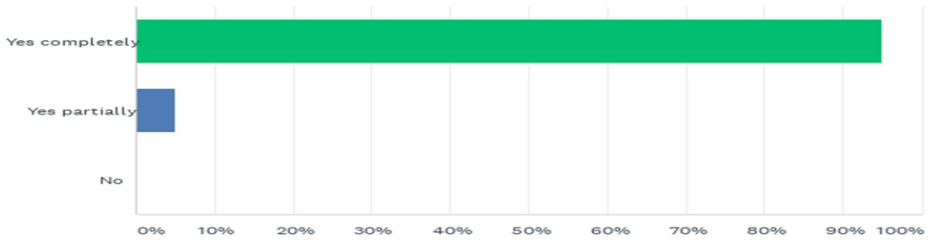
Q7: Were your concerns listened to?

Answered: 61 Skipped: 0



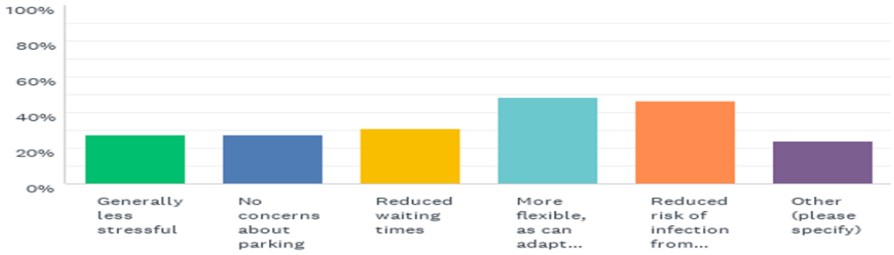
Q10: Did you feel you were treated in a caring and considerate manner?

Answered: 61 Skipped: 0



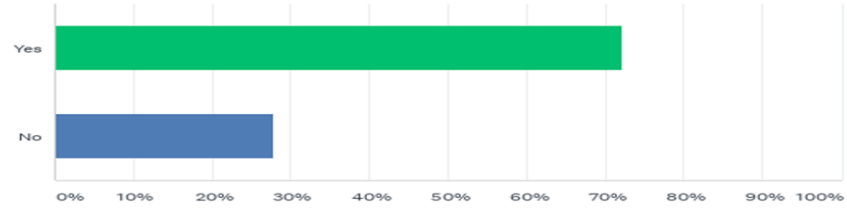
Q11: Was there anything particularly good about having a 'virtual' consultation? (please choose all that apply)

Answered: 58 Skipped: 3



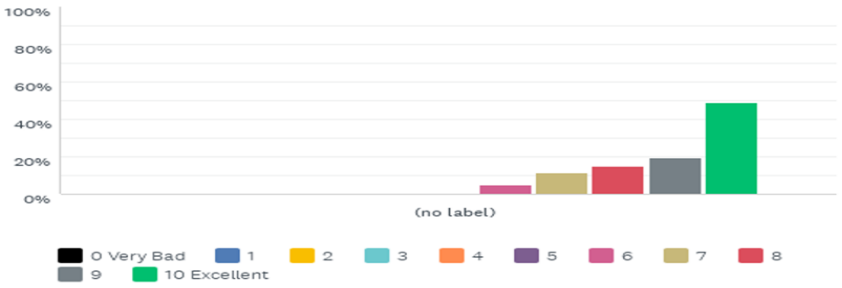
Q14: Would you find it useful to continue with this type of consultation for some of your future appointments?

Answered: 61 Skipped: 0



Q15: On a scale of 0-10 (where 0 is very bad and 10 is excellent) how would you rate your overall experience?

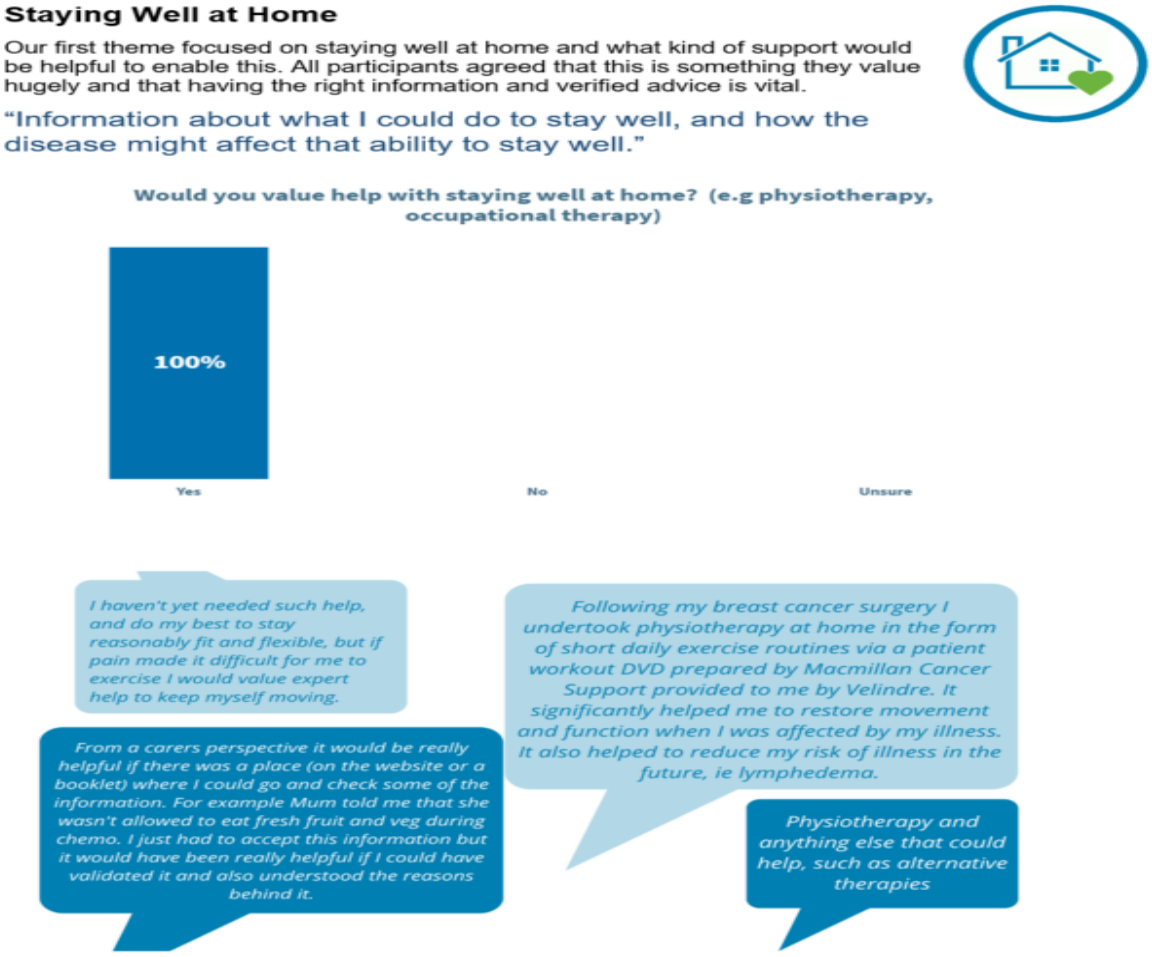
Answered: 61 Skipped: 0



The results from the satisfaction survey of the 'virtual' clinics was generally positive. We continue to undertake 'virtual' clinics for some patients, and we will use the survey results to improve the experience of our patients who attend them.

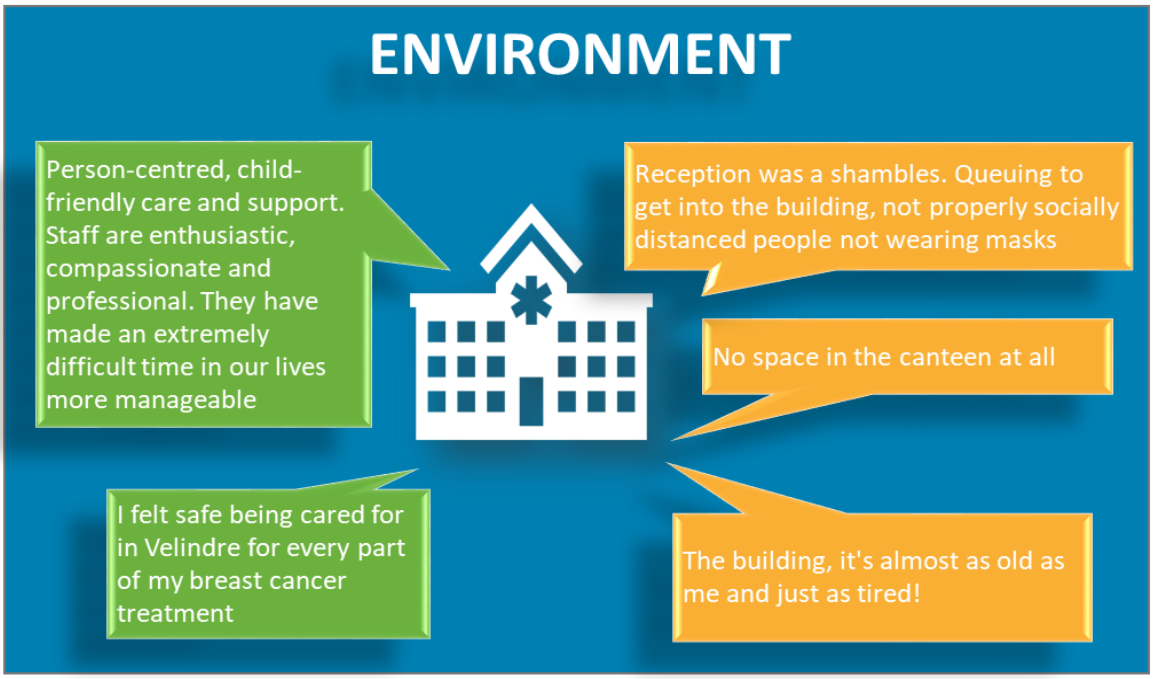
The risk of contracting COVID-19 was of great concern to our patients who were receiving chemotherapy treatments. Their concern was justifiable given the known increased risks to immuno-compromised patients.

In order to better understand how we could support these patients during the Pandemic, the Acute Oncology Team conducted online focus groups to capture patient and carer views. Two sessions were held in late August 2020 and involved eight participants, followed by ten participants completing an anonymous online poll.

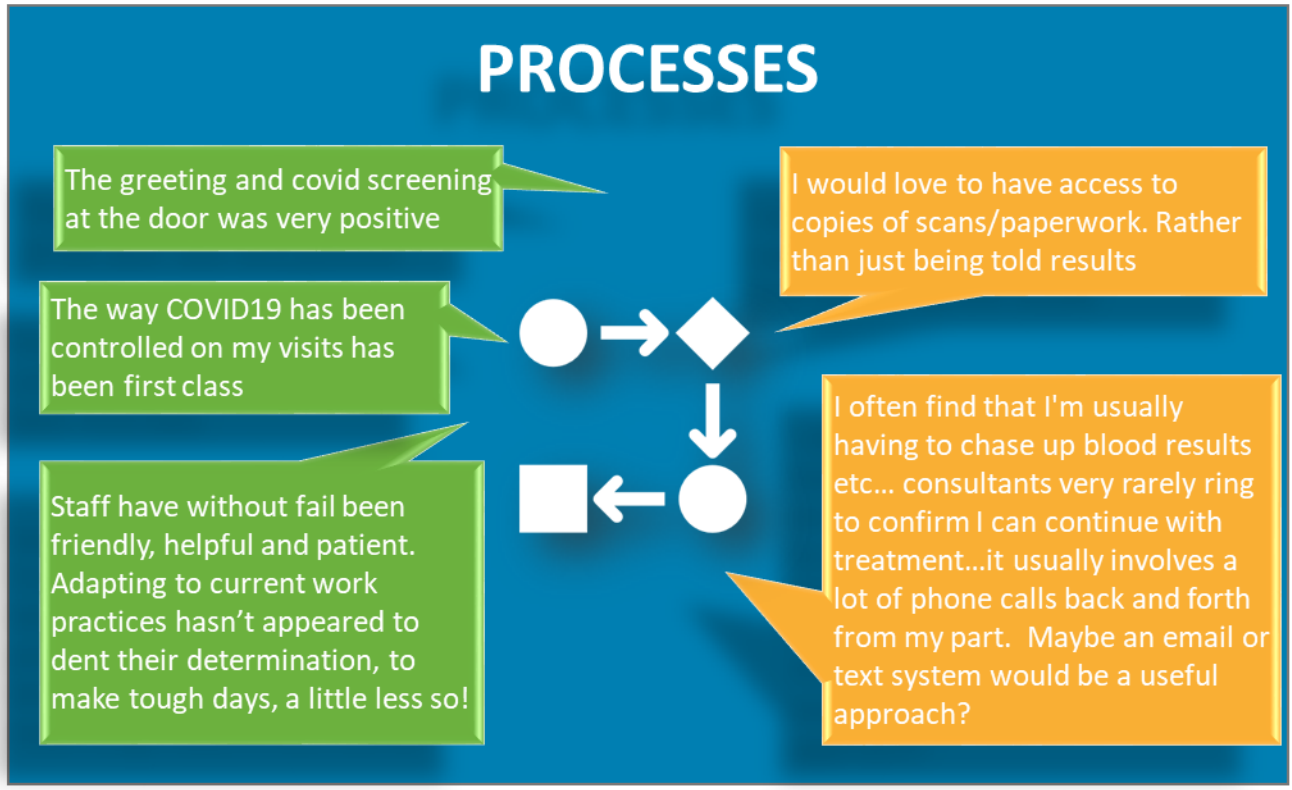


4.2 Comments received from Patients and their Carers

The comments below provide a snapshot overview about what patients and carers have told us about their experience at the Cancer Centre, along with their ideas for improvement. For ease of review, the feedback received has been categorised as below:




COMMUNICATION
Always someone available to answer questions
Difficult to hear and lip read staff in PPE
Felt listened to
I would have liked more explanation of how radiotherapy treatment worked before I started, the exact areas being treated etc
Always someone available to answer questions
Have more time to explain how you are feeling
Telephone consultations have been excellent and should be continued beyond the lock-down
Allow family to be present by video, what's app, etc if not physically, so we can be involved and know what we need to do


PROCESSES
The greeting and covid screening at the door was very positive
I would love to have access to copies of scans/paperwork. Rather than just being told results
The way COVID19 has been controlled on my visits has been first class
I often find that I'm usually having to chase up blood results etc… consultants very rarely ring to confirm I can continue with treatment…it usually involves a lot of phone calls back and forth from my part. Maybe an email or text system would be a useful approach?
Staff have without fail been friendly, helpful and patient. Adapting to current work practices hasn't appeared to dent their determination, to make tough days, a little less so!

WAITING TIMES

I never had to wait very long to be seen

Sometimes we waited hours after the appointment time to be seen as it was so busy

Wonderful staff throughout, everything went smoothly and on time, a really pleasant experience, staff all great couldn't fault them

The current waiting experience of sitting in a tent outside in this cold weather is unacceptable for patients who are immune compromised

The clinics have adapted quickly to the Covid situation. Waiting times in out patients are shorter and I think having consultations by phone works well

I waited 3 hours for 20 min appointment. Cannot do that again. Exhausting

TRANSPORT & CAR PARKING

Access to the hospital was easy by car and bike

Hospital provided transport is a bit hit and miss. Often need to chase it up. Have had transport cancelled for no reason, transport turn up despite it being cancelled

The staff have organised home transport by ringing the taxi company when I'm ready to leave. Exemplary service from all the nurses

Parking space!

Maybe a more comfortable waiting area. Parking was difficult. My husband often had to leave me in my wheelchair to go and wait for a parking space

Both me and my wife who transports me have felt safer there than anywhere else

During 2020 – 2021, the qualitative feedback was mainly very positive, and many supportive messages were received from our patients during this time. However, a number of formal concerns were also raised around communication, staff attitude and behaviour, appointments and treatment.

The concerns raised regarding appointments and treatment mainly related to changes in our services due to the COVID-19 Pandemic. Deep dives are now taking place to better understand the reported communication issues in order that we can work to improve this area.

Our patients and carers have been very generous in providing us with their feedback, and for their suggestions for improvement. We will continue to ensure that we learn from what they have told us, and that we improve our services as a result.

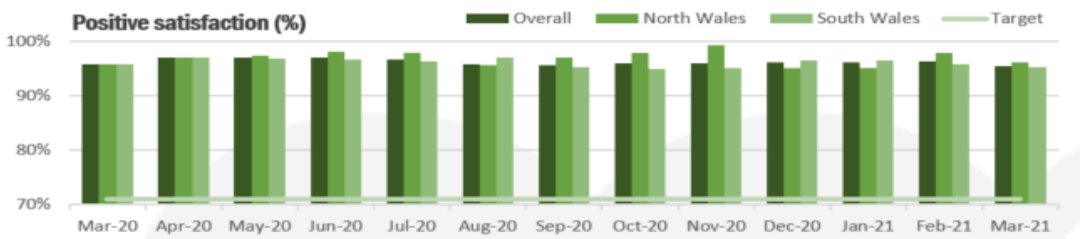
5.0 WELSH BLOOD SERVICE DONOR SATISFACTION RESULTS

5.1 Donor Satisfaction Results

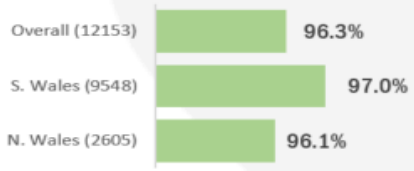
The Welsh Blood Service continues to actively seek and obtain Donor feedback.

As part of our routine questionnaire, we ask respondents questions about the service we provide. Respondents are asked to score these services, with six being totally satisfied and one being totally dissatisfied.

The chart below shows National satisfaction scores and the North and South Wales regions' scores from March 2020 to March 2021.



Donor satisfaction for those who had successfully donated remained above target at 96.3 per cent.



Respondent satisfaction for clinic attendees, including those who did not make a full donation, was slightly lower.

In total, 11,751 (80.4%) donors rated the service six out of six. Here is a selection of the comments received from these respondents.

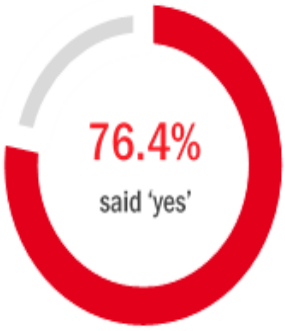
Respondents were also asked to answer eight questions regarding their experience of attending the Donation clinics on a scale of one to six, with six being totally satisfied and one being totally dissatisfied. Any respondent selecting one or two were provided with the opportunity to add a qualitative response. The results are shown overleaf.

Donation exp. matrix response	n	1	2	3	4	5	6	Mean
Overall	**124,710**	**382**	**464**	**1,137**	**3,311**	**13,889**	**104,937**	**5.78**
Your greeting on arrival	14,069	70	66	161	464	1,555	11,707	5.74
The professionalism and politeness of our staff	14,062	28	21	87	237	1,197	12,450	5.85
Your comfort during the donation process	13,598	21	44	138	369	1,531	11,451	5.78
How informative and knowledgeable staff were throughout the process	14,054	20	45	86	250	1,421	12,108	5.82
Your overall satisfaction of the donation experience	14,050	56	75	155	339	1,665	11,681	5.76
Making you feel valued and appreciated	13,933	67	65	167	549	1,853	11,156	5.71
Treating you with consideration and sensitivity	13,927	50	43	118	328	1,528	11,801	5.79
Making you feel supported while on clinic	13,909	46	49	111	373	1,589	11,649	5.78
Time taken to complete the donation process	13,108	24	56	114	402	1,550	10,934	5.77

Respondents' overall satisfaction is grouped below by the point at which the donation process concluded. Evidence shows that donor satisfaction is closely linked to a donor's ability to achieve their goal (a completed donation) on a session.

n	54	47	309	364	13,738
Pos %	**65.4%**	**62.2%**	**68.6%**	**46.9%**	**96.3%**

On certain occasions, and for a number of reasons, Donors may not actually progress to being able to donate blood when they attend the Donation clinic. Each respondent who had not successfully donated was asked if they were happy with the explanation that they received regarding why they were unable to proceed to donate blood. The results are shown overleaf:



There were 584 respondents to this specific survey. 76.4% were happy with the explanation they received, and 16.6%) were not satisfied with the explanation provided, 53 (6.9%) selected 'N/A'.

The Team is currently working to review and improve our communications as to why progressing to donating blood was not possible, and we will continue to monitor the feedback received regarding this issue

Respondents were asked to provide feedback regarding their satisfaction with the Donation Clinic venues.

Eight questions were posed which were rated on a scale of one to six, with six being totally satisfied and one being totally dissatisfied. Any respondent selecting one or two were provided with the opportunity to add a qualitative response. The results are shown below:

Venue matrix response	n	1	2	3	4	5	6	Mean
Overall	**114,086**	**598**	**895**	**2,798**	**7,418**	**12,240**	**84,137**	**5.58**
The frequency of our visits to your area	14,231	143	245	740	1,843	2,851	8,409	5.27
The availability of information to check your eligibility to give blood	14,239	77	65	199	539	1,977	11,382	5.70
The location of the clinic	14,292	81	143	466	1,144	2,259	10,199	5.52
The accessibility of the clinic	14,282	57	74	235	658	2,030	11,228	5.68
The cleanliness of the venue	14,282	30	15	76	394	2,078	11,689	5.77
The opening times of the clinic	14,261	49	87	304	864	2,471	10,486	5.60
The facilities of the clinic (i.e. parking and restrooms)	14,253	103	165	410	1,031	2,240	10,304	5.53
The availability of a donation time convenient to you	14,246	58	101	368	945	2,334	10,440	5.58

Respondents were asked how satisfied they were with the frequency with which they were contacted by our donor contact centre. Three questions were asked on a scale of one to six, with six being totally satisfied and one being totally dissatisfied. The results are shown below:

	n	1	2	3	4	5	6	N/A	Mean
Post	13,021	353	171	384	646	957	4,431	6,079	5.16
SMS	13,752	231	148	342	686	1,523	9,388	1,434	5.54
Telephone	12,837	284	132	295	468	704	3,340	7,614	5.14

5.2 Comments received from our Donors

Below is a selection of the positive comments that we have received from our Donors

"The Welsh blood services initially alerted my mum to her rare bowel cancer, her low iron levels were the only indication. It was because of staffs insistence that she has her levels checked with the GP that the cancer was detected so early. Hopefully she makes a full recovery but we owe so much to the staff of the Welsh blood service. The staff in Talbot Green are absolutely amazing".

"Team in Chirk were fabulous. I was apprehensive having not donated for several years previous but the team made me feel welcome and at ease".

"Your organisation is a credit to your staff, your members, the NHS and Wales"

"I was very nervous about the process, and had put it off for a long time, however the staff could not have been more supportive and helpful. Every person I spoke to was reassuring, kind and helpful. They talked through the process and really put my mind at ease. They were very professional, but also made me feel relaxed. Thank you!"

And the not so positive comments …….

"Twice in succession been turned away. Once for travel reasons (Tanzania just under 6 months prior to visit) and once for having an injection the week before the visit. There have been several other occasions in the past when similar things have happened. There is no current way to check with certainty before turning up to the appointment"

"The process was extremely slow compared to other times I have been. The man in the next cubicle had assessed 4 people whilst I was being assessed. I get fed up of the same questions with me giving the same answers and yet they still need to be checked"

"They stopped the process because it wasn't flowing quick enough. I have donated over 40 times and never had this before"

"I waited an hour for a test to show that I couldn't give. That is a very long time for absolutely no purpose"

Overall, the feedback received from our Donors over the past year has been very positive, this is despite the many rapid changes (for example alterations in clinic venues) that needed to be made to our services due to the COVID-19 Pandemic.

As always, the Welsh Blood Service remains committed to learning from the feedback provided, and improvement work remains ongoing in certain areas, for example communication.

We will continue to actively seek Donor feedback over the next year.

6.0 LEARNING FROM FEEDBACK RECEIVED FROM DONORS AND PATIENTS

Patient and donor feedback is vitally important to us. It is only through their feedback that we can make meaningful improvements to our services.

6.1 Velindre Cancer Centre 'You Said, We Did' Examples

The following spotlight on learning provides examples of how we developed our services during 2020-2021 using learning from the feedback received.

Fe ddywedoch chi... fe wnaethom ni...

You said... We Did...

You Said...
"I worry about people waiting outside in the cold"

We Did....
We've added a heated shelter to our Outpatients entrance to make sure that patients are safe, warm and socially distanced as they wait to enter the department.

Fe ddywedoch chi... fe wnaethom ni...

You said... We Did...

You Said...
"Parking can sometimes be a nightmare"

We Did....
Our front car park is now fully dedicated to patient parking, with clearly marked patient only parking bays.

Managing Systemic Anti-Cancer Therapy (SACT) appointments

As a result of concerns received within the Cancer Centre relating to appointments for SACT, work was undertaken to improve the clinic booking process and patient letters. This included clarifying the process when a clinical decision had been made to defer treatment at short notice, and the way in which these discussions are held with patients.

The SACT booking manager has introduced additional checks to ensure the accuracy of patient information, contact details, address and other details required for appointment bookings.

Administration of virtual clinics

In response to the Covid-19 Pandemic, the Cancer Centre introduced virtual clinics for many of its patients. Concerns raised have informed work being undertaken to improve the administration of virtual clinics, including;

- *Standard Operating Procedure (SOP) developed to alleviate identified administration issues.*
- *All clinics are reviewed a week ahead to ensure that all information is thoroughly checked including the 'clinic type' for example, virtual or face to face arrangements.*
- *During this check, the letter confirming the appointment is also reviewed to ensure it contains the correct information.*
- *Additional resource has been provided to support the medical secretaries in ensuring that the management and administration of all clinics is improved.*
- *All Consultants, Clinical Nurse Specialists and Non-Medical Prescribers have been reminded of the requirement to complete a clinic outcome form in a timely manner.*

6.2 Welsh Blood Service 'You Said, We Did' Examples

Theme	Response
Children on clinic	A full review and a new SOP has been developed. Supporting staff comms have also been shared for clarity on parents who bring children along to their blood donation session following the changes introduced to sessions during Covid-19.
Transgender donors	Training Awareness (TA) developed and provided to Collection team staff and DCC for staff awareness on terminology and how to deal with difficult situations. Full Transgender training to be delivered in Autumn training sessions provided by VUNHST's Diversity and Equality Manager, an SOP will also be developed.
Donor face coverings	Revisited donors unable to wear a face covering due to an exemption. Exemption lifted, donors can now donate blood without a face covering if exempt in line with PHW guidance and relaxed restriction due to the Covid-19 pandemic. Collection team/DCC staff updated.
Cold temperature at donation venues	The Service has been working very closely with our venue contacts to ensure that heating is put on prior to the team arrival to maximise the temperature of the clinic area. The planning team continued to actively source alternative locations with more ambient conditions for donors.
Travel distance to donation venues	Following feedback from donors when changing our donation programme to 'regional' donation venues, the Service was able to predict the levels of attendance based more accurately, taking into account donors' willingness to travel to venues.
SMS invites	During the pandemic, the number of invites sent to nearby regional hubs to donors was increasing. The Service closely monitored satisfaction levels regarding the number of invites received.

7.0 COMPLIMENTS AND COMPLAINTS

7.1 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:

‘Care/compassion and that of the team at Velindre, and Rookwood is absolutely outstanding. There are no words ... Pasg Hapus i bawb xxxx

‘A year ago today, I started treatment at @VelindreCC We had just gone into the first lockdown and I was feeling extremely apprehensive. I’ll never forget the kindness, care and compassion of the team of nurses in the trials unit. I’ve lost count of my lucky stars. Diolch’

‘I had my second to last infusion today, and wanted to say how wonderful the staff were on the new Rowan Ward. Thank You. 3 years ago today, the news gave me that sinking feeling. But care, support and treatment has been amazing’

‘Thanks to the amazing staff @VelindreCC I'm celebrating 7 years cancer free, 8 years since my op, & being discharged from their care...no more annual check ups. They looked after me through both cancer diagnosis & I'll be forever grateful to them all’

‘A year tomorrow I started my first treatment. I have never felt so scared but everyone was so wonderful. I later spent two weeks on a ward, the care I was given was amazing. I will never forget and I will always be grateful. Thank you xxxx’

‘You are fantastic at putting patients at ease, and explaining processes really well- thank you for your kind understanding’

7.2 Complaints

Complaints are received via a number of routes including verbal, social media, email, formally in writing and through our websites. Overleaf is a summary of the complaints we have received during the reporting period together with the key themes.

The Trust has a robust mechanism in place to ensure that we learn from all the complaints received, and that we work to improve our services as a result.

8.0 PATIENT AND DONOR ENGAGEMENT

The Trust is committed to engaging and working in partnership with our patients and donors, as it is only through co-design that we can ensure that our services truly meet the needs of our patients and donors.

8.1 Patient engagement at Velindre Cancer Centre

Efforts have been made to continue to engage with our patients and their carers during the past year, although traditional methods of doing this were challenging due to the COVID-19 Pandemic. Therefore, a switch was made to greater digital engagement methods, including online focus groups.

The Patient Liaison Group meetings continued to be held using video conferencing. This enabled the continuance of the group to engage, inform and advise.

At the Velindre Cancer Centre, a Patient Liaison Group (PLG) is well established, and the designated patient 'leaders' from this group actively participate in the running of the cancer centre. Below is a statement from the group which provides an overview of their role and purpose:

"We are a group of enthusiastic and passionate people who have experienced the work of Velindre, either as a patient or as a carer. We come from all over the region and help Velindre to understand things from a patient or carer's perspective.

Our role is varied and valued. One day we might be commenting on documents, co designing new services or giving presentations. Another day we could be offering our ideas for improvement. Each member has their own strengths and interests and Velindre works closely with us so that we can all make the most of our wide range of skills and networks."

8.2 Donor engagement at the Welsh Blood Service

Within the Welsh Blood Service, Donor Engagement is hugely important, not only to ensure that the Donor experience is optimised, but also to ensure that people engage with the service and that they chose to donate their blood.

The Service has two distinct teams: the Donor Contact Centre team and the Communications, Marketing and Engagement team. The two areas are responsible for six areas within the Welsh Blood Service as shown below.

Donor interactions
To manage donor admin and inspire current donors to donate again.

Research
Gather and share donor feedback to improve service provided.

Communications
Using local and national media to educate and inspire people in Wales to donate or advocate for the Service.

Partnerships
Create relationships with national organisations that can be used in local communities, across Wales.

Celebrating donors
Support donors through the donation lifecycle including donor award ceremonies.

Local engagement
Promote upcoming donor sessions within local communities, using key advocates and influencers to maxmise publicity.

To improve our ability to provide information that engages with, and resonates with potential donors, the Welsh Blood Service procured a mobile journalism kit. Staff were trained to use the kit in producing short videos such as interviews, news bulletins and vox pops to enable donors and advocates of the service to tell their stories. Several videos were created and/or edited throughout the financial year using the kit. Research has shown that video content generates 1,200% more shares than text and images combined.

Sue – Sue started donating after her sister received a lifesaving blood transfusion during childbirth. Her mother also received a lifesaving transfusion whilst suffering from bowel cancer.

Kathryn – Kathryn share's her family's story regarding Les, her father, and his battle with cancer. The video includes a feature of Les before he passed away, encouraging people to continue donating and the value of donating blood.

Abby – Abby made her first blood donation as a New Year's Resolution, alongside her friend. She said: "I definitely feel like I have done something great today, and I think that everyone should have a chance to feel like that."

Shaun – A professional footballer and club captain for Wrexham AFC, Shaun Pearson is used to being in front of the camera. After making a plea to Wrexham AFC fans to become blood donors, Shaun donated blood for the first time himself.

Kayleigh– Gave blood during the pandemic and encouraged others to consider donating whilst letting people know how safe and clean the clinical environment felt, and how friendly the staff were.

These videos have been integral to the engagement strategy of donors. There is now a wider opportunity for advocates to share their messages to our stakeholders in their own words, allowing for more authentic and emotive content to engage donors.

Donor Contact Centre

The key purpose of the Donor Contact Centre is to be the first point of contact for blood donors in Wales, with main functions including: booking appointments, answering queries, seeking feedback and keeping consistent lines of communication with our donors.

The Donor Contact Centre's key aim is to deliver an exceptional standard of service and care for our donors, whilst ensuring that hospital blood stocks are consistently at the optimum levels.

- ✓ During 2020-2021, the team adapted to the COVID-19 restrictions by:
- ✓ *Making contact with donors to advise on last-minute changes with clinics.*
- ✓ *Moved to SMS invites instead of letters to allow for greater agility with clinic changes and collection requirements.*
- ✓ *Contacting donors around the change to regional hubs giving them an alternative option to their regular donation clinic.*
- ✓ *Proactive contact of over 70s regarding clinic attendance following shielding.*
- ✓ *Maintained appointment bookings at an average of 93 per cent.*
- ✓ *Total calls handled by Contact Centre were 115,000 (39,498 inbound calls & 75,718 outbound calls)*
- ✓ *Total appointments booked from calls: 17,520 (13,312 inbound calls & 4,208 outbound calls).*

9.0 COMMUNITY PARTNERSHIPS

9.1 Community Health Council

The Community Health Council is the independent voice of people in Wales who use NHS services. The South Glamorgan Community Health Council Officers & Members have continued to provide support and advice to the Trust, and are very much valued partners of the Velindre University NHS Trust.

The Community Health Council are members of a number of the Trust's committees and advocate for patient and service user centred healthcare and engagement. They have actively worked with the Trust throughout 2020-2021, and will be undertaking

some independent audits regarding patient satisfaction at the Cancer Centre during Quarter 1 of 2021 – 2022.

9.2 Community Partnerships within the Welsh Blood Service

The Welsh Blood Service's Community Partnerships Officer is responsible for creating strategic relationships with key partners across Wales. The Officer aims to work with socially engaged groups on a national level to create a suite of engagement material that our donor engagement coordinators can share locally as they visit the towns and villages of Wales to promote our donation sessions.

The Community Partnership Officer works with a wide range of socially engaged groups that are present across Wales, from football, cricket, rugby and other leisure clubs to choirs, churches or community groups.

One such example is the recent partnership with the Football Association of Wales for the JD Cymru Leagues and the Orchard Welsh Premier Women's League for the 2020/21 and 2021/22 football seasons.

The project has already been a huge success:

- ✓ All 52 clubs across the leagues have engaged in the blood donation campaign
- ✓ Over 250 direct appointments have been made to donate.
- ✓ Nearly 20,000 clicks have been made on our bespoke club links, directing our clubs and their supporters to their nearest donation sessions.
- ✓ 73,000 accounts reached to date via Facebook.
- ✓ The Welsh Blood Service will continue to support the partnership next season, which will also welcome 15 new clubs through the new Genero Adran Leagues.

10.0 PRIORITIES FOR PATIENT & DONOR EXPERIENCE IN 2021-22

The Trust will continue to actively seek feedback from patients and donors to help strengthen and improve our services.

We will continue with the rollout out of our new electronic feedback system that will enable participants to provide feedback through a channel of choice. This will provide

real-time insights that will enable us to immediately identify any issues, thus enabling a quicker response to undertaking any required remedial action.

We will continue to strengthen our processes for responding to and learning from concerns. This includes a continued focus on seeking to set up additional reports and dashboards in complaint management to improve current reporting requirements and continue to implement and train staff in the use of the Once for Wales reporting system. A training plan will be implemented to ensure that all staff receive training in the management of complaints.

We will also work to improve our Welsh language service to ensure an equal service is available for our Welsh speaking population.

11.0 CONCLUSION

Ensuring good patient and donor experience is at the heart of everything that we do. The constructive patient and donor feedback from 2020-2021 highlights this. It would be fair to say that the past year has been a new experience for everyone, bringing changes and adaptions required to keep staff, patients and donors safe during the COVID-19 Pandemic. Whilst at times, it has been testing for all involved, it has also provided us with opportunities to do things differently.

We have learnt so very much from what our patients and donors have told us over the past year, and have made improvements to our services as a result. We remain committed to ongoing improvements in patient and donor experience, and to truly working in partnership with the people we serve.

Velindre University NHS Trust

Quality, Safety & Performance Committee

Annual Report 2020-2021

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Foreword

Jan Pickles,

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

Independent Member

(2012-2021)

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

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

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

Jan Pickles

Nicola Williams,

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

Executive Lead for the Quality, Safety & Performance Committee

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

Nicola Williams

1. Introduction

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

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

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

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

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

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

2. Roles and Responsibilities

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

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

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

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

3. Agenda Planning Process

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

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

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

4. Terms of Reference and Operating Arrangements

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

5. Membership, Frequency and Attendance

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

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

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

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

6. Quality, Safety & Performance Committee Activity

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

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

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

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

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

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

6.1 Patient / Donor / Staff Stories

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

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

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

6.2 Divisional Assurance Mechanisms and Reports

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

6.3 Presentations

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

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

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

6.4 Policy Approvals

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

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

6.5 External Reviews, Internal Audit Reviews and Reports

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

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

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

6.6 Highlight Reports

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

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

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

6.7 Items ENDORSED for Board APPROVAL by the Committee

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

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

6.8 Risk Management and Safe Services

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

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

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

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

6.9 Strategy, Policy and Performance

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

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

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

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

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

6.10 Cycle of Business Review

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

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

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

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

1. NHS Wales Informatics Service

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

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

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

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

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

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

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

7. Discussion held in Part B / Private Committee

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

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

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

8. Reporting the Committee's Work

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

9. Quality, Safety & Performance Committee Annual Effectiveness Survey

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

9.1 Methodology

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

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

9.2 Findings

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

9.2.1 Survey question 1

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

Members:

The Committee is made up of 4 ‘Members’ i.e. Committee Chair and 3 Independent Members, all 4 ‘Members’ responded to the survey, providing an overall response rate of 100% by the Committee’s Members.

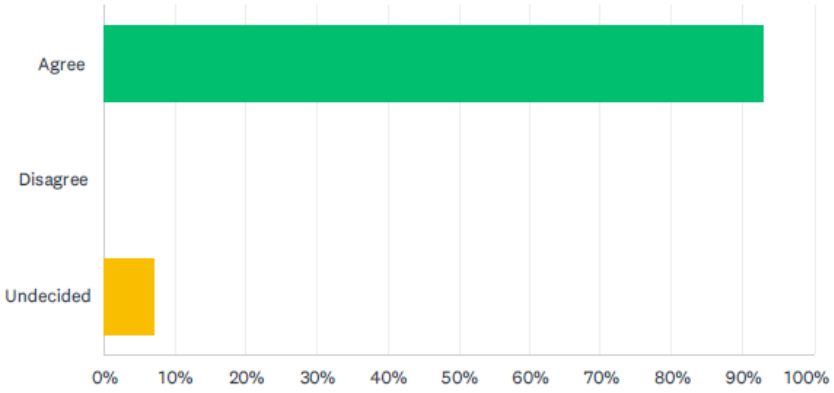
Regular Attendees:

In the Committee’s first year of operation there were a total of 16 ‘Regular Attendees’. This includes representatives of independent and partnership organisations and our regulators including, Healthcare Inspectorate Wales, Audit Wales and the Community Health Council. A total of 10 ‘Regular Attendees’ responded to the survey, providing an overall response rate of 62.5% by the Committee’s ‘Regular Attendees’.

9.2.2 Survey question 2

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

Answered: 14 Skipped: 0



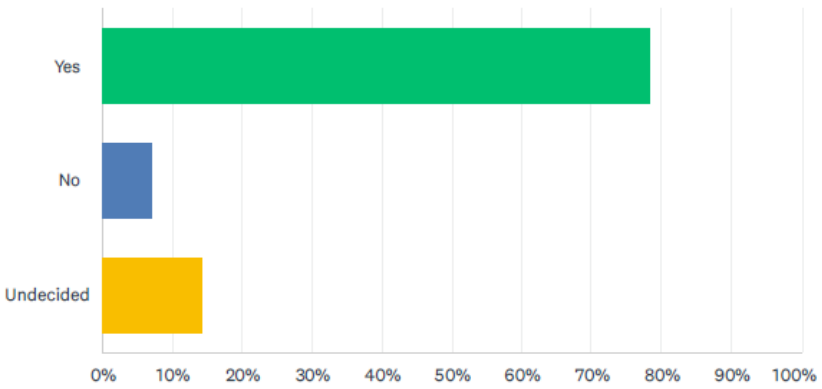
ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

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

9.2.3 Survey question 3

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

Answered: 14 Skipped: 0

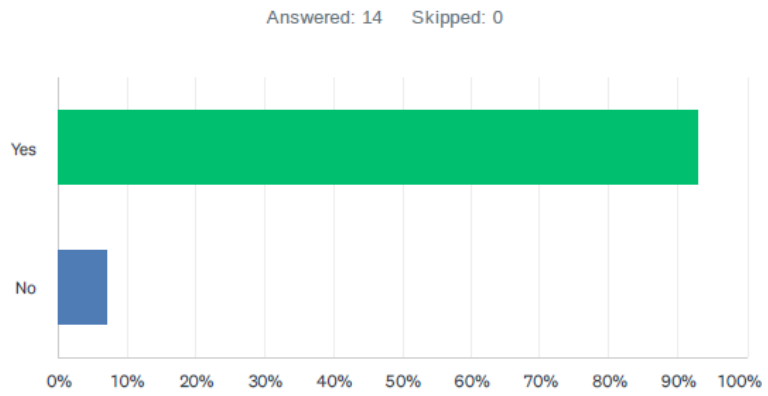


ANSWER CHOICES	RESPONSES	
Yes	78.57%	11
No	7.14%	1
Undecided	14.29%	2
TOTAL		14

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

9.2.4 Survey question 4

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

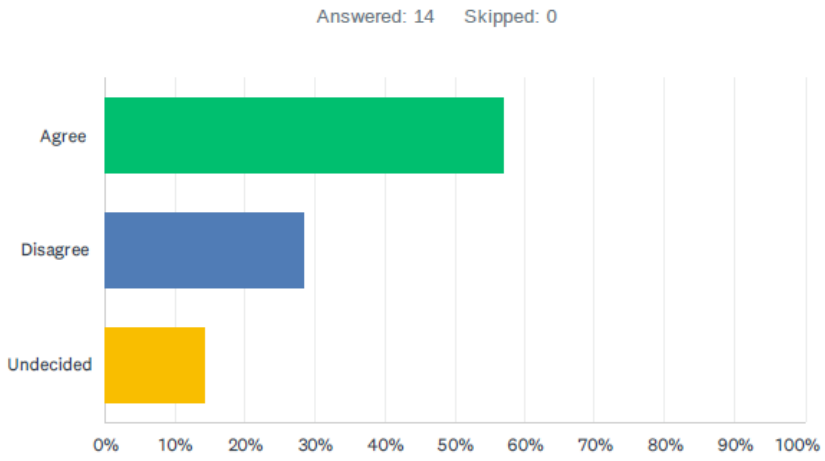


ANSWER CHOICES	RESPONSES	
Yes	92.86%	13
No	7.14%	1
TOTAL		14

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

9.2.5 Survey question 5

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



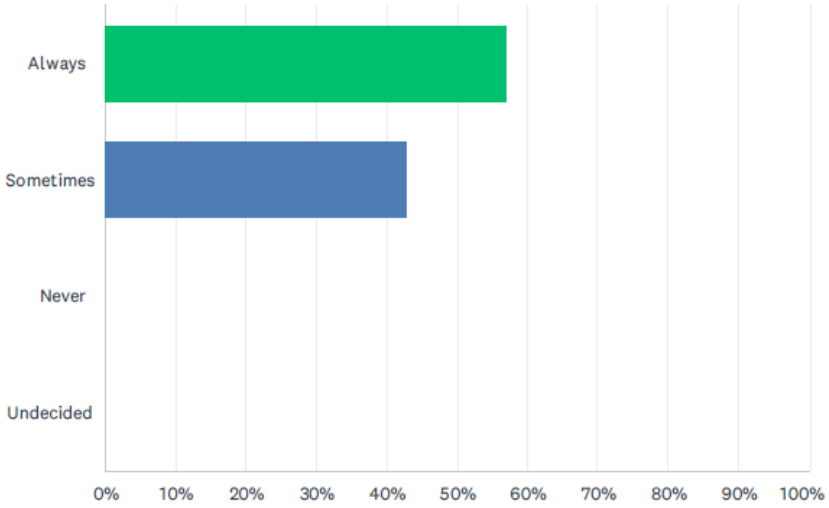
ANSWER CHOICES	RESPONSES	
Agree	57.14%	8
Disagree	28.57%	4
Undecided	14.29%	2
TOTAL		14

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

9.2.6 Survey question 6

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

Answered: 14 Skipped: 0

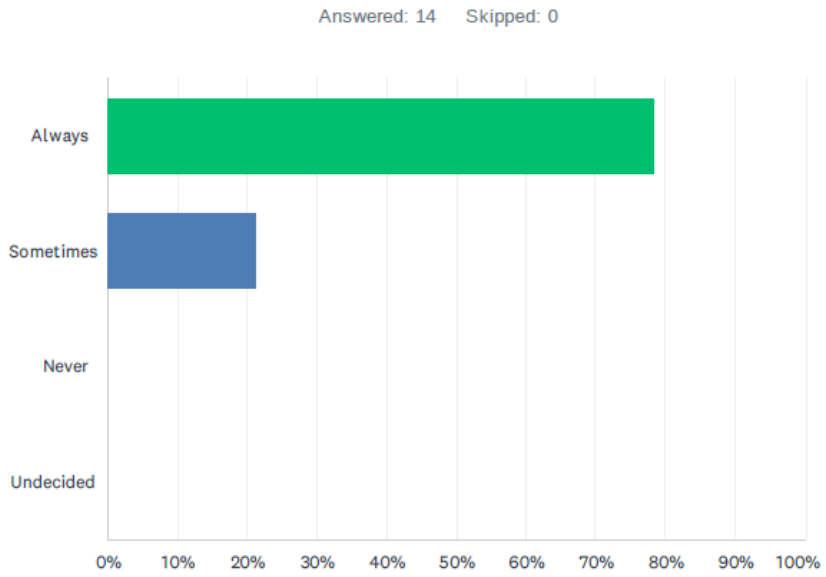


ANSWER CHOICES	RESPONSES	
Always	57.14%	8
Sometimes	42.86%	6
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.7 Survey question 7

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



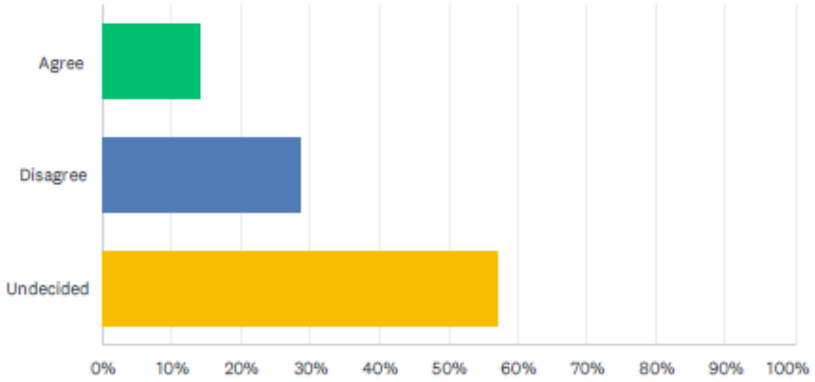
ANSWER CHOICES	RESPONSES	
Always	78.57%	11
Sometimes	21.43%	3
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.8 Survey question 8

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

Answered: 14 Skipped: 0

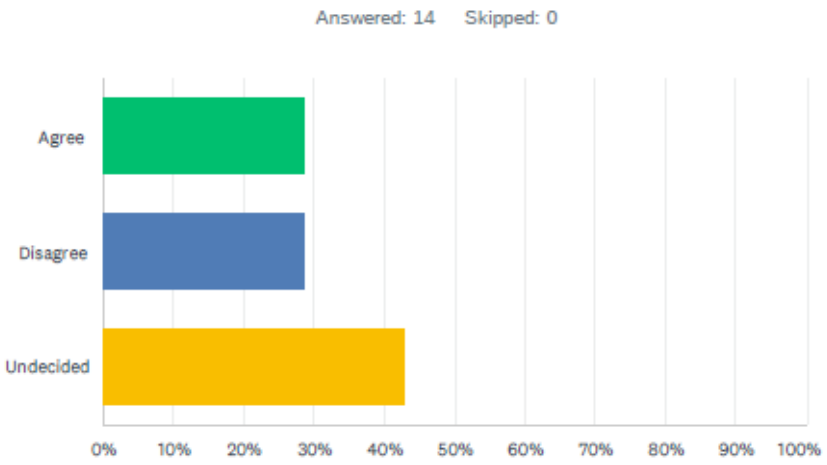


ANSWER CHOICES	RESPONSES	
Agree	14.29%	2
Disagree	28.57%	4
Undecided	57.14%	8
TOTAL		14

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

9.2.9 Survey question 9

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

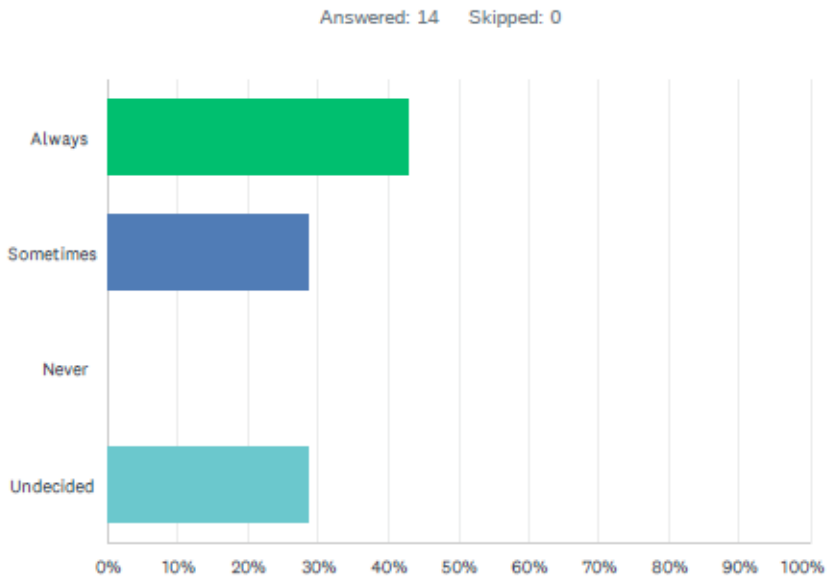


ANSWER CHOICES	RESPONSES	
Agree	28.57%	4
Disagree	28.57%	4
Undecided	42.86%	6
TOTAL		14

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

9.2.10 Survey question 10

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



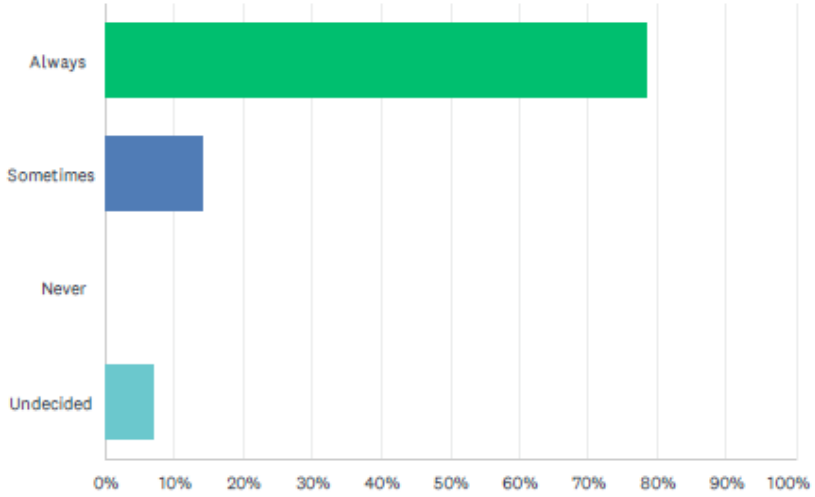
ANSWER CHOICES	RESPONSES	
Always	42.86%	6
Sometimes	28.57%	4
Never	0.00%	0
Undecided	28.57%	4
TOTAL		14

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

9.2.11 Survey question 11

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

Answered: 14 Skipped: 0

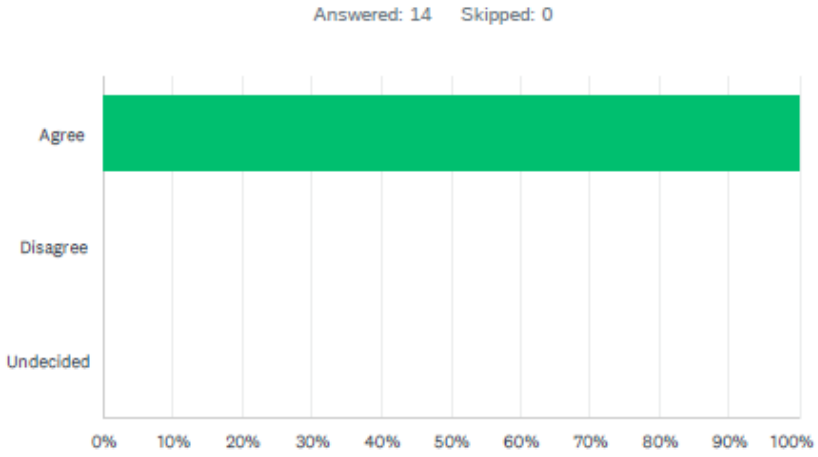


ANSWER CHOICES	RESPONSES	
Always	78.57%	11
Sometimes	14.29%	2
Never	0.00%	0
Undecided	7.14%	1
TOTAL		14

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

9.2.12 Survey question 12

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



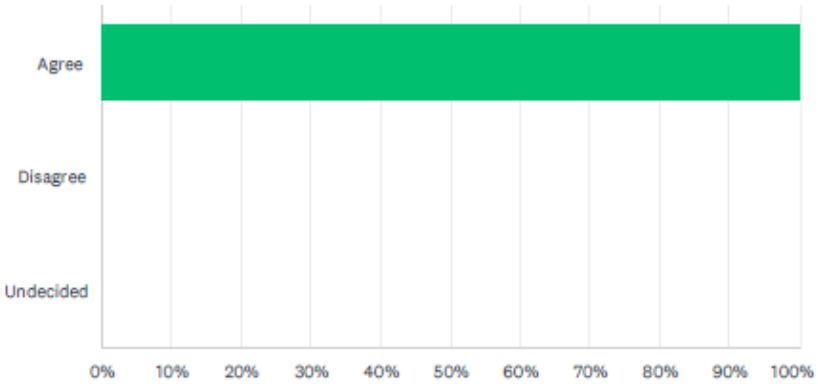
ANSWER CHOICES	RESPONSES	
Agree	100.00%	14
Disagree	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.13 Survey question 13

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

Answered: 14 Skipped: 0

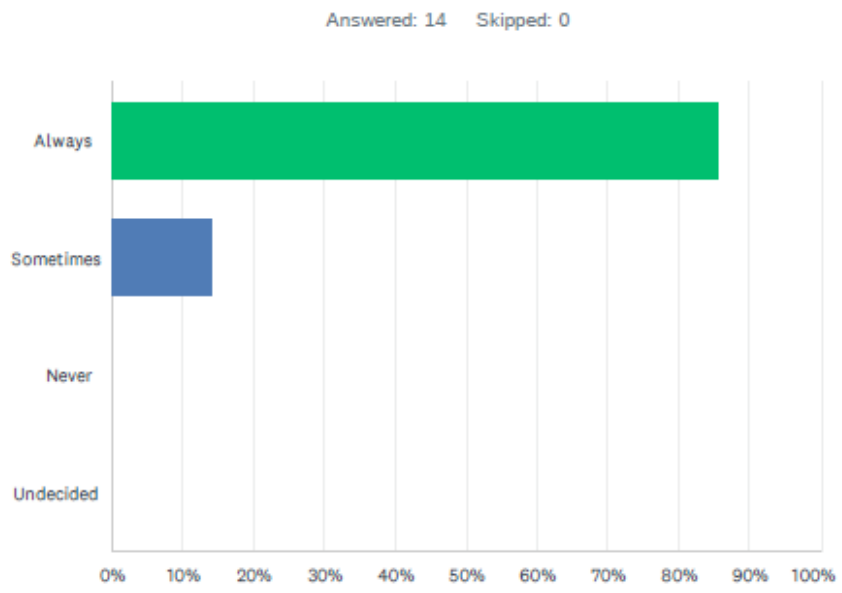


ANSWER CHOICES	RESPONSES	
Agree	100.00%	14
Disagree	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.14 Survey question 14

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

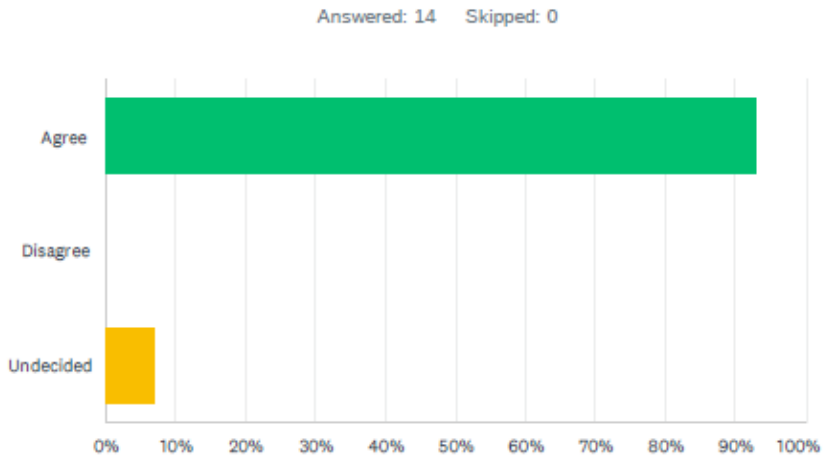


ANSWER CHOICES	RESPONSES	
Always	85.71%	12
Sometimes	14.29%	2
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.15 Survey question 15

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

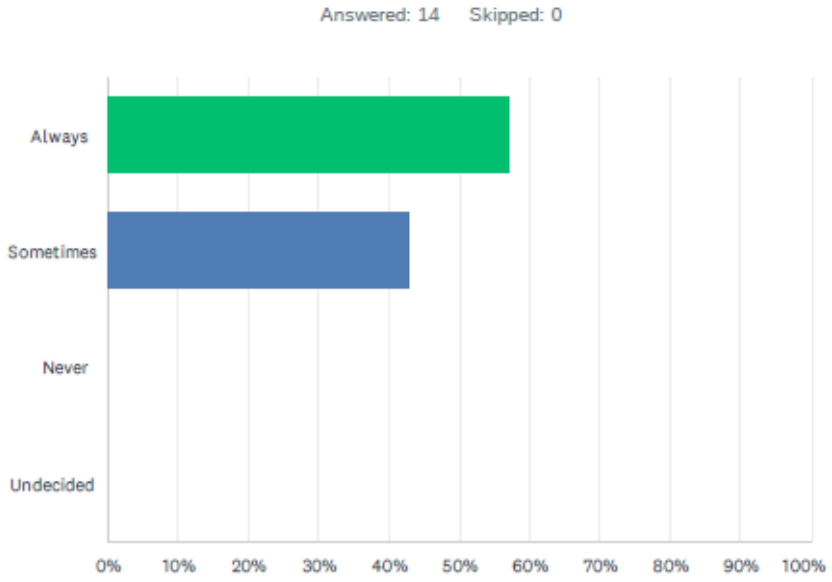


ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

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

9.2.16 Survey question 16

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



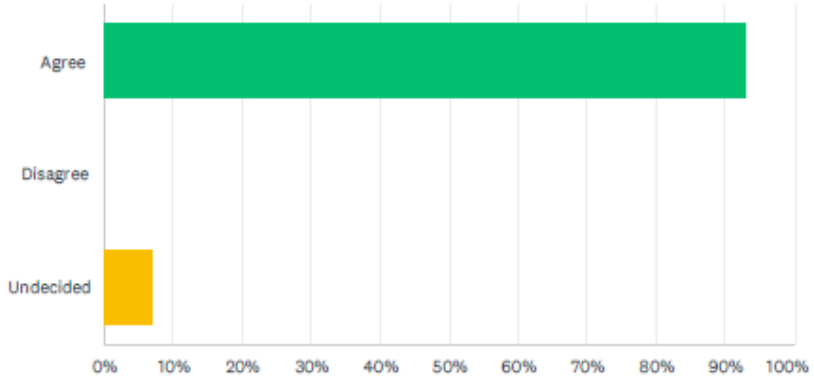
ANSWER CHOICES	RESPONSES	
Always	57.14%	8
Sometimes	42.86%	6
Never	0.00%	0
Undecided	0.00%	0
TOTAL		14

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

9.2.17 Survey question 17

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

Answered: 14 Skipped: 0

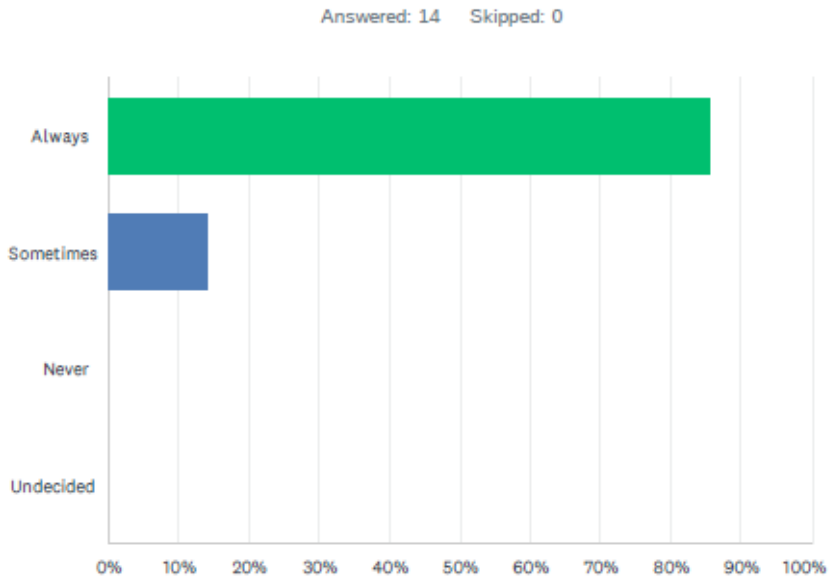


ANSWER CHOICES	RESPONSES	
Agree	92.86%	13
Disagree	0.00%	0
Undecided	7.14%	1
TOTAL		14

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

9.2.18 Survey question 18

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



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

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

10. Conclusions and way forward

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

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

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

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

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

END OF REPORT

TRUST BOARD

DELIVERING EXCELLENCE PERFORMANCE REPORT SEPTEMBER 2021

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Anna-Marie Jones, Business Support Manager Wayne Jenkins, Head of Planning and Performance Alan Prosser, Director WBS
PRESENTED BY	Cath O'Brien, Interim Chief Operating Officer
EXECUTIVE SPONSOR APPROVED	Cath O'Brien, 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**
WBS SMT MEETING	13.10.21	Noted
WBS PERFORMANCE REVIEW MEETING	20.10.21	Noted
VCC SLT MEETING	19.10.21	Noted
VCC PERFORMACE REVIEW MEETING	21.10.21	Noted
QS&P COMMITTEE	18.11.21	Noted

ACRONYMS	
VUNHST	Velindre University NHS Trust
UHB	University Health Board
VCC SLT	Velindre Cancer Centre Senior Leadership Team
WBS SMT	Welsh Blood Service Senior Management Team
PADR	Performance Appraisal and Development Review
KPIs	Key Performance Indicators
SACT	Systemic Anti-Cancer Therapy
WTE	Whole Time Equivalent (staff)
EMB	Executive Management Board
COSC	Clinical Oncology Sub-Committee stretch targets
SPC	Statistical Process Control

1. SITUATION/BACKGROUND

1.1 The attached Trust performance reports provide an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of September 2021 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Workforce and Wellbeing respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The reports set-out performance at Velindre Cancer Centre **(*appendix 1*)** and the Welsh Blood Service **(*appendix 2*)**. 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 VCC and WBS reports are highlighted below.

2.2 The divisional performance reports were initially presented to the WBS Senior Management Team (SMT) and VCC Senior Leadership team (SLT) and have been reviewed by the Chief Operating Officer, Cath O'Brien at the performance review meetings on the 20th of October for WBS and the 21st of October for VCC

2.3 Velindre Cancer Centre:

The continuing restrictions imposed by COVID19, absence of staff due to sickness, and increasing patient numbers are continuing to impact on services provided by us at VCC. We are expecting to get a surge in Breast referrals in January as a result of surgery planned in the Health Boards at present. We continue to look at the overall service challenge and also focus on each tumour site service to prioritise where the hotspots and pinch points will be during the expected surge.

6 targets were reporting red in September's performance report. These included all three COSC targets in radiotherapy (Scheduled Patients Beginning Radiotherapy Within 21-Days, Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days and Emergency Patients Beginning Radiotherapy Within 1-Day). Breaches were partly due to specific planning requests made by consultants, Brachytherapy capacity and booking/administrative issues.

The remaining three targets that were red were the National Target for waiting times for patients seen within 30 minutes of the Scheduled Appointment Times, occupational therapy outpatients seen within 6 Weeks and patient falls.

Radiotherapy Waiting Times

COSC targets were red for scheduled, urgent scheduled and emergency patients. The total number of referrals received in September 2021 (405) represented one of the busiest months ever in terms of new patient referrals received at VCC, far exceeding the average number received in any given month since the beginning of 2019.

163 patients referred for radiotherapy treatment with radical intent were scheduled to begin treatment in September. Of this total, 12 patients did not begin treatment within the 28 day; an overall performance rate of 92% (target is 98%). There is also concern that there is an increase in the number of patients who are waiting for a longer period of time (over 46 days). The delays are due to clinicians changing the treatment plan for patients. We will re-look at the review process for patients who are about to breach their targets to see what we can do to improve the situation. We are also looking to automate the breach patient information, so it will be easier to share among colleagues. It is important to note that we are engaging with patients and keeping them informed of the waits.

23 patients did not begin their palliative radiotherapy treatment within the 14-day target, so our overall performance rate was 74% (target is 98%). Request for and development of 3D conformal plans is the principle reason for treatment delays. 3D plans is an area of growing volume due to the potential for better patient outcomes through normal tissue sparing. A clinical decision is made with the patient for a more individual complex plan as a result. This is an area where there has not been specific capacity increased to meet the growing requirement. This is being prioritised by the service.

The COSC improvement group in radiotherapy has developed a plan outlining their approach with specific actions and timelines to carry out changes to the pathway to

support target compliance. The plans have been transferred to the Velindre Futures work stream for monitoring and follow up. Other mitigations to improve performance include filling posts in radiotherapy and radiotherapy physics. It is also important to note that social distancing and other infection control measures have reduced the capacity by 25% in the delivery of radiotherapy.

The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

For background information, since April 2021, we have been mandated by the Welsh Government to also report against the Clinical Oncology Sub Committee (COSC) targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway. The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Our systems are not currently designed to intuitively respond to both the criteria and time points for COSC as the patient pathways and the Radiotherapy planning and scheduling systems, have been designed to respond to the original RCR targets.

The relatively low performance within Velindre Cancer Centre and the other cancer centres across Wales against the COSC targets currently, does not mean that patients are waiting any longer than they were previously under the RCR targets, only that we have changed the way in which we now categorise patients. We are continuing to report against both measures for comparison at present and will continue to do so until the end of the financial year.

SACT Waiting Times

Both waiting times targets for SACT were met again for September.

For non-emergency patients treated within 21 days, 301 patients were referred, and 8 patients did not begin treatment within target. One patient started their treatment on day 29. The delays were due to capacity challenges and patients listed for treatment while awaiting further scans.

The delivery of the plan developed in conjunction with Aneurin Bevan UHB focused on reopening Neville Hall SACT delivery capacity has been delayed until November 2021 due to logistical and facility issues at Neville Hall. This is a key part of our surge capacity strategy and we are working with the Health Board to ensure readiness to meet that aim.

Outpatient waiting times

This target is reporting as red as we are not hitting the 30-minute target. It has remained steady this month at 53%. We will now be splitting the targets into waits from first arriving in the department both to consultant outpatient attendance and to phlebotomy separately and then the wait from phlebotomy reporting to seeing the consultant. The data has been collected for October and will be reflected in the next PMF as:

- Time to consultant only appointment.
- Time to blood test.
- Time from blood result posting to consultant appointment.

This will then align us with the national target which measures time waiting for a consultant appointment excluding phlebotomy.

We are also seeing more patients saying they prefer to come to Velindre for blood on the same day as their appointment as they do not have to travel to two separate healthcare settings. Some patients also need blood testing on the day, so the picture is a complex one.

All this information is being fed back into the overall PMF review. In addition, we are undertaking an outpatient space and design review to identify options for the best use of existing facilities to improve patient flow and experience.

Therapies

The occupational team were short of two members of staff which is the reason performance dropped to 33%. 4 patients requiring occupational therapy support were not seen within the 6-week routine outpatient target. We have now recruited two additional occupational therapists, with one already in place and the other due to start in November. No patient experienced any reported harm as a result of the delays described above.

Other areas

Falls – During September 2021 there were 2 falls reported on first floor ward, affecting 2 patients. In each instance, a full investigation was undertaken by the VCC Falls Scrutiny Panel. One fall was deemed unavoidable following investigation and the second has been identified as avoidable. For the avoidable fall, the patient was identified as 'at risk of falls' but no intervention was put in place to prevent this. Learning has been shared with the nursing team and also the importance of reassessing patients as conditions or environment changes.

Pressure Ulcers – There was 1 Velindre acquired pressure ulcers reported in September 2021. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Panel. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).

Healthcare Acquired Infections – No healthcare acquired infections were reported in September 2021

SEPSIS bundle NEWS score – Four patients met the criteria for sepsis treatment in September 2021. Of these, three patients received all elements of the sepsis bundle within one hour. The other patients Sepsis bundle was not completed fully as there was

no start clock time or signature. The incomplete record keeping was raised with the staff member who was dealing with the patient and a general reminder sent to all staff.

Further detailed performance data is provided in Appendix 1

2.4 Welsh Blood Service

Although continuing to maintain our services for our donors and patients, the Welsh Blood Service is managing a variety of challenges. We are currently experiencing high staff absences throughout the operation from collection team staff to laboratory staff across all grades. This is impacting on staff that are currently working and will also impact on longer term operational projects including validation of new equipment such as blood group analysers, software upgrades and procurement contracts.

In addition, blood collection has been under strain in September and has suffered from a combination of issues including delays getting to collection venues due to traffic problems, the fuel shortage, continuing social distancing at blood collections and high 'did not attend' (DNAs) rates which presents an added challenge as we prepare to build our stock ahead of the Christmas period.

Manufacturing Productivity is above the threshold target and whilst this appears to be a positive the underlying issue is staff sickness combined with a high vacancy factor and represents a service under pressure.

All demand for red cells was met, and all stock groups continued to be maintained above 3 days for September averaging at 1500 units per week which is close to pre pandemic demand.

There has been an increase in DNAs at clinics. We continue to txt donors to remind them of their appointments and we are discussing improvement to our donor engagement to mitigate this.

There was a high cancellation rate for stem cell collection in September. There were 3 cancellations at the preparation/work up stage and one failed medical, which has impacted the collection performance for this month. The new collection service will go live in the cancer centre in November.

Demand for platelets was also met despite demand being at pre COVID19 levels. There were 4 new apheresis donors in September 2021, bringing the total to 15 and exceeding our quarterly target of 14.

2.4.1 Recruitment of new bone marrow volunteers

There were 208 new bone marrow donors added to the Welsh Bone Marrow Donor Registry (WBMDR) this month, which is an increase on last month. It is important to note the inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment. The service was able to launch the recruitment of Bone marrow

donors via a buccal swab administration this month to help improve the performance going forwards.

2.4.2 Quality

Incidents closed within 30 days

There was a 10% decrease in performance in September compared to August; the number of incidents not closed within the required timeframe has increased from 6 in the previous three-month rolling period to 17 in this reporting period. This breaks down as 8 incidents in DATIX and 9 in Q-Pulse. The Q-pulse incidents have been particularly complex to investigate and identify the root cause, but all investigations are now complete with preventative actions in place and being monitored.

With regards to the Datix reports, it appears there is sometimes a gap of several days between the date the incidents were reported and the date they were opened (for review, investigation and close out); this prolongs the total time to closure. All reports were closed on the same day they were opened for review. The reason for the gap between reporting incidents into Datix Once for Wales and opening them for review will be explored further, but the lack of a comprehensive dashboard and reporting suite for managers has already been raised at the Datix project board. This issue, combined with the known risk of incidents being assigned to the wrong division, (WBS incidents being allocated to VCC and vice versa) has resulted in some incidents being difficult for managers to access and follow up. There have also been challenges with user access rights which are in the process of being resolved.

UK NEQAS for Histocompatibility & Immunogenetics were inspected by UKAS for compliance against ISO 17043 during September. The overall recommendation is that accreditation to the standard is retained. There were 3 mandatory findings, with no further recommendations.

Part Bag Rates

The combined 'Part Bag' rate for September remains within tolerance for the fifth consecutive month, at 2.76%. However, work with East A and East B teams are outside of this tolerance and work is ongoing to improve this performance.

Failed Venipuncture Rates

Failed Venipuncture (FVP) rate increased slightly this month to 1.58 % but remains within the tolerance threshold of 2%.

Number of Concerns Received

7,000 donors were registered at donation clinics in September 2021, with seven concerns (0.1%) reported in this period. All 7 concerns were managed within the required time as early resolution.

Donor Satisfaction

415 new donors completed a donation in September and overall donor satisfaction continues to exceed target satisfaction at 95.1%. In total there were 850 respondents who made a full donation and shared their donation experience.

Further detailed performance data is provided in Appendix 2

3.0 Workforce & Wellbeing

1. PADR compliance continues to grow steadily across the organisation with a 5.06% increase in the last 12 months from 68.61% in September 2020 to 73.67% in September 2021:

    a. WBS 78.03% Workforce Team continue to highlight PADR compliance in regular meetings with managers and reminder of PADR compliance will be added to next SMT
    b. VCC at 76.57% following September agreement for SLT to highlight September's figure decline in respective directorates there has been a rise in overall PADR compliance of 1.40%.

2. Sickness absence has once more seen a slight increase in monthly sickness absence for September 2021 at 5.14%. On a rolling 12-month basis (Oct 2020 – Sep 2021) sickness absence remains relatively stable with an average rate of 5.09%:

    a. WBS increase again to 7.19% with an increase in both short and long-term sickness absence has increased in to 1.96% and 5.23% respectively.
    b. VCC slight increase in figures to 5.43% Short-term sickness remains relatively low in VCC and has declined again to 1.49%. SLT have discovered not all departments are inputting absence data into ESR a spike in sickness % is expected as this is corrected.

3. Statutory & Mandatory training compliance has a very minor dip of 0.29% to 84.95%:

    a. WBS remain within compliance at 92.22% and will aim to continue
    b. VCC has steady increase in compliance with an overall increase of 5.10% in 12 months.

4. Job Planning – overall compliance 22.67%. WBS 100% compliant, VCC continue to progress with Job planning however recent IT issues have meant medical directorate are unable to input into ESR

4.0 IMPACT ASSESSMENT

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

5.0 RECOMMENDATION

5.1 Trust Board is asked to **NOTE** the contents of the attached performance reports.

Appendices

1. VCC May PMF Report
2. WBS May PMF Report
3. WOD PMF Report

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (September 2021)

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 6) ***(JCCO Measure)***	Actual	94%	91%	92%	95%	97%	92%	89%	95%	94%	97%	96%	92%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Palliative Radiotherapy Within 14-Days (page 8) ***(JCCO Measure)***	Actual	82%	91%	93%	90%	97%	90%	85%	95%	84%	82%	82%	74%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency Radiotherapy Within 2-Days (page 10) ***(JCCO Measure)***	Actual	97%	94%	93%	95%	97%	100%	97%	100%	100%	97%	100%	85%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 11) ***(COSC Measure)***	Actual							35%	28%	37%	35%	31%	27%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 11) ***(COSC Measure)***	Actual							41%	48%	40%	54%	52%	52%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 11) ***(COSC Measure)***	Actual							83%	88%	85%	82%	86%	82%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 14)	Actual	68%	79%	86%	79%	77%	88%	98%	98%	98%	99%	99%	98%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-	Actual	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	Days (page 16)	Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 20)	Actual	72%	93%	67%	66%	65%	57%	66%	79%	76%	76%	53%	53%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	2%	2%	2%	3%	2%	3%	3%	4%	4%	5%	5%	5%
		Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Therapies	Therapies Inpatients Seen Within 2 Working Days (page 23)	Actual (Dietetics)	95%	96%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Therapies Outpatient Referrals Seen Within 2 Weeks (page 23)	Actual (Dietetics)	98%	96%	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%

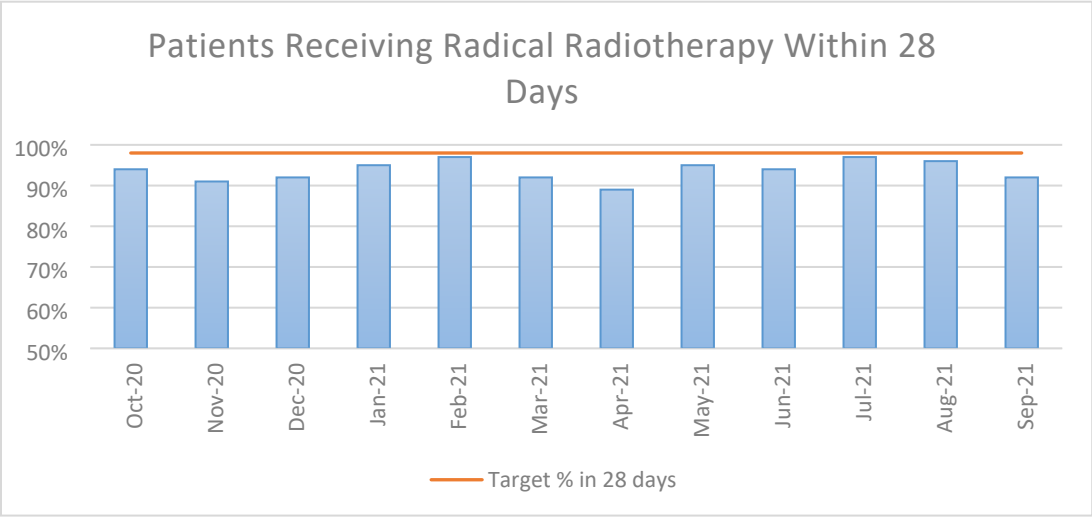
			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Routine Therapies Outpatients Seen Within 6 Weeks (page 23)	Actual (Dietetics)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Physiotherapy)	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	96%	33%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Safe and Reliable Care	Number of VCC Acquired, Avoidable Pressure Ulcers (page 25)	Actual	3	2	2	0	0	0	1	0	0	0	2	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Pressure Ulcers Reported to Welsh Government as Serious Incidents	Actual	0	0	0	0	0	0	1	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0

			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
	Number of VCC Inpatient Falls (page 27)	Actual (Total)	4	0	2	1	1	1	2	3	1	3	4	2
		Unavoidable	3	0	2	1	1	1	1	3	1	3	4	1
		Avoidable	1	0	0	0	0	0	1	0	0	0	0	1
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	1	1	0	0	0	0	0	0	0	0	1	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Potentially Avoidable Hospital Acquired Thromboses (HAT)	Actual	0	0	0	0	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Patients with a NEWS Score Greater to or Equal to Three Who Receive all 6 Elements in Required Timeframe (page 29)	Actual	100%	75%	100%	100%	100%	100%	100%	100%	100%	80%	100%	75%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 30)	Actual	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
Percentage of Patients Who Rate Experience at Velindre at 9 or Above		Actual	78%	85%	Routine Reporting Currently Interrupted									
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date	Actual	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%	98%	%
	Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

RAG rating above indicates: Green - Target was achieved. Amber - 85% Compliance or above. Red - Target not achieved.

Patients Receiving Radical Radiotherapy Within 28-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin radical radiotherapy treatment in September 2021 (163) exceeded the monthly average observed in 2020-21 (150) and was higher than the number scheduled to begin treatment in September 2020 (143).

Social distancing and other infection control measures present particular challenges in the delivery of radiotherapy. Capacity has been reduced by 25% due to these COVID precautions.

163 patients referred for radiotherapy treatment with radical intent were scheduled to begin treatment in September. Of this total, 12 patients did not begin treatment within the 28 day target constituting an overall performance rate of **92%.**

The 12 patients who did not begin treatment within 28 days, commenced their treatment at the following points:

Treatment Intent	≤ 35 days	≤ 40 days	≥ 46 days
Radical (28-day target)	4	3	5

Summary of delays:
A combination of very specific planning clinic requests made by consultants, Brachytherapy treatment capacity and Booking challenges.

Of the patients waiting over 46 Days, Brachytherapy and Urological capacity was the prime reason.

Action:

- Delay reasons to be reviewed with clinical teams.
- Brachytherapy expansion business case being written to obtain support for increased capacity with WHSCC.

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (September 2021)
Radical	167	150	163
	Patients Scheduled to Begin Treatment (September 2019)	Patients Scheduled to Begin Treatment (September 2020)	
	163	143	

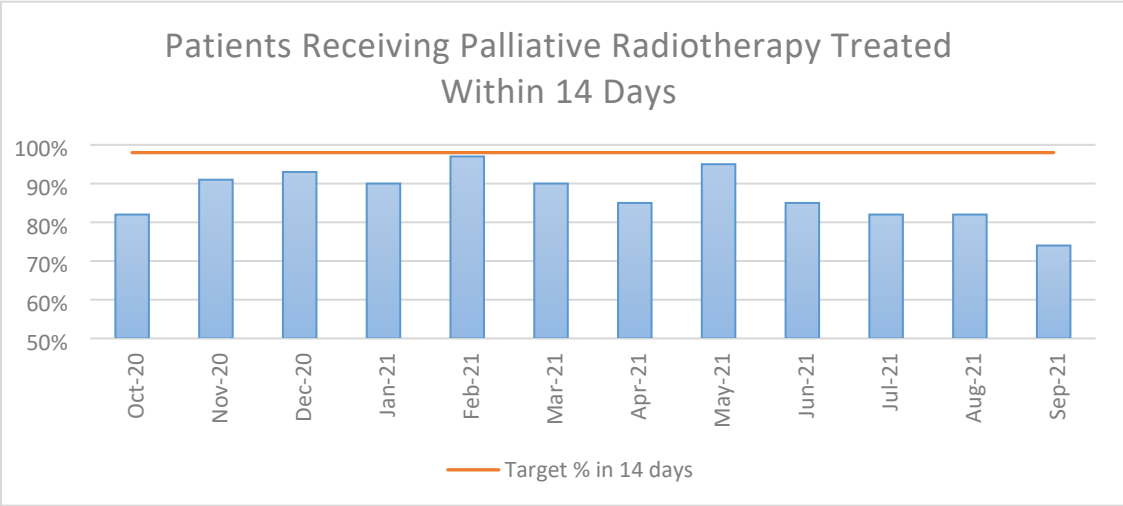
Wider Actions

- Radiotherapy short and long-term workforce requirements under review.
- Further demand modelling ongoing, aim is to maximise the service's ability to anticipate and to react to changes in demand for radiotherapy. (October 2021).
- Radiotherapy patient pathway project initiated. Project will identify efficiencies for implementation and areas for overall improvement. Meetings continue to take place on a fortnightly basis (October-November 2021).
- Project initiated to identify process issues and ensure timely delineation of plans (October 2021).
- Implementation of COSC targets: Head and Neck patients currently on 21 day pathway. Development of options appraisal and implementation plan to identify steps required to move to this target for all SST's (October 2021).

Patients Receiving Palliative Radiotherapy Within 14-Days

Target: 98%

Trend



The number of patients scheduled to begin palliative radiotherapy treatment in September 2021 (90) exceeded the monthly average observed in 2020-21 (74) and was higher than the number scheduled to begin treatment in September 2020 (76).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (September 2021)
Palliative	82	74	90
	Patients Scheduled to Begin Treatment (September 2019)	Patients Scheduled to Begin Treatment (September 2020)	
	75	76	

SLT Lead: Radiotherapy Services Manager

Current Performance

90 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in September. Of this total, 23 patients did not begin treatment within the 14 day target constituting an overall performance rate of **74%.**

The 19 patients who did not begin treatment within 14 days, commenced their treatment as follows:

Treatment Intent	≤ 20 days	≤ 25 days	≥ 26 days
Palliative (14-day target)	7	12	4

Summary of delays:

- Request for and development of 3D conformal plans (12) is the principle reason for treatment delays.

3D plans is an area of growing volume due to the potential for better patient outcomes through normal tissue sparing.
A clinical decision is made with the patient for a more individual complex plan as a result.

Action:

- 3D plan capacity plan to be developed with clinical team as they are the major cause of breaches.

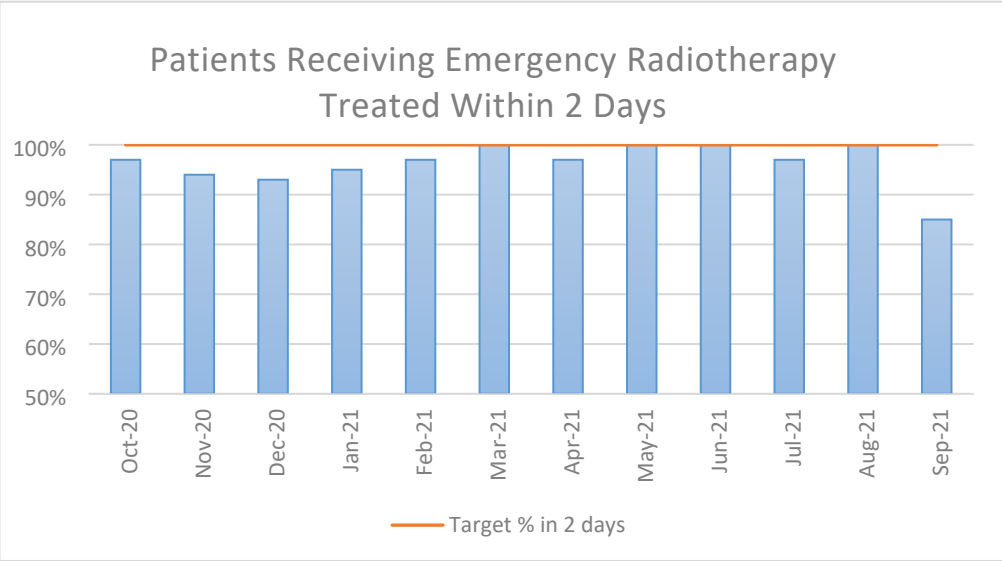
	Wider Actions
	• Radiotherapy short and long-term workforce requirements under review. • Further demand modelling ongoing, aim is to maximise the service's ability to anticipate and to react to changes in demand for radiotherapy. (October 2021). • Radiotherapy patient pathway project initiated. Project will identify efficiencies for implementation and areas for overall improvement. Meetings continue to take place on a fortnightly basis (October-November 2021). • Project initiated to identify process issues and ensure timely delineation of plans (October 2021). • Implementation of COSC targets: Head and Neck patients currently on 21 day pathway. Development of options appraisal and implementation plan to identify steps required to move to this target for all SST's (October 2021).

Patients Receiving Emergency Radiotherapy Within 2-Days

Target: 98%

SLT Lead: Radiotherapy Services Manager

Trend



The number of patients scheduled to begin emergency radiotherapy treatment in September 2021 (28) exceeded the monthly average observed in 2020-21 (27) and the number scheduled to begin treatment in September 2020 (23).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (September 2021)
Emergency	25	27	28
	Patients Scheduled to Begin Treatment (September 2019)	Patients Scheduled to Begin Treatment (September 2020)	
	30	23	

Current Performance

28 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in September 2021. 2 patients did not begin radiotherapy treatment within 2 days of referral constituting an overall performance of **85%.**

Treatment Intent	Day 3	Day 4
Emergency (2-day target)	1	1

Summary of delays:

- Change of treatment intent from palliative to emergency.

Actions

Radiotherapy – Operational Context

Latest Performance Consolidated

Measure		Target	VCC Sep-21	SBUHB Jun-21	BCUHB Jun-21
Radical (28-day target)		98%	**92%**	**70%**	**92%**
Scheduled (21-day target)	COSC	80%	**27%**	**31%**	**53%**
Palliative (14-day target)		98%	**74%**	**87%**	**91%**
Urgent (7-day target)	COSC	80%	**52%**	**45%**	**41%**
Emergency (within 2-days)		100%	**93%**	**100%**	**67%**
Emergency (within 1-day)	COSC	100%	**82%**	**100%**	**100%**

The table shown here sets out the latest available performance of the 3 Wales centres relative to the extant time to radiotherapy targets based on Royal College of Radiologists best practice guidance and the novel Clinical Oncology Sub-Committee (COSC) stretch targets.
The two other centres commenced COSC implementation a year earlier than VCC. Despite that VCC is outperforming both centres on the 7 day target.

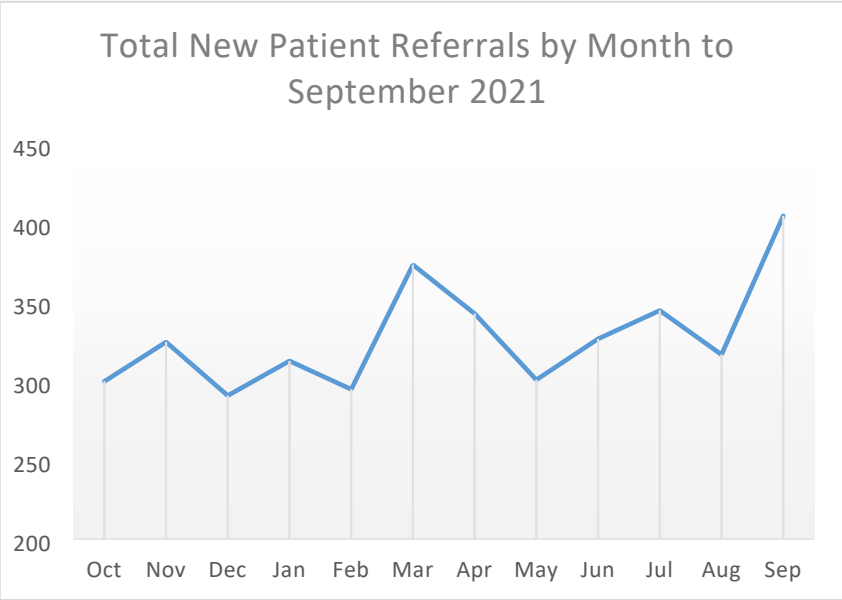
Clinical Oncology Sub-Committee (COSC) Time to Radiotherapy Targets

- Velindre Cancer Centre continues to report good Radiotherapy performance against UK agreed targets as set by the Royal College of Radiologists (RCR), particularly given that we are continuing to deliver services within a COVID driven reduced capacity.
- Since April 2021, we have been mandated by the Welsh Government to also report against the Clinical Oncology Sub Committee (COSC) targets. These targets align more closely with the direction of travel for reporting against the Single Cancer Pathway.
- The COSC targets present different criteria and different time points of reporting (Scheduled, Urgent and Emergency- within 1 day). Our systems are not currently designed to intuitively respond to both the criteria and time points for COSC as the patient pathways and the Radiotherapy planning and scheduling systems, have been designed to respond to the original RCR targets.
- The relatively low performance within Velindre Cancer Centre and the other cancer centres across Wales against the COSC targets currently, does not mean that patients are waiting any longer than they were previously under the RCR targets, only that we have changed the way in which we now categorise patients. We are continuing to report against both measures for comparison at present.
- Work is underway to ensure that we can accurately manage patients and report against these newly adopted COSC measures and to ensure our patient pathways are redesigned in order to meet the new criteria definitions.
- The challenge in meeting the revised COSC targets may require significant investment from our commissioners, to enable us to implement the changes required over and above patient pathway efficiency improvements that are already being worked through.

The table below describes the allocation of individual patients scheduled to begin treatment in terms of the new COSC definitions for September 2021:

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
159	86	27

Referral Trends - Overall



Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (September 2021)
357	315	405

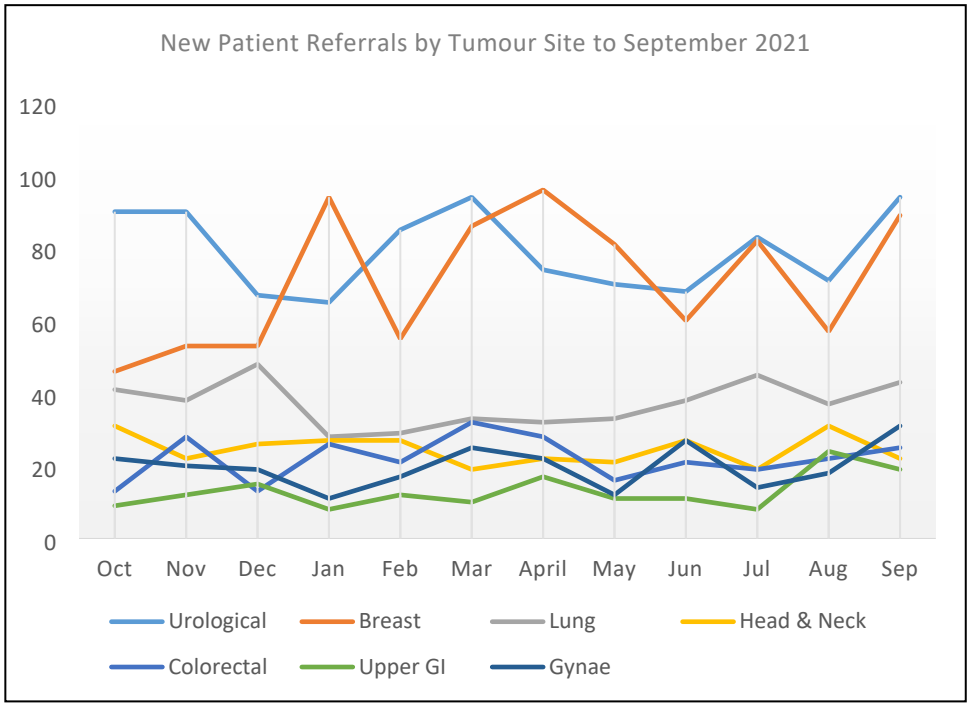
The total number of referrals received in September 2021 (405) represented one of the busiest months ever in terms of new patient referrals received at VCC. The number of new referrals far exceeded the average number received in any given month in 2020/21 (315) and the number received in August 2021 (317).

It has been observed that, historically, new patient referrals tend to increase in September relative to July and August. However, the step change in demand observed was drastic. Forecasting carried out by the VCC Business Intelligence team indicated that a relative peak in new referrals could be expected in September.

The number of referrals received in September 2021 was the largest number observed in a single month since January 2019 (423). The upturn was driven by increased demand relative to the majority of tumour sites.

Radiotherapy – Operational Context

Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patients (September 2021)
Breast	**88**	**60**	**-32%**	89
Urology	**82**	**82**	**0%**	94
Lung	**47**	**38**	**-19%**	43
Colorectal	**20**	**22**	**+10%**	25
Head and Neck	**23**	**23**	**0%**	22
Gynaecological	**18**	**18**	**0%**	31
Upper Gastrointestinal	**16**	**13**	**- 19%**	19
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		78%

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

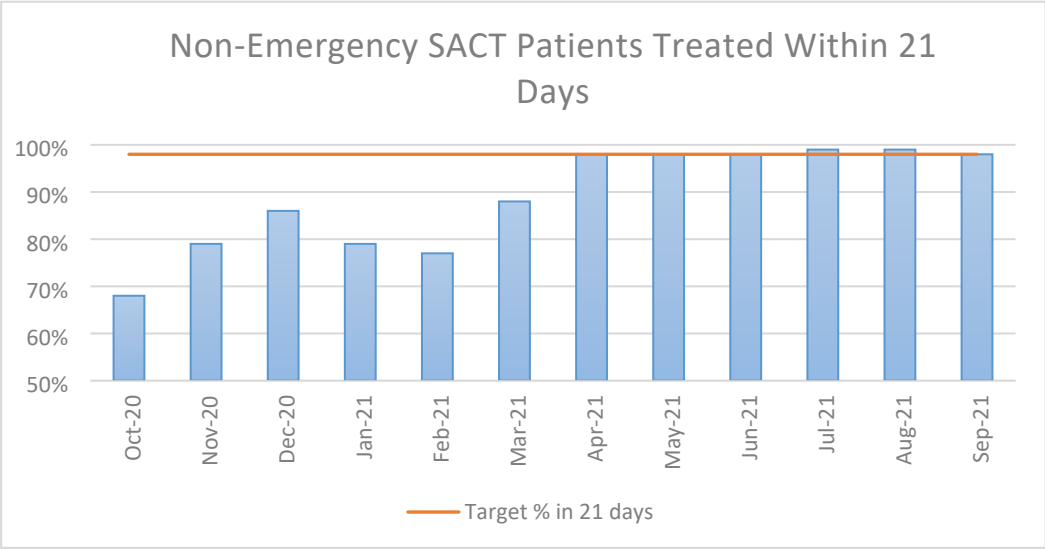
- Referrals overall and across most tumour sites now back to pre Covid levels.
- Surges in referrals weekly from health boards occurring across individual tumour sites, impacting on our ability to meet demand in a timely fashion. Engagement with health boards ongoing to understand their backlog clearance plans.
- All options being explored by SSTs to meet short term surges and to respond to health board backlog clearance.

Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



The number of patients scheduled to begin non-emergency SACT treatment in September 2021 (301) was above the monthly average observed in 2020-21 (298) and exceeded the number scheduled to begin treatment in September 2020 (252).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (September 2021)
Non - emergency	328	298	301
	Patients Scheduled to Begin Treatment (September 2019)	Patients Scheduled to Begin Treatment (September 2020)	
		252	

Trend

301 patients referred for non-emergency SACT treatment were scheduled to begin treatment in September. Of this total, 8 patients did not begin treatment within the 21 day target, due to capacity challenges, constituting an overall performance rate of 98%.

The 8 patients who did not begin treatment within 21 days, commenced their treatment as follows:

Treatment Intent	21 – 28 days	29 - 35 days
Non-emergency (21-day target)	7	1 (treated on day 29)

Actions

This position has been achieved through:

- Improvements in booking processes.
- Maximising capacity through pre-empting non-attendance rates and overbooking to a compensatory level.
- Improved utilisation of chair capacity across VCC site.
- Additional day on Tenovus mobile unit.
- Increases in oral SACT volumes.
- Streamlined management of non-chair activity, eg Sub cutaneous injections.

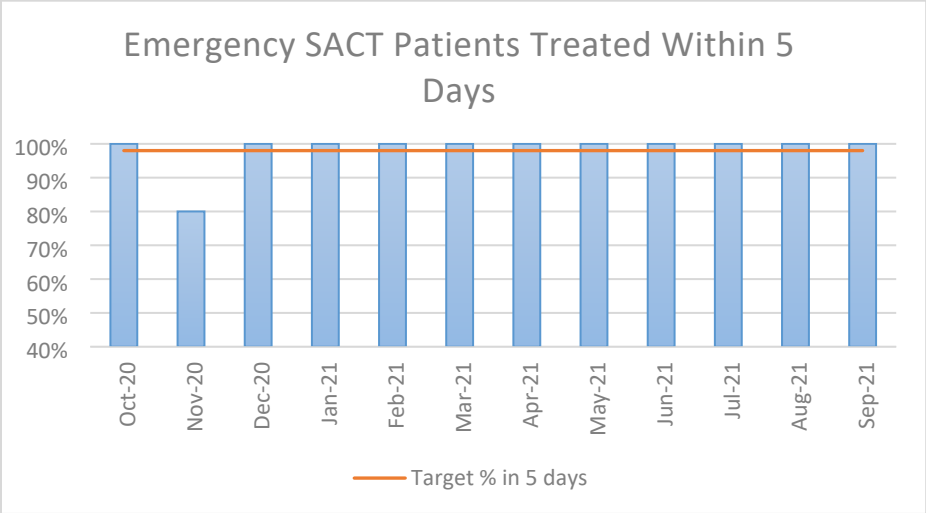
Delivery of plan focused on reopening Neville Hall SACT delivery capacity (Delayed from May 2021. Anticipated delivery in November 2021 due to facility and logistical issues at Neville Hall).

Emergency SACT Patients Treated Within 5-Days

Target: 98%

SLT Lead: Chief Pharmacist

Current Performance



The number of patients scheduled to begin emergency SACT treatment in September 2021 (3) was below the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (September 2021)
Emergency	4	4	3
	Patients Scheduled to Begin Treatment (September 2019)	Patients Scheduled to Begin Treatment (September 2020)	
		9	

Trend

3 patients referred for emergency SACT treatment were scheduled to begin treatment in September 2021. All patients began treatment within the target time.

- Ring fencing of emergency chair capacity has allowed us to improve the compliance in this area. This took a number of months until the correct balance between ring fencing and chair utilisation was achieved.

Actions

- Continue to balance demand and ring fencing with capacity.

SACT – Operational Context

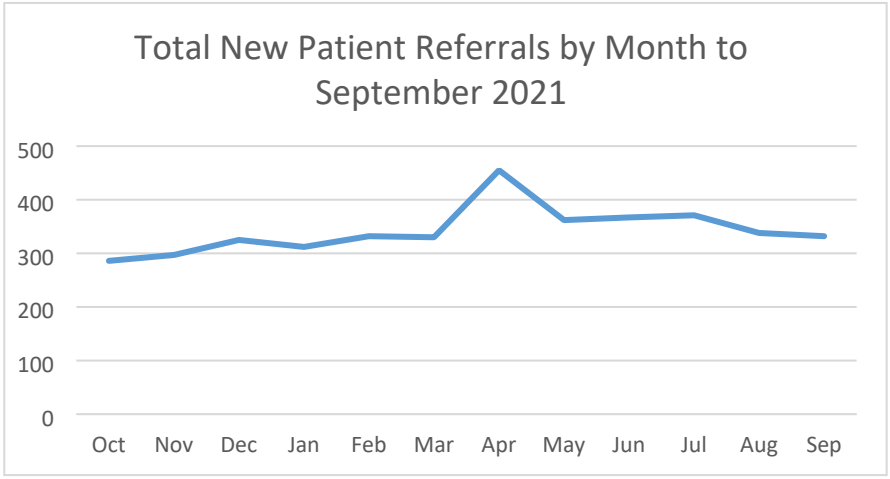
Current Performance Consolidated

Measure	Target	Sep-21
Non-emergency (21-day target)	98%	**98%**
Emergency (5-day target)	98%	**100%**

The table shown here sets-out performance relative to the extant time to SACT targets.

Social distancing and other infection control measures present particular challenges in the delivery of SACT. Additionally, overall delivery capacity remains restricted. All services, previously delivered in outreach contexts, were repatriated to VCC in response to the pandemic. With the exception of a limited service at the Macmillan Unit at the Prince Charles Hospital in Merthyr Tydfil, this remains the case.

Referral Trends - Overall



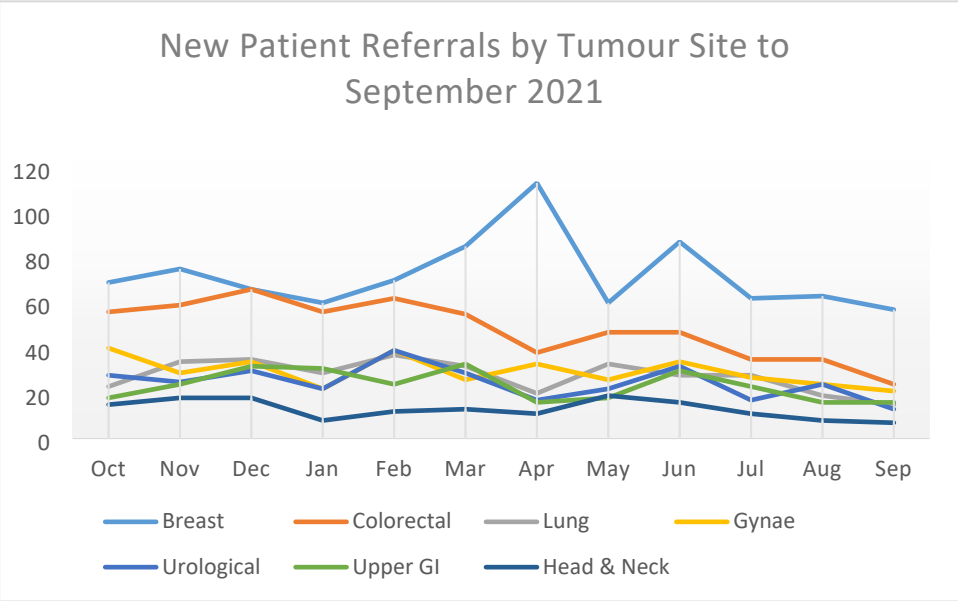
Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (September 2021)
325	301	332

The total number of referrals received in September 2021 (332) was above the average number received in any given month during 2020-21 (301). The number of referrals received in September also exceeds the average number received per month in 2019-20.

Referrals fell dramatically following the first national lock-down in March 2020. Subsequently, referrals have returned to pre-pandemic levels.
Referrals include new patients for 1st definitive treatment and repeat treatments for patients mid cycle or on a revised treatment cycle.

SACT – Operational Context

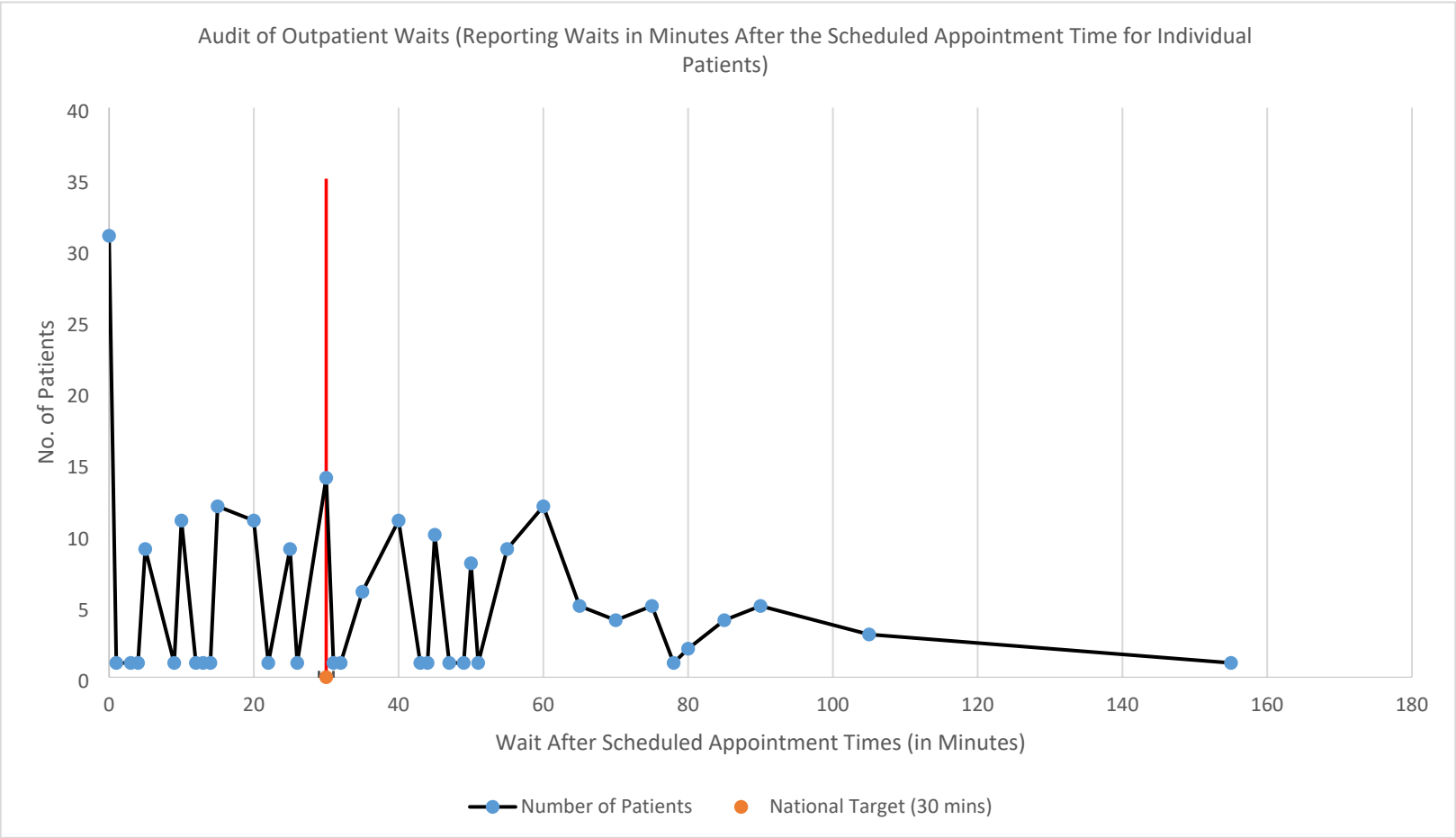
Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (September 2021)
Breast	**92**	**76**	**-17%**	57
Colorectal	**54**	**55**	**+2%**	24
Lung	**33**	**32**	**-3%**	15
Gynaecological	**31**	**31**	**0**	21
Urological	**36**	**26**	**-28%**	13
Upper Gastrointestinal	**18**	**26**	**+44%**	16
Head and Neck	**16**	**14**	**-12%**	7
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		46%

The graph and table show referrals for the tumour sites most commonly referred for SACT treatment.
SACT referrals are being driven by a high level of internal demand as a result of new/combination regimens, increasing patient treatment cycles etc.

New Patient, Other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target)	
Target: 100%	**SLT Lead: Director of Operations**
Current Performance	



Total	No. of Patients Subject to No Wait	Median Wait (50% of Patients Seen)	Mean (Average) Wait	No. of Patients Seen Within 30 Minutes	Longest Wait
199	31 (16%)	30 minutes	34 minutes	106 (53%)	155 minutes (1 patient)

This data is obtained from a manual data collection exercise undertaken by nursing staff for one week each month. This can result in some clinic and waiting time data not being fully captured. The exercise relates only to face-to-face appointments and does not capture virtual interactions
We will now be splitting the targets into waits from first arriving in the department both to consultant outpatient attendance and to phlebotomy separately and then the wait from phlebotomy reporting to seeing the consultant. The data has been collected for October and will be reflected in the next PMF as:-

- Time to consultant only appointment.
- Time to blood test.
- Time from blood result posting to consultant appointment.

This will then align us with the national target which measures time waiting for a consultant appointment excluding phlebotomy.

NB. All patients waiting over 10 minutes are reviewed by the Outpatient Department management team to access reasons and to identify improvement actions are required.

Trend	Actions
Outpatient activity delivered in outreach contexts prior to the advent of the COVID-19 pandemic was repatriated to VCC. Demand for phlebotomy services at VCC, typically delivered in primary and secondary care contexts prior to the pandemic, continues to be extremely high. Longest patient wait (155 minutes) was a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant. The ratio of face-to-face to virtual appointments remains at approximately 50:50. Vacutainer supply issues have delayed the repatriation of some phlebotomy activity to primary care contexts.	• Capital funding to be used to scope departmental needs and design requirements was approved by Executive Management Board in July 2021. A consultant has been commissioned to undertake work and to develop options. A preferred option is to be identified (October 2021).

Equitable and Timely Access to Services - Therapies	
Target: 100%	**SLT Lead: Head of Nursing**

Current Performance

Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dietetics	98%	96%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

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

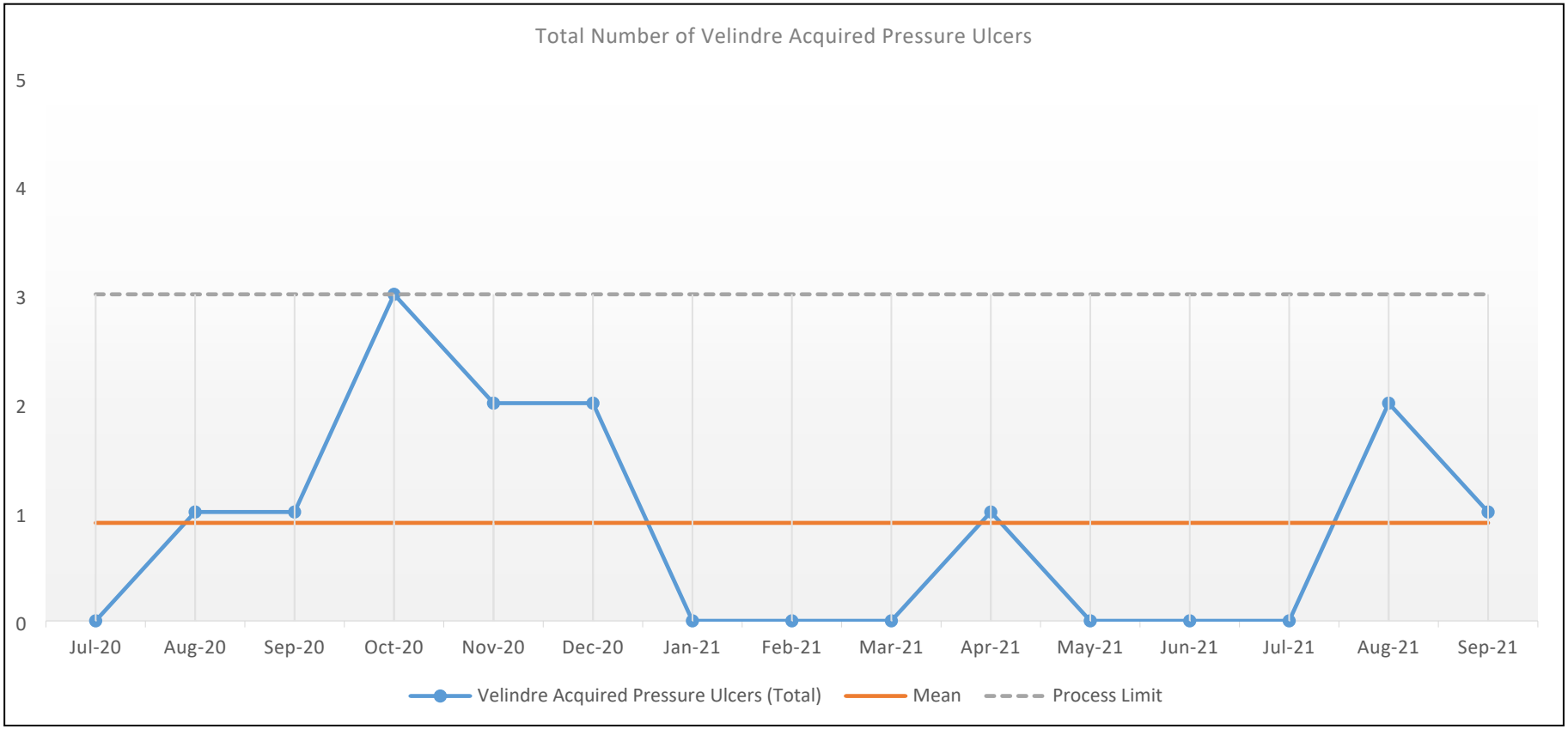
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dietetics	98%	96%	97%	100%	100%	100%	100%	100%	84%	94%	94%	98%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	96%	33%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%	100%

Trend	Action
1 dietetic patients were not seen within the 2 week urgent outpatient referral target. The patient was seen early in the third week following referral. No patient experienced any reported harm as a result of the delay. 4 patients requiring occupational therapy support were not seen within the 6 week routine outpatient target. This was due to restricted capacity – the occupational therapy team has been running with two vacancies. No patient experienced any reported harm as a result of the delays described above.	• Recruitment of two additional occupational therapists was successful. One team member has commenced with the second starting November 1st 2021.

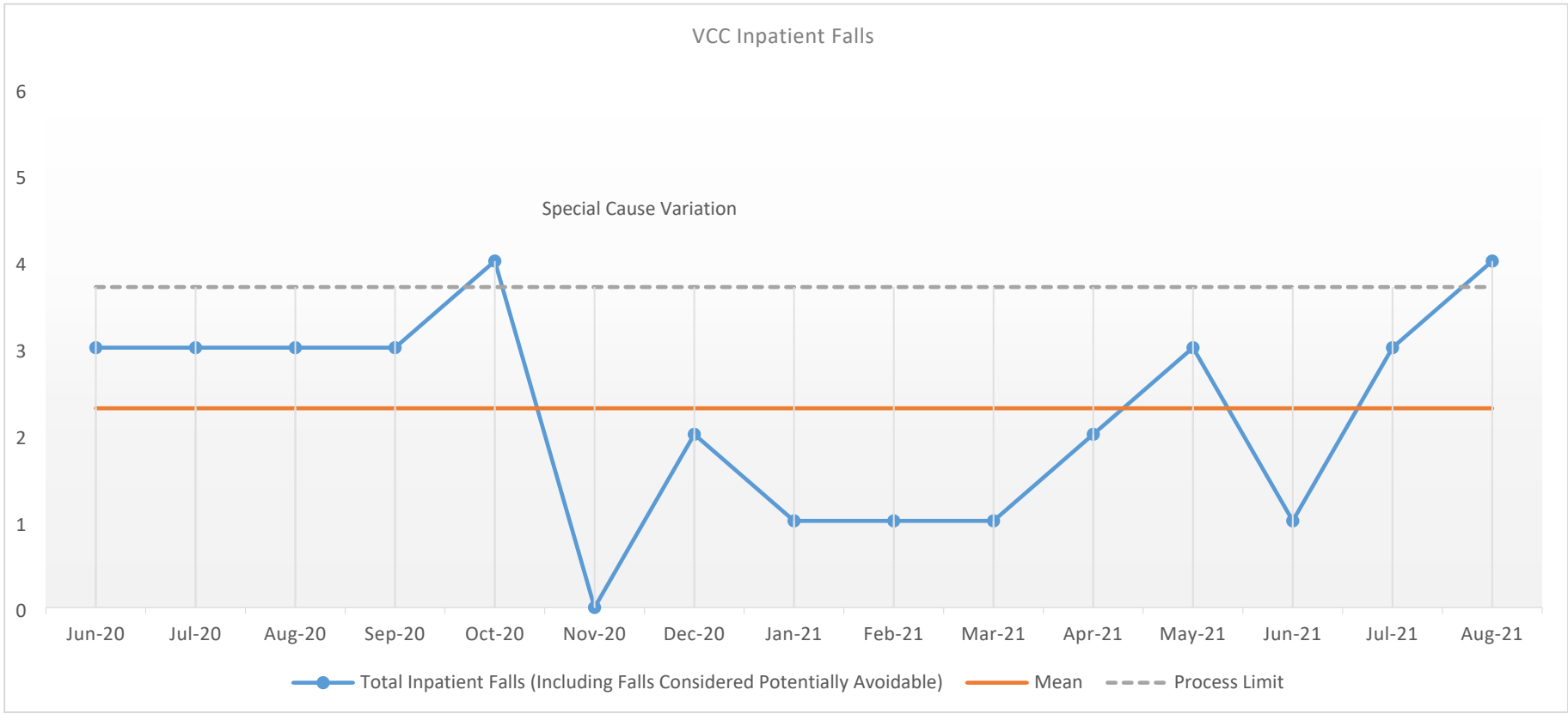
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Velindre Acquired Pressure Ulcers (Total)	0	1	1	3	2	2	0	0	0	1	0	0	0	2	1
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0

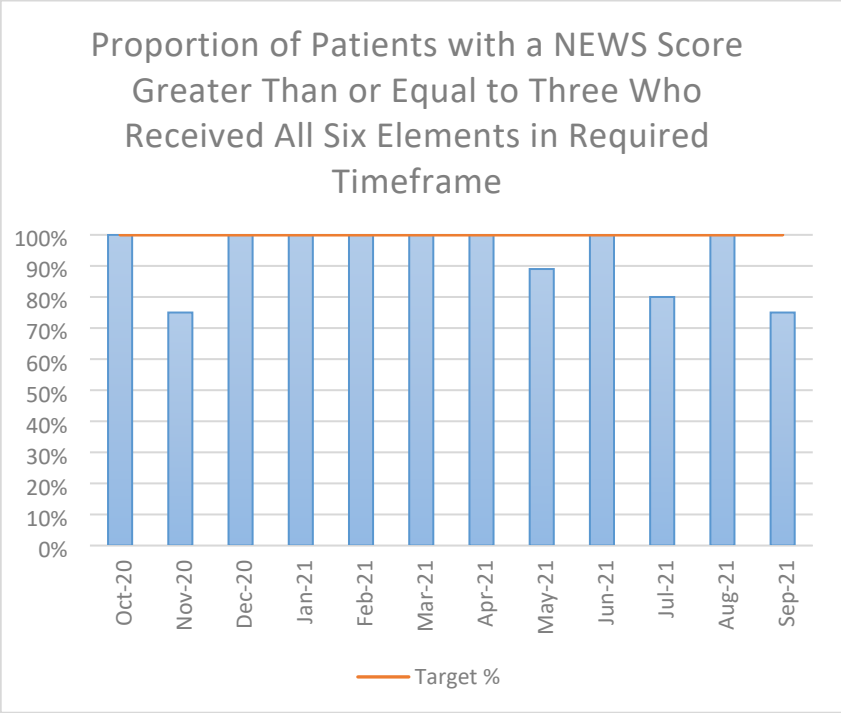
Trend	Action
There was 1 Velindre acquired pressure ulcers reported in September 2021. The ulcer was deemed unavoidable by the VCC Pressure Ulcer Panel. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	• The patient was assessed for pressure ulcer risk within six hours of admission, as required. • The patient was nursed with an appropriate mattress system to minimise likelihood of a pressure ulcer occurring. • The patient was subject to skin inspections every six hours when areas of skin deterioration were identified. • When ulcer was identified, the mattress system was upgraded and a repose wedge introduced. Inspections took place every four hours thereafter. • The Panel, on review, commended the observational skills of the nurse and the actions taken when the ulcer was identified.

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



	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Total Inpatient Falls	3	3	3	4	0	2	1	1	1	2	3	1	3	4	2
Potentially Avoidable Inpatient Falls	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1

Trend	Action
During September 2021 there were 2 falls reported on first floor ward, affecting 2 patients: One fall was deemed unavoidable following investigation and the second has been identified as avoidable. In each instance, a full investigation was undertaken by the VCC Falls Scrutiny Panel.	In both cases, the patient was the subject of a falls risk assessment on admission. • In the case of the unavoidable fall, the patient the patient mobilised independently contrary to their care plan. The patient was subject to a medical review and was deemed not to have sustained any injuries. Periodic, post-fall observations were undertaken and recorded in accordance with the post-fall pathway process. • In the case of the avoidable fall, the patient had been identified as being at risk of falls, but the Falls Scrutiny Panel found that insufficient measures had been put in place to avoid such an event. The patient mobilised independently, did not use the nurse call bell and fell. The patient was subjected to a post-fall review by the medical and the physiotherapy teams. The patient incurred a minor graze. Periodic, post-fall observations were undertaken and recorded in accordance with the post-fall pathway process.

Patients with a NEWS Score Greater Than or Equal to Three Who Receive All 6 Elements in Required Timeframe	
Target: 100%	**SMT Lead: Clinical Director**
Current Performance	Trend
	Four patients met the criteria for sepsis treatment in September 2021. Of these, three patients received all elements of the sepsis bundle within one hour. The other patients Sepsis bundle was not completed fully – There was no start the clock time or signature. The other patients Sepsis bundle was not completed fully as there was record entered of the start time. No harm was experienced by the patient who did not receive the full bundle within an hour.
	Actions
	The incomplete record keeping was raised with the staff member who was dealing with the patient and a general reminder sent to all staff.

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
C.diff	0	0	0	1	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	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
No healthcare acquired infections were reported in September 2021.	

Welsh Blood Service Monthly Report

September 2021

Gwasanaeth Gwaed Cymru
Welsh Blood Service

- All demand for red cells was met, and all stock groups continued to be maintained above 3 days for September averaging at 1500 units per week.
- All clinical demand for platelets was met, and continues to be at pre Covid levels (approx. 200 units per week).
- There was an increase in the numberof new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) reaching 208 for September. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment.
- At 97%, the turnaround time for routine Antenatal tests in September remains above the target of 90%.
- There is an 11% improvement on the Red Cell testing metric for September compared to August, and work continues to be prioritised based on clinical need with all compatibility testing (>55% of referrals) completed to the required time/date.
- Whole Blood Collection productivity is at 0.93 for September. Additional staffing was again deployed to add resilience at some larger clinics impacting this efficiency metric for September. Meanwhile the ongoing COVID 19 response need to resource Triage at donation clinics also continues to affect productivity.
- At 2.76% the combined 'Part Bag' rate for September remains within tolerance for the fifth consecutive month. Failed Venepuncture (FVP) rate increased slightly to 1.58 % but remains within the tolerance threshold of 2%.
- There were no mandatory reports of Serious Adverse Events (SAE) reported to the regulators and licensing authorities in September.
- In September overall donor satisfaction continued to exceed target satisfaction at 95.1%. In total there were 850 respondents who made a full donation and shared their donation experience, 155 were from North Wales and 594 were from South Wales.
- There were 4 new apheresis donors in September 2021, making a total of 15 new apheresis donors, exceeding the qaurterly target of 14.
- The manufactoring efficiency figure of 477.01 reflects departmental staffing challenges during this month. Factors that impacted on the September metric include; staff vacancies, recruitment process, absence/sickness levels and ongoing training of new staff
- In September approximately 7,000 donors were registered at donation clinics, with seven concerns (0.1%) reported in this period. All seven concerns were managed within the required time as early resolution.

5 Key Performance Indicators were above the previous month's performance

7 Key Performance Indicators remained the same as the previous month's performance, 7 achieved target.

9 Key Performance Indicators were down on the previous month's performance, with 6 achieving target..

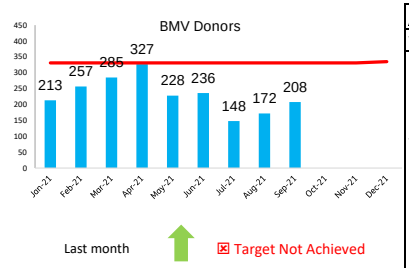
Reference Table

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

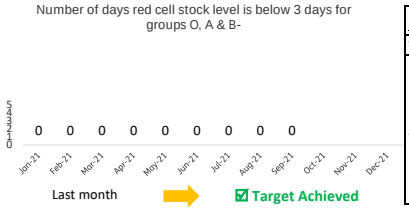
Sep-21



Annual Target: 4000 (ave 333 per month)	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Action (s) being taken to improve performance	By When
There were 208 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in September. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new BMV's (Bone Marrow Volunteers).	The new donor recruitment and retention strategy for the WBMDR became live on 03/08/2021. Further work to raise the public awareness of the strategy to support the desired increase in volunteers is currently being reviewed. WBS to agree on the methods used to raise the level of awareness across the public.	The new system is live as of 03/08/2021

Safe and Reliable Service

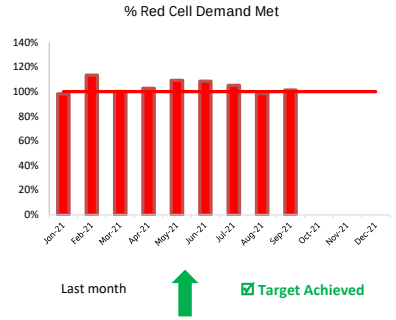
Sep-21



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 continue to be maintained above 3 days for September.	Daily Resilience meetings held between blood collection and manufacturing teams continues to facilitate operational responses to the challenges in maintaining adequate stock levels to minimise blood shortages.	Business as Usual, reviewed daily

Safe and Reliable service

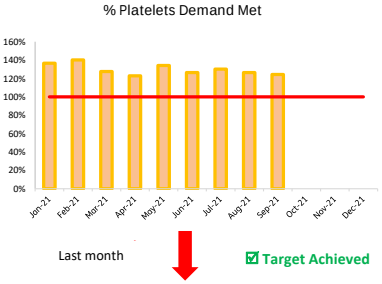
Sep-21



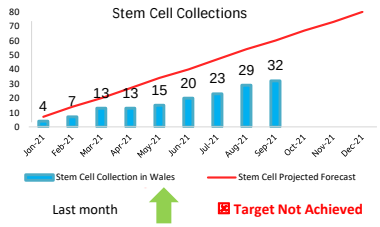
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All demand for red cells was met. Communications between the Collections and Laboratory teams continues to enable agile responses to variations of stock levels and service needs. Demand in September (full weeks) averaged at 1500 units per week.	Daily Resilience meetings between blood collection and manufacturing teams continues to facilitate operational actions in maintaining adequate stock levels in order to minimise blood shortages.	Business as Usual, reviewed daily

Safe and Reliable service

Sep-21



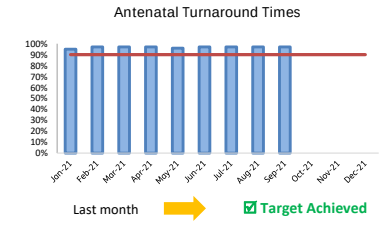
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Platelet demand was 205 units per week on average and remains at Pre Covid levels.	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production continue to be made to align with demand.	Business as Usual, reviewed daily



Safe and Reliable service

Sep-21

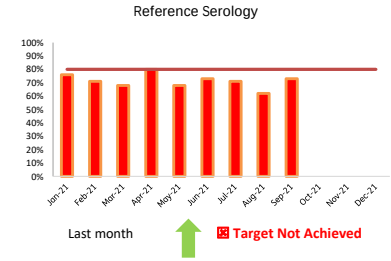
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 3 Stem Cell Collections in September, all by the Peripheral Blood Stem Cells (PBSC) collection method. NOTE: WBS also performed 1 x Peripheral Bood Lymphocyte collection (PBL). There were 3 cancellations at the preparation/work up stage and one failed medical, which has impacted on collection performance for September, and the Year to Date target.	The process to fit out the rooms in VCC to replace the apheresis stem cell collection service previously supported through St Josephs continues. In the interim, the service is being provided from the Nuffield Hospital in the Vale, and the new service from VCC is on track to 'go-live' in October 2021. Define and agree future strategy for Stem Cell collection as part of wider review of future strategy for the WBMDR.	October 2021 31/03/2022



Safe and Reliable service

Sep-21

Monthly Target: 90%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 97%, the turnaround time for routine Antenatal tests in September remains above the target of 90% Continued monitoring and active management remains in place.	Continuation of existing processes are maintaining high performance against current target.	Business as Usual, reviewed daily



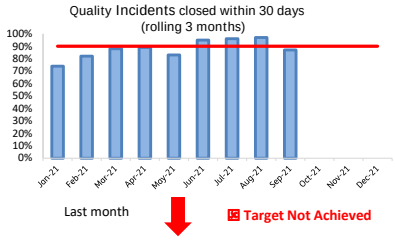
Safe and Reliable service

Sep-21

Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There is an 11% improvement on this metric for September. Work continues to be prioritised based on clinical need, and all compatibility testing (>55% of referrals) was completed to the required time/date. There were 258 hospital patient referrals in September 2021 compared to average of 181 in 2020.	A review of complex patient referrals will be undertaken as part of a laboratory modernisation project which is currently being scoped. This work was suspended due to COVID, but is now recommencing. The implementation of a project aimed to increase automation in RCI (Red Cell Immunohematology) is also anticipated to improve performance in this area.	Date yet to be decided due to scoping project.

Safe and Reliable service

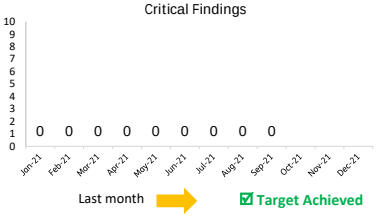
Sep-21



Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Incidents closed within 30 days has dropped below target. There are two main reasons behind this; A number of complex GMP incidents have occurred which required detailed multidisciplinary investigations in order to properly rectify the root cause, these have now all been completed and closed. In addition, difficulties with user access to and lack of reporting dashboards from the Datix Once for Wales system have caused some incident closures to slip beyond their target date for closure. User access issues have been partially resolved, dashboards and reporting remain outstanding and with the project team for resolution.	The revised process for managing low-impact incidents was implemented on 1st June, new reports are reviewed and risk assessed daily and the majority of incidents are fully closed within a few days of reporting. The Datix User Access and Reporting issues have been escalated to the Datix Project Board for resolution.	Continue with close monitoring.

Safe and Reliable service

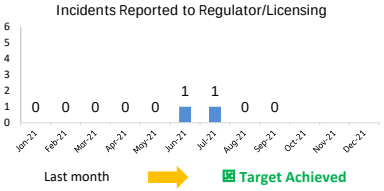
Sep-21



What are the reasons for performance?	Action(s) being taken to improve performance	By When
UK NEQAS for Histocompatibility & Immunogenetics were inspected by UKAS for compliance against ISO 17043 during September. There were 3 mandatory findings, with no further recommendations. Of the 3 findings, 2 will require a submission of evidence to UKAS before the 18th of October, to detail the changes being implemented to address these findings. The overall recommendation is that accreditation to the standard is retained.	Actions from previous MHRA and UKAS inspections are being managed as business as usual via action plans.	Evidence to be submitted to UKAS by 18th October 2021.

Safe and Reliable service

Sep-21



Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no mandatory reports of Serious Adverse Events (SAE) reported to the regulators and licensing authorities in September.	No further action required	N/A

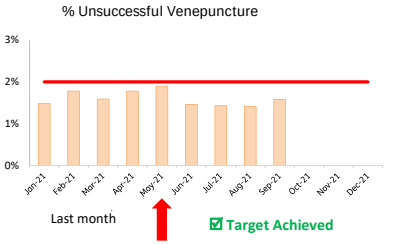
Spending Every Pound Well

Sep-21

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 2.76% for September, the combined 'Part Bag' rate remains within the required tolerance level. Analysis of the data indicates that South Wales East A and East B teams are over tolerance for September 2021 (3.7% and 3.8% respectivley). Causes of Part Bag are various and include: needle placement, donor is unwell, donor request to stop donation, and equipment failure. This is a separate factor to FVPs. Further work to ascertain the reasons for the performance of the South Wales East A & East B teams is taking place, including analysing collection dates, the types of clinic where 'events' occured and the performance of individual venepuncturists involved to identify any trends emerging.	Close monitoring of part bag rates (overall and by team) continues. Further work to identify the reasons for the tolerance breach for South Wales East A and East B teams is taking place. If trends are identified, interventions will be actioned, e.g. for venepunctruists with higher levels of issues identified, individual support plan will be put in place by the Ops team.	Monthly monitoring and reporting continues. Work with Ops Team - 31/10/2021

Spending Every Pound Well

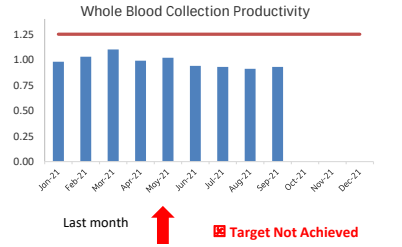
Sep-21



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 for September 2021 is at 1.58 % and remains within the tolerance threshold of 2%. FVP rates remain higher on the Wrexham Team 2.1%, however improvement has been seen in recent Months. North Wales Operational management continue to review performance to identify any further improvement work required within this specific team.	Ongoing monitoring of FVP rates continues with performance trend analysis taking place. So far analaysis of the situation on the Wrexham team has identified the need for support for a small number of venupuncturists with higher FVP rates and an action plan to support them is underway with improvement being seen, (3.9% in May and 2.1% in September.). The north Wales Operations Manager and Training R.N. link continue to monitor this situation closely.	Monthly monitoring with continued focus upon Wrexham team performance rates.

Spending Every Pound Well

Sep-21



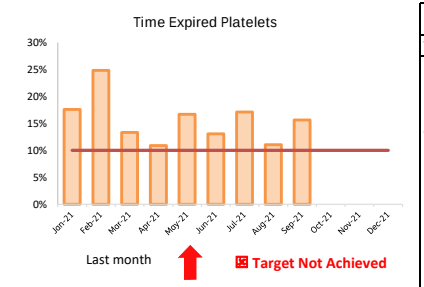
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Collection productivity continues to be below target, at 0.93 for September. The ongoing COVID 19 response requirement to resource the additional Triage role on donation clinics will also continue to affect productivity. In addition to this, throughout September there has been an small degree of overstaffing in order to add resilience at some larger clinics.	Staffing requirement for donation clinics continue to be monitored in line with WG and PHW guidance on social distancing and IPC measures. Adjustments to increase productivity will be made in accordance with any relaxation of these measures.	Quarter 4 2021/22

Spending Every Pound Well

Monthly Target 392	SMT Lead: Tracey Rees	
What are the reasons for performance?	Actions(s) bring taken to improve performance	By When
The September figure of 477.01 is a reflection of the departmental staffing challenges during this month; factors that impacted on the availability of staff include staff vacancies, recruitment process, absence/sickness levels and ongoing training activities of new staff. Blood collections have remained relatively stable compared to August.	This target measures the manufacturing productivity by assessing the staffing levels against the number of blood components being manufactured. Active management of vacancies and staff absence/sickness, participation in recruitment and retention initiatives is taking place.	Dec-21

Spending Every Pound Well

Sep-21



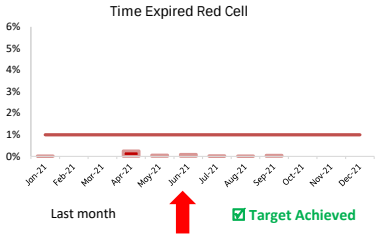
Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There was excees time expiry of platelets following the August Bank Holiday impacting on the September measure. Production of platelets is increased prior to bank holidays to account for additional uncertainty of platelet demand due the loss of the collection day.	Ongoing platelet production will continue to be based in line with required daily targets, leading to decreased platelet expiry percentages.	Ongoing and reviewed daily

Spending Every Pound Well

Sep-21

Monthly Target: Maximum 0.5%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Controllable losses for September are at 0.12% and remain within tolerance to be below 0.5%. The losses were (units): Automated Blood Press:3 Heat Seal Failure:3 Poor Packing: 1 Storage: 1	Reporting and management of incidents, ongoing monitoring of losses when occurring and lessons learned analysis takes place. The metric for September is within tolerance and represents a very low percentage of processed units.	Business as Usual, reviewed monthly

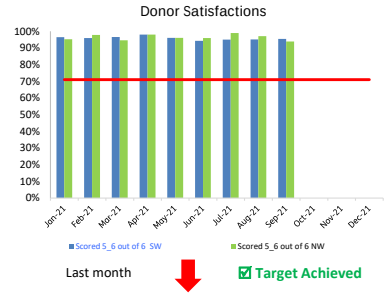
Spending Every Pound Well



Sep-21

Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Red cell expiry remains within tolerance and very low.	Monitoring continues	Business as usual, reviewed daily

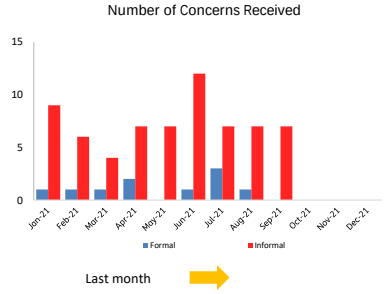
First Class Donor Experience



Sep-21

Monthly Target: Minimum 71%	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In September overall donor satisfaction continued to exceed target at 95.1%. In total there were 850 respondents, who had made a full donation and shared their donation experience, 155 were from North Wales and 594 were from South Wales (where location was able to be defined).	Findings to be reported to management at Collections meeting for actions from individual teams.	Business as usual, reviewed monthly

First Class Donor Experience

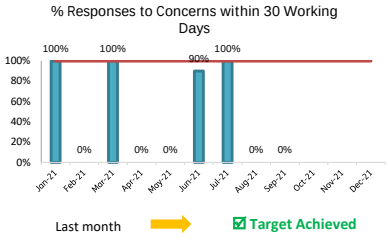


Sep-21

Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In September 2021, approximately 7,000 donors were registered at donation clinics. Seven concerns (0.1%) were reported within this period, all 7 concerns were managed in timeline as early resolution, and included: 1. Lack of information for donors on Website around receiving a (PCR/lateral flow test) 2. Donor not happy with updated SAHH question asking for donors asigned sex at birth 3. Donor turned away, too soon to donate. 4. Donor expresed concerns about staff members inappropriate conversation around Covid-19 5. Discomfort and pain following cannulation X 3	Actions taken to address Concerns: 1. (FAQ) and 'Can I Donate' section of Website to be updated to reflect this query 2. Letter sent to donor explaining the importance of such information as Male and Female donors have different blood components (ensuring blood supply is safe) 3. IT solution submitted to change control for approval, to eliminate such errors moving forward. 4. Clinic Lead RN to monitor and control situation following conversation with staff member 5. Clinic RN to monitor and identify any training needs and action appropriately following conversations with staff member X 3	Business as usual, reviewed daily

First Class Donor Experience

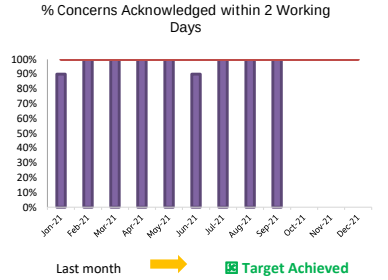
Sep-21



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were no formal concerns recorded under the "Putting things Right" regulations during this period.	Continue to monitor Formal complaint response progress, and 30 day target compliance.	Business as Usual, reviewed daily

First Class Donor Experience

Sep-21



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Initial responses to all early resolution and formal concerns received in September 2021 were managed within timeline.	Continue to monitor initial complaint acknowledgement progress as two working day target compliance.	ongoing, reviewed daily

Workforce Monthly Report

September 2021

Workforce Report provides the following:

- Overview of Key Performance Indictors for Sickness, PADR, Statutory and Mandatory training in all Divisions of the Trust, including Corporate Divisions, TCS and Research and Development (excluding hosted);
- Corporate Divisions include Finance, Workforce and OD, Corporate Estates and Planning, Corporate IT, Clinical Governance, Infection Control, Fundraising and Trust Management and Board;
- The report provides a 12 monthly trend report for Sickness, PADR, Statutory and Mandatory training;
- Hotspots identified, with in month actions to explain improvement trajectory work. Hotspots defined as areas where KPIs are not met and there has been a downward trend over the last three months;
- In month Job Planning figures with narrative to notify areas of improvement;
- Usage of Work in Confidence platform.

At a Glance for Velindre (Excluding Hosted)

Velindre (Excluding Hosted	Current Month	Previous Month	Target
	Sep-21	Aug-21	
PADR	73.67	73.58	85%
Sickness	5.14	5.07	3.54%
S&M Compliance	84.95	85.24	85%

Workforce Dashboard

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

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude Trainee Doctors, those on Maternity, Starters within first 6 Months, those currently off on sickness absence.													
PADR	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	44.35	44.07	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69
Research, Development & Innovation	71.11	75.00	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67
Transforming Cancer Services	62.50	50.00	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25
Velindre Cancer Centre	71.61	73.63	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31	75.17	76.40
Welsh Blood Service	70.22	71.46	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78	78.27	77.93
Velindre Organisations	68.61	70.02	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

Key	85%-100%		50% - 84.99%		0% - 49.99%								
These figures exclude those on Maternity and those currently off with sickness absence													
Stat and Mand Compliance (10x CSTF)	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	66.67	70.00	69.45	70.47	71.61	70.62	69.47	69.06	70.08	69.08	69.26	70.45	71.36
Research, Development & Innovation	72.41	75.71	76.73	76.25	77.45	82.50	83.73	82.59	83.08	85.69	86.00	85.80	86.25
Transforming Cancer Services	70.00	65.26	70.56	70.56	71.18	69.38	64.12	65.29	70.00	76.00	76.84	85.26	82.50
Velindre Cancer Centre	77.79	78.94	80.13	80.23	80.69	81.53	81.57	80.98	81.77	82.45	82.70	83.16	82.89
Welsh Blood Service	90.65	89.69	91.67	91.42	90.43	89.54	90.90	90.43	92.23	92.39	93.38	92.66	92.21
Velindre Organisations	80.57	81.26	85.59	82.66	82.81	83.06	83.39	82.92	84.09	84.59	84.97	85.24	84.95

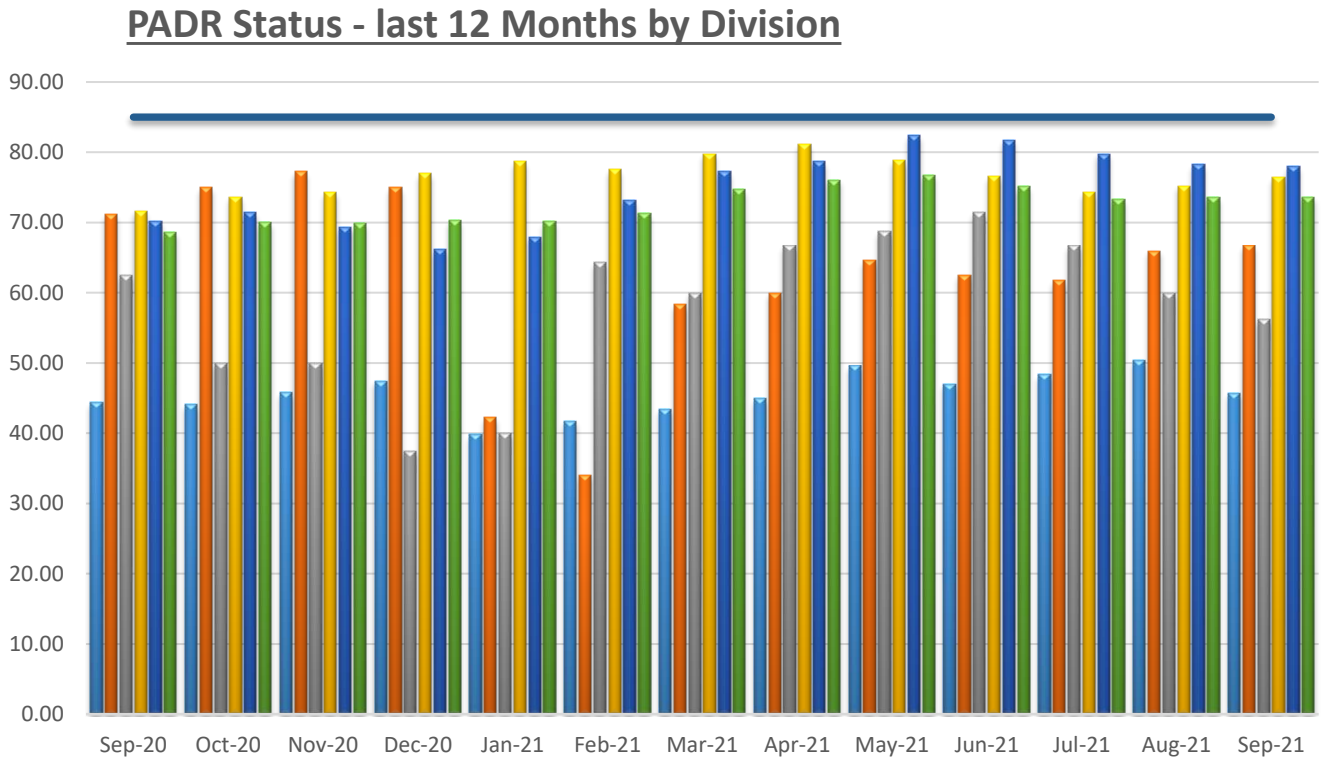
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	5.38	5.40	5.19	5.21	5.26	5.16	4.87	4.62	4.54	4.46	4.36	4.16	4.14
Research, Development & Innovation	4.68	4.51	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.97
Transforming Cancer Services	2.38	2.31	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.32
Velindre Cancer Centre	5.73	5.74	5.76	5.86	5.86	5.94	5.74	5.37	5.34	5.38	5.43	5.43	5.41
Welsh Blood Service	4.53	4.43	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.80	5.06	5.32
Velindre Organisations	5.25	5.22	5.21	5.27	5.26	5.28	5.08	4.82	4.84	4.90	5.00	5.07	5.14
Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54

Monthly Sickness Rolling Covid Only Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Sickness Leave Covid Related	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	0.20	0.23	0.28	0.42	0.56	0.61	0.58	0.53	0.58	0.63	0.68	0.79	0.91
Research, Development & Innovation	0.31	0.35	0.36	0.43	0.45	0.46	0.42	0.35	0.44	0.45	0.45	0.43	0.43
Transforming Cancer Services	0.29	0.28	0.28	0.27	0.26	0.26	0.21	0.00	0.00	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.94	1.02	1.09	1.28	1.39	1.44	1.31	0.96	0.89	0.86	0.87	0.88	0.84
Welsh Blood Service	0.21	0.26	0.30	0.37	0.42	0.44	0.39	0.31	0.29	0.28	0.29	0.29	0.32
Velindre Organisations	0.62	0.68	0.74	0.88	0.96	1.00	0.91	0.68	0.65	0.63	0.64	0.66	0.66

Monthly Special Leave Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	0.42	0.39	0.38	0.37	0.30	0.23	0.17	0.11	0.05	0.04	0.06	0.06	0.03
Research, Development & Innovation	0.70	0.65	0.67	0.71	0.74	0.65	0.50	0.46	0.42	0.51	0.60	0.74	0.88
Transforming Cancer Services	0.02	0.02	0.16	0.32	0.51	0.51	0.51	0.51	0.51	0.51	0.53	0.56	0.55
Velindre Cancer Centre	0.38	0.39	0.39	0.40	0.42	0.43	0.43	0.41	0.41	0.43	0.45	0.48	0.50
Welsh Blood Service	0.54	0.58	0.57	0.62	0.63	0.61	0.62	0.58	0.59	0.58	0.60	0.61	0.62
Velindre Organisations	0.44	0.45	0.45	0.48	0.49	0.48	0.47	0.44	0.43	0.44	0.46	0.49	0.51

Monthly Special Leave Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	0.58	0.59	0.59	0.58	0.58	0.58	0.49	0.32	0.25	0.18	0.12	0.03	0.01
Research, Development & Innovation	1.96	1.94	1.99	1.98	1.96	1.95	1.45	1.04	0.76	0.49	0.21	0.13	0.13
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	1.83	1.87	1.97	2.16	2.29	2.38	2.14	1.73	1.43	1.19	1.02	0.92	0.92
Welsh Blood Service	1.39	1.46	1.52	1.63	1.74	1.79	1.71	1.40	1.14	0.93	0.79	0.75	0.79
Velindre Organisations	1.56	1.60	1.68	1.81	1.92	1.99	1.80	1.45	1.19	0.97	0.82	0.74	0.75

PADR – The Figures



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	44.35	44.07	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33	50.43	45.69
Research, Development & Innovation	71.11	75.00	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70	65.96	66.67
Transforming Cancer Services	62.50	50.00	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67	60.00	56.25
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Velindre Organisations	68.61	70.02	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28	73.58	73.67
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85

PADR – The Narrative

Performance Indicator	RAG / change from previous month	August Figure	Hotspot Areas	%	Comment to include reasons for change / rates high or low
PADR Compliance (85%)	**73.67%** ↑	73.58%	**Welsh Blood Service (78.03%)**		
			Collections	79.23%	Slight decrease on last month 79.13%
			General Section	55.10%	Further decrease reported, from 58.33% in Aug.
			Quality Assurance	78.38%	Increase from 76.38% in Aug.
			Velindre Cancer Centre (76.57%)		
			Medical Staffing	47.27%	Medical staffing continue to improve month on month with an increase of 13.46% since March 2021 (increase on 43.33 in July)
			Palliative/Chronic Pain	52.63%	Work being undertaken in Pall Care/Chronic Pain to support the duality of the appraisal and PADR process similarly to Medical Staffing (increase from
			Cancer Services Management Office	51.61%	New hotspot area due to decline in completed reviews and increase in overall headcount.
			Corporate Areas		
			Corporate Services	45.69%	Workforce BP for corporate services escalated to Lauren Fear as this includes board Members
			TCS	53.33%	*No identifiable reasons reported*

Action/initiatives:

<u>Velindre University NHS Trust</u>

PADR compliance continues to grow steadily across the organisation with a 5.06% increase in the last 12 months from 68.61% in September 2020 to 73.67% in September 2021.

<u>Welsh Blood Service</u>

Workforce Operational Team continue to highlight PADR compliance in regular meetings with managers and reminder of PADR compliance will be added to next SMT

Clinical Services requested a breakdown report to further analyse their PADR status.

VCC

Following September agreement for SLT to highlight September's figure decline in respective directorates there has been a rise in overall PADR compliance of 1.40%

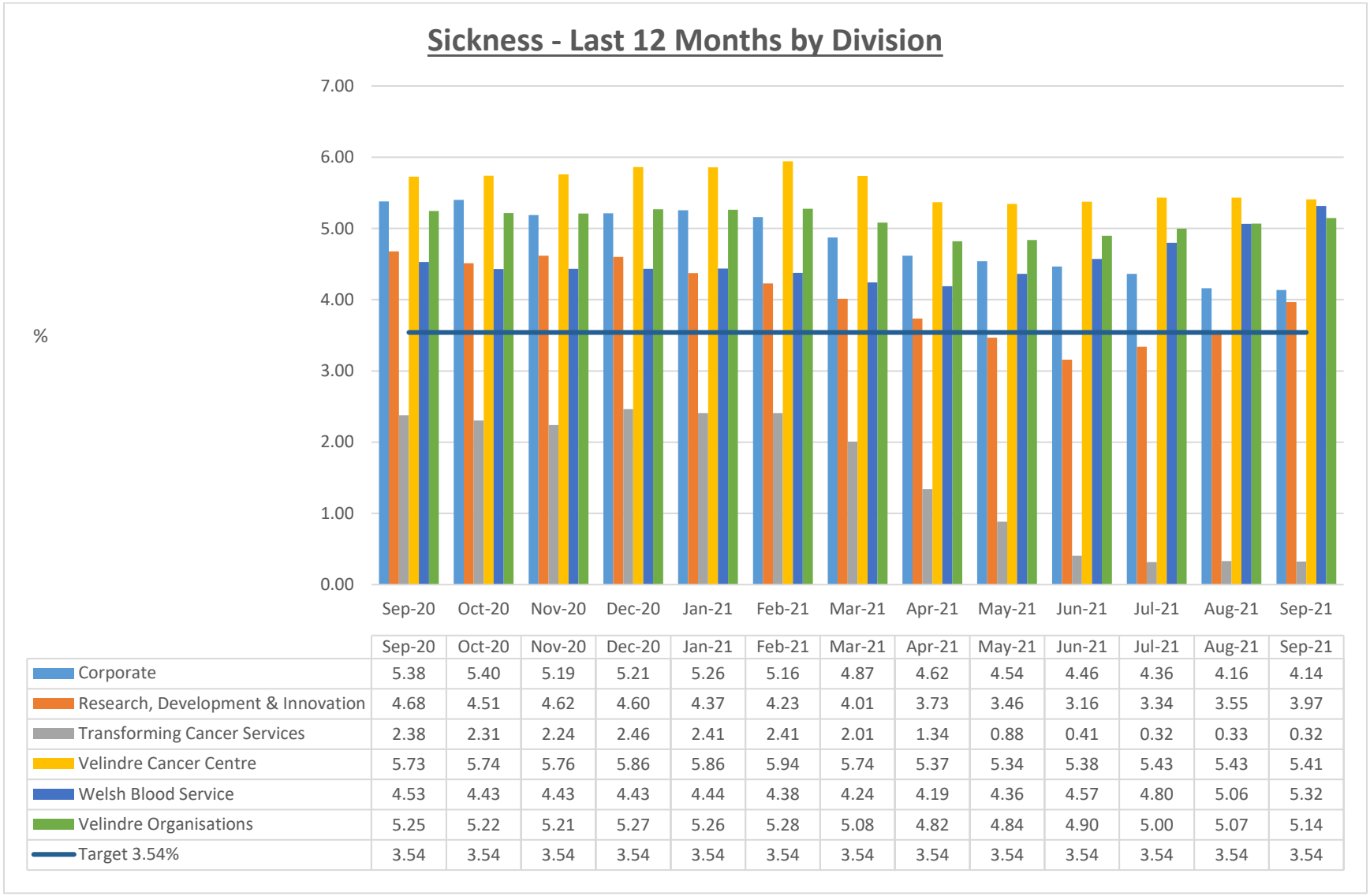
Establishment and ESR work ongoing to realign ESR with current directorate structures.

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

Managers reporting that working arrangements (WFH) are making PADR compliance more difficult.

Not everyone is aware of how to update PADR data in ESR.

Sickness Data – The Figures



	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Corporate	5.38	5.40	5.19	5.21	5.26	5.16	4.87	4.62	4.54	4.46	4.36	4.16	4.14
Research, Development & Innovation	4.68	4.51	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.34	3.55	3.97
Transforming Cancer Services	2.38	2.31	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32	0.33	0.32
Velindre Cancer Centre	5.73	5.74	5.76	5.86	5.86	5.94	5.74	5.37	5.34	5.38	5.43	5.43	5.41
Welsh Blood Service	4.53	4.43	4.43	4.43	4.44	4.38	4.24	4.19	4.36	4.57	4.80	5.06	5.32
Velindre Organisations	5.25	5.22	5.21	5.27	5.26	5.28	5.08	4.82	4.84	4.90	5.00	5.07	5.14
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

Performance Indicator	RAG/ Change from previous month	August Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Sickness absence (3.42%)	**5.14%** ↑	5.07%	**Welsh Blood Service (7.19%)**		
			Collection Services	9.98%	Increase from 8.49% in August
			Laboratory Services	7.67%	Decrease from 8.22% in August
			Quality Assurance	8.10%	Increase from 3.34% in August
			Clinical Services	4.48%	New hotspot area due to increase from 1.71% in August.
			Velindre Cancer Centre (5.43%)		
			Clinical Audit	48.12%	Clinical Audit are a small team and 1 case increases the sickness absence % significantly.
			Outpatients	12.16%	Outpatients continue to manage the LTS cases with continuing improvements in overall absence from 17.19% in August
			Pharmacy	9.04%	Pharmacy continue to manage the LTS cases with continuing improvements in overall absence from 11.83% in August
			Corporate Areas		
			Corporate Services	5.72%	1.65% Covid related absence 33.6% of absence due to long term stress/anxiety/depression.
			RD&I	8.67%	2 LTS cases and increase in STS for cold/flu/cough (non-covid related)

Action/ initiatives:

Velindre University NHS Trust

There has once more been a slight increase in monthly sickness absence for September 2021

On a rolling 12 month basis (Oct 2020 – Sep 2021) sickness absence remains relatively stable with an average rate of 5.09%

WBS

Both short and long-term sickness absence has increased in September, to 1.96% and 5.23% respectively.

Stress Related absence continues to be the highest reason for absence at 29.1% of all absences over the last 12 months, followed again by back problems at 10.5%.

VCC

WOD team have held 121's with hotspot areas in August and September 2021 with progress of a resolution made in 6 long term sickness cases.

Short-term sickness remains relatively low in VCC and has declined again to 1.49%

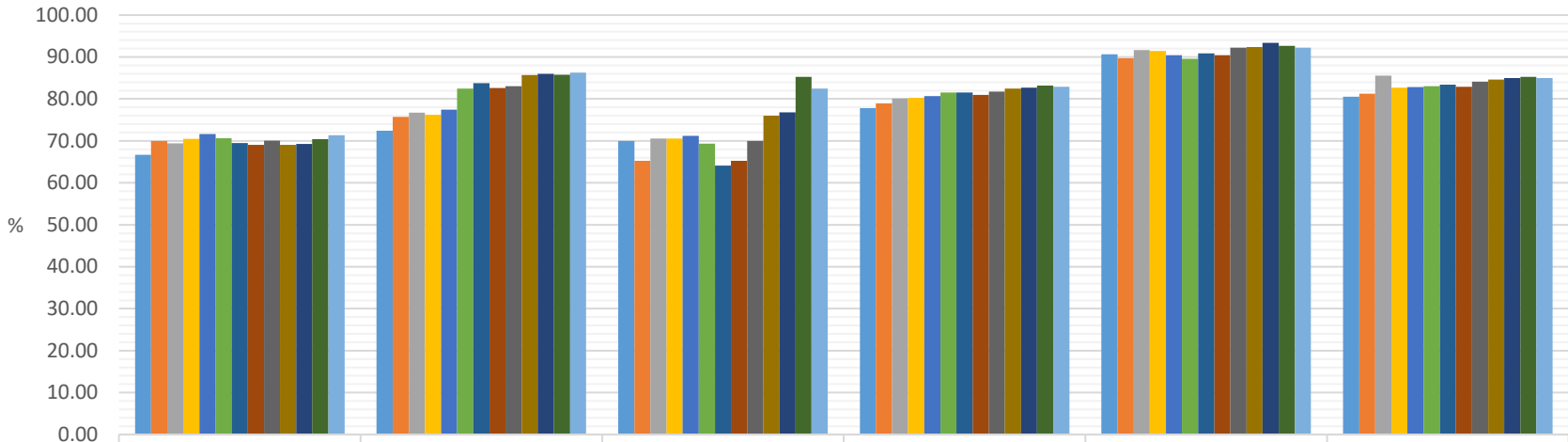
VCC SLT have discovered not all departments are inputting absence data into ESR a spike in sickness % is expected as this is corrected.

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

Corporate has around 130 (headcount) across 11 departments so 1 employee can have 3% to 50% impact on that department's overall figures.

Managers are engaging in WOD team to progress ongoing cases.

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Sep-20	66.67	72.41	70.00	77.79	90.65	80.57
Oct-20	70.00	75.71	65.26	78.94	89.69	81.26
Nov-20	69.45	76.73	70.56	80.13	91.67	85.59
Dec-20	70.47	76.25	70.56	80.23	91.42	82.66
Jan-21	71.61	77.45	71.18	80.69	90.43	82.81
Feb-21	70.62	82.50	69.38	81.53	89.54	83.06
Mar-21	69.47	83.73	64.12	81.57	90.90	83.39
Apr-21	69.06	82.59	65.29	80.98	90.43	82.92
May-21	70.08	83.08	70.00	81.77	92.23	84.09
Jun-21	69.08	85.69	76.00	82.45	92.39	84.59
Jul-21	69.26	86.00	76.84	82.70	93.38	84.97
Aug-21	70.45	85.80	85.26	83.16	92.66	85.24
Sep-21	71.36	86.25	82.50	82.89	92.21	84.95

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	August Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**84.95%** ↓	85.24%	**Welsh Blood Service (92.22%)**		
			All areas above 90% compliance		
			Velindre Cancer Centre		
			Velindre Cancer Centre (83.16%)		
			Palliative/Chronic Pain	55.41%	Increase on previous month 54.47%
			Medical Staffing	61.63%	Decrease on previous month 64.56%
			Corporate Areas		
			Corporate Services	71.36%	Continuing improvement in compliance and 4.69% growth in comparison to September 2020 (66.67%)
			HTW	79.44%	Slight decrease in however divisional headcount of 18 means significant impact on overall % from 1 employee.

Action/ initiatives:

Velindre University NHS Trust

Statutory and Mandatory compliance has a slight dip of 0.29% in Trust compliance however 12 monthly compliance remains relatively stable at an average 83.79%

WBS

To continue to maintain target compliance across WBS.

VCC

VCC has steady increase in compliance with an overall increase of 5.10% in 12 months.

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

Divisional managers' report ESR portal issues as impact – *no known issues reported to WOD from ESR Wales in September 2021*

Job Planning Figures – VCC & WBS combined

Combined

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	61	37	60.66%	12	19.67%	13	21.31%
Medical Director	2	0	0.00%	0	0.00%	2	100.00%
Specialty Doctor	12	10	83.33%	0	0.00%	2	16.67%
Grand Total	**75**	**47**	**62.67%**	**12**	**16.00%**	**17**	**22.67%**

VCC

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	58	37	63.79%	12	20.69%	10	17.24%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	11	10	90.91%	0	0.00%	1	9.09%
Grand Total	**70**	**47**	**67.14%**	**12**	**17.14%**	**12**	**17.14%**

WBS

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	3	0	0.00%	0	0.00%	3	100.00%
Medical Director	1	0	0.00%	0	0.00%	1	100.00%
Specialty Doctor	1	0	0.00%	0	0.00%	1	100.00%
Grand Total	**5**	**0**	**0.00%**	**0**	**0.00%**	**5**	**100.00%**

NB

Data on the job plans associated with other 'medical' posts within the Trust have not been included in the above; this is due to the relatively small numbers involved and therefore the immediately identifiable nature of this information.

WBS

To continue to maintain compliance across WBS

VCC

ESR imputing issues from Pall/Care and Medical directorate raised with ESR Central team

Work In Confidence (WIC)

No detail has been provided this month in terms of the number of staff who have accessed the WIC platform, or categorisation of the type of conversations that have taken place; this is primarily the result of low usage of the platform over the last month and therefore the potential to identify those who have made contact.

In all contacts with staff, staff are encouraged, where appropriate, to share their concerns with their Line Manager (or next appropriate Manager), in order to achieve an early, informal resolution. The WOD Team have also been previously involved in facilitating discussions between the Manager and member of staff.

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST OCTOBER 2021 (M7)

DATE OF MEETING	25th November 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Steve Coliandris, Financial Planning & Reporting Manager
PRESENTED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Quality, Safety & Performance Committee	18/11/21	Noted

ACRONYMS	
IMTP	Integrated Medium Term Plan
WBS	Welsh Blood Service
WTAIL	Welsh Transplantation and Immunogenetics Laboratory
WG	Welsh Government
VCC	Velindre Cancer Centre

1. SITUATION/BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of October 2021.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	1	8	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	462	2,506	9,133
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.7%	94.9%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget continues to remain broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven.

The overall position against the profiled revenue budget to the end of October is an underspend of **£8k**, with an underachievement against income offset by an underspend within Pay.

A large element of the underachievement on planned income relates to WBS WTAIL and Blood Components due to the impact of Covid, for which the Trust is receiving WG funding to cover.

Cost pressures which have / will surface during the year, in line with normal budgetary control procedures, are managed by budget holders to ensure the delegated expenditure control limits are not exceeded.

At this stage the Trust is currently planning to fully achieve the savings target during 2021-22. There remain £200k of schemes relating to post Covid savings that are RAG rated as amber. These savings have been replaced with non-recurrent vacancy factor savings as the targets will not be achieved this year whilst still in the pandemic as the cost reductions are offset against the additional costs of Covid as required by WG for Covid funding.

Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as additional vacancy factor.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however finance colleagues in WG have provided written assurance that the Trust will be fully funded for Covid related expenditure during 2021-22.

The Trust is therefore reporting a year end forecast breakeven position on the assumption that the savings target for the year is achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust is currently 95.6% against a target of 95%, however the performance against the Core Trust excluding NWSSP is presently falling just short of the target at 94.9%.

PSPP compliance levels have significantly recovered during September and October following a temporary dip in performance. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved this financial year.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Recevied / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	247	392	213	179
Cleaning Standards	439	774	367	407
PPE	134	305	147	158
Covid Recovery	629	3,304	3,479	(175)
Other Covid Related Spend & Cost Reduction	1,305	1,365	1,176	189
BFWD Savings Loss	409	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,080**	**6,757**	**5,999**	**758**

The overall gross funding requirement related to Covid is £6,757k which includes £5,974k of directly associated expenditure or cost reduction, £700k in relation to the non-achievement of savings carried forward from 2020/21, and the return of surplus NHS bonus payment £(83)k.

The Trust has now received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in table above will be funded.

2.5 Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

The remaining recurrent unallocated budget is £615k.

In addition to the recurrent and emergency reserve, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to October '21 is £487k (includes £39k of new commitments) with £608k forecast spend and slippage anticipated of £450k due to delays in implementation of several investments which are mainly fixed term posts. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2021/22 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k.

2.6 Financial Risks

There is a small revenue forecast overspend of £17k in the TCS Programme which relates to pay costs within the Service Change Team, however the TCS Finance Team have identified mitigating actions to offset this risk.

All other financial risks are expected to be mitigated at divisional level

2.7 Capital

a) All Wales Programme

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

The Trust has recently been provided with confirmation of £675k funding from WG for Covid recovery schemes which is expected to form part of the CEL in November. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building.

Following a request from WG the Trust has submitted a further £1,396k of bids to WG which will be considered as part of the WG slippage money. WG Capital Finance team submitted a paper summarising the capital slippage bids received from NHS Wales to the Health & Social Care Minister on the 10th November for consideration. The Trust bids include upgrades required on the Linacs in VCC, replacement of Hemoflow Agitators, and equipment to establish a component development Laboratory in WBS, along with several Digital and IT requirements.

Since the submission WG have been informed the Hemoflow Agitators will not be delivered before the end of the financial year due to difficulties within the supply chain and the items not being on the NHS framework.

Other Major Schemes in development that will be considered during 2021/22 and 2022/23 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients, and WBS Plasma fractionation.

The net capital overspend in the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

b) Discretionary Programme

The Trust Discretionary Programme is progressing and expected to deliver for 2021/22.

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 October 2021 is an underspend of £8k 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 October 2021 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even.

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 OCTOBER 2021/22

TRUST BOARD
25/11/2021

1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2021-22.

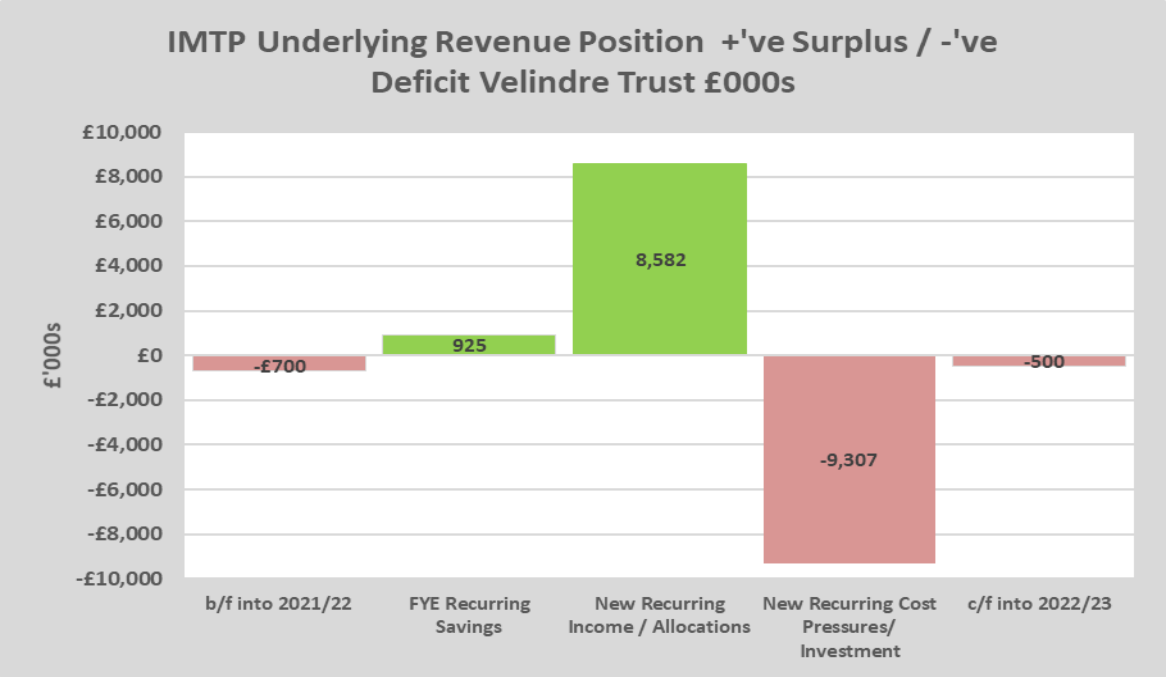
2. Background / Context

The Trust Financial Plan for 2021-22 was set within the following context.

- The Trust submitted a balanced one-year financial plan, covering the period 2021-22 to Welsh Government on the 30 June 2021.

- For 2021-22 the Plan (excl Covid) included;
  - an underlying **deficit of -£700k brought forward from 2020-21,**
  - FYE **of new cost pressures / Investment** of **-£9,307k,**
  - offset by **new recurring Income** of **£8,582k,**
  - and Recurring FYE **savings schemes** of **£925k.**

- Due to the ongoing pandemic and the inability to fully enact savings schemes & cost reduction, the Trust is not expecting to be able to fully eliminate the underlying deficit during 2021-22, however in line with the submitted financial plan the Trust will be aiming to reduce the deficit by £200k to carry forward an underlying position of £500k into 2022-23.
- **To reduce the underlying deficit, the savings target set for 2021-22 must be achieved.**



Underlying Position +Deficit/(-Surplus) £000s	b/f into 2021/22	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2022/23
Velindre NHS Trust	- 700	925	8,582	- 9,307	- 500

3. Executive Summary

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

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue	Variance	1	8	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	462	2,506	9,133
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	97.7%	94.9%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£1k** in-month underspend position for October'21, with a cumulative position of **£8k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at October 2021 is **£9,133k** for 2021-22. This represents all Wales Capital funding of **£7,420k**, Discretionary funding of **£1,911k.** The Trust reported capital spend to October '21 of £2,506 and is forecasting to remain within its CEL of £9,133k.

PSPP (Excluding Hosted Organisations)

During October '21 the Trust (core) achieved a compliance level of **97.67%** (September'21: 98.26%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **94.9%** to the end of October, and a Trust position (including hosted) of **95.6%** compared to the target of 95%.

PSPP compliance levels have significantly recovered during September and October following a temporary dip in performance. Finance colleagues working alongside NWSSP are confident that the 95% target will be achieved this financial year.

Efficiency / Savings

The Trust is currently planning to fully achieve the savings target during 2021-22. Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature such as increased vacancy factor. Where non-recurrent savings schemes are implemented this will require additional recurrent savings schemes to be delivered in 2022-23.

4. Revenue Position

Cumulative				Forecast		
£7,620 Underspent				Breakeven		
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Income	(93,562)	(93,157)	(406)	(163,505)	(163,217)	(288)
Pay	41,878	41,471	407	71,553	71,483	70
Non Pay	51,684	51,678	6	91,952	91,733	218
Total	(0)	(8)	8	0	(0)	0

The overall position against the profiled revenue budget to the end of October is an underspend of **8k**, with an underachievement against income offset by an underspend within both Pay and Non-Pay.

The Trust has now received confirmation that all Covid related expenditure it has forecast will be funded by WG.

4.1 Revenue Position Key Issues

Income Key Issues

- Income underachievement to October is **£(406)k** and is largely where activity is lower than planned on Bone Marrow and Plasma Sales in WBS which is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.
- The underperformance in WBS is being partly offset within VCC via an increase in VAT savings from providing additional SACT Homecare.

Pay Key Issues

The Trust has reported a cumulative year to date position of **£407k** underspent on Pay and is forecasting an outturn underspend of circa **£70k**.

Expected reduction in current underspend position against forecasted outturn position, is a result of decisions made in VCC to invest in positions that had associated savings placed against the divisional CIP target. Further alignment of staff to non-staff is expected in future months to help reduce the divisional CIP target.

- Allied Health Professionals are experiencing a small overspend to date which is due to the use of agency in both Radiotherapy and Medical Physics. VCC is aiming to recruit on a permanent basis against some of these posts which began in September. This is expected to create a saving going forward from the removal of the premium cost for agency, however due to the difficulty being experienced in recruiting into these posts along with the

requirement to cope with the expected surge capacity, the majority of agency staff will be re-directed to support Covid recovery which is being funded by WG.

- Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.
- Each Division of the Trust holds a savings and vacancy factor target which is delivered in year via establishment control. Any forecast adverse variance against the target will be offset through various underspends across numerous staff groups. Largest underspends are currently being experienced in both Admin & Clerical and Nursing due to the high level of vacancies being carried.

Non Pay Key Issues

The Trust has reported a cumulative year to date position of **£6k** underspent on Non-Pay and is forecasting an outturn underspend of circa **£218k**.

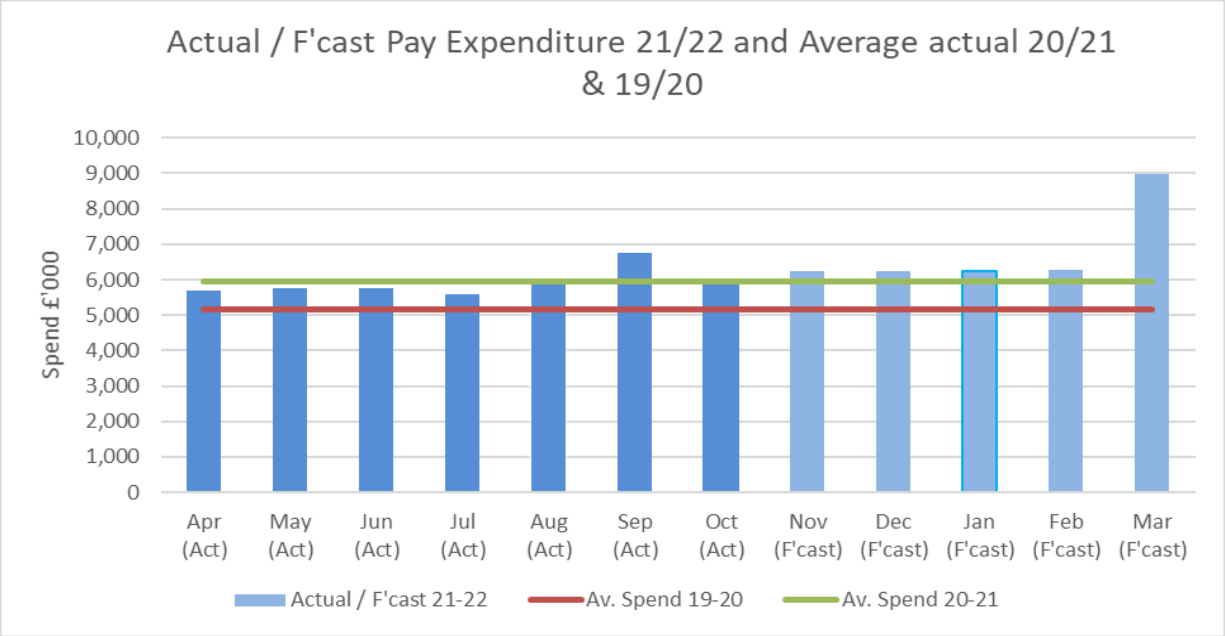
- WBS blood components currently underspent by £134k, whilst drugs underspend to October is £84k, both are a result of reduced activity related to Covid.
- Facilities Management, along with Maintenance & Repairs are under review in WBS with Trust Estates following increased compliance requirements against new contracts which is pushing the outturn into a forecast overspend position.
- Transport underspend is due to non-recurring fuel savings and consequently maintenance costs relating to the fleet following reduction of vehicle use related to Covid.
- Starting to experience additional Travel & Subsistence costs in relation to increased travel of WBS collections team to clinic which is starting to offset general staff Travel & subsistence
- Printing / Stationary & Postage is underspending due to a reduction in office-based activity and paper-based communications given the increased homeworking. A proportion of this underspend is anticipated to be permanent and will be taken as recurrent saving once the Trust has agreed the operating model of future working arrangements.
- General Reserves / Savings Target relates to the Cost improvement Plan (CIP) targets that are held centrally within divisions. These CIP's will be achieved through the underspends in several areas of non-pay. Additionally, as noted above further alignment of staff underspends to the CIP should result in an underspend within non-staff.
- The Trust reserves and investment funding is held in month 12 and will be released into the position to match spend as it occurs.

Further details on performance against Income, Pay and Non-Pay is provided within the Divisional analysis later in the paper.

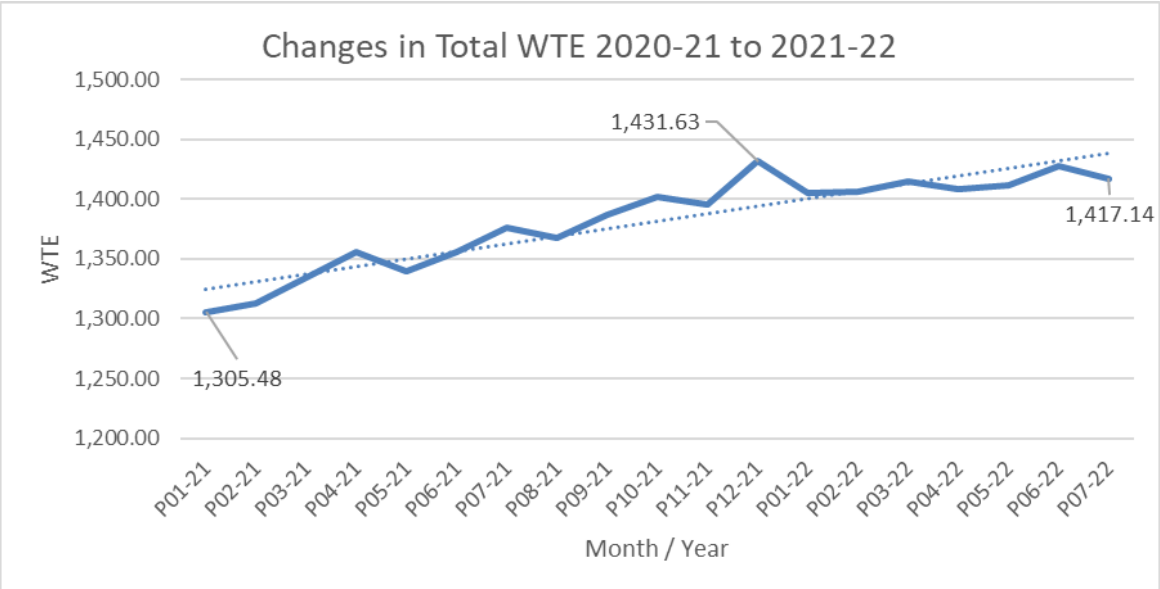
4.2 Pay Spend Trends (Run Rate)

The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% was accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% related to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the pay costs associated with Covid.

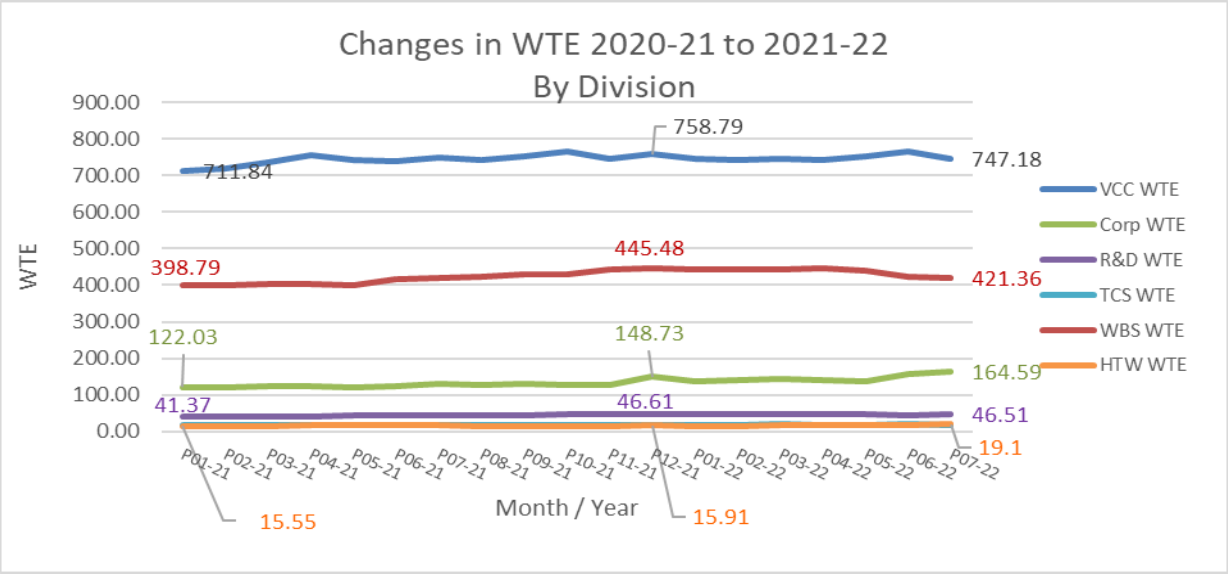
Staff received the 2021/22 pay award of 3% and arrears dated back to April 2021 in their September pay. Excluding the Pay award, spend is still expected to increase with the recruitment of additional posts to meet 'surge' capacity in both VCC and WBS in response to Covid recovery. Whilst the plan was to reduce agency costs within the Trust Core staffing structure, due to the difficulty being experienced in recruitment, the agency staff replaced with substantive recruits will now be utilised as part of the Covid recovery.



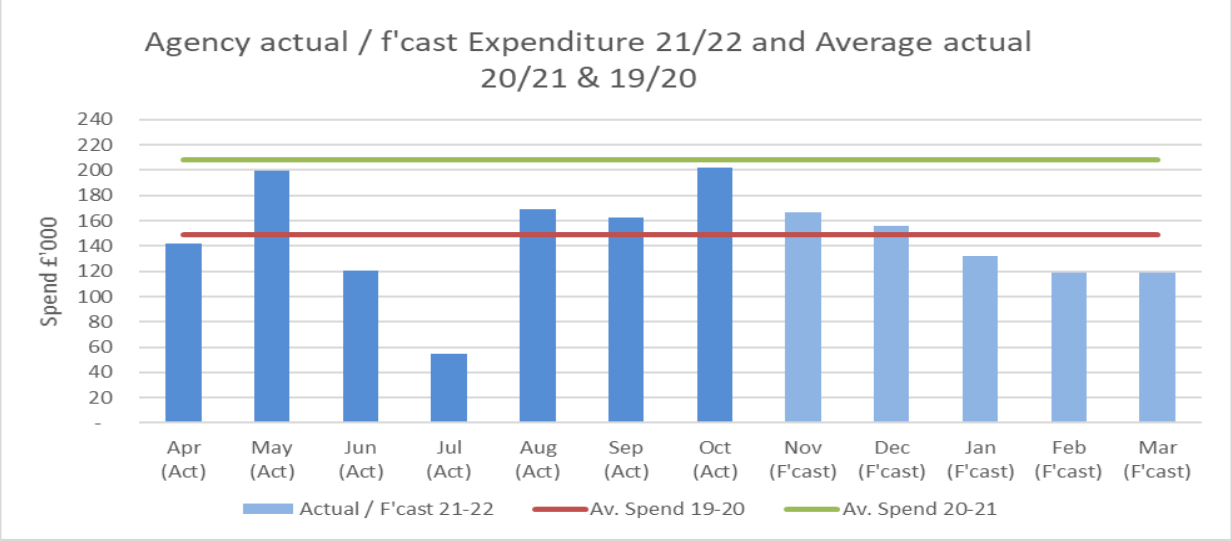
*Sep costs include Pay Award (3%) backdated to April. March costs included the increase in NHS pension (6.3%), which is paid every year in month 12 and funded by WG.



*20wte included in period 12 for the Patient Vaccination clinics which have now disbanded. Core Staff increase for 21-22 to October is 6wte.



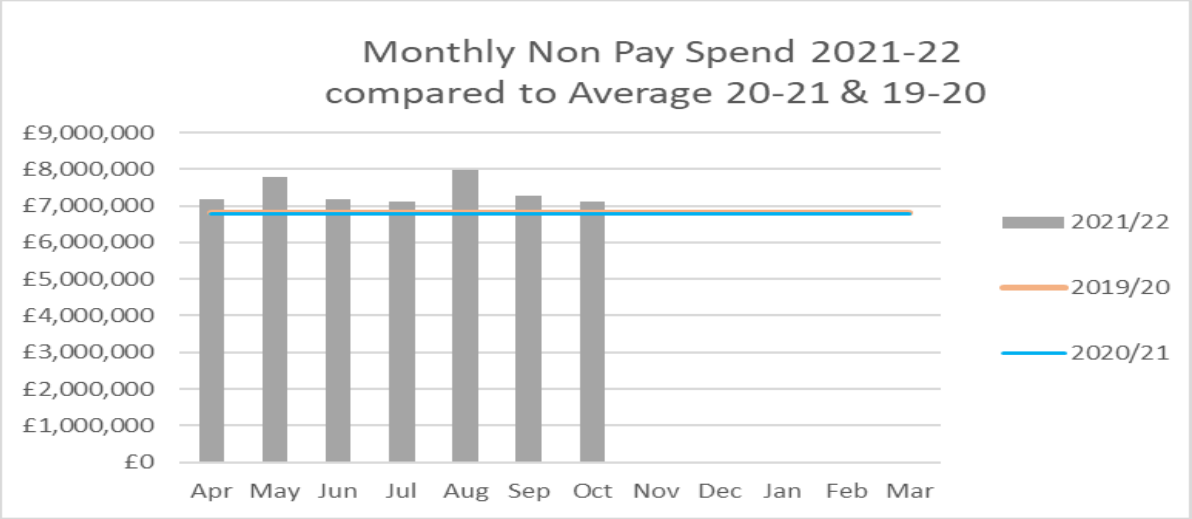
The spend on agency for October was £202k (September £162k), which gives a cumulative year to date spend of **£1,050k** and a forecast outturn spend of circa **£1,744k.** Of these totals the year to date spend on agency directly relating to Covid is £450k and forecast spend is circa £785k.



*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised within VCC.

4.3 Non Pay

Non-pay 20/21 (c£81.2m) av. monthly spend remained static between 19/20 and 20/21 at £6.8m. The average monthly spend for 21-22 is currently £617k (8.4%) more than 20/21, which is largely due to the increase NICE / High-Cost drug usage following the recovery from the impact of Covid.



4.4 Covid-19

Covid-19 Revenue Spend/ Funding				
	YTD Actual £000	Plan 2021/22 £000	Funding Received / Allocated £000	Balance Remaining £000
Mass & Booster Covid Vaccination	247	392	213	179
Cleaning Standards	439	774	367	407
PPE	134	305	147	158
Covid Recovery	629	3,304	3,479	(175)
Other Covid Related Spend & Cost Reduction	1,305	1,365	1,176	189
BFWD Savings Loss	409	700	700	0
Return of Bonus Payment (over allocated)	(83)	(83)	(83)	0
Total Covid Spend /Funding Requirement 2021/22	**3,080**	**6,757**	**5,999**	**758**

The Trust has currently received or been allocated funding from WG to the sum of £5,999k, £3,479k towards Covid recovery, £1,903k to cover the first six months of Covid response and £700k to cover the underlying savings loss bfwd from 2020/21, and the Trust has returned £83k which was surplus money received toward the NHS bonus payment. This leaves funding to be allocated by WG of £758k.

The Trust is yet to receive a formal funding letter for the remaining balance of Covid requirement, however it has received e-mail confirmation from the WG Interim Director of Finance Health and Social Services Group that all the Trust Covid related expenditure identified in the table above will be funded.

Covid Recovery

The spend and funding requirement to deliver Covid Recovery and Surge Capacity comprises direct outsourcing and enablement of additional clinical sessions within VCC, and an additional collection team within WBS. The resources required will provide coverage for a surge in capacity of up to 20% above pre-Covid levels for VCC (£2,840k) and 10% for WBS (£600k).

Covid recovery funding has been flexibly managed with Covid response requirements, whilst delivering the capacity intended by the funding. This has maintained the overall funding envelope though recovery has been re-categorised to £3,304k via a reduction in outsourcing to date, but forecast to have a sustained increase in utilisation to the end of the Financial Year.

The Trust has received confirmation that the increase in NICE/ High cost drugs will be funding by commissioners. Latest estimate is circa £2,900k above existing forecast which is based on potential demand should the additional capacity be fully utilised. These figures are excluded from the table above.

Vaccinations

The Trust is expecting to spend circa £392k on the Covid Mass & Booster Vaccination programme during 2021/22. The £392k revenue spend requirement largely relates to the WBS storage and distribution for NHS Wales (£312k), delivery of vaccinations to front line staff in both Velindre and WAST, and the rollout of the Patient Vaccination programme which has now ended (£53k), with the balance being ringfenced for the booster programme (£27k).

5. Savings

The Trust established as part of the IMTP a savings requirement of £1,100k for 2021-22, £525k recurrent (£925k full year recurrent) and £575k non-recurrent, with £1,050k being categorised as actual saving schemes and £50k being income generating schemes.

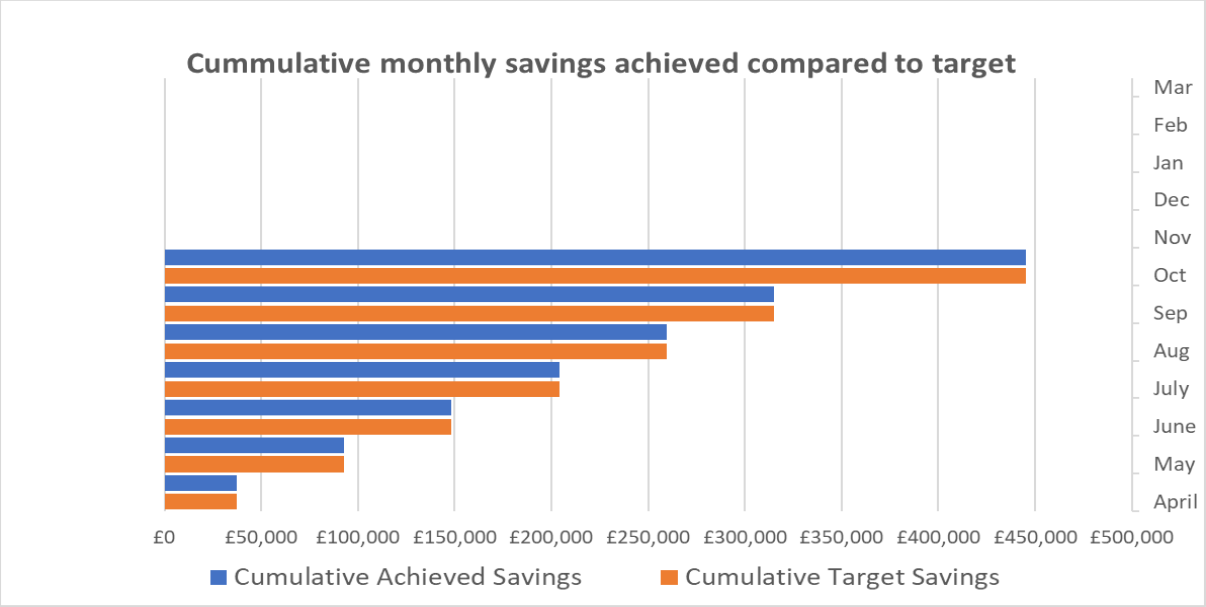
The schemes identified as amber relate to the £200k post Covid savings which have been replaced with non-recurrent vacancy factor savings as the target will not be achieved this year whilst still in the pandemic.

The Divisional share of the overall Trust savings target has been now been re-allocated following the slippage on post Covid savings to VCC £300k (27%), WBS £300k (27%), and Corporate £100k (9%), with £400k (36%) being set at Trust level for combined vacancy factor above the baseline target set by each Division. This was distributed in the September position and included within the divisional savings plans.

Any slippage or non-delivery against savings targets will be managed through implementation of alternative savings / cost avoidance measures, which may be non-recurrent in nature. Any non-recurrent schemes will need to be replaced by additional recurrent savings schemes in 2022-23.

ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	413	71	71	0	300	(113)
			100%		73%	
WBS TOTAL SAVINGS	368	175	175	0	300	(68)
			100%		82%	
CORPORATE TOTAL SAVINGS	119	58	58	0	100	(19)
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	304	304	0	700	(200)
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	141	141	0	400	200
TRUST TOTAL SAVINGS	1,100	445	445	0	1,100	0
			100%		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							
Premium of Agency Staffing	Green	150	25	25	0	150	0
Premium of Agency Staffing	Green	100	17	17	0	100	0
Post Covid Savings (VCC)	Amber	113	0	0	0	0	(113)
Blood Supply Chain 2020	Green	75	44	44	0	75	0
Blood Supply Chain 2020	Green	25	15	15	0	25	0
Stock Management	Green	200	117	117	0	200	0
Post Covid Savings (WBS)	Amber	68	0	0	0	0	(68)
Establishment Control	Green	100	58	58	0	100	0
Post Covid Savings (Corporate)	Amber	19	0	0		0	(19)
Total Saving Schemes		**850**	275	275	0	650	(200)
Income Generation							
Maximinsing Income Opportunities	Green	50	29	29	0	50	0
Total Income Generation		**50**	29	29	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	141	141	0	400	200
TRUST TOTAL SAVINGS		1,100	445	445	0	1,100	0
				100%		100%	



6. Reserves

The financial strategy for 2021-22 facilitated the development of a recurrent and non-recurrent reserve in support of the Trust transformation and delivery agenda. These reserves could only be accommodated on the basis that all income expectations are received, planned savings schemes delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of 522k.

The current remaining available funding is shown below: -

Summary of Total Reserves Remaining Available in 2021/22	£k
Recurrent Reserve Available 2021/22	618

Summary of Total Non-Recurrent Reserves Remaining Available in 2021/22	£k
Anticipated slippage on NR Allocated reserves	450
Emergency Reserve	522
Total	**972**

In addition to the recurrent and emergency reserve, the Executive Management Board (EMB) agreed to make available £1,545k of non-recurrent funding for investment during 2021/22 from the release of accountancy gains. The current spend to October '21 is £487k (includes £39k of new commitments) with £608k forecast spend and slippage anticipated of £450k due to delays in implementation of several investments which are mainly fixed term posts. EMB has agreed that non-recurrent funding of £450k will be re-provided in 2021/22 to enable all the approved investments to be fully implemented, provided it can be demonstrated that recruitment of posts or procurement has commenced by the end of December '21.

The non-recurrent reserves still available to invest and cover new unavoidable cost pressures is £972k.

7. End of Year Forecast / Risk Assessment

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

TCS Programme (Medium)
The revenue forecast overspend of £17k in the TCS programme relates to the pay costs within the Service Change Team. The TCS Finance Team have identified mitigating actions to offset this risk.

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 @ M7 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	1,432	0	2,279	3,711	0
VCC Radiotherapy Procurement Solution	312	124	0	188	312	0
IT - WPAS (CANISC replacement phase 2)	993	569	0	424	993	0
Fire Safety	600	132	0	468	600	0
National Programmes - Decarbonisation	109	30	8	71	109	0
National Programmes - Imaging	1,020	0	0	1,020	1,020	0
Covid Recovery	675	0	0	675	675	0
Total All Wales Capital Programme	7,420	2,286	8	5,125	7,420	0
Discretionary Capital	1,911	220	57	1,634	1,911	0
Total	9,331	2,506	65	6,759	9,331	0

The approved 2021/22 Capital Expenditure Limit (CEL) as at October 2021 was £9,331k (excl. Charity). This includes All Wales Capital funding of £7,420k, and discretionary funding of £1,911k.

Major Schemes in Development

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

Other Major Schemes in development that will be considered during 2021/22 and beyond in conjunction with WG include:

	Scheme	**Scheme Total £'000**	**Stage (i.e., OBC development, FBC development, scoping etc.)**	**21/22 £'000**	**22/23 £'000**	**23/24 £'000**	**24/25 £'000**
1	VCC Outpatients	800	Feasibility & design study currently being undertaken	0	800	0	0
2	WBS HQ	22,000	PBD approved by WG OBC under development	0	1,000	11,000	10,000
3	Ventilation	2,490	BJC to be submitted	0	2,490	0	0
4	IRS	38,429	OBC & PBC approved by WG, FBC under development	0	9,922	7,048	21,459
5	Plasma Fractionation	TBC	Feasibility study to be developed	TBC	TBC	TBC	TBC

In addition to the above the Trust has received confirmation of £675k funding from WG towards Capital related Covid recovery. This will be used to support additional donor chairs in WBS, urgent ventilation work, and increased capacity in VCC such as improvements to the outpatient area and Bobarth building. This is expected to form part of the Trust CEL from November.

Following a request from WG the Trust has submitted a further £1,396k of bids to WG which will be considered as part of the WG slippage money. WG Capital Finance team submitted a paper summarising the capital slippage bids received from NHS Wales to the Health & Social Care Minister on the 10th November for consideration. The Trust bids include upgrades required on the Linacs in VCC, replacement of Hemoflow Agitators, and equipment to establish a component development Laboratory in WBS, along with several Digital and IT requirements.

Since the submission WG have been informed the Hemoflow Agitators will not be delivered before the end of the financial year due to difficulties within the supply chain and the items not being on the NHS framework.

Performance to date

The actual cumulative expenditure to October 2021 on the All-Wales Capital Programme schemes was £2,286k, this is broken down between spend on the TCS Programme £1,432k, Integrated Radiotherapy Procurement Solution £124k, IT WPAS £569k, Fire Safety £132k, and Decarbonisation £30k.

The Trust Discretionary funding has now been allocated for 2021-22 and was approved at EMB on the 2nd August. All funds have been committed to schemes other than a contingency being held for emergencies.

Spend to date on Discretionary Capital is currently £220k with a further £57k committed.

Due to supply chain issues we are starting to see an emergence of slippage against some of the discretionary schemes that were previously approved. This was discussed at the internal Capital Planning Meeting on the 18th October where other organisational priorities were discussed and agreed to replace the schemes that were anticipated would not be fully delivered during 2021/22.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position, with any further slippage being managed through the Capital Planning and Delivery Group.

The net capital overspend in the TCS Programme will be managed within the overall Programme budget and from slippage / contingency within the Trust discretionary programme.

9. BALANCE SHEET (Including Hosted Organisations)

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

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

The Trust has now formally removed DHCW from the Trust SoFP, following the transfer of assets and liabilities that took place on the 31 October.

Non-Current Assets

The balance on PPE and intangible assets will move up and down depended on the agreed purchases from the Trust Capital programme (including hosted), offset against the depreciation charges on owned assets.

Trade debtors and receivables will move up and down each month depending on timing of when invoices are raised and consequently paid by organisations.

Current Assets

NWSSP continues to hold high levels of stock in response to Covid which will be passed out to the HB's. In addition, the Trust is 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 was intending to unwind the contingency stock during 2021-22 and repay the £7,000k cash provided by WG to purchase the Brexit stock, however given the uncertain situation around supply chains which has arisen due to Covid the Trust is currently continuing to hold this stock.

The balance on receivables will move up and down each month depending on the timing of when invoices are raised, and when the cash is physically received from debtors. The Trust actively chases its debts to ensure prompt payment.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels are fluctuating significantly on a daily / weekly basis. Cash levels are being continually monitored using a cash flow forecast to maintain appropriate levels.

Current Liabilities & Non-Current Liabilities

Liabilities will move up and down each month depending on timing of when commitments are made, and invoices are received and paid.

Taxpayers Equity

The movement on PDC relates to the transfer of Capital assets relating to DHCW.

	Opening Balance Beginning of Apr 20	Closing Balance End of Oct-21	Movement from 1st April Oct-21	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	127,944	(8,614)	127,944
Intangible assets	20,821	4,846	(15,975)	4,846
Trade and other receivables	817,142	817,124	(18)	817,124
Other financial assets	0	0	0	0
Non-Current Assets sub total	974,521	949,914	(24,607)	949,914
Current Assets				
Inventories	95,564	89,784	(5,780)	89,784
Trade and other receivables	548,836	414,305	(134,531)	417,755
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	21,968	(21,295)	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	687,663	526,057	(161,606)	526,057
TOTAL ASSETS	1,662,184	1,475,971	(186,213)	1,475,971
Current Liabilities				
Trade and other payables	(353,136)	(195,659)	157,477	(195,659)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,395)	564	(316,395)
Current Liabilities sub total	(670,103)	(512,054)	158,049	(512,054)
NET ASSETS LESS CURRENT LIABILITIES	992,081	963,917	(28,164)	963,917
Non-Current Liabilities				
Trade and other payables	(7,301)	(7,000)	301	(7,000)
Borrowings	0	0	0	0
Other financial liabilities	0	0	0	0
Provisions	(818,782)	(818,782)	0	(818,782)
Non-Current Liabilities sub total	(826,083)	(825,782)	301	(825,782)
TOTAL ASSETS EMPLOYED	165,998	138,135	(27,863)	138,135
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	27,978	27,978	0	27,978
PDC	122,468	94,597	(27,871)	94,597
Retained earnings	15,552	15,560	8	15,560
Other reserve	0	0	0	0
Total Taxpayers' Equity	165,998	138,135	(27,863)	138,135

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.

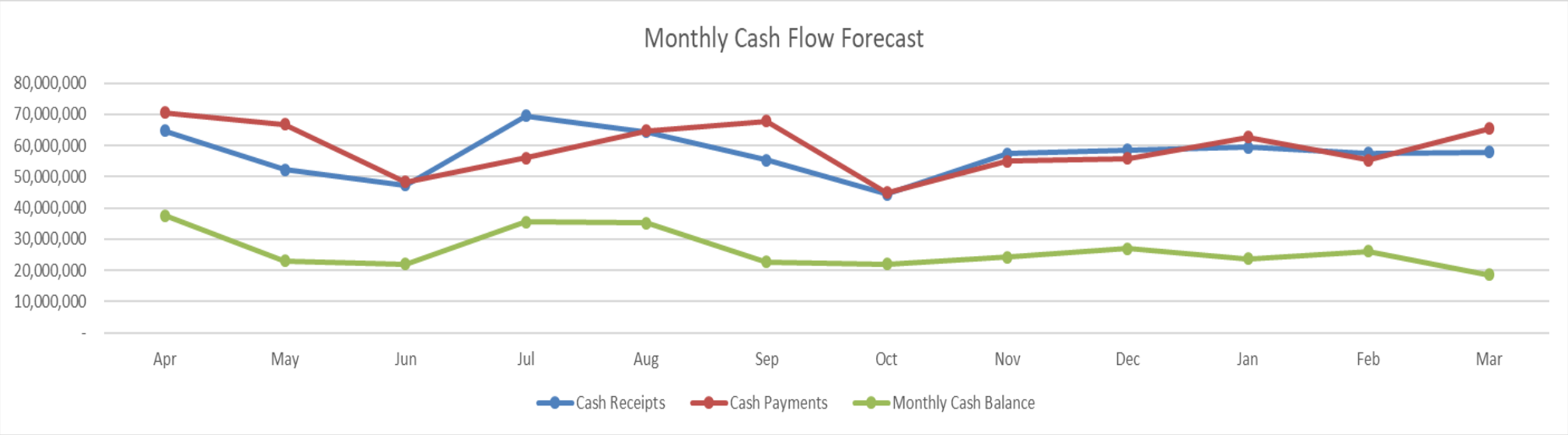
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019/20. WBS did intend to run down the commercial blood stock, however given the uncertain situation with Covid and potential impact on supply chains the Trust will continue to hold this stock and assess the situation throughout the year. NWSSP are continuing to liaise with WG regarding the level of Brexit stock to maintain but it is anticipated that the repayment of the additional cash will not take place now until at least January 2022.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year or so have been significantly higher than usual and may continue to be above average with ongoing need for Covid related purchases. Due to this, the cash balance can fluctuate significantly on a daily / weekly basis.

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

		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	23,348	22,492	30,672	34,078	32,225	28,886	33,252	32,870	34,053	34,865	33,978	29,728	370,445
2	WG Income	33,807	26,132	11,582	30,431	27,512	21,398	6,388	22,323	21,045	22,670	21,698	22,725	267,709
3	Short Term Loans													0
4	PDC												3,205	3,205
5	Interest Receivable													0
6	Sale of Assets													0
7	Other	7,643	3,682	4,973	5,006	4,613	5,004	4,673	2,195	3,500	1,950	1,950	2,175	47,364
8	TOTAL RECEIPTS	**64,797**	**52,306**	**47,227**	**69,515**	**64,350**	**55,288**	**44,314**	**57,387**	**58,597**	**59,484**	**57,625**	**57,832**	**688,723**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	19,284	24,383	25,582	25,100	25,120	25,165	25,197	31,581	281,531
10	Non pay items	52,989	43,749	25,742	35,377	45,158	42,830	18,755	27,422	29,180	29,139	28,410	30,378	409,130
11	Short Term Loan Repayment										7,000			7,000
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	225	623	631	2,534	1,613	1,448	1,644	3,445	15,807
15	Other items													0
16	TOTAL PAYMENTS	**70,552**	**66,760**	**48,297**	**56,011**	**64,667**	**67,836**	**44,968**	**55,056**	**55,913**	**62,752**	**55,250**	**65,404**	**713,468**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(317)	(12,548)	(655)	2,331	2,684	(3,268)	2,375	(7,571)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	35,171	22,623	21,968	24,298	26,982	23,714	26,090	
19	Balance c/f	37,508	23,054	21,984	35,488	35,171	22,623	21,968	24,298	26,982	23,714	26,090	18,518	



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	20,936	20,936	0	36,325	36,325	0
RD&I	72	72	0	(365)	(365)	0
WBS	11,650	11,650	0	20,652	20,652	0
Sub-Total Divisions	**32,658**	**32,658**	**0**	**56,612**	**56,612**	**0**
Corporate Services Directorates	5,104	5,097	7	8,623	8,623	0
Delegated Budget Position	**37,762**	**37,754**	**8**	**65,234**	**65,234**	**0**
TCS	357	357	0	635	635	0
Health Technology Wales	(20)	(20)	0	28	28	0
Trust Position	**38,099**	**38,091**	**8**	**65,897**	**65,897**	**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	**35,230**	**35,343**	**113**	**62,435**	**62,686**	**251**
Expenditure						
Staff	23,622	23,502	120	40,583	40,737	**(154)**
Non Staff	32,543	32,777	(233)	58,177	58,274	**(97)**
Sub Total	**56,166**	**56,279**	**(114)**	**98,760**	**99,011**	**(251)**
Total	**20,936**	**20,936**	**0**	**36,325**	**36,325**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of October 2021 was **breakeven**, and an expected outturn position of **breakeven**.

Income at Month 7 represents an overachievement of **£113k**. This is largely from an increase in VAT savings from providing additional SACT Homecare, a small over achievement against private patient income due to drug performance, along with increased income against the Radiation protection SLA, and HSST income within Physics Management. This is offsetting the divisional savings target and loss of income from closure of gift shop and volunteer's office in response to Covid.

VCC have reported an underspend of **£120k** against staff for October. The division continues to have a high level of vacancies, sickness, and maternity leave predominantly in Nurse

Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target and is offsetting the cost of agency (£733k to end of October) although £400k is directly related to Covid. Inpatients underspend relates to the holding off on recruitment due to reduced bed capacity from social distancing measures. Medical costs have increased due to additional temporary staff recruited at risk to ensure that all Jnr Dr rotation placements are filled, and to provide additional resilience against pressured consultants. In addition, enhanced out of hours service, for advanced life support which will be nursing led is currently being covered by Jnr Dr's.

Expected reduction in current underspend position against forecasted outturn position, is a result of decisions made in VCC to invest in positions that had associated savings placed against the divisional CIP target. Further alignment of staff to non-staff is expected in future months to help reduce the divisional CIP target.

Non-Staff Expenditure at Month 7 was **£(233)k** overspent. There are underspends on general drugs from reduced activity, cost avoidance generated from closure of gift shop and volunteer's office, along with various underspends across other services due to reduced activity, including the closure of outreach clinics. This is in part offsetting the one off spend on uniforms and consumables in Pharmacy, One Wales cost pressure and bulk purchase of frameless masks.

WBS

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**12,865**	**12,328**	**(537)**	**20,479**	**19,973**	**(506)**
Expenditure						
Staff	9,909	9,749	160	16,914	16,904	**10**
Non Staff	14,605	14,228	377	24,216	23,720	**496**
Sub Total	**24,514**	**23,977**	**537**	**41,131**	**40,625**	**506**
Total	**11,650**	**11,650**	**0**	**20,652**	**20,652**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of October 2021 was **breakeven** with an outturn forecast position of **breakeven** expected.

Income underachievement to date is **£(537)k**, where activity is lower than planned on Bone Marrow and Plasma Sales, due to freezer breakdown and Covid suppressed activity. Plasma sales recovery to business-as-usual levels delayed from October to November 21. Transitional operating sites for Bone Marrow and increasingly curtailed procedures is resulting in income loss above Covid support, with assessments as to scale and sustainability ongoing.

Staff reported a year-to-date underspend of **£160k** to October, which is above the division's vacancy factor target. Vacancies remain high at 34 as at end of month 7. Plasma fractionation staffing costs to be supported by division during 2021/22.

Trust approval to appoint a 4th collection team in response to NHS Wales surge capacity and meeting blood demand commenced on 6th September 2021. Confirmation received that these costs will be met by WG.

Non-Staff underspend of **£377k** is largely due to reduced costs from suppressed activity, underspend on Collections Services, Laboratory Services, WTAIL, and General Services, which is offsetting the divisions savings target.

Corporate

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**834**	**857**	**24**	**1,218**	**1,185**	**(33)**
Expenditure						
Staff	5,663	5,545	118	9,428	9,214	**214**
Non Staff	274	409	(135)	413	594	**(181)**
Sub Total	**5,937**	**5,954**	**(17)**	**9,841**	**9,808**	**33**
Total	**5,104**	**5,097**	**7**	**8,623**	**8,623**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of October 2021 was an underspend of **£7k**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Forecast Income underachievement is due to vacancies within fundraising including a period for the Charity Director where the costs are not recharged to the Charity, which is offset by a forecast underspend against the staff in post. Year to date income overachievement relates to income received upfront in IM&T but is expected to be utilised later in the year.

Staff is forecasting an underspend due to vacancies being held, including the Deputy Director of finance which will go towards offsetting the CIP target in non-staff.

The forecast Non pay overspend circa **£(181)k** is due to the divisional savings target which is expected to be met in year via staff vacancies but remains a risk. Other main cost pressure relates to the estates budget in VCC which is under immense strain due to the increased repair and maintenance costs of the hospital, recently added costs for statutory compliance and increased material costs, along with general inflation. In addition, several departments have little or no non pay budget to allow for unforeseen and unexpected spend.

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**1,609**	**1,603**	**(6)**	**3,251**	**3,251**	**0**
Expenditure						
Staff	1,557	1,548	9	2,645	2,645	**0**
Non Staff	124	127	(3)	241	241	**0**
Sub Total	**1,681**	**1,675**	**6**	**2,886**	**2,886**	**0**
Total	**72**	**72**	**0**	**(365)**	**(365)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of October 2021 was **breakeven** with a current forecast outturn position of **breakeven**.

Currently no issues to report.

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	297	297	0	529	529	**0**
Non Staff	59	59	0	106	106	**0**
Sub Total	**357**	**357**	**0**	**635**	**635**	**0**
Total	**357**	**357**	**0**	**635**	**635**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of October 2021 is a **£17k overspend** with a forecasted outturn position of **£17k overspent,** however it is anticipated that the *cost pressure of £17k will be mitigated.*

HTW (Hosted Other)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**960**	**960**	**0**	**1,645**	**1,645**	**0**
Expenditure						
Staff	830	829	0	1,453	1,453	**0**
Non Staff	110	110	0	220	220	**0**
Sub Total	**940**	**939**	**0**	**1,673**	**1,673**	**0**
Total	**(20)**	**(20)**	**0**	**28**	**28**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of October 2021 was **breakeven,** with a forecasted outturn position of **breakeven** on the basis that any potential slippage which is starting to emerge will be handed back to WG**.**

TRUST BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 OCTOBER 2021

DATE OF MEETING	25th November 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mark Ash, Assistant Project Director
PRESENTED BY	Mark Ash, Assistant Project Director
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
TCS Programme Delivery Board	16/11/21	NOTED

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
PBC	Project Business Case
PMO	Programme Management Office
EW	nVCC Enabling Works
nVCC	New Velindre Cancer Centre
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
SDT	Service Delivery and Transformation

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 2021-22, outlining spend to date against budget as at Month 07.

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 As at March 2021, the Cabinet Secretary for Health, Well-being and Sport, had approved capital and revenue funding for the TCS Programme and associated Projects of £20.710m and £1.678m respectively.

2.3 Included in this approval was funding for the IRS Project (Project 3a). The PBC for this project was endorsed by WG in 2019-20, providing capital funding of £1.110m from July 2019 to December 2022. The provision was £0.250m in 2019-20, £0.548m in 2021-22, and £0.312m in 2021-22.

2.4 In addition to WG funding, NHS Commissioners agreed in December 2018 to provide annual revenue funding towards the TCS Programme. £0.400m was provided in the initial year of 2018-19, with £0.420m annually thereafter.

2.5 Further revenue funding was provided by Trust in 2019-20 and 2020-21 from its own baseline revenue budget. Funding of £0.060m and £0.030m respectively was provided for nVCC Project Delivery (previously provided by WG until March 2019). Another £0.039m (2019-20) and £0.166m (2020-21) was provided to cover the costs of staff secondment from Velindre Cancer Centre.

2.6 The total funding and expenditure for the TCS Programme and associated Projects by the end of March 2021 was £23.923m: £20.710m Capital, £3.213m Revenue.

3. FUNDING

3.1 Funding provision for the financial year 2021-22 is outlined below.

3.2 In August 2021, the Trust Board approved that the nVCC Project provide interim funding of **c£0.350m** to the EW Project. The funding is to support the work packages associated with tree and vegetation clearance (c£0.250m) and site management and security (c£100k). The EW Project will secure this funding from the approval of its FBC in January 2022. The Project(s) financial plans will be updated in November 2021.

3.3 To date no revenue funding has been provided by WG. The Trust has provided revenue funding of **£0.084m**.

Description	Funding	
	Capital	Revenue
Programme Management Office There is no capital funding requirement for the PMO at present Allocation from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Allocation from WG 2021-22 revenue pay award funding	**£ nil**	**£0.246m** £0.240m £0.006m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021	**£0.346m** £0.346m	**£ nil**
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021 The Trust has provided revenue funding for Project Delivery The Trust has provided revenue funding for the Judicial Review	**£3.365m** £3.365m	**£0.084m** £0.026m £0.058m
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st August 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m Additional funding provided by the Trust for the Project's increased legal costs	**£0.460m** £0.312m £0.148m	**£ nil**
Project 4 – Radiotherapy Satellite Centre The project is led and funded by the hosting organisation, Aneurin Bevan University Health Board; no funding requirement is expected from the Trust for 2021-22	**£ 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 Allocation from £0.420m funding provided from Commissioners for 2021-22 to cover direct clinical/management support and Programme Management Funding provided from the Trust's core revenue budget towards the costs of the Project Director post and the Project Manager post Allocation from WG 2021-22 revenue pay award funding	**£ nil**	**£0.305m** £0.180m £0.116m £0.009m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	**£ nil**	**£ nil**
Total funding provided to date	**£4.170m**	**£0.635m**
	£4.805m	

4. FINANCIAL SUMMARY AS AT 31ST OCTOBER SEPTEMBER 2021

4.1 The summary financial position for the TCS Programme for the year 2021-22 is outlined below:

- **CAPITAL** spend is **£1.549m** with a forecast outturn of **£4.283m;** and
- **REVENUE** spend is **£0.374m** with a forecast outturn of **£0.652m**

TCS Programme Budget & Spend 2021-22

CAPITAL	Cumulative to Date			Financial Year		
	Budget to Oct-21	Spend to Oct-21	Variance to Oct-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	110,281	101,062	9,219	193,000	186,382	6,618
Project 1 - Enabling Works	100,000	124,162	-24,162	100,000	216,011	-116,011
Project 2 - New Velindre Cancer Centre	377,828	376,870	958	1,008,500	988,600	19,900
Project 3a - Radiotherapy Procurement Solution	188,900	201,393	-12,493	204,113	320,392	-116,280
Capital Pay Total	**777,009**	**803,487**	**-26,478**	**1,505,613**	**1,711,386**	**-205,773**
NON-PAY						
nVCC Project Delivery	23,870	19,048	4,822	78,500	78,500	0
Project 1 - Enabling Works	131,250	130,553	697	245,500	406,945	-161,445
Project 2 - New Velindre Cancer Centre	480,363	466,364	13,999	2,084,500	1,829,887	254,613
Project 3a - Radiotherapy Procurement Solution	132,528	129,492	3,035	255,728	255,803	-76
Capital Non-Pay Total	**768,010**	**745,458**	**22,553**	**2,664,228**	**2,571,136**	**93,091**
CAPITAL TOTAL	**1,545,019**	**1,548,945**	**-3,926**	**4,169,840**	**4,282,522**	**-112,682**

REVENUE	Cumulative to Date			Financial Year		
	Budget to Oct-21	Spend to Oct-21	Variance to Oct-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	119,679	119,679	0	224,833	224,833	0
Project 6 - Service Change Team	177,703	189,272	-11,570	304,633	320,974	-16,340
Revenue Pay total	**297,381**	**308,951**	**-11,570**	**529,466**	**545,807**	**-16,340**
NON-PAY						
nVCC Project Delivery	16,307	14,028	2,279	26,000	26,000	0
nVCC Judicial Review	43,000	43,000	0	58,000	58,000	0
Programme Management Office	0	8,100	-8,100	21,534	21,534	0
Project 6 - Service Change Team	0	155	-155	0	266	-266
Revenue Non-Pay Total	**59,307**	**65,283**	**-5,976**	**105,534**	**105,800**	**-266**
REVENUE TOTAL	**356,688**	**374,235**	**-17,546**	**635,000**	**651,607**	**-16,607**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST OCTOBER 2021

CAPITAL SPEND

Project Leadership, Projects 1 and 2 Pay Costs

5.1 ***WG Funded Staffing -*** An in-year spend of **£0.602m** for posts funded by WG reflects the current position against a budget of **£0.588m**. There is a forecast spend of **£1.391m** for the year against a budget of **£1.302m**. The pay costs have been analysed by each element of the Project(s).

nVCC Project Delivery, Projects 1 and 2 Non-Pay Costs

5.2 ***nVCC Project Delivery -*** There is an in-year capital spend of **£0.019m** against a budget of **£0.024m** for project support and running costs for Projects 1 and 2. This is made up of office costs and document portal fees. The spend for this financial year is forecast to break even against a budget of **£0.079m**.

5.3 ***Project 1 Enabling Works -*** There is a cumulative capital spend to date of **£0.255m** against a budget of **£0.231m**, with a forecast spend for the year of **£0.623m** against a budget of **£0.346m**.

Work package	Spend to 31st October 2021 £m	Forecast Annual Spend £m
Pay	**£0.124**	**£0.216**
Third Party Undertakings	£nil	
Technical Advisers	£0.101	
Works	£0.012	
Legal Advice	£0.017	
Enabling Works Reserves	£nil	
Non-pay	**£0.130**	**£0.407**
Total	**£0.254**	**£0.623**

5.4 ***Project 2 - nVCC -*** There is a cumulative capital spend to date of **£0.963m**, against a budget of **£0.968m**. The forecast spend for the years is **£3.084m** against a budget of **£3.286m**.

Work package	Spend to 31st October 2021 £m	Forecast Annual Spend £m
Pay	**£0.478**	**£1.175**
Project Delivery costs	£0.019	£0.079
Competitive Dialogue – PQQ & Dialogue	£0.462	£1.695
Legal Advice	£0.012	£0.053
nVCC Reserves	-£0.008	£0.082
Non-pay	**£0.485**	**£1.909**
Total	**£0.963**	**£3.084**

Project 3a – Integrated Radiotherapy Procurement Solution

5.5 There is a cumulative capital spend to date of **£0.331m** (£0.201m pay, £0.129m non-pay) for the IRS Project against a budget of **£0.321m**. The Project is currently forecasting a spend of **£0.576m** (£0.320m pay, £0.256m non-pay) against a budget of **£0.460m**.

5.6 The Project delay and the Final Tender phase work have increased the project staff resource requirement for the Project, which is now forecast at £0.320m for 2021-22, resulting in a **forecast overspend of £0.116m**. The plan is for the other TCS Projects and / or Trust discretionary capital funding to cover the increased pay costs for the IRS Project.

REVENUE SPEND

Programme Management Office

5.7 The PMO spend to date is **£0.128m** (£0.120m pay, £0.008m non-pay) against a budget of **£0.121m** (pay). The Project is currently forecast to break even in the financial year 2021-22 against a budget of **£0.246m** (£0.225m Pay, £0.021m Non-pay).

Projects 1 and 2 Delivery Costs

5.8 There is a revenue project delivery cost to date for the nVCC and Enabling Works Projects of **£0.014m** against a budget of **£0.016m,** with a budget and expected spend for the year of **£0.026m**. This spend relates to costs associated with office costs and project support, such as audit, training and Competitive Dialogue support.

nVCC Judicial Review

5.9 There is a cumulative to date revenue spend of **£0.043m** against a budget of the same for the legal advice to deliver the requirements of the judicial review process as the Trust is an interested party. The current budget and forecast spend for the year is **£0.058m**.

Project 6 – Service Delivery, Transformation and Transition (Service Change)

5.10 Service Change spend to date is **£0.189m** against a budget of **£0.178m,** made up of pay costs. The Project is currently forecasting a spend of **£0.321m** for the year against a budget of **£0.305m**. The overspend remains a financial risk to the outturn position for the Project, which the Project Team are working to mitigate.

6. Financial Risks & Issues

6.1 The forecast overspend of £0.116m (capital) for the IRS Project and £0.017m (revenue) for the Service Change Project remains a risk to the outturn position for the Programme, however it is anticipated that these overspends will be funded through other TCS programme underspends or Trust discretionary capital funding.

7. CONSIDERATIONS FOR BOARD

7.1 This report is included as an appendix to the Trust Board Finance Report.

8. 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.

9. RECOMMENDATION

9.1 The Board are asked to **NOTE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 31st October 2021.

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST RISK REGISTER

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not applicable

PREPARED BY	Lenisha Wright, Chief of Staff Manager
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	1 November	
Quality, Safety and Performance Committee	18 November	

ACRONYMS	
VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
TCS	Transforming Cancer Services
SLT/SMT	Divisional Senior Leadership Teams / Senior Management Teams
EMB	Executive Management Board

1. SITUATION AND BACKGROUND

The purpose of this report is to present the Trust Board with information on the status of organisational Risks recorded in the Trust Risk Register, as part of the ongoing management and mitigation of risks. The Trust Risk Register includes risks that meet the Trust Board risk appetite criteria for reporting, which for most risk categories are risks >=12 and in addition all risks with an impact of 5. Risk information for level 20, 16 and 15 are highlighted in this cover report. No level 25 risks have been recorded in the Trust Risk Register.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Executive Management Board, Trust Board and Committees. Risks on the Trust Risk Register presented in this report have been reviewed at Divisional Senior Team meetings on scheduled meeting dates. Going forward any additional input other than data recorded in the risk register, from SMT/SLT meetings for will be shared in papers to QSP Committee.

The Trust Board is requested to:

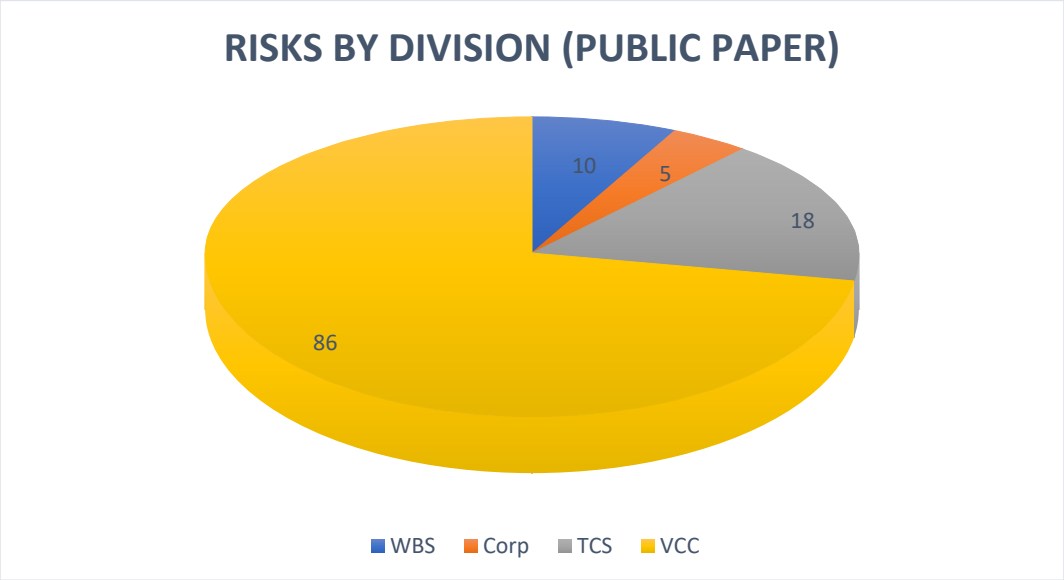
- **NOTE** and support the continued work being undertaken on the management of risks in the organisation which includes the ongoing validation, authentication and mitigation of risks.
- **SCRUTINISE** the data in the risk registers including, risk ratings, review dates and identified controls.
- **NOTE** the following work that is currently progressing:
  - Implementation of the board approved risk process, risk appetite and risk framework;
  - Establishing a new risk process;
  - Risk mitigation from version 12 to version 14 of Datix;
  - User set up and access to the new system;
  - Training for staff.

3. THE TRUST RISK REGISTER

There are risks recorded in two registers currently, version 12 and version 14 of Datix. Trust Risk Registers for Corporate, VCC and TCS are recorded in Vs 14 of Datix, and Risks for WBS is currently recorded in version 12 of Datix. A process is currently underway with final amendments and updates being made to version 14 to align legal and process requirements ensuring version 14 is fit for purpose for all Divisions. Following the completion of this process, all risks will be recorded on one risk register, in version 14 of the Datix system.

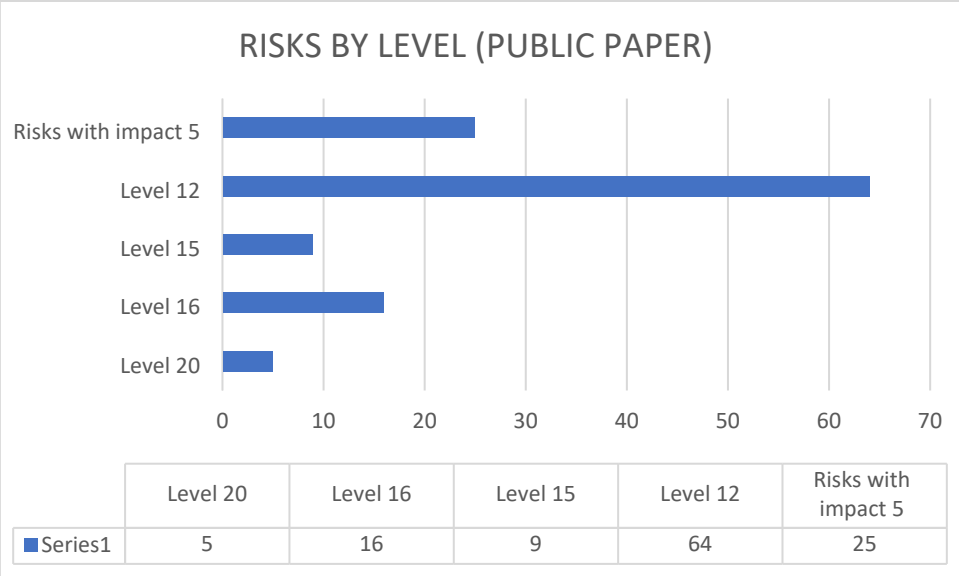
3.1. Total Risks

There are a total of 119 risks recorded in Datix Trust Risk Registers, for both version 12 and version 14. This compares to 111 in the September 2021 reporting cycle. The graph below provides a breakdown of the total number of risks by Division.



3.2. Risks by level

The graph below provides a breakdown of risks by level across the Trust.



The September reporting period focused on providing further analysis in this report on risks rated 20 and 16. This report includes further focus on those rated 15. For the next period, those with an impact rating of 5 will have further analysis also.

3.3. Risks level 25

There are no risks with a risk rating of 25 recorded in the Trust Risk Register at the time of the data being extracted from Datix.

3.4. Risks level 20

The table below provides a breakdown of risks level 20. There are currently five risks with a current risk rating of 20 recorded, two for VCC, two for TCS and one for WBS. This compares to six in the September 2021 reporting cycle.

Of the five recorded risks with a rating of 20, two relate to performance and service sustainability and three to workforce. Four of these were rated as 20 in previous reporting cycle.

There is one new risk, 2437, relating to the delay in new radiographer graduates to start. The risk is described as that the service will be relying on locum/ agency staff - more staff to train and higher risk of error. The actions and controls are described as Digital Health and Care Record training team can offer flexible training sessions to fit around clinical commitments. Digital Health and Care Record team can provide financial assistance to support additional staff resource.

There are two risks which have reduced scores from September 2021 reporting cycle:

- 2252 has reduced to a score of 15 - large number of development projects in radiotherapy. The risk describes actions undertaken to reduce the risk in terms of a prioritisation of projects underway and a core team resilience approach identified to allow scientists back to project work. It describes that the programme plan for radiation services is being developed and will require input from the Integrated Radiotherapy team and the Digital Health and Care record team;
- and 2188 has reduced to a score of 12 – lack of physical space at VCC to accommodate the current service requirement and related standards. The risk describes a number of actions as being completed, including around approval of capital business cases, to support the reduction in risk score.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2191	Velindre Cancer Centre	31/01/2022	Inability to meet COSC / SCP targets
	14764	Trust Wide (managed obo Trust by Welsh Blood Service)	06/04/2022	Brexit - Implications of Exiting the EU
Workforce	2437	Velindre Cancer Centre	29/11/2021	DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021
	2401	Transforming Cancer Services	05/11/2021	Risk of insufficient resources being made available to the Project 3 - Integrated Radiotherapy Solution

Risk Type	ID	Division	Review date	Title
	2400	Transforming Cancer Services	16/09/2021	Risk that there is lack of project support to Project 5 – Outreach Services

3.5. Risks level 16

The table below provides information of level 16 risks as per the Risk Register. There are currently a total of 16 risks with a current risk rating of 16, two for TCS and 14 for VCC.

This compares to 16 in the September 2021 reporting cycle. There are two new and two closed risks.

The two new risks opened in this reporting period are:

- 2428 - There is a risk of increased infection transmission due to poor ventilation. The risk describes that further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. There are a number of controls identified including: infection control and prevention measures in line with Trust polices; additional COVID19 precautions; full root cause analysis undertaken to ascertain cause(s) of any infections; and business case delivery;
- 2440 –SACT service are unable to significantly reduce the capacity of SACT daycase clinics and there is a risk regarding reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients. The risk is to be fully considered and analysed following confirmation of go live date.

There are also two risks which have closed since the September 2021 reporting period:

- 2212 – The threat to systems and processes against cyber security. Instead of this overarching risk, there has been work over the period to record and manage against the components of the cyber risk profile. There are now 11 cyber related risks in the profile, all with a risk score of 10, risks 2458 and 2444 to 2451;
- 2213 – Resilience of VCC phone system due to dependency on legacy/ end of life infrastructure. This risk was a legacy record and no longer relevant therefore closed.

Risk Type	ID	Division	Review date	Title
Compliance	2428	Velindre Cancer Centre	29/11/2021	There is a risk of increased infection transmission due to poor ventilation.
Financial Sustainability	2198	Velindre Cancer Centre	13/12/2021	*There is a risk due to the lack of contracts/ Service Level Agreements for services delivered by NHS organisations and external companies - robust governance structures needed for better management of contracts*

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2440	Velindre Cancer Centre	29/11/2021	DHCR046(R) – There is a risk of not being able to significantly reduce the capacity of SACT daycase clinics over the Go-Live period
	2402	Transforming Cancer Services	01/09/2021	Project 5: There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care
	2329	Velindre Cancer Centre	29/11/2021	DHCR034(R) - There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required
	2328	Velindre Cancer Centre	29/11/2021	DHCR035(R) - The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care. There is a risk that Documentation will not be accurate impacting on clinical decision making
	2326	Velindre Cancer Centre	31/12/2021	There is a risk that the Service will be unable to significantly reduce the capacity of outpatient clinics over the DCHR go-live period
	2221	Velindre Cancer Centre	29/11/2021	DHCR019(R) - Clinical Coding Copy Functionality within WPAS
	2211	Velindre Cancer Centre	29/11/2021	DHCR004(R) - Requirements for Standardisation, process redesign and agreed Ways of Working - Business Change

Risk Type	ID	Division	Review date	Title
	2203	Velindre Cancer Centre	29/11/2021	DHCR013(R) - Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed
	2200	Velindre Cancer Centre	31/12/2021	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards
	2196	Velindre Cancer Centre	01/12/2021	Radiotherapy Department capacity -COVID isolation impact for staff
	2193	Velindre Cancer Centre	01/04/2022	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)
	2190	Velindre Cancer Centre	31/03/2022	BI Support for reporting of Breaches
Quality	2403	Transforming Cancer Services	12/11/2021	Risk that enabling works construction exceeds timescale
Safety	2197	Velindre Cancer Centre	12/09/2022	Breach of current Welsh Government Social Distancing

3.6. Risks level 15

There are currently nine level 15 risks recorded in the Trust Risk Register. All nine risks for this level are recorded for VCC with six relating to performance and service sustainability, two to safety and one to workforce.

The reporting in the September report focused on risks scored 16 to 25. Therefore a fuller trend and tracked change position will be reporting on the 15 scored risks in the next reporting period.

To note that eight of these risks have remained scored at 15 from the previous reporting period and one (2252) has reduced from score of 20 as described in that section of this report.

Risk Type	ID	Division	Review date	Title
Performance and Service Sustainability	2296	Velindre Cancer Centre	29/11/2021	DHCR010(R) - Data Migration Resource
	2253	Velindre Cancer Centre	01/05/2022	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff
	2252	Velindre Cancer Centre	01/04/2022	Large number of development projects in Radiotherapy
	2220	Velindre Cancer Centre	31/12/2021	There is a risk that some patient treatment plans cannot be completed as a result of the Oncentra MasterPlan (OMP) treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP
	2205	Velindre Cancer Centre	31/01/2022	If CANISC is unavailable, there is no “fall-back” method for certain activities and to ensure compliance with IR(ME)R 217 regulations.
	2187	Velindre Cancer Centre	31/12/2021	The ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced
Safety	2218	Velindre Cancer Centre	12/09/2022	Reduction in the car parking at VCC increases the potential risk of accidents and injuries to patients, visitors and staff

Risk Type	ID	Division	Review date	Title
Safety	2185	Velindre Cancer Centre	31/05/2021	There is a risk of physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets
Workforce	2217	Velindre Cancer Centre	01/12/2021	Medical time for Radiotherapy Planning within job plans is not efficient, timely or in many cases, sufficient, particularly with the RCR requirement for peer review

4. IMPACT ASSESSMENT

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

5. RECOMMENDATION

The Trust Board is asked to:

- **NOTE** the risks level 20, 16, 15 and 12 reported in the Trust Risk Register and the highlighted risks 20, 16 and 15 in this cover paper.
- **SCRUTINISE** the data in the risk registers including, risk ratings, review dates and identified controls.
- **NOTE** and support the continued work being undertaken on the management of risks in the organisation which includes the ongoing validation, authentication and mitigation of risks.
- **NOTE** that a project plan is in place and actions undertaken to expedite progress in establishing a consolidated risk process for the Trust.

ID	Division	Department	Approval status	RA Date	Review date	Closed date	Title	Description	Controls in place	Rating (initial)	Risk Rating (Current)
14764	Welsh Blood Service	Affecting Whole Service	Final approval	09/10/2018	06/04/2022		Brexit - Implications of Exiting the EU - No Deal Situation	Increased expenditure	Public Contract Regulations Budgeting and financial controls	20	20
13819	Welsh Blood Service	Field Not Required	Final approval	21/02/2018	18/11/2021		Blood Supply Chain 2020 Initiative - Impact on Staff	Revised roles and contractual changes. New ways of working.	Early engagement with staff. Full support package available on intranet. Occupational Health support available. Potential for staff opportunities. Involvement of staff in decision making.	20	12
14508	Welsh Blood Service	Human Resources-WBS	Final approval	09/07/2018	01/09/2021		Management of Work Place Related Stress	Could affect every activity within WBS including collections, processing and distribution etc. of blood products	Policy (Trust wide Mental Health , Wellbeing and Stress Management WF43) Toolkit to support Good Mental Health, Wellbeing and Reduce Stress. Employee assistance programme All Wales Wellbeing Tool Kit Stress risk assessment (completed by manager with staff member) Sickness absence policy Manager Training Mindfulness / complementary therapy Team Assistance Organisation Development facilitated discussion and mediation Organisation change RA Blood Supply 2020 relating to stress. Work life balance - flexible working. Health and wellbeing - Cycle to work scheme to promote healthy activities. Monitoring of sickness and absence reasons and levels. PADR process - clear roles and responsibilities. Manager support. Update Oct 2019 Continue to monitor sickness and absence levels	16	12
15373	Welsh Blood Service	IT Software-WBS	Final approval	27/06/2019	28/02/2022		Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	Increased complexity of networking / integration architecture in respect of the middleware used to interface devices that require interfacing to MAK-System products (e.g. ePROGESA). Additional costs incurred for establishment and maintenance of interfaces to MAK-System products (e.g. ePROGESA).	Ability to liaise with suppliers during procurement to advise on WBS preferences in respect of middleware arrangements for connected devices. MAK have recently confirmed "non partners" will still be permitted to interface devices to ePROGESA and other related MAK services. Subject to ongoing monitoring and discussion via International MAK-System User Group (IMUG)	12	12
873	Welsh Blood Service	Transport-WBS	Final approval	30/04/2008	05/03/2022		Collection point for staff at WBS	21-Jan-2008 - Original assessment completed 22/09/06 - The staff collection point was to the right of the main entrance, the driver of the pick up vehicle would have to reverse into and turn in the visitors car park. The turning circle was cut into the right hand bay to alleviate the problem of the staff reversing in a confined space car park.	Visitors parking area sign posted. Disabled spaces colour coded.	12	12

15932	Welsh Blood Service	Affecting Whole Service	Final approval	23/04/2020	05/11/2021		Impact of COVID-19 stabilisation phase to WBS	Re-introduction of elective procedures including Haematology activities. WBS are aware that WG have written to all Health Boards regarding the re-introduction of this work.	VUNHST planning team and WBS blood health team are liaising with hospitals to determine future demand. Existing MOU with the UK blood services to support in the event of a shortage in a blood component. WBS planning team have forecasted future collection models based on potential scenarios. Currently working on a proof of concept around trailer use in a socially distanced environment and also considering fixed site options	16	12
16266	Welsh Blood Service		Final approval	15/09/2020	01/08/2022		Inability to secure venues during response /recovery plan for Covid-19 - Impact to Blood Supply Chain	Inability to operate clinics at the same efficiency verses pre-Covid 19 due to social distancing and IPC measures/amount of donors able to attend venue due to social distancing measures.	Escalated to the Director of WBS And Chief Operating Officer for VUNHST, Head of Planning Logistics and Resource to submit SBAR outlining emerging situation and required support. Explored with MOD available venues. Ongoing dialog with PHW and WG about conflict between vaccination and WB venues. Update 28/01/2021 - A number of Health Boards have not yet responded to email , those that have showed that there will be some conflict with venues in certain regions. Working on proof of concept for use of trailers in a socially distanced environment, Also looking at options around a potential fixed site.	20	12
16398	Welsh Blood Service	Affecting Whole Service	Final approval	11/12/2020	23/12/2021		Review of modules used in Oracle Finance & Procurement System - GxP impact	Purchasing - used to manage the procurement of both stocked items (using the Inventory module), and non-stocked items (using the IPROC module).	Functionality verified in CQ test scripts for IPROC and Inventory (Note: issues would only be identified in the Live environment during CQ testing)	12	12
16703	Welsh Blood Service	Facilities-WBS	Final approval	23/06/2021	17/12/2021		Risks identified for implementation of Oracle R12.2.9	Lack of end to end testing	None	12	12
16883	Welsh Blood Service	Facilities-WBS	Final approval	20/09/2021	31/12/2021		Implementation of Oracle Release R12.2.9 (Phase 1)	IPROC module - allows users to order catalogue and non-catalogue for non-stock items from suppliers.	(1) Participation in several phases/iterations of UAT have helped identify issues/errors in the system. Servicepoint tickets were raised when required for issues/errors identified. (2) Smoke testing has been performed by eEnablement which incorporated end-to-end testing.	12	12

ID	Risk Type	Division	Approval status	Opened	Review date	Closed date	Title	Risk (in brief)	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)
2428	Compliance	Velindre Cancer Centre	Accepted	02/08/2021	29/11/2021		There is a risk of increased infection transmission due to poor ventilation.	Concerns have been raised around the poor ventilation and seasonal extremes of temperature that exist within inpatient areas at VCC impacting both staff and patients, this risk assessment relates to First Floor (FF) ward. Patients receiving care in the inpatient ward at VCC are often immunocompromised and/or neutropenic and therefore would benefit from improved air quality which can only be guaranteed through a compliant mechanical ventilation system. See document for full description	UPDATE 03.11.21 - Further detailed planning to be undertaken by estates and operational services teams in conjunction with nursing team with timescales and decant plan. * Infection control and prevention measures in line with Trust polices. Including regular audit, training, enhanced cleaning etc. * Additional COVID19 precautions - Use of PPE, regular testing of patients and staff etc. * Full root cause analysis undertaken to ascertain cause(s) of any infections. * Business Case currently under development to seek funding for compliant ventilation system.	16	16	9
2251	Compliance	Velindre Cancer Centre	Accepted	18/03/2016	30/09/2021		XVI imaging termination faults resulting in repeat acquisitions	There is a risk that the patient will require an additional CBCT scan to confirm treatment position as a result of a known fault with XVI which may lead to additional patient imaging dose. Under new IRMER guidance if 3 scans are required to achieve 1 usable dataset this becomes reportable. This fault is known UK wide issue. When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining	15	12	9
2235	Compliance	Velindre Cancer Centre	Accepted	16/02/2014	13/12/2021		There is a risk of health and safety breaches due to lack of dedicated H&S support at VCC which may lead to harm, financial loss	An internal audit of Trust wide H&S management was undertaken in 2011. At that time it was reported that “the systems and structures in place within the Velindre Cancer Centre were not sufficient to ensure that Health & Safety is being effectively managed in all areas”. Due to the lack of dedicated H&S operational resources, the Trust H&S Manager was located on site and provided operational support to the VCC for an initial 6 month period to support the development of H&S structures and processes. A divisional H&S plan was developed and many improvements were implemented under the leadership of the Trust H&S Manager (A divisional H&S focus group, a programme of H&S departmental inspections, delivery of professional H&S training). The Trust H&S Manager has provided operational support to the VCC since 2011. This resulted in an	1.Trust Quality & Safety Advisor providing advice and support for H&S management 2.A number of staff and managers have completed professionally accredited H&S training 3.A trust M&S trainer has been employed who will deliver H&S related training 4.Improvements in COSHH management. Operational Services supporting the division in taking this are forward. Main departments with the exception of nursing are up to date. Funded an increase in licences and users to allow expanded access 5.Improvements in risk register process – H&S risks are included on the risk register which is referred to Trust H&S Committee 6.Increase in the number and improved content of risk assessments 7.Process in place for replenishing first aid boxes and contents 8.Incidents continue to be investigated locally with Trust H&S	16	12	3

2234	Compliance	Velindre Cancer Centre	Accepted	01/07/2020	09/09/2022		Non-compliance to COSHH regulations, which may lead to staff injury or ill health when using chemicals not in the SYPOL system.	VCC have purchased the Alcumus (SYPOL) system to collate and generate the COSHH Risk Assessments. There is a risk of injury or ill health to staff who use chemicals that are not listed on the Alcumus (SYPOL) system, which may lead to accidents, incidents and ill health or claims against the organisation. The operational lead for H&S at VCC has delegated the management of the Alcumus (SYPOL) system to the VCC Compliance Manager. All Managers at VCC are responsible for ensuring: * the Alcumus (SYPOL) system is implemented within their department * access to up-to-date Risk Assessments for working with chemicals are available * safe systems of work/procedures have been developed and are in place for the use of chemicals * the Risk Assessments are	1. Alcumus (SYPOL) system is in place, but has not been fully rolled out. 2. Alcumus (SYPOL) Action Plan has been developed and has been presented to VCC's Health & Safety Forum and its Quality & Safety Committee. The Action Plan is being continuously monitored and updated. 3. All chemicals have been identified across departments and respective Risk Assessments completed. 4. Alcumus (SYPOL) system has been promoted to Departmental Managers / H&S Leads via meetings and emails. 5. The responsibility of Departmental Managers / H&S Leads in relation to staff acknowledgement and acceptance of Alcumus (SYPOL) Risk Assessments has been communicated in a Divisional Health & Safety Procedure document which has been presented to VCC's Health & Safety Forum and its Quality & Safety Committee.	12	12	4
2227	Compliance	Velindre Cancer Centre	Accepted	22/05/2020	12/01/2022		Inability to comply with Health Protection (Coronavirus Restriction) (Wales) Regulations 2020	Inability to comply with Health Protection (Coronavirus Restriction) (Wales) Regulations 2020 There is a risk a risk that that non-compliance with the regulations could place patients and staff at increased risk of infection and contracting COVID-19	UPDATE June 21 - Continue to implement IPC measures and social distancing and ensure all patients are triaged and assessed. Additional measures have been put in place to reduce footfall and plans to relocate the phlebotomy dept. are being progressed. Continue to monitor numbers of patients and footfall as the OPD continues to see increasing numbers of patients for F2F appointments as demand increases. Continue to monitor any changes to the regulations or all Wales guidance which will impact on the OPD. Continue to adhere to visitor guidance	12	12	12
2188	Compliance	Velindre Cancer Centre	Accepted	18/04/2018	24/01/2022		There is a risk that services cannot be expanded to meet demand as a result of lack of accommodation which may affect service de	Lack of physical space to accommodate the current service requirements, statutory building note requirements, health and safety standards and other legal requirements at Velindre Cancer Centre. This risk affects all areas within VCC. A number of internal and external audits have demonstrated a significant lack of physical space within all areas of VCC. COVID 19 pandemic has further reduced available site capacity by 40-50%. Increased provision of clinical services and workforce requiring additional space. Requirement for Digital Programme Team to return to VCC site in view of DHCR replacement programme, testing and training requirements etc.	1. Ongoing review of current accommodation to ensure best use and maximisation. 2. Review service models and the balance between on site and outreach services to make best use of all resources. 3. Implement changes in working practices where appropriate (e.g. working from home, extend the working day) 4. Office sharing principles reviewed in light of COVID19 which has led to reduction in available office accommodation due to 2m rule. 7. Open plan and flexible working. 8. Additional space within CRW to be utilised as a temporary measure for Digital Programme Team as part of DHCR Programme. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work.	12	12	6

2260	Compliance	Velindre Cancer Centre	Accepted	02/09/2011	03/08/2021		Control of Asbestos at VCC	Working on the infrastructure or fabric of the building and causing the release of asbestos which may endanger patients, staff, visitors and contractors.	Large areas of Asbestos have already been removed from Velindre Cancer Centre. Trust Asbestos Policy and Management Action Plan in place. Supervision on site has received "Management of Asbestos in Building Training" (P405). VCC has and maintains an asbestos register which Estates staff can access. The maintenance ducts have been identified as having asbestos material within them; maintenance staff have been informed not to enter these ducts. Safe systems of work are in place at VCC, all jobs competed by Estates staff are automated through the FACTS system which locates any asbestos in the working area and records them on the job sheet identifying the risk as Level 1, 2, or 3. Estates staff have completed Asbestos Awareness Training within the last 12 months. Estates staff complete Health and Safety training.	15	10	5
2343	Compliance	Velindre Cancer Centre	Accepted	20/12/2010	27/07/2021		Water Systems - Legionella	Maintaining the water systems free of Legionella at the Velindre Cancer Centre using a range of monitoring and control systems for water treatment and flushing across the VCC site. Continual improvement to remove redundant pipework and upgrade water systems where possible.	Regular monitoring of water temperatures. Regular testing and sampling. HEPA filters on shower outlets in the patient areas. Risk assessment and audit of water system by external consultant. Water Safety Group in place with appropriate members which meet regularly. Water Safety plan and written scheme are in place. Pre-planned preventative maintenance are also on FACTS and are routinely undertaken by competent staff. Removal of redundant pipe work where possible. Legionella management policy in place. Responsible person trained. Water sampling regime has been constructed and reviewed by Water Safety Group members and is currently in place on all sites.	20	5	5
2340	Compliance	Velindre Cancer Centre	Accepted	22/10/2013	03/08/2021		Risk of injury to staff, patients, visitors if equipment hasn't been PAT tested	There is a potential risk of injury to building users if equipment have not been PAT tested.	No equipment to be used on site unless it has a valid PAT sticker. Patients equipment is tested and PAT sticker is applied (staff are responsible for informing Estates via the FACTS system of patients' equipment which requires testing. Industry Guidelines consulted to decide frequency of testing for IT equipment (every three years). Medical equipment is tested by Bio engineering (outside of the Estates remit). All other equipment is tested annually. Asset register of appliances created during testing by contract labour. Department managers are informed prior to annual testing taking place within their department. Any incidents regarding portable electrical equipment are raised on DATIX and discussed at the Electrical Safety Group.	15	5	5

2198	Financial Sustainability	Velindre Cancer Centre	Accepted	29/12/2017	13/12/2021		VCC mayface financial loss, legal action, inaequate service provision as a result of no coordinated system for SLAs, contracts	VCC has numerous contacts and SLA's for services delivered by NHS organisations and external companies. To manage such legal agreements it is crucial to have robust governance structures for the development, management, monitoring and renewal of such documents. There are a lack of processes, clarity regarding responsibility regarding responsibility, management etc and a varied level of monitoring.	Specialist procedure advice via NWSSP Agreement for planning team to take ownership (delayed due to COVID) VCC Planning team to take responsibility for establishing database and monitoring mechanism	16	16	6
2255	Financial Sustainability	Velindre Cancer Centre	Accepted	24/02/2021	31/03/2022		Private Patients Debt	An internal audit under in 20/21 reviewed debt management as one of its objectives. A key area requiring attention was the management of aged debtors by the Private Patient Service. The conclusion was that the aged debtors are not monitored or acted upon and there was no action plan in place to improve the situation. Also that there is no liaison between the private patient service and the corporate finance team. Analysis has shown that debtors go back a number of years and include self paying individuals as well as insurance companies. As at the time of submitting this risk the outstanding amount is £328,791.	1. Full review of all debtors in 2017 and 2018 to assess current situation and recommendation for follow up to be provided to Director of Finance. 2. Action plan developed for Trust Audit Committee which will be monitored by weekly meetings. 3. All debtors to be written to by 5th March 2021 providing 14 day payment period requirement. 3. Meeting arranged to discuss automation of process options. 4. Private Patient Manager to benchmark systems with other organisations. 5. Private Patient Manager to review current Standard Operating Procedures (SOP's) to improve current process. 6. Head of Operations and Delivery to work with Deputy Director of Finance to review Trust SOP's and engagement process. 7. Regular meetings with Private Patient Manager and corporate Finance lead to be established.	12	12	4
2249	Financial Sustainability	Velindre Cancer Centre	Accepted	27/02/2020	20/12/2021		Risk of service disruption due to number of posts funded by soft monies leading to financial instability,recruitment difficultie	A high proportion of VCC workforce are funded via 'soft monies' from the Trust Charity or Third Sector. This leads to risks around service continuity, recruitment and retention and staff wellbeing. It also poses a financial and reputational risk for the Trust should funding be ceased. For 20/21 there is approximately £2.8 million of charity/3rd sector funding which is supporting service delivery.	Funding ending in the next year to be included in cost pressures for 2020/21. Review posts funded externally to establish: Number of posts, length of funding, contribution to service, and contractual position of postholder. Establish Financial contingency. Through the scrutiny process ensure future risks are considered for all new and extended posts. Prioritise work in order of funding stream end date	12	12	4
2411	Partnerships	Transforming Cancer Services	Accepted	04/11/2020	30/11/2021		Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS	Risk that there is potential misalignment of scope and timeliness of decisions between VF & TCS Causes - Poor communications between VF & TCS teams Delays in agreement of VF scope & governance arrangements Lack of clarity of scope for VF Lack of understanding of the interdependent timescales and activity Lack of knowledge and understanding of both programme objectives Consequences - key deliverables get missed as not picked up by either TCS or VF Delaying progress of current live projects Change of priorities Adjustment of plans Agreements / decisions have been made already (i.e. could be contractual agreements in place)	1) Agree clear scope and role of VF and its programme board. 2) Understand the interfaces that VF has on the scope of TCS and its programme board to be clear about the delegations that result. 3) Communicate the scope of both and any implications for TCS 4) Prioritisation of key work items and workshops to agree the appropriate routes for decision making 5) Understanding and agreement of key stakeholders within and outside the organisation.	12	12	6

2191	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	31/01/2022		Inability to meet COSC / SCP targets	Inefficiencies in current pre-treatment pathways and failure to meet agreed timescales - link to breach report against time to treat targets.	Workforce requirements highlighted Service improvement project to be initiated	20	20	4
2440	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	18/08/2021	29/11/2021		DHCR046(R) - unable to significantly reduce the capacity of SACT daycase clinics	SACT & MM service are unable to significantly reduce the capacity of SACT daycase clinics and concern re: reducing pre-assessment clinics over the Go-Live period due to cyclical nature of SACT treatment and potential consequences of delays for SACT patients Mimimal amount of SACT treatments can be paused due to nature of service provision. Clinics are monitored regularly to manage ongoing constraints with capacity.	Regular capacity review meetings by SACT & MM leads to discuss ongoing capacity constraints 23/08/21 - There are a small amount of specific regimens where there is scope to reschedule treatment dates and therefore reduce patient numbers for go-live week. Decision to reduce capacity at go live is a strategic level decision requiring project board/SMT/Exec approval. Risk can only be fully considered when go live date is agreed.	16	16	6
2402	Performance and Service Sustainability	Transforming Cancer Services	Accepted	10/05/2021	01/09/2021		Risk of time-consuming infrastructure work	There is a risk that time-consuming infrastructure work i.e. the refurbishment of a current site or identification of a new build is required to deliver the agreed outreach model of care. This could lead to delays in outreach services not being established or operational ahead of the new VCC as agreed within Programme objectives	1) Identify location 2) Identify refurb / new build required 3) Establish level of local engagement with CHCs/public required 4) Identify appropriate resources from all HBs & VUNHST (inc Project Leads, Planning etc) to ensure project is supported and managed to align with project & programme timelines 5) Establishment of ownership and governance of Project within TCS/VF environment	16	16	9
2329	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/06/2021	29/11/2021		DHCR034(R) - SACT & Medicines Management – Cashing Up Daycase Clinics	There is a risk that the 'cashing up' of the daycase clinics in WPAS (including SACT, Clinical Trials, OPs and ambulatory and supportive care) will not be completed as required. Documentation and performance data will not be accurate. Protracted administrative process causing stress to clinical teams whose primary focus is clinical care.	SACT, Clinical Trials, Supportive care an OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role Attendance data is reviewed manually by the nursing administration team when they process the daycase clinics to change certain attendances to WACs as necessary. This is not comprehensive and does not cover all of the clinics at present.	16	16	16
2328	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/06/2021	29/11/2021		DHCR035(R) - SACT & Medicines Management – processes	The process of booking / admitting patients as they arrive in real time on the unit is time consuming and complex whilst clinical staff are concentrating on safe delivery of care Potential risk to patient safety because clinical staff are distracted by the administrative task Documentation will not be accurate impacting on clinical decision making Protracted administrative process causing stress to clinical teams whose primary focus is clinical care	SACT, Clinical Trials, Supportive care and OP daycase are all scheduled via Chemocare therefore the patient record will be complete in Chemocare Explore requirements for administrative role	16	16	16

2326	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	24/05/2021	31/12/2021		There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care R	A Minimal amount of outpatient activities can be paused due to the nature of the service provision. Some non-cancer and follow-up clinics can be reduced however. Clinics will be running at normal capacity - ideal situation on a large go-live would be for reduced clinics for a few days after go-live to allow users a little additional time to get used to the new system.	1. Service managers and teams to be available on site. 2. Training champions/super users to support on site during the Go-Live period. 3. Minimise annual leave as much as possible.	16	16	9
2221	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	24/02/2021	29/11/2021		DHCR019(R) - Clinical Coding Copy Functionality within WPAS	DHCR019(R) - Clinical coding require a 'Copy Coding Functionality' within WPAS. Currently within Canisc VCC Clinical Coding staff are able to choose an option to 'copy exact coding to all linked Radiotherapy (RT) Regular Day Admissions (in same sequence of admissions)'. This means that if a patient has received 10 episodes of radiotherapy the coder can code the first episode and then click the copy function to copy to the other 9 episodes. This saves the coder time and ensures the accuracy of the coding. This functionality is not available within WPAS; therefore it is requested that the functionality be developed. There is a risk that NWIS are unable to deliver an exact replica of the functionality within the timescales - there is also a prerequisite on the Radiotherapy Admissions work	The proposed interim solution will enable 'manual selection instead of automated selection and copy'. This will enable the user to select multiple episodes across multiple admissions, within a single patient's record, and copy the coding from the 'coded' episode, to all other episodes selected. The user will have to verify that they want to complete this transaction to ensure the correct admissions is selected	16	16	12
2211	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/10/2020	29/11/2021		DHCR004(R) - Requirements for Standardisation, process redesign and agreed Ways of Working - Business Change	Requirements for standardisation, process redesign and agreed Ways of Working - Business Change The scope of the deliverables for the workstreams will change after being signed off and planned and may cause delays. There is a risk that without an element of standardisation; process redesign and agreed ways of working; system configuration, testing and training becomes very complicated and time consuming.	Ways of Working sessions to be held. Key advocates for change, standardisation and process redesign to be involved in the project Project Governance - Workstreams will be established to ensure key decisions are made with all involved in a timely manner required by the project. SMT and Clinical Lead support on standardisation of Ways of Working	16	16	12
2203	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	12/01/2021	29/11/2021		DHCR013(R) - Accelerated Timelines of the DHCR Programme	Due to the accelerated timelines of the DH&CR Programme, the data migration phase is having to be compressed from 18 months to 6 months. Data Migration Phase 1 (Patient Demographics and casenotes) and Phase 2 (Referrals, activity, Clinics, pathways and waiting lists) both need to be completed by prior to UAT testing which is due to commence in July 2021. There is a risk that any delay to these data migration activities could have a direct impact on the quality of the patient data migrated from Canisc into WPAS as there will be no time to review and cleanse the data prior. There is also a risk that any delay to the data migration activities will have a direct impact on the WPAS implementation date which may lead to the Service having to rely on an unstable and unsupported Canisc	Data Migration Phase 1 near completion and there are dedicated WPAS team resources working hard to complete all phase 2 activities by the end of April 2021, in line with the current DH&CR Project Plan which has been approved by the DH&CR Project Board.	16	16	8

2200	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	01/05/2011	31/12/2021		Radiotherapy Capacity	Availability of sufficient radiotherapy capacity within available financial resource affects achievement against national cancer standards. Patients may not be treated to optimum treatment timescales, which may affect the overall patient experience and lead to poorer outcomes. 2/7/19 update Hazards broken down into safety / quality and service sustainability sections. Narrative clarified – risks defined (PJ). This will be linked to Risk 2245	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy	16	16	4
2196	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	01/12/2021		Radiotherapy Department -COVID Isolation Impact	COVID Isolation Impact Staff isolation as a result of coming in to contact with a COVID positive person, exhibiting COVID symptoms or receiving a COVID positive test result will affect the capacity (Linac & Pre-Treatment hours) of the radiotherapy department as the majority of staff are patient facing and are unable to work from home. Resulting in the need to contract the radiotherapy service.	Ability to work from home with relevant IT equipment on completion of DSE risk assessment Isolations rules to be reviewed regularly. 7/5/2021 – risk reviewed by HP & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service. 1/11/2021 – risk reviewed by CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. The need to maintain the controls mentioned above continue to ensure safety of staff, patients and the radiotherapy service.	16	16	4
2193	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	05/02/2021	01/04/2022		Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)	Medical Physics Experts (MPEs) for Nuclear Medicine. This risk combines 8438 (submitted by S Hooper – MPE cover for clinical trials) and 15684 (submitted by M Talboys – Ra223 service) on the current risk register and has been expanded to encompass new developments on the immediate horizon. There is a significant risk is that Velindre Cancer Centre will not be in a position to safely and sustainably offer the Molecular Radiotherapy (MRT) demand, likely to be required in the next 12-18 months. This arises because of a lack of experienced Medical Physics Experts (MPEs), the timescales over which the implementation of new MRTs may be required, the predicted increase in workload and the anticipated number of other significant developments which will lead to not being able to implement MRT	Current control measures include:- Not participating in clinical trials involving MRT Not implementing any new MRT until a safe, sustainable service can be provided Organising workload to minimise the impact of a lack of MPE back-up. Expectation to date has been to ask C&V Medical Physics to provide any additional MPE cover. However, the depth of MPE cover has been critically eroded over the years and recent resignations mean the current position is there will be only 2.5 WTE physicists left by the end of April (only 2.0 WTE being MPEs). One of those MPE is already providing 1 WTE support to VCC under an SLA for over >30 years. This leave 1.0 WTE MPE at C&V. (C&V provides MPE support to other HB as well as its own).	20	16	2

2190	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	31/03/2022		BI Support for reporting of Breaches	BI Support for reporting There is a risk that lack of high quality data informing in real time key activity (demand/ capacity) Key data inputs (RTDS) are done manually Different staff groups only understand their own systems. Resulting in a lack of ability to accurately forecast and model future demand for services which may impact on accurate capacity planning for the scheduling of patient pathways	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes	16	16	10
2296	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	11/01/2021	29/11/2021		DHCR010(R) - Data Migration Resource	DHCR010(R) - The Head of Information who manages the Business Intelligence (BI) Service within VCC is actively involved with the Data Migration work. This includes assisting the Data Migration Specialist with the development and testing of data migration extracts from Canisc to WPAS. In addition, the Head of Information provides subject matter advice and guidance to the whole project team. There are currently competing priorities on the Head of Information time due and the need to delivery Capacity and Demand planning, ad hoc information requests etc. during the COVID pandemic, whilst supporting a new team. The impact of these competing demands and a number of new team members is the reduced availability of focused time for the Head of Information to undertake the complex data migration work.	Clear prioritisation of the BI Service work and Head of Information's workload is required. Notification to service users of unavoidability of BI Head for 3 weeks period in April 2021. A deep dive is planned to support this prioritisation. 09/06/2021 - LM & JH reviewed risk - situation still stands. LM to discuss with WJ.	15	15	6
2253	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	27/10/2020	01/05/2022		Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient	15	15	5

2253	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	27/10/2020	01/05/2022		Availability of CANISC System	There is a risk that clinical/patient services across VCC would be critically endangered as a result of the prolonged loss of CANISC, which may lead to significant patient harm and treatment delays due to the lack of availability of critical clinical information for VCC clinical staff. In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks	Full geographical resilience for CANISC was restored in August 2021 following completion of the migration of national IT services out of the Blaenavon Data Centre (BDC) by DHCW. This means the CANISC service can be 'failed over' to the new 'CDC' data centre in the event of there being issues in the primary 'NDC' data centre. This significantly reduces the risk of the permanent loss of CANISC services. In the event of CANISC becoming unavailable for short periods of time, access to relevant clinical documentation is avialable via alternative systems - e.g. - WCP CANISC Case Note Summary to provide historic record - Chemocare (existing patients) - Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. - WCP is linked to Master Patient Index (MPI) to access patient	15	15	5
2252	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	01/04/2022		Large number of development projects in Radiotherapy	Large number of development project Multiple development and research projects exist There is no single point of oversight or prioritisation of resource There is poor linkage between projects and the risk register or strategic service/ VCC/ Trust priorities. there is a risk that specialist and scarce resources will be required for multiple project simultaneously as a result of which there will be a reduction in patient pathway resource or a delay in the implementation of a number of projects which may lead to patient pathway breaches or delivery delays agreed within the programs Some Physics developments delayed as redirected resource into paperless planning project and increasing resilience in treatment planning. This enabled staff to work from home and prepared for potential staff absences / future increase in demand	Prioritisation process underway. Program to support delivery Medical Physics and RT Ongoing review of major projects. Core team with resilience approach identified to allow scientists back to project work Program plan for Radiation Services being developed will require resourcing input from IRS nVCC and DHCR	20	15	10
2220	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	07/11/2018	31/12/2021		Treatment Planning System End of Life	There is a risk that some patient treatment plans cannot be completed as a result of the OMP treatment planning system breaking down and being past end of life, which may lead to inability to plan / treat sites not transferred from OMP. The Oncentra MasterPlan treatment planning system is end of life and is no longer be supported by the manufacturer. A replacement treatment planning system, RayStation, is being commissioned but due to understaffing within physics, and a change of priorities due to Covid, commissioning is taking longer than initially estimated. Should a catastrophic failure of OMP occur at this point in time (March 2021) the centre will be without a planning system for the Varian 2100 machines (breast patients), and 10 MV treatments on Truebeam and Elekta machines. There is a risk that the existing treatment system will fail and without the implementation and	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place. Outsourcing contract in place and being utilized with Rutherford Detailed contingency plan is being worked through	15	15	1

2205	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	31/01/2022		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully	Engagement with NWIS & DCHR to develop MVP ongoing. DCHR-led project underway. Initial option appraisal highlighted high likelihood of gap between CANISC and OIS; several discussions occurring to confirm this and identify optimal bridging solution. Approved Design in place for WCP IRMER as an interim solution - this now is subject to acceptance testing of the software delivery by VCC service leads	25	15	9
2187	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	14/09/2020	31/12/2021		Radiotherapy Physics Staffing	NB - see Progress Notes for latest update 13/09/21 The recently received ATTAIN report highlighted that in comparison to the Institute of Physics and Engineering in Medicine (IPEM) guidance, Radiotherapy Physics were under resourced by approximately 25%. The IPEM recommendations for the provision of a physics service to radiotherapy are recognised as a benchmark for minimum staffing guidance. The Head of Medical Physics retired in November 2019. This post has not been replaced and, consequently, approximately 0.5 WTE of management or Medical Physics Expert (MPE) tasks have been absorbed by the department at the detriment to other tasks as described below. Senior staff are also working significantly over their contracted hours, which can be evidenced as time owed in lieu.	Medical Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation. Whilst the situation to establish a full complement of staff in the service remains a challenge, development of a medium term workforce planning, and long term workforce strategy, with HEIW and W&OD colleagues continues alongside recruitment there will need to be support to focus on service critical projects. These have been determined as DHCR replacement, IRS and nVCC.	25	15	5
2438	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	21/06/2021	29/11/2021		DHCR043(R) - Completion of process maps and ways of working	Further maps now having to be drafted due to development of e-IRMER and migration issue. e-IRMER workflow maps required, increased workload for project team, with limited resource.	Project team structure undergoing revision & recruitment planned. Workshop to be arranged to finalise workflow process maps with clinical input	20	12	9
2431	Performance and Service Sustainability	Transforming Cancer Services	Accepted	23/07/2021	28/10/2021		There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption	There is a risk that the impact of Covid-19 on Programme activity will continue to cause longer-term disruption resulting in potential misalignment of project activity and as such further impacts to Programme Plans and Deliverables	1) Project plans being reviewed with programme support to ensure they are up to date and where projects are now 'unpaused' to bring plans in line with more mature projects. Complete 2) Master Programme Plan updated to reflect update to projects and to show dependencies across projects and programme activity. Complete 3) Review and reporting on Master Plan to PDB and Scrutiny committee. Ongoing	16	12	4
2423	Performance and Service Sustainability	Transforming Cancer Services	Accepted	08/09/2021	05/11/2021		Risk that IRS evaluation process is delayed due to resource pressures	There is a risk that as the nVCC Competitive Dialogue clashes with the IRS Final Tender evalutation, there is pressure on resource availability leading to delays in finalising the evaluation process	1) Works has started to understand which staff and resource are impacted to explore availability and potential impact of this to the Project	12	12	6

2414	Performance and Service Sustainability	Transforming Cancer Services	Accepted	10/12/2020	01/11/2021		Risk that application to create public right of way could impact project's ability to use for a TCAR	There is a risk that an application to create a public right of way in the railway cutting might affect the project's ability to use it for a TCAR, leading to delays to enabling works construction	Allowance has been made for handling correctly the newly established public right of way through the railway cutting, that affects the proposed enabling works. We will ensure that we will comply with all necessary timelines for planning, advertisement and enactment of the public right of way diversion to all of the enabling works to proceed uninhibited by this. Timely application to Cardiff CCC will be undertaken. This has been documented on the project plan for the enabling works which is being discussed regularly by PLT. Liability issues and timing to be looked at closely.	6	12	4
2413	Performance and Service Sustainability	Transforming Cancer Services	Accepted	29/06/2020	30/09/2021		Risk that Radiotherapy Satellite Centre will not have required skilled staff in place to run facility	There is a risk that the Radiotherapy Satellite Centre will not have required skilled staff in place to run the facility once ready to be operational. This would impact on radiotherapy capacity and resilience for the Trust.	1) An integrated Radiotherapy and Physics workforce plan is required to consider the service as a whole taking account of a full operating model that includes current activity, projected activity, IRS and RSU. 2) Provisions from across the whole service will be reconfigured to meet the requirements of the satellite unit.	15	12	6
2408	Performance and Service Sustainability	Transforming Cancer Services	Accepted	22/04/2021	05/11/2021		Risk that IRS Project FBC is delayed or not approved	There is a risk that the approval for the FBC for the IRS Project is delayed or not approved, due to changes in approval timescales which would lead to delays to project delay, project abandonment impacting on other TCS Projects (nVCC & RSC) deliverables	1) Engagement with Capital & Treasury teams - ongoing 2) Previous presentations to IIB - complete 3)OBC shared with WG Officers for comment - complete 4)WG notified of timescales for FBC so they can align resources - complete 5)Specialist advisors used to support delivery of Business Case - ongoing	16	12	8
2407	Performance and Service Sustainability	Transforming Cancer Services	Accepted	17/01/2020	19/11/2021		Risk of overlapping timeframes and interdependancies between RSC & IRS Projects	There is a risk that as the IRS Project needs to be phased in parallel with RSC Project, due to overlapping timeframes and interdependancies resulting in the RSC project being restricted to planning assumptions until the Equipment Project is concluded which has an inherent risk.	1) RSC project requires a clear view IRS Project Risk landscape and links between the 2 projects in terms of risk registers and project plans 2) Ensure design is flexible and futureproof to allow for IRS solution 3) Review impact of delays to IRS Project on RSC Timeline	16	12	4
2396	Performance and Service Sustainability	Corporate Services	Accepted	20/04/2017	28/10/2021		PADRs	Not all employees are receiving meaningful PADRs -PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	-PADRs do not underpin the requirement of the Velindre NHS Trust Integrated Medium Term Plan (IMTP) and the Trust Values. -Failure to complete quality PADRs will have direct impact on the All Wales Pay Progression Policy. -Employees do not understand what is expected of them in their role (objectives not agreed for next 12 months) and do not take responsibility for their own performance and development. -Personal Development Plans are not established for next 12 months - missed development opportunities for employees. -The Trust are not easily able to audit the quality of PADRs undertaken.	9	12	6

2394	Performance and Service Sustainability	Corporate Services	Accepted	21/04/2016	28/10/2021		Fundraising Income Targets	This risk applies to external charities as well as those based on site at Velindre Cancer Centre. However, the control measures and focus of the remainder of this risk assessment relates to onsite charities.	The Trust has a clear fundraising strategy in place. Velindre Cancer Centre's branding guidelines introduced in July 2015 states that: - The Velindre University NHS Trust, NHS Wales, Velindre Cancer Centre and Velindre Fundraising will be the prominent brands on Velindre Cancer Centre premises. - Only 'Velindre Fundraising' and 'Friends of Velindre', charities which raise funds exclusively for Velindre NHS Trust, will be allowed to display publications, materials or media alluding to any form of fundraising on Velindre Cancer Centre premises. - Non-fundraising materials from other charities and organisations will be promoted where there are clear benefits for patients and carers.	12	12	3
2361	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	12/06/2020	01/12/2021		Radiotherapy Dept - COVID Social distancing	COVID Social distancing – Radiotherapy In response to national guidance to reduce the risk of contraction of COVID-19 due to close contact with persons and objects, social distancing measures have been introduced into the radiotherapy department in line with COVID-19 guidance. This may result in reduced capacity and the contraction of the radiotherapy service.	High-risk staff shielding. Symptomatic staff isolating. Staff aware of social distancing guidelines. See attached risk assessment for controls within each zone. 22.7.20. No change to actions. 20.10.20. Risk reviewed. New lockdown announced 19.10.20. No change to social distancing measures in radiotherapy department pj. 16.2.21. No change to measures in radiotherapy pj. 21/5/2021 – Risk reviewed by PJ & CRD. The risk due to COVID -19 remains despite the relaxation of national regulations. High risk staff are no longer required to shield, but are advised to continue to work from home where possible if a safe working environment with VCC cannot be provided. The need to maintain the controls mentioned above continue, to	16	12	2
2325	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/06/2021	29/11/2021		DHCR026(R) - SACT & Medicines Management – Affect of Canisc Shutdown on the Department	There is a Risk of Canisc being shut down on 17/09/21 before SACT & MM have completed required activity in Canisc. Clinical teams will be unable to access patient records during Canisc switch off, leading to delays in decision making and potential error, along with poor patient experience There could also be an impact on data migration if all SACT switch off activities are not completed in time	All clinical teams and SACT administration to complete all work before switch off deadline. During this time, SACT & MM have requested that switch off of Canisc be delayed until 19:00 on Friday 17/09/2021. This aligns with RT & OP clinics	20	12	8

2324	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/06/2021	29/11/2021		DHCR024(R) - SACT & Medicines Management – DH&CR Project Support	DHCR024(R) - DH&CR project support: There is a risk regarding the availability of SACT support for the DH&CR project, due to increased demand on the SACT service if & when SACT surge demand occurs or SACT capacity reduces The SACT DH&CR operational lead also provides clinical leadership for SACT booking services. Impact on clinical patient escalation & prioritisation process for SACT scheduling with potential impact on clinical outcomes if SACT DH&CR operational lead is unable to provide sufficient time to this element of service should SACT demand increase or capacity reduce. Conversely, there is the potential impact on the DH&CR SACT project progressing if resource is focussed on clinical prioritisation	Continuous review of service capacity of SACT and MM clinical team to support clinical prioritisation process. Twice-weekly review undertaken. Daily contact can be made with the booking team if required. If the workstream operational lead is required by the service, this resource would not be able to be replaced.	16	12	8
2290	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	07/11/2019	31/03/2022		Patients at risk of being lost to follow up	Patients at risk of being lost to follow up Due to the volume of patients and the processes by which patients are booked for follow up appointments, There is a risk that patients could be lost to follow up.	UPDATE June 21 - Third analysis of FUNB ongoing and additional validation also being undertaken. Expected completion date is 30 June 2021. Clinic Outcome Forms to be completed after each patient consultation documenting next steps in patient pathway and ensuring appropriate outcome and that patient not lost to follow up. New Clinic Outcome Form has been implemented and if completed correctly for each patient appointment should help to reduce FUNBs. However, recent audit shows poor compliance. Medical records team to continue to work with SSTs to improve compliance. Further audit to be undertaken next month. Regular FUNB reports submitted to the OP Operational Group.	10	12	8
2290	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	07/11/2019	31/03/2022		Patients at risk of being lost to follow up	Patients at risk of being lost to follow up Due to the volume of patients and the processes by which patients are booked for follow up appointments, There is a risk that patients could be lost to follow up.	UPDATE June 21 - Third analysis of FUNB ongoing and additional validation also being undertaken. Expected completion date is 30 June 2021. Clinic Outcome Forms to be completed after each patient consultation documenting next steps in patient pathway and ensuring appropriate outcome and that patient not lost to follow up. New Clinic Outcome Form has been implemented and if completed correctly for each patient appointment should help to reduce FUNBs. However, recent audit shows poor compliance. Medical records team to continue to work with SSTs to improve compliance. Further audit to be undertaken next month. Regular FUNB reports submitted to the OP Operational Group.	10	12	8

2258	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	17/05/2021	31/12/2021		Medicines at Home Service:	There is a risk that patient pathways and supporting professional procedures and practices (eg SOPs) will not be appropriately or adequately reviewed because of a lack of resource OR that pharmacist attempts to review in the absence of an alternative suitable clinician are clinically insufficient which may lead to patient safety incidents There is a risk to service continuation and sustainability because of limited alternative clinical leadership within pharmacy (or wider SACT and MM Directorate) for the MaH service which may lead to the service needing to be reduced or discontinued with resultant negative impact on SACT and MM capacity and cost savings opportunities. There is a risk to financial	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision	16	12	4
2256	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	26/03/2020	01/11/2021		SACT / Divisional	Reporting on treatment pathway changes As a result of the COVID-19 Pandemic, it is likely that some patients will not be initiated on a new Systemic Anti-cancer Treatment (SACT) treatment regimen, whilst others will have their current SACT regimens deferred or discontinued earlier than originally planned. It is expected that VCC will be requested to report on the number of patients whose treatment pathway has been affected by the COVID-19 Pandemic. Thus, the number of patients that require deferral or cancellation of their SACT or who are not offered / do not accept SACT must be captured. There is a risk that this data will not be captured correctly / adequately which will result in VCC being unable to report the information	A paper providing an overview of the possible methods which are available to capture this data along with the challenges of doing so was submitted to the VCC Clinical Group on 26.03.20 and accepted. Staff guidelines for clinical staff were sent out in the daily Coronavirus Staff Update via e-mail and also made available in the Coronavirus section of the VCC Intranet 1 - All Clinical Staff to be directed to (where appropriate): - utilise the drop down reason code “COVID-19” on ChemoCare, - include COVID-19 in all Canisc annotations and - include “COVID-19” as the “Description” title when utilising the “Other” tab in Canisc 2 - Clinical Audit Department to lead on the capture on this data and to ensure compliance with these recommendations	16	12	12
2254	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	16/06/2020	06/12/2021		Lack of mechanical ventilation at the VCC site (including inpatient ward areas)	This risk has 3 elements – 1. Potential for increased risk of infection due to a lack of mechanical ventilation, 2. Staff and patient discomfort in hot weather due to sub-optimal ventilation, and 3. Breach of Health & Safety regulations and Health & Safety Executive regulation to provide ventilation systems that are sufficient to ensure that high risk patients are protected from exposure to potentially harmful airborne microbiological organisms	Taking each of the three key elements of the risk: 1. Increased potential for infection due to sub-optimal ventilation • Full infection prevention processes are in place, and any patient with suspected infection is cared for in a side room which usually has a window for natural ventilation (in the summer months). 2. Staff and patient discomfort in warm weather due to sub-optimal ventilation • Some mitigations are in place, but further work is required with pace to ensure the well-being of staff and patients during the rest of this summer. • An external specialist will be commissioned to provide recommendations to reduce the heat, and a Task & Finish group has been set up w/c 15/06/20 to develop a hot weather business continuity plan	12	12	4

2245	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	12/04/2019	31/12/2021		Service impact of delay in equipment replacement	Service impact of delay in equipment replacement Current provisions for Radiotherapy Services at VCC are based on the assumption that a new Cancer Centre and associated Satellite Centre will be clinical by 2021/22. Delays on these projects will impact negatively on the Radiotherapy Department at VCC. Linear Accelerators have a recommended clinical life of 10 years. In 2019, there are currently 3 (out of 8 (38%)) linacs aged 10 years or above. In 2021 there are currently 5 (out of 8 (62%)) linacs aged 10 years or above. Identified hazards are to be found in the risk assessment attached as a document.	Timely / effective communication with Commissioners / Government re. Linac life, performance etc. Older linacs can receive deep services / upgrades with the intention of extending clinical life. Ability to add functions / services to older linacs / equipment such as RPM / DIBH make this viable. Uptime is maximised by good in-house engineering support. Engineers are very experienced at VCC. Service contracts allow access to Manufacturer's engineers when required. Complaints procedure in case of issues with quality of service. Gaps procedure assist with direction in times of breakdown. Experience and skill of staff allow effective dealing with delays and patient issues. RCR guidelines guide protocols for acceptable prolongation of treatment courses prior to compensation (NB. Latest update suggests that standard 3-week course of breast	15	12	3
2224	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	07/11/2019	12/01/2022		Demand for services outstripping capacity	Demand for services outstripping current capacity resulting in patients not being seen in a timely manner and waiting time breaches. Also results in overbooked clinics which are extremely busy. In addition, many of the outreach clinics continue to be run from VCC which is adding to the pressure on clinic rooms.	UPDATE June 21 - Risk rating increased to reflect current situation. Increasing referrals are leading to an increase in outpatient attendances resulting in very busy clinics. Continue with planning for any surge in activity due to cancer backlog and latent demand from health boards is being undertaken by VCC. Continue with weekly monitoring of outpatient referrals and activity. Progress with the work of the Demand Modelling group being led by the BI team. Continue to have discussions with health boards re. outreach clinics and likely demand for services.	16	12	16
2223	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	21/07/2020	12/01/2022		Delay in re-starting outreach activity	The delay in re-starting outreach activity which is as a result of the COVID-19 pandemic, is impacting on outpatients resources and the availability of clinic rooms in VCC. This is because all outreach services have been repatriated to the cancer centre for the duration of the COVID-19 pandemic.	UPDATE June 21 - Discussions to repatriate outpatients clinics continue with health boards. Previously agreement from ABUHB to re-start outreach clinics in Nevill Hall but subsequently notified that space is not available, although not Royal Gwent. VCC group established to manage repatriation of clinics and SACT to NHH. Continue with ongoing discussions with other HBs as this remains a priority for VCC. SSTs have been asked to review all their clinics and highlight priority clinics for repatriation. Undertake surge planning and discuss impact with health boards	12	12	12

2222	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	07/11/2017	31/07/2021		Loss of CANISC - compromise patient care	There is a risk that as Canisc is an 'end of life' system, it could fail which could compromise patient care. It could mean that some patients cannot be seen in clinic or some would experience long delays. This can lead to increased patient anxiety, frustration and stress for staff, overcrowding in waiting areas and a possible delay in prescribing chemotherapy.	Update June 2021 – DH&CR project continues at pace which includes plans to replace CANISC with WPAS. Regular meetings taking place to review OPD processes and clinics. CANISC BCP remains in place. Implementation of the Document Management Solution – copy of correspondence available electronically on local infrastructure. Correspondence viewable in the Welsh Clinical Portal. Correspondence sent to the GP electronically (via WCCG). Welsh Clinical Portal to link to the Master Patient Index – in the event of Canisc being unavailable this version of the WCP would be invoked enabling access to documents, test results and the GP Summary. Authorised staff members have direct access to Synapse (local infrastructure) – VCC radiology images and reports available to view.	16	12	12
2213	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/07/2018	01/05/2022		VCC Phone System - External Phone Lines	There is a risk that external telephony services in VCC may be disrupted as a result of the ongoing use of the 'end of life' PBX gateway ISDN30 line, which may lead to the inability to make inbound and outbound external calls, resulting in significant disruption to clinical / patient and administrative services.	22 phone lines are strategically placed around VCC site to enable dialling to public telephones in the event that an ISDN30 line is lost. Discussion with supplier commenced. Capital funding to be secured for delivery of resilient SIP.	16	12	4
2206	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	09/10/2020	29/11/2021		DHCR003(R) - IM&T Dept - Covid-19 Pandemic	DHCR003(R) - Could impact on key project team members capacity due to service requirements being prioritised, childcare needs, the need to self-isolate etc. The ongoing impact of the Covid 19 outbreak continues to have a significant impact of staff in terms of their well-being, their availability and their ability to absorb new ways of working and new systems within an already stretched environment. Also, additional clinical pressures/ demand on; clinics, inpatient activity, treatments and the presentation of potentially sicker patients, resulting from the impact of COVID19.	Following guidance from VUNHST & Government Project team are all enabled to work from home as required. Early engagement and communication plan in place to keep staff updated and included in the process. Departmental leads being identified to ensure that all departments have a voice at the table and a mechanism to feed in their requirements. DHCR producing Contingency plans as part of COVID-19 response. Canisc will be moved as part of the data centre project, if this failed the contingency would be a single instance of Canisc running in Newport data centre.	20	12	9
2458	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - End of Life Server Operating Systems on the VCC Network	There is a risk of a cyber security breach as a result of the ongoing presence of servers within the VCC network running the legacy Operating Systems (Server 2003, Server 2008 etc.), which may lead to the disruption or loss of IT services across VCC. There are numerous end of life server operating systems within Velindre Cancer Centre (including Windows 2003 & 2008), which increases the risk of a successful cyber-attack as these devices are not appropriately patched and vulnerable to exploit.	Current controls in place include Firewalls (DHCW), Antivirus software (Mcafee and Defender), access control lists and network segmentation.	20	10	5
2451	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - No Client Firewalls on VCC devices	There is a risk of a cyber security breach as a result of the lack of client firewalls on VCC devices, which may lead to the disruption or loss of IT services across VCC.	National firewalls in place. Anti-virus may mitigate malicious software, if attempted.	20	10	5

2450	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - Inactive Edge Firewalls on VCC Servers	There is a risk of a cyber security breach as a result of VCC server firewalls being in 'passive' mode (meaning communications are not filtered), which may lead to the disruption or loss of IT services across VCC.	National firewalls used as protection for VUNHST.	20	10	5
2449	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - VCC Software Patch Management	There is a risk of a cyber security breach as a result of the lack of a formal patch management approach for software being used within VCC, which may lead to the disruption or loss of IT services across VCC.	Migration of VCC patch management onto Trust-wide 'PDQ' solution. Internal and external (NHS Wales) network protections (device / service isolation, firewalls etc.) in place.	20	10	5
2448	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - NTLM hashed credentials stored in memory	There is a risk of a cyber security breach as a result of NTLM hashed credentials being stored in memory, which can be leveraged and result in the disruption or loss of IT services across VCC.	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.	20	10	5
2447	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - Cleartext credentials stored in memory	There is a risk of a cyber security breach as a result of due to the storage of account credentials in 'cleartext' format, which can be leveraged and result in a loss of IT services across VCC.	Controls in place to prevent attackers from reaching the network i.e Firewalls, ACLs etc. However, if an attacker did access the network there are very little controls in place that would prevent lateral movement.	20	10	5
2446	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - Weak Passwords in use on Admin / Privileged IT accounts	There is a risk of an external agent compromising VCC admin/privileged IT accounts as a result of the use of weak passwords in use within the VCC Digital Services team, which may lead to a cyber security breach and/or the loss of IT services across VCC, resulting in the disruption or loss of IT services across VCC.	Various Cyber Security tools in place including national firewalls, AV and ACLs which provides defence in depth. Work ongoing to remove weak passwords.	20	10	5
2445	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - Risk of malicious payloads not being blocked by anti-virus (McAfee)	There is a risk of a cyber security breach as a result of malicious payloads not being blocked by VCC anti-virus (McAfee),, which may lead to the disruption or loss of IT services across the VCC.	VCC currently migrating to Defender Anti-Virus and will be moving towards Defender DLP. Mcafee still in use on various servers and DLP enabled.	20	10	2
2444	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - CVE-2019-0708 BlueKeep Vulnerability	There is a risk of a cyber security breach as a result of the presence of the CVE-2019-0708 BlueKeep vulnerability within the VCC network, which may lead to the disruption or loss of IT services across VCC.	Affected Radiology services are protected behind IT security (firewalls - external to NHS Wales) with access to those systems limited to a small number of named access.	20	10	5
2443	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - MS17-010 (Wannacry) Vulnerability	There is a risk of a cyber security breach as a result of a ransomware attack using the MS17-010 WannaCry vulnerability, which may lead to the disruption or loss of IT services across VCC.	National firewalls and service isolated on network (external to NHS Wales) - only accessible to a limited amount of users.	20	10	5
2442	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - End of Life Desktop/Client Operating Systems on the VCC network	There is a risk of a cyber security breach as a result of the ongoing presence of devices within the VCC network running the legacy Windows Operating System (Windows 7, XP etc.), which may lead to the disruption or loss of IT services across VCC.	National Firewalls. Anti-virus controls in place.	20	10	5

2199	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	18/11/2015	28/03/2022		Medical Device Management Database Software -VCC	There is a risk to patients and staff from medical devices that are not identified managed and maintained, currently there is no Medical Device Management Software System in place to manage these Devices.	In place there are individual departmental list, spreadsheets and in-house developed databases. Which are inadequate because they reduce accessibility of critical information. The above systems do not necessarily encompass all the equipment in use in all departments therefore some equipment may easily be mismanaged. 26/10/2017: Current status is that the case for a Medical Equipment Database was submitted for VCC Capital Funding at the start of this financial year (after an unsuccessful submission for Trust Capital Funding last financial year) so currently awaiting a response to this submission. It is anticipated that the imminent Welsh Audit Office review of Medical Equipment Management will highlight the lack of a comprehensive database as a major shortcoming. The lack of such a system has already considerably hampered our preparations for this	25	9	3
2460	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/05/2022		Cyber Security - Risk of privilege escalation on local user accounts	In the event of a successful cyber attack against Velindre Cancer Centre there is a risk that a local user account could be leveraged, to the spread the attack further due to excessive privileges.	Controls in place include national firewalls, Anti Virus & ACLs.	20	5	5
2368	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	04/12/2008	20/03/2022		Radiology Dept - Reliance on IT	We are completely reliant on hardware, software, network connectivity power and communications to do our jobs.	National IT support. Local on site IT support. Preventative Maintenance, Anti Virus software firewalls. backups . PACS disaster recovery system. Short term storage on modality. Report back ups on different systems. PPM on equipment. Various systems in use which duplicate storage so reducing risk on one system only. Rolling programme of hardware replacement and software upgrades	15	2	1
2403	Quality	Transforming Cancer Services	Accepted	08/06/2020	12/11/2021		Risk that enabling works construction exceeds timescale	There is a risk that enabling works construction, including bridges, exceeds 15 months, leading to delays to nVCC construction and incurring financial loss claims from the MIM contractor.	1. Regular review of possible areas which may cause delay: 2. Partial mitigation through normal contract condition re liquidated and ascertained damage – where events in the contractors control can result in compensation for costs incurred by the client resulting from time or cost overruns. Need to be within expected reasonable limits. Care required in setting that limit to steer away from punitive damages as few contractor would price the works, pushing up tender prices. 3. Focus to be applied to detailed construction programme following return of EW D&B bids.	12	16	9
2416	Quality	Transforming Cancer Services	Accepted	30/06/2020	31/08/2021		Risk that COVID may lead to delays on Project progress	There is a risk that potential further waves of COVID may lead to delays that effect the development & key activity of the outreach project	Agreement with HBs of ways of working during any possible covid resurgence to ensure that project is able to continue making progress	20	12	6

2415	Quality	Transforming Cancer Services	Accepted	17/12/2019	03/12/2021		Risk that key resource involved in a number of projects leading to not enough capacity to fulfill commitments	There is a risk that as key resource are involved in both the RSC, IRS & nVCC Projects which are being managed in parallel could mean there is not enough capacity to fully commit to both projects. This could impact on the quality of the work or the ability to complete the requirements to agreed schedules.	1) A matrix to consider commitments of colleagues to consider priorities and timings to be developed. - ongoing 2) Resource review to understand if additional resource may be required to support project teams. 3) Alignment of meetings and agenda's for 'pressured' colleagues to be looked at to manage this. E.g. when there are items in meetings that are not relevant they can be released from the meeting	16	12	6
2409	Quality	Transforming Cancer Services	Accepted	05/10/2020	30/11/2021		Risk that Clinical Model does not meet required Business needs	Risk that Clinical Model does not meet required Business needs Causes - Patient need has changed / Medical & tech advances make model redundant / Lack of consensus at the start of planning the model / Change in demand Consequences - Stops Programme / Doesn't deliver expected levels of quality, safety and experience / Benefits are not fully realised / Value for money cannot be demonstrated / Staff disengagement with aims and objectives of programme / Reputational impact / Not futureproofed for ongoing delivery of services	1) Established TCS Programme 2) Regional Clinical Ownership advisory groups to develop model 3) External Gateway review 4) Clinical leadership involvement 5) Re-fresh based on clinical & tech advances 6) Benchmark against other models 7) Established CCLG 8) Established Velindre Futures clinical plan to refresh clinical service model 9) Need to finalise key aspects of model (actue oncology & unscheduled care) review / refresh of model 10) Leadership of 4 medical directors at regional level to address key outstanding areas 11) Seek external expertise in design of remaining areas 12) Seek seats on local health board cancer services	12	12	4
2405	Quality	Transforming Cancer Services	Accepted	30/06/2020	16/09/2021		Risk that projected growth assumptions for Outreach will be less than required	There is a risk that the projected growth assumptions for outreach delivery of SACT, ambulatory care and outpatients is less than will be required, leading to undersized locations.	1) Re-run projections around growth assumptions. 2) Activity model will be re-run with outputs presented to project Board. Any additional requirments will be presented to the Programme Delivery Board with recommendations. Individual meetings with Health Boards to ascertain their requirments will be undertaken.	16	12	6
2236	Quality	Velindre Cancer Centre	Accepted	08/04/2019	03/01/2022		There is a risk of poor patient experience as a result of insufficent space and poor environment	The design of the OPD department is not fit for purpose, there is a lack of available accommodation, insufficient space in waiting area, the reception desk is not ideally placed and the fabric of the area is in poor condition.	1. Nurse 'rounding' in place to monitor patients on regular basis 2. External 'canopy' waiting area 3. Information provided explaining visiting restrictions but process in place to call relatives into consultation if appropriate 4. High level of virtual consultations 40-50% 5. Clinic planning and preparation undertaken daily 6. Task and Finish Group to lead repatriation of OPD and phlebotomy to HB's 7. Service improvement programme to reduce waiting times, improve experience etc 8. Appointment system implemented for phlebotomy appointments	15	12	12

2418	Reputational	Transforming Cancer Services	Accepted	05/10/2020	10/09/2021		Risk that TCS Programme does not have support from Stakeholders	Risk that the TCS Programme does not have support from Stakeholders (pts, HB, politicians, WG, clinicians) Causes - Lack of engagement with all relevant stakeholders/ Misinformation shared from external sources / Inconsistent engagement from specialist resource / Change of views over a period of time / Lack of alignment between TCS programme and other strategic priorities across the organisation and individuals / Political leadership change Consequences - WG and LHBs do not support key decisions / Reputational damage for Velindre Trust as an organisation / Petitions & opposition to plans for TCS Programme / Delays to programme and project progress / Failure to deliver some/all of programme benefits	1) Further engagement is being planned with specialist stakeholders – broader and more targeted who are not fully supportive. Programme Communications resource in place & recruitement of additional comms resource to support comms/engagement activities 2) Better use of technology being reviewed and rolled out to share key messages 3) Variety of stakeholder events held over a number of years - complete 4) Clinical workshops held throughout Programme lifetime - ongoing 5) Professional meeting forums held e.g. DoPs, MDs, CEO's etc - ongoing 6) Ongoing engagement with local elected members (MS, MP, Councillors)	16	12	4
2417	Reputational	Transforming Cancer Services	Accepted	08/07/2020	10/09/2021		Risk that there is lack of TCS Programme Comms Plan	There is a risk that there is a lack of TCS Programme wide communications plan resulting in the objectives of projects and interdependant links are not communicated effectively and the wider networked clinical model not understood.	1) Revise TCS website - complete 2) Improve internal TCS teams Comms - complete 3) Improvements to intranet - started 4) Improvements to the link between Programme Governance and Comms - tbc	12	12	4
2197	Safety	Velindre Cancer Centre	Accepted	05/05/2020	12/09/2022		Breach of current Welsh Government Social Distancing	Welsh Government have issued formal guidance to health organisations in supporting them to provide a safe environment for staff, patients and donors as they progressed through the 'recovery' period following COVID-19 pandemic.	Staff who can work from home and staff rostering being assessed and if applicable currently doing so to reduce footfall on site - Shift patterns have been altered and breaks are staggered further reducing use of the toilets to a minimum. - Maximum occupancy signs are displayed on all WC doors Cleaning/ Disinfection measures have been enhanced, throughout the working day and therefore more regular cleaning of the toilets, doors, handles etc - If Welsh Government guidelines are applied we will to reduce occupancy of all W/C to 1per facility where the normal occupancy may be 3 units for example (2 x Urinal 1 x W/C) or (3 W/C's) ultimately becomes 1. - Only 1 person to use wash hand basins at any one time - Use of accessible toilets to be encouraged	16	16	9

2218	Safety	Velindre Cancer Centre	Accepted	23/10/2015	12/09/2022		Reduction in the car parking at VCC increases the potential risk of accidents and injuries to patients, visitors and staff	Reduction in car parking spaces for patients and staff, due to Contractor works and mobile units, is causing loss of visibility and inappropriate parking which may lead to increased risk of accidents injury	Current loss of parking spaces is as follows:- 3 Disabled spaces lost in total across the site 2 staff spaces in rear car park due to lack of storage on site 3 spaces lost in consultants car park again due to lack of on site storage, over all total 8 spaces lost space lost in West car park due to works schemes, (Bollard replacement and Portacabin removal), work now complete and all spaces fully reinstated for use, of 370 spaces current total available 362 As in previous years congestion increases on site due to season closures, expected to ease in due course. Previous measures - Patient parking protected at front of hospital or near clinical entrance points.	20	15	3
2185	Safety	Velindre Cancer Centre	Accepted	14/09/2020	31/05/2021		Delination Risk treatment delay (16284)	There is a risk of physics planning rework and patient delay as a result of errors in tumour volume delineation / margin growth, which may lead to a reduction in physics capacity and inability to meet planning targets. These errors are generally not picked up at medic peer review or during the physics planning process but by more experienced clinical scientists at final physics check, often the day before treatment. There is a lower risk that errors are missed at physics check and make their way to treatment. A number of Datix incidents have been attributed to target and organ at risk delineation errors. These incidents are generally identified at final physics check and so the effect is treatment delay and repeat work (planning) within physics. However, these errors would be classed as near misses as the errors were not detected during the medic peer review process, approval, or at the	Discussions at the RMG quality focused meeting to ensure the medical workforce are aware of the issues and to enable discussions and learning within SSTs. Medic peer review processes (for some treatment sites). A physics quality improvement project has been initiated to ensure effective multidisciplinary learning. This should reduce the requirement to replan due to errors not being detected until the final checking stages, and should also reduce the likelihood of a radiotherapy mis-treatment. Further controls required – a Datix medic representative to ensure joint investigations.	15	15	9
2424	Safety	Velindre Cancer Centre	Accepted	28/07/2021	05/11/2021		Risk of WT breaches & poor patient experience as a result of reduced Dietetic staffing levels	There is a risk that there could be breaches of waiting times, reduced patient experience and outcomes as a result of reduced staffing levels in the Dietetics department which may and stress on the remaining staff members. Due to x1 maternity leave (Clinical Lead DT) and x1 LTS (band 6 PSU cover) with the Dietetic department the workforce is currently reduced from 5wte qualified staff to 3.5wte. Scrutiny approved 1.0wte band 6 DT and an internal upgrade band 6-7. Unfortunately we did not recruit into either of these posts. Our locum also finished on 7th July 2021. Scrutiny have however approved an external band 7 Clinical Lead DT 1.0wte, which is currently out to advert and in the recruitment process. There is therefore a current risk on the workforce that will hopefully be mitigated by recruitment into the	Remaining DT staff are trained to appropriate levels and clear re what they can and cannot do Clear prioritisation criteria is in place Discussions with Senior managers and exec colleagues to make them aware of situation Locum agency searches. Temporary cessation of some services will be required. Recruitment for the 1x external Clinical Lead Dietitian vacancy is underway	12	12	6

2397	Safety	Corporate Services	Accepted	18/05/2018	28/10/2021		Infection Prevention & Control Service including staff attendance	1. Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2. Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3. Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4. There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT	Control Measures in place: 1. Risk assessment in place for ICNet and duplication of data entry but it doesn't take into account additional demands of imminent National Enhanced surveillance. 2. Core Microbiology service provision continues but opportunities for learning and clinical review missed as reduction in weekly microbiology ward rounds to every 3/ 4 weeks	16	12	9
2395	Safety	Corporate Services	Accepted	26/05/2020	28/10/2021		Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	Deficiencies in compartmentation (fire-resisting construction, fire doors and fire dampers) – Velindre Cancer Centre	1. As noted above, site has holistic fire strategy where compartmentation plays a key role 2. Site has high level of fire detection to WHTM 05 (Firecode) 3. Provision of fire safety training to support implementation of fire safety strategy 4. Program of fire safety risk assessments and annual fire safety audits including the identification and assessment of compartmentation 5. Inspection of compartmentation by 3rd party accredited surveyors and receipt of report and remedial actions in 2020 6. In support of management and prevent, Department managers responsible for regular workplace inspections including the monitoring of local fire precautions 7. Fire doors subject to regular visual inspection as part of Estates planned preventative maintenance regime 8. Consideration of fire risk assessment findings (including	15	12	9
2393	Safety	Corporate Services	Accepted	19/06/2020	28/10/2021		Infection control	There is a risk that staff could contract COVID-19 in their working environment as a result of poor social distancing or hygiene Majority of control measures in Welsh Government guidance now in place. However the work on site utilisation and linking of this to the capacity planning framework is complex	To be inserted	12	12	9

2389	Safety	Velindre Cancer Centre	Accepted	28/05/2021	03/12/2021		Risk that patients with altered airways may not receive appropriate care from the MDT clinical team	There is a risk that patients with altered airways may not receive care from the MDT clinical team with the necessary skills and competencies due to the frequency of staff being required to use these competencies (months between patients) and therefore their ability to train and maintain. This situation has been exacerbated by the retirement of a specialist nurse with expertise in airways management. Definition of these patients fall into 3 groups; • Head and neck patients with tracheostomy or laryngectomy stoma. • Respiratory patients requiring suction • Palliative patients requiring suction	Update 03.11.21 - additional mitigating actions: We are currently in the process of recruiting a Head & Neck Advanced Nurse Practitioner whose role will be to provide training for staff in the management of altered airways and ensure that there is appropriate cover for this service. MDT discussions take place pre-admission for this group of patients to assess needs and treatment requirements. Additional training has been sourced from C&V UHB and a Speech & Language Therapist with the relevant skills and expertise has recently been appointed to the VCC Therapies team. •Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level • Advice available from PSU nursing team Mon-Fri in basic competency levels - needs scoping as there is potential for enhancing	12	12	6
2388	Safety	Velindre Cancer Centre	Accepted	18/06/2021	31/03/2022		There is a risk of high temperatures, increased spread of infection a result of lack of ventilation	OPD Environment - Temperature of the Outpatients department There is a risk that during the summer months, due to a lack of ventilation and air conditioning in the outpatients department, the temperature exceeds that which is comfortable or safe for patients and staff. There is a risk that due to the extremes of heat, patients and staff could become unwell. Wall mounted fans should not be used due to covid restrictions.	Doors and windows left open where possible to increase ventilation. Staff providing cold drinks to patients in the department throughout the day. Increased seating outside the OPD entrance. Staff issued with lightweight scrubs. Staff to take regular breaks to ensure they remain hydrated.	12	12	8
2248	Safety	Velindre Cancer Centre	Accepted	29/10/2020	03/12/2021		There is a risk that non-compliance with COVID-19 Health Regulations may place staff and patients at higher risk of infection	There is a risk a risk that that non-compliance with the Health Protection (Coronavirus Restriction Wales) Regulations 2020 could place patients and staff (FFW, CIU) at increased risk of infection and contracting COVID-19, resulting in illness. Regulation 7A of the Health Protection (Coronavirus Restrictions) (Wales) Regulations 2020 dictates: - that all reasonable steps have been taken for staff to work from home; - when they are in work environment, all reasonable steps have been taken to maintain a 2m distance; - and where people cannot be 2m apart, everything practical done to manage transmission risk.	Mitigation -Cleaning regime reviewed as part of changes made, e.g. all ward staff including visiting staff wearing suitable PPE (e.g. cleaners,admin, pharmacy, RT etc) - Hand Sanitiser stations installed - Hand washing posters at sinks - Sterilising materials, wipes, spray etc available for all staff - Enhanced hand washing regime - Staff who can work from home being assessed and if applicable currently doing so - Care taken to manage 2m space where applicable - Social distancing posters - If appropriate reduce amount of staff in working area where applicable. The FFW offices, are areas where social distancing is unable to be maintained for hand overs etc.PPE is provided for use on the FFW at all times. Process constantly reviewed against guidance.	16	12	12

2239	Safety	Velindre Cancer Centre	Accepted	06/06/2012	23/11/2021		Pharmacy Stores – inadequate space	There is an increased risk of accidents and injuries to staff and a security of product issue, due to inadequate space in the pharmacy stores, which is leading to products being stored outside official areas.	Staff are trained in manual handling. Regular contact with VCC Manual Handling Advisor. Staff are partially involved in managing risks. 25.06.19 - new aseptic unit expected to be clinically operational September 2019 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will allow further reconfiguration of stores. Ongoing work between pharmacy and nursing to identify nursing consumables and non-medical dressings to be relocated to nursing stores. 20.01.2020 updated by RWD- new aseptic unit expected to be clinically operational February 2020 which will give additional storage space and allow reconfiguration of current stores. Refurbishment of old aseptic unit planned October 2019 which will	12	12	9
2262	Safety	Velindre Cancer Centre	Accepted	16/08/2018	03/08/2021		Releasing passenger lift release	In the event of a person being trapped in a lift, they will need to be released in a manner that will not endanger themselves or others.	The lift release key has been removed from Switchboard and has been placed in the Estates key safe to prevent unauthorised use. Staff will not release people or the lift be lowered by manually hand winding unless they have been trained on that lift in accordance with BS 7255 (training has been provided by OTIS). Furthermore there must be at least three members of staff available if the lift is to be lowered by manually hand winding. Persons trapped within a lift are only to be assisted out of a lift if they are within 200mm of a landing. A maintenance contract for lifts at VCC which includes the releasing of persons have been set up with OTIS Lift Company. Any derogation from the above in an emergency situation must be discussed with a senior member of the Estates Management team prior to any action. British Engineering insurance inspections are also undertaken on all lift throughout the Trust.	10	10	5
2342	Safety	Velindre Cancer Centre	Accepted	22/10/2013	03/08/2021		Risk of patient using curtain track as ligature point	Risk of patient using curtain track as ligature point.	Approved contractors will install and validate anti ligature curtain rails where it has been identified via discussions with department managers as they are required.	10	5	5
2341	Safety	Velindre Cancer Centre	Accepted	02/12/2006	03/08/2021		Risk of injury to staff/contractors when working at height where there is a lack of edge protection	Injury to persons from falling from roof, and exposure to radiation whilst being on the roof.	Method statements and permits to access roofs from contractors. Working at heights has been a topic during team meetings to raise Estates staff awareness. Roof edge protection fitted to commonly accessed areas. Access to roof areas controlled through gate and locking system.	5	5	5

2339	Safety	Velindre Cancer Centre	Accepted	07/04/2007	03/08/2021		Risk of injury to staff whilst using single and double extension ladders and steps	Risk of injury to staff whilst using single and double extension ladders and steps.	Operative using ladder will inspect before use and report any defects. Safety man should be utilised when required. Barriers are available should they be required. Steps and ladders are regularly inspected and results are documented. Ladder training provided to staff.	15	5	5
2338	Safety	Velindre Cancer Centre	Accepted	03/11/2005	01/09/2021		Risk of injury or ill health to staff whilst working in subterranean ducts (confined space)	Maintenance staff working in confined spaces such as the subterranean service ducts to either run in new services or to maintain existing ones. The ducts are not full height and therefore staff will have to crawl along these spaces. In the event of a person collapsing, difficulties would arise with emergency evacuation. Issues noted when working in confined areas include, but are not exclusively, cramped conditions, heat, gas, fire/explosion, radon gas, exposure to asbestos and problems carrying out an emergency evacuation in the event of injury or illness.	Staff not trained in confined spaces are prohibited from entering confined spaces under any circumstances, therefore should an occasion arise when entry to a confined space is required out of hours and an untrained Estates worker is on call, he will have to contact one of the confined space trained tradesman to assist. Members of the Estates department have received confined space training and two have received confined space supervisory training. Lighting has been upgraded in the ducts. An asbestos removal has taken place in the ducts, however residual asbestos is still in the Horseshoe and main duct therefore Estates workers are not to enter either the Horseshoe or main duct. An asbestos survey was carried out in the Whitchurch duct and no asbestos was recorded (additional sampling is to take place). Staff have completed Health and Safety	15	5	5
2336	Safety	Velindre Cancer Centre	Accepted	08/06/2009	03/08/2021		Risk of injury or ill health to Estates staff whilst working in a lone working environment	Risk of injury or ill health to Estates staff whilst working in a lone working environment and a possible delay in receiving medical treatment in the event of an adverse event. Due to slips, trips and falls, contact with machinery, contact with electricity, serious illness, overcome by noxious fumes, falls from height or coming into contact with an aggressive violent person.	Safety shoes with non-slip soles provided. Hard hat areas identified or hazard tape used to identify bump hazards. Toughened gloves available. Two way radios are available should the Estates worker deem them necessary. Machinery has guards to prevent entrapment. Trained qualified staff to work within their capabilities. Staff carry Cisco WIFI phones and/or mobile phone. Some plant rooms have telephones Permit to work required for electrical work. Ongoing program to barrier roof areas. Violence and aggression training is provided. Health and Safety training is provided. All plant rooms have automatic smoke detection. Co2 detector is fitted in the main boiler house. All boiler rooms have ventilated doors. Regular boiler maintenance is carried out. Basic Life Support training level 1 with practical CPR for maintenance technicians is delivered. Outside stairs are	15	5	5
2335	Safety	Velindre Cancer Centre	Accepted	17/03/2014	12/09/2022		Risk of Injury /collision to Pedestrians by vehicles whilst crossing the site to gain access to Departmental Entrances.	Pedestrians accessing the main entrance and all departments, from the hospitals car parks. Crossing the busy car parks via the clearly designated pedestrian crossings and walkways. There is an Equality Act compliant safe route including tactile paving for the visually impaired lead to and from walkways through car parks leading to and from the main buildings. Vehicles traversing the site and car parks looking for available spaces.	Wall lighting fault has been identified and resolved. Vegetation by reception has been removed to enhance lighting from the wall mounted lighting on main building Security office in situ to patrol and monitor vehicular and pedestrian activity on a daily basis. Designated Safe Equality Act compliant walkway Flashing speed indication sign- acceptable as a deterrent and reminds drivers to slow down, max speed limit (5MPH). Designated parking bays to prevent obstructive parking. Car parking spaces have been repainted and DDA complaint dropped kerbs have been installed with tactile paving as required in some areas. Car parking lighting is acceptable for present conditions. Road re-surfacing has taken place March 19 at the main entrance.	15	5	6

2437	Workforce	Velindre Cancer Centre	Accepted	22/10/2021	29/11/2021		DHCR042(R) - Delay in new Radiographer graduates starting, likely to be October/ November 2021	Delay in new Radiographer graduates starting, likely to be October/ November 2021. Service will be relying on locum/ agency staff - more staff to train and higher risk of error.	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource.	20	20	12
2401	Workforce	Transforming Cancer Services	Accepted	26/02/2021	05/11/2021		Risk of insufficient resources being made available to the Project	There is a risk that insufficient resources (people) being made available to the project will have an adverse impact on the quality of the procurement process	1) Detailed project Plan to identify resource requirements 2) Approved Capital Budget for the Legal & Staffing Costs 3) Regularly monitor staff availability (annual leave & sickness)	16	20	8
2400	Workforce	Transforming Cancer Services	Accepted	30/06/2020	16/09/2021		Risk that there is lack of project support	There is a risk that the lack of appropriate project support from the programme will lead to delays in developing the solutions required for the project success.	1) Programme Board will look to allocate resources as appropriate. Funding request to WG to support ongoing work - Ongoing 2) Clarification required on whether Outreach Project is an Operational or an Infrastruture Project - Ongoing TBC	20	20	6
2217	Workforce	Velindre Cancer Centre	Accepted	14/09/2020	01/12/2021		Medical Capacity for RT Planning in Job Plans	Medical time for RT Planning within job plans is not efficient, timely or in many cases, sufficient, particularly with the RCR requirement for peer review. Any time allocated may not be protected due to the increase in clinical admin work and email requests. Outlining delays have a knock-on impact on the pathway which has the potential to delay the patient's treatment start date and increase breaches.	Review job plans to ensure adequate time available. Job Planning is ongoing annual process however it is not always possible to allocate time for RT Planning into the job plan without dropping alternative work. Each case is individually assessed to factor RT Planning into job plans.	4	15	2
2436	Workforce	Velindre Cancer Centre	Accepted	22/10/2021	29/11/2021		DHCR041(R) - Service expecting a 'surge' in patients end of October 2021	Service expecting a 'surge' in patients end of October 2021. Will place increased pressure on service & staff, difficult to release for training & UAT. Risk of staff burnout.	DH&CR training team can offer flexible training sessions to fit around clinical commitments. DH&CR team can provide financial assistance to support additional staff resource. To continually review & monitor situation via workstream leads	16	12	12
2432	Workforce	Velindre Cancer Centre	Accepted	05/10/2021	03/12/2021		Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care	Risk that DHCR work may be delayed as result of staff prioritising service demands & patient care DHCR036(R) - DHCR project support: Availability of Inpatient Staff, Psychology, Therapies, Infection Control, Clinical Coding, Assessment Unit and Supportive Care staff and CNSs, to support DHCR project due to continued increased demand across all these services. 1. Project timelines could be delayed as training, testing may be seen as secondary to providing clinical care. 2.Once ways of working have been identified, time required to employ, train any additional resource required could impact project implementation.	Update 03.11.21 - Update 27/10/2021 - Regular update meetings scheduled with project team leads to review progress and outstanding work. Attendance at Project Team meetings. Dedicated time made available for operational lead. Continuous review of service capacity across the inpatient workstream prioritisation process. Weekly reviews with the Department Leads to monitor progress in DHCR project, but also to sense check the demands of the services.	16	12	4

2410	Workforce	Transforming Cancer Services	Accepted	05/10/2020	10/12/2021		Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet needs of the TCS Programme	Risk that there will be inadequate and / or insufficient workforce capability and capacity to meet the needs of the TCS Programme outputs. Causes - Workforce supply not available in required professionals groups or with required skills / Requirements for workforce capacity and capability no longer accurate. Consequences - Inadequate staffing of Velindre facilities across the SE Wales region / Impact on providing treatment and care to patients	1) Service planning is sufficiently developed to facilitate effective workforce planning techniqies to be applied 2)Ensuring each project has clear and well developed workforce plans which are predicated on clear service plans 3) Clarity of expectations for workforce team involvement 4) Clarity of Role & Responsibility for Workforce planning input team in relation to Project & Programme need 5) Workforce team to support service to ensure the right people are available and allocated to support	12	12	2
2257	Workforce	Velindre Cancer Centre	Accepted	28/05/2021	31/01/2022		OPD Nursing Establishment	OPD Nursing Establishment - There is no contingency in the OPD nursing establishment. Current sickness levels are 6%; staff vacancy 1 WTE RN & 1.2 WTE HCSW. This is a challenge for providing a safe and efficient level of service. It also means that the service is heavily reliant on using bank and agency staff to maintain staffing levels so that clinics can continue to run.	OPD Nurse Manager is currently undertaking a review of nurse establishment in OPD to ascertain minimum safe staffing levels. To manage the current shortfall the department is reliant on the use of bank staff and nurses working overtime. Nurse Staffing Review to be presented to Outpatient groups. If required, business cases to be developed for additional posts. Findings and recommendations to be presented to SLT. Further work to be undertaken on nursing skill mix and roles within the OPD as detailed on the Outpatients IMTP	12	12	12
2244	Workforce	Velindre Cancer Centre	Accepted	14/09/2020	12/02/2021		Senior Management Capacity	Senior Med Physics Management Capacity is under pressure due to some staff being utilised on IRS Multiple major programmes pull senior staff away from service delivery. COVID exacerbates the situation Separation between service and major programme means there is a loss of continuity and ownership	Deputies for the programs to be identified without affecting service delivery	12	12	4
2229	Workforce	Velindre Cancer Centre	Accepted	12/03/2019	24/01/2022		Risk to timely communication/engagement activities as a result of dedicated resource leading to low morale, reputational damage	There is a risk that positive communications are not distributed in a timely manner as a result of lack of dedicated VCC resource therefore positive communication is not provided in a timely manner to staff or externally. VCC has no dedicated specialist communication resource to support the patient and staff experience. This limits the processes that can be developed and also poses a risk to media handling. There is no dedicated support to develop social media policy or channels which limits communication options.	Resource increased within corporate communications and TCS teams.	12	12	4
2202	Workforce	Velindre Cancer Centre	Accepted	23/02/2021	01/12/2021		Consultant cover for long term absences	Two consultants will be taking Maternity Leave in 2021 in Urology and Breast tumour sites. One Consultant is planning a sabbatical in Spring 2022. One Consultant on Long Term Sick Covid related from Mar 2020.	The Directorate has employed a Consultant for a 1 year post to cover the Urology gap for Mat Leave in 2021 but may require extending the contract to Mid 2022 depending on how long the Consultant will be off on Mat Leave and also to cover the sabbatical in 2022. An additional temporary consultant will be required to cover the breast sessions for the 2nd Mat Leave.	20	12	4

2247	Workforce	Velindre Cancer Centre	Accepted	09/02/2021	20/05/2021		Lack of Permanent Sessions for Skin Cancer in Consultant Job Plans	The Thyroid and Skin services at Velindre Hospital is delivered to patients by a single handed Consultant. The Thyroid Service is funded by 5 Consultant sessions. A recent unplanned absence by this Consultant resulted in emergency cover being arranged and provided by Gloucester Health Board Trust for a period of 4 months. Although the Consultant has now returned to work - she remains a single handed consultant in her tumour site. There is a regulatory requirements that the Consultant is a licensed ARSAC practitioner and able to refer and prescribe radioactive substances for diagnostic and therapy services and therefore internal cover was not possible. Update 25.06.2021 – The consultant has handed in their notice, so will be leaving in 3 months.	The Consultant has returned to work. An SLA was originally set up with Gloucester Trust to cover the period of absence of the Consultant - VCC have now requested that a further SLA be set up with Gloucester to provide cover for the Thyroid service when the Consultant is on annual leave or sick. This remains in negotiation stage at this point. The Clinical Director is also reviewing the service provision and income and how this service can be expanded within new consultant posts. Update 25.06.21 - We are actively putting a job plan together and there are discussions with other HB's to try to mitigate the risk.	20	8	6
2452	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	29/10/2021	01/02/2022		Intermittent IP telephony failure	There is a risk of ongoing (intermittent) IP telephony failures as a result of a recent upgrade to the Wi-Fi central controller, which does not fully support the older Cisco 7925 Wi-Fi IP phones in use across VCC, which may lead to telephony disruption for around 150 users.	New Wifi phones are in stock to replace the critical areas that require upgrades immediately. New Batteries are required to install these which will be ordered ASAP. Plan to replace all 149 handsets ASAP Attempt to fix the issue with the 7925 in the interim.	15	12	3
2243	Performance and Service Sustainability	Velindre Cancer Centre	Accepted	30/06/2021	15/12/2021		SACT staff turnover	There is a risk that SACT Daycase may not be able to deliver care at the current level as a result of staff turnover which may lead to SACT reducing capacity at the SACT Daycase Unit which will impact on patient care and patient experience.	Senior SACT management working in the numbers Clinical trainer working alongside junior staff closed mobile unit on MONDAY Senior staff working on helpline Deputy Director of Nursing undertaking a review on the turnover/retention and education pathways	16	12	3

TRUST BOARD

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2020/2021

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sara Walters, Clinical Audit Manager Zoe Gibson Head of Nursing
PRESENTED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SPONSOR APPROVED	Jacinta Abraham, Executive Medical Director

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
EMB	08/07/21	NOTED
Quality, Safety & Performance Committee	15/07/21	ENDORSED FOR BOARD APPROVAL
Audit Committee	14/10/21	ENDORSED FOR BOARD APPROVAL

ACRONYMS	
CAD	Clinical Audit Department
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
NCEPOD	National Confidential Enquiry into Patient Outcome
RCR	Royal College of Radiographers

1. SITUATION/BACKGROUND

1.1 The purpose of this paper is to provide the Trust Board with the Trust Clinical Audit Report for financial year 2020 to 2021.

1.2 This is the inaugural Annual Trust Clinical audit report which will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit activity and Programme of work

1.3 The Trust Annual Audit report was endorsed for Board approval in Quality, Safety and Performance Committee in July 2021 and the Audit Committee in October 2021. It is being presented to the Trust Board for approval.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Velindre University NHS Trust has developed its first Trust Clinical Audit Plan which was published in June 2020. This Annual report reflects the Clinical Audit Programme delivered as defined by that plan and covers the period from 1st April 2020 to 31st March 2021. It has to be acknowledged that this reporting period has been affected by the COVID 19 Pandemic, however, there has still been an extraordinary amount of clinical audit activity across both divisions as demonstrated in this report. The presentation of this Trust report occurs in two halves as reflected by the varying nature of clinical activity and clinical audit requirements of each division.

The appointment of two clinical leads, Dr Catherine Pembroke, Consultant Clinical Oncologist at Velindre Cancer Centre and Mrs. Zoe Gibson, Head of Nursing at the Welsh Blood Service, in April 2020, have helped to provide the necessary clinical leadership for the divisional clinical audit systems and processes, ensuring that patient and donor outcomes are scrutinised, and safe and high quality clinical practice

is maintained. These roles are still relatively new and are evolving. In the Welsh Blood Service, the clinical audit oversight lead role is performed by Mr. Peter Richardson, Head of Quality Assurance and Regulatory Compliance, with the support of the clinical team, which helps to differentiate Clinical Audit from the already extensive programme of Quality Assurance monitoring in blood and transplant services. In the Cancer Centre, there is a small but well-formed infrastructure of clinical audit managerial support, expertly led by Mrs. Sara Walters, Clinical Audit Manager, which continues to deliver an impressive portfolio of clinical audit activity for both national and local programmes.

A total of 169 Clinical Audit projects have been submitted at Velindre Cancer Centre, 55 active, 60 completed, 41 are ongoing, 6 on hold and 5 discontinued with reasons and actions accounted for in the report. There were 30 Cardiff University linked Student Selected component projects coordinated through the Clinical Audit team during this time. Exemplary SSTs include Palliative care and Breast whose audits have contributed to peer reviewed, posters and awards. In the Welsh Blood Service, the FAIR project: 'For the Assessment of Individualised Risk' has been commended for its impact on changing UK policy by implementing the recommendations to change blood donor eligibility assessments for lifestyle issues on 14th June 2021. There are 9 National audits coordinated by the Blood Health team to inform the national direction of the blood transfusion strategy.

The highlights of this Trust Clinical Audit report are centred on the activity relating to the COVID-19 pandemic. There are 27 COVID -19 related Clinical audits at Velindre Cancer Centre, 10 which are completed and 17 still ongoing. (Page 77-84) At a national level, these include the UK Coronavirus Cancer Monitoring Project and the UK COVID Radiotherapy project, seeking to understand the impact of the pandemic on Cancer outcomes. We have locally audited the impact of Virtual Consultations in a COVID-era in a pilot of 248 Systemic anti-cancer therapy assessments, showing that most treatments were able to be successfully delivered through remote consultations. The monitoring of the psychological effects of the pandemic on the wellbeing of medical trainees, has demonstrated that it has had a profound effect, necessitating the appropriate support structures to be put in place. A showcase of these COVID audits were presented on 23rd November 2020 in an Extraordinary grand round with 8 oral and 10 poster presentations, to disseminate the key learning and messages to the wider clinical staff. In the blood service, the already robust Infection and prevention measures such as hand hygiene, donning and doffing and venipuncture skin cleaning (Page 32) have been intensified through a vigorous monthly clinical audit programme providing high levels of assurance on quality and compliance.

Moving forward, the Trust ambition for Clinical Audit is that it will be strengthened through the development and local implementation of the National Quality and Safety

Framework and the National Clinical Framework, both designed to put Quality at the heart of the NHS in Wales. Discussions are ongoing on how we will achieve this, and the concept of a substantial Trust Quality Hub is currently being considered. This would bring together Clinical Audit, Quality Improvement, Mortality and Morbidity Reviews, Learning from Datix, Concerns and complaints, and Donor and Patient Experience under one roof, to ensure that the systems for each of these components are linked and speak to each other.

This report aims to provide assurance to the Audit Committee that Clinical Audit remains a high priority and is being conducted according to the principles set out in the Trust Audit Plan for 2020-21. It demonstrates that high quality care is being delivered through cycles of clinical audit which is now embedded throughout the organisation. The emerging understanding of the importance of continuous quality improvement to include quality planning and quality assurance will inform the next iteration of the Trust Clinical Audit Quality Plan 2021-22. The Trust Annual Audit report was endorsed for Board approval in Quality, Safety and Performance Committee in July and it is being presented here also for endorsement prior to going to the November Trust Board for approval.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes (Please see detail below)
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applie please list below:
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related t the activity outlined in this report.

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a resu of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to **APPROVE** the report to continue to support the function of Clinical Audit.

Velindre NHS Trust

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

CLINICAL AUDIT Report 2020/2021

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VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2020/2021

1. INTRODUCTION

The purpose of this paper is to provide the Quality and Safety Committee with the Trust Clinical Audit Report for financial year 2020 to 2021. This is the inaugural Annual Trust Clinical audit report which will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit activity and Programme of work.

2. EXECUTIVE SUMMARY

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Moving forward, the Trust ambition for Clinical Audit is that it will be strengthened through the development and local implementation of the National Quality and Safety Framework and the National Clinical Framework, both designed to put Quality at the heart of the NHS in Wales. Discussions are ongoing on how we will achieve this and the concept of a substantial Trust Quality Hub is currently being considered. This would bring together Clinical Audit, Quality Improvement, Mortality and Morbidity Reviews, Learning from Datix, Concerns and complaints, and Donor and Patient Experience under one roof, to ensure that the systems for each of these components are linked and speak to each other.

This report aims to provide assurance to the board that Clinical Audit remains a high priority and is being conducted according to the principles set out in the Trust Audit Plan for 2020-21. It demonstrates that high quality care is being delivered through cycles of clinical audit which is now embedded throughout the organisation. The emerging understanding of the importance of continuous quality improvement to include quality planning and quality assurance will inform the next iteration of the Trust Clinical Audit Quality Plan 2021-22 which will be finalised following approval of this annual report.

3.0 VELINDRE CANCER CENTRE ANNUAL REPORT

Canolfan Ganser Felindre
Velindre Cancer Centre

3.1 FOREWORD

I was appointed as Clinical lead for Audit and Quality Improvement Velindre Cancer Centre (VCC) in the summer of 2020. As demonstrated by this report, the audit department, led by Sara Walters, clearly has a successful framework in which to support professional groups in completing projects, and has continued to do this throughout the pandemic. The Service Improvement Group, however, has had to pause its activity due to COVID secondments and the team and subsequent education/ mentorship have ceased temporarily. We are now working closer together so that respective teams have opportunities for greater support and closer collaboration in the future.

Part of my role as clinical lead is to encourage and create space for Audit and Quality Improvement (QI) within the clinical environment, so that this can become embedded within our culture at VCC. Patient safety and high quality care is all our priority but we need to engage and empower all professional groups in order to fulfil this. We aspire to create an environment for continuous learning and mentorship so we can deliver the high quality healthcare we strive to achieve.

In March 2021, we have surveyed the clinical staff (consultants and trainees) regarding their experience at attitudes to QI. This demonstrated shortcomings in terms of clinician's knowledge and confidence and has led to a program of work to help address these difficulties. A 'Fundamentals of Quality Improvement' introductory session led by HEIW and Dr Gethin Pugh will be held on 23rd June 2021. The survey has now been circulated to other professional groups including nursing, pharmacy, physics, and radiotherapy.

During 2020, VCC has impressively stepped up by auditing the impact of the pandemic on the health of our patients, quality of our care and wellbeing of staff. We hosted a well-attended 'Grand Round COVID-19 special' in September 2020 showcasing the great work, where eight people delivered oral presentations with a further 10 posters circulated.

In February 2021, we invited an internationally recognised academic, Dr Todd Pawlicki from the University of San Diego, who delivered a fantastic Grand Round on Quality and Safety in Radiation Oncology. The audience was multi-disciplinary and gave us all an opportunity to reflect on how we should foster a culture of openness and constructive discussion concerning patient safety.

Key points that need addressing

- Fostering a culture of Audit/QI/Patient Safety reporting within Velindre Cancer Centre
- Integration of Audit and Service Improvement teams to create a Quality Improvement Hub
- Poor Senior House Officer engagement with audit and QI
- Lack of patient engagement/representation in majority of projects
- Limited opportunities to disseminate and showcase work within hospital
- Limited SST engagement and often projects are not properly planned and completed
- It is unclear the relevance of National Audit data to our local population. This needs to be better articulated.
- We lack artificial intelligence platforms in which to collate and analyse date, survey ongoing projects and to collect PROMS. Greater resource for staff and AI is required.

In order to address these key issues, we now have a 3-year plan in which we outline some suggestions in improving systems so that QI and Audit become core values amongst all professional groups. These include:

Education

In an attempt to foster a culture of audit and QI within the cancer centre we need to ensure people are well equipped with the core principles and skillsets. A 'Fundamentals of Quality Improvement' led by HEIW and Dr Gethin Pugh (QI lead for Wales Deanery will be held on 23rd June 2021. We also aim to deliver a VCC-specific specialty-trainee/trainer 9-month educational QI/Audit program with structured academic workshops and project-specific mentorship. (Please see attached publication and proposed framework). We will ensure that patient engagement and participation are a vital component of the program. This will be a pilot project and will aim to commence in September 2022. An annual QI/Audit event will be held in June following the academic program. The objective would be for trainees to showcase their work to the hospital and for others to learn. There would be prize giving to demonstrate recognition of outstanding achievements. If, following formal review, this is thought to be successful we would aim to expand this to other professional groups including nursing, pharmacists, radiotherapy and physics in subsequent years.
We also need to revise the induction packs for SHOs who typically rotate to VCC 3-6 monthly. This would include

- A brief survey to ascertain prior knowledge and experience
- A written summary of audit/QI principles including references for further reading
- An academic fundamentals session held by service improvement/audit team
- A list of 'ready to go' projects defined as relevant by previous SHO cohort/SSTs. Designed to be short, achievable projects with 3-6 month placements

Departmental Engagement

We propose bi-annual meetings with Site-Specific Teams and professional groups (physics, pharmacy, nursing and radiotherapy) in order to address the following key issues

- Annual key-performance indicators for that year (start with 1-2 a year)
- Patient reported Outcome Measures (PROMS)

- Patient safety (by encouraging a culture of DATIX reporting within SST and teams)
- This will allow important clinical and safety issues to be addressed as well as ensuring that projects are properly planned, completed, supervised and reviewed.
- How National Audits are applicable to VCC patient population

We also hope to connect with the Patient Safety group who are aiming to foster a culture of openness and constructive discussion concerning DATIX reporting. This will serve as platforms for further QI/audit projects.

Dissemination of Information

In order to display the successful audit work taking place within the cancer centre we propose a six monthly hospital-wide Audit/QI afternoon. All professional groups will be invited to present completed projects either in oral or poster formats. A quarterly newsletter highlighting success stories would supplement this.

Artificial Intelligence Platforms and Funding

As an institution, we need to move away from excel spreadsheets. Without appropriate resource and up to date AI platforms we will struggle to achieve the ambition as highlighted above. Exploring appropriate platforms will aid surveillance of active projects and progress, KPIs and PROMS

In Conclusion

This report demonstrates the substantial audit activity and the hard work of others taking place within Velindre Cancer Centre. This is particularly impressive given the unprecedented COVID-19 pandemic. It does, however, demonstrate a need to align audit and service improvement departments in an attempt to develop a QI hub. It highlights a need to build upon education and mentorship as well as departmental engagement to ensure the projects are most applicable to the population we serve. Looking to the future, through the newly formed Velindre Futures programme at VCC and the local implementation of the National Quality and Safety Framework, I have every confidence that there are significant opportunities for Clinical Audit and QI to be embedded within our organisation in a meaningful way. I would like to acknowledge Ms Sara Walters and the audit department who have worked exceptionally during a difficult time.

Catherine Pembroke
Clinical Lead for Audit and Quality Improvement

3.2 **VELINDRE CANCER CENTRE SUMMARY**

The Clinical Audit Department remains an essential pillar within the Clinical Governance structure in Velindre Cancer Centre. The Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments. The COVID-19 pandemic has brought new challenges to our working environment and highlighted areas of need and improvement. Subsequent constraints in our time and reduced medical student activity has meant that some Site Specific Team (SST) audit activity has fallen. We have been able to demonstrate significant amounts of COVID-related audit work (27 complete and active projects) which have been of pivotal importance. Important local audit projects during the COVID-19 era include evaluation of virtual consultations (patient and staff), impact on SACT delivery, 30 day mortality, PPE education, lung and brain radiotherapy and

improvements in trainee experience and well-being. Important National COVID audits include the CT-RAD (Radiotherapy: National Cancer Research Institute) and the UK Coronovirus Cancer Monitoring Project). Project leads had the opportunity for oral and poster presentations at our COVID-19 Audit event held in September 2020.

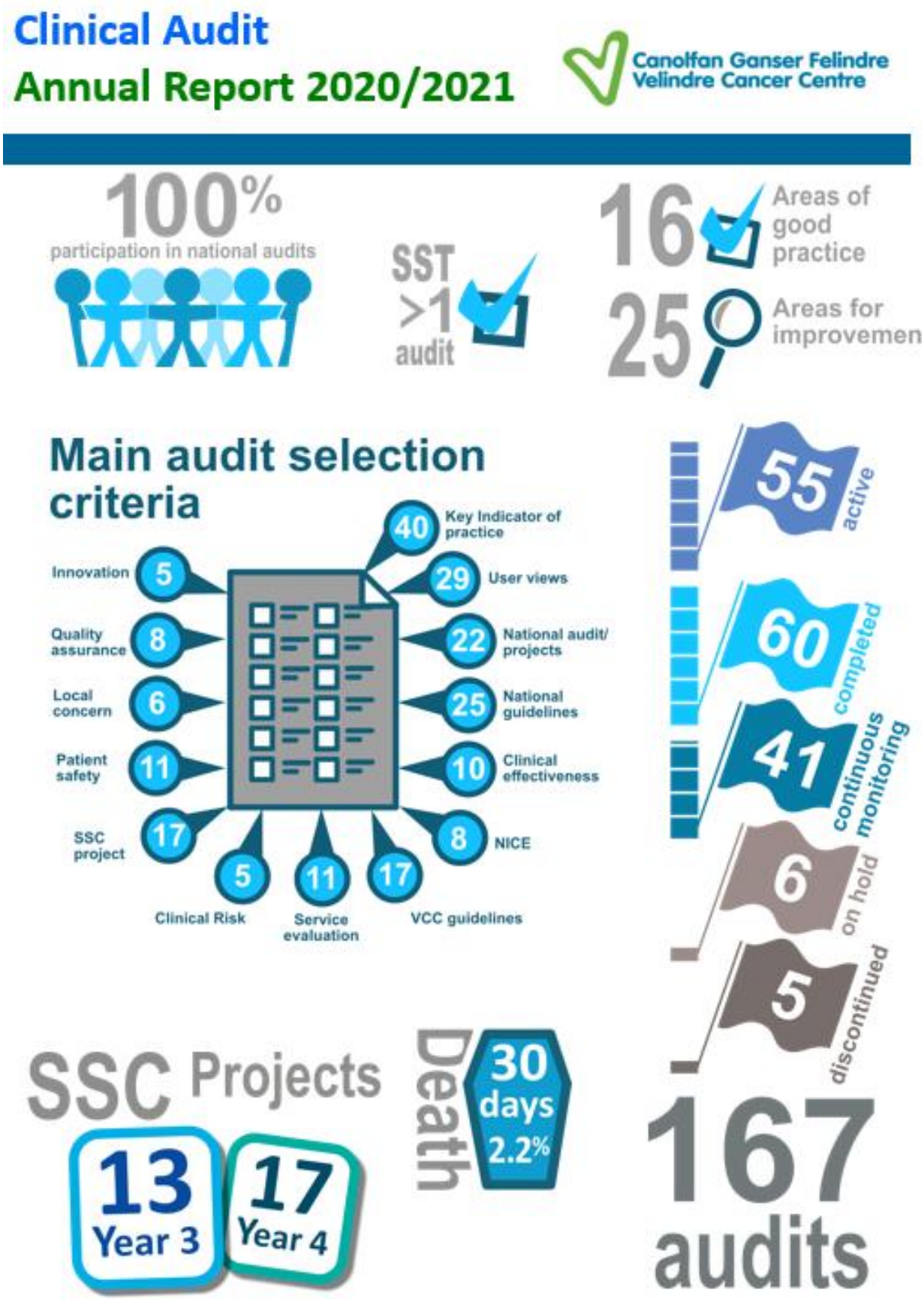
The Clinical Audit team continue to provide and quality assure data for the National Clinical Audit and Outcome Review Plan. Participating in these collaborative projects ensures that we are involved in the dialogue and improving the quality of care on a national scale. Predetermined performance indicators allow us to benchmark our own practice ensuring we can demonstrate good standards of care within our SSTs.

The Audit team seek to support, facilitate and all aspects of audit work within the cancer centre. All upcoming projects are reviewed on a monthly basis at the Project Review Group meeting. Those in attendance include representatives from Planning and Performance, Service Improvement, Patient Safety, Patient Representation, Clinical Governance and Audit. The projects are directed to the appropriate leads of service to ensure maximal support is given to the project lead. The Audit team actively engages with the SSTs to ensure we are addressing National and local priorities. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2020/2021 a total of 169 projects have been submitted, 55 active, 60 completed, 41 are ongoing, 6 on hold and 5 discontinued. The discontinued audits were mainly due to a change of priorities to the service as a result of COVID, more details can be found in the project progress document. Exemplary SSTs include Palliative care and Breast whose audits have contributed to peer reviewed, posters and awards. Areas of good practice remain patient-focused with implementation of the virtual app to aid understanding of deep-inspiratory breath-hold techniques, support groups in Colorectal Cancer and addressing holistic needs for urology patients.

The audit report does highlight the need for improvement within the service and we will aim to implement these in the coming years. In line with Velindre Future Program, we aim to align ourselves with Service Improvement, Patient Safety, Morbidity and Mortality and Education to create a Quality Hub. The intention for this is to provide a focus group to help educate, support and mentor project proposals to ensure maximal output and to implement sustained change. In order to encourage a culture of Quality Improvement (QI) and Audit within the Cancer Centre we aim to engage with SSTs by improving the dialogue between our two groups to ensure we address key areas of concern and interest are met. We will require SSTs to define the local implications from the National Audits we participate in at the end of every audit year. We also need to foster education and support for our trainees and trainers so that they are well versed in the audit/ QI methodologies and principles. We also realise there is a need to present this ongoing work for the benefit of others and proposals are underway for a six monthly hospital-wide audit meeting.

The annual report demonstrates the consistent commitment from healthcare professionals working within Velindre Cancer Centre to fully engage with clinical audit as a driver for change and improve the quality of care for our patients.

3.3 INFOGRAPHIC



3.4 CLINICAL AUDIT DEPARTMENT

Clinical Lead for Audit and Improvement	Catherine Pembroke
Clinical Audit Manager	Sara Walters
Clinical Audit Analyst	Margaret Thomas
Clinical Audit Support Officer	Becky Quinlan
Clinical Audit Support Officer	Janzib Alyas

3.5 PROJECT REVIEW GROUP

The project review group is now well established and meets the first Thursday of every month. The main remit of the group is to review and assess all project proposals submitted by members of staff, in order to provide advice on the aims, standards, methodology and data analysis prior to commencement of the project. The projects are then assigned to relevant department, i.e. Audit, SI Patient experience

Velindre are actively participating in eighteen National audits/projects. Six of which are included in the National Clinical Audit and Patients Outcomes Programme (NCAPOP), where annual participation is a requirement. These include NLCA (Lung), NOGCA (Oesophago-gastric), and Prostate Cancer (NPCA), Breast (NABCOP), NBoCA (Bowel), NACEL (Care at end of life). Other topic specific audits are set by NCEPOD (National Confidential Enquiry for Patient Outcome and Death), RCR (Royal College of Radiologists audits) and NOTCH (The National Oncology Trainees Collaborative for Healthcare Research). In addition Velindre submit data to a number of National COVID projects established this year to monitor the impact of the pandemic.

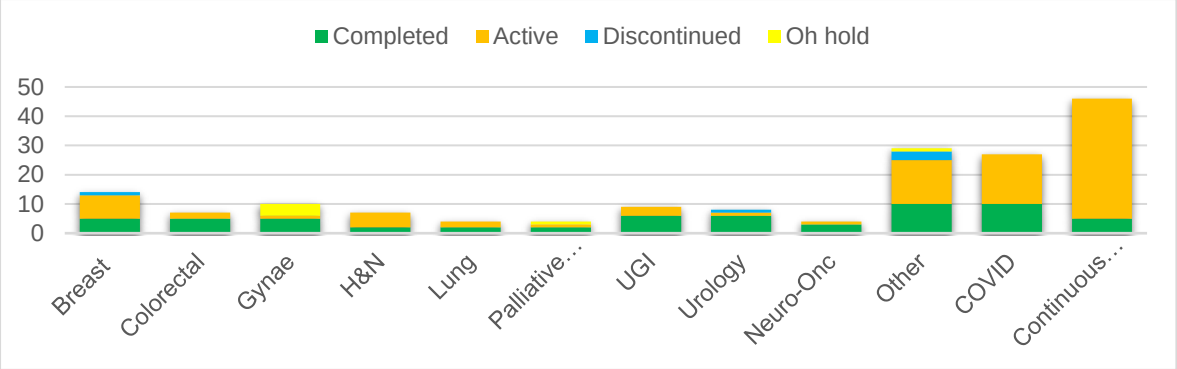
3.6 CLINICAL AUDIT ACTIVITY

The table below demonstrates the current audit activity within Velindre Cancer Centre.

	Total 2020/2021
Active	55
Completed & Presented	60
Ongoing/Continuous	41
On Hold	6
Discontinued	5
Total	**169**

Complete	**Active**	**Discontinued**	**On hold**
60	**103**	**5**	**6**

3.7 CLINICAL AUDIT ACTIVITY PER SST APRIL 2020 TO MARCH 2021



3.8 CLINICAL AUDIT ACTION PLAN

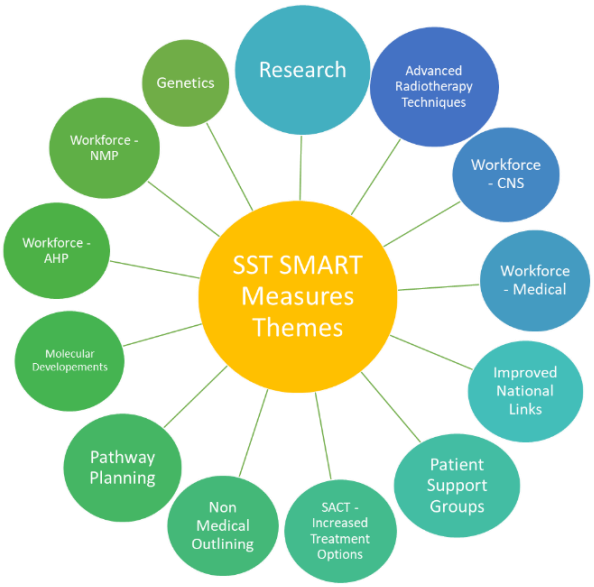
A clinical audit action plan has been developed and is monitored by the department in conjunction with the SST's. All audit activity and action plans are discussed within the quarterly meetings and updated accordingly.

3.9 PLANNED CLINICAL AUDIT PROGRAMME

The Planned Clinical Audit Programme is a proactive approach to carrying out audit within each SST. The programme is developed before the start of each financial year with the aim of identifying areas for audit including National and local priorities. The programme is prominently made up of key indicators of practice, NICE guidelines, patient experience, local concern and national audits; these are identified and prioritised within each SST through the implementation of new radiotherapy techniques, the introduction of new drugs with specific toxicities and any serious adverse events

The planned audit programme for financial year 2021/2022 was reconfigured to relate to the Health Care Standards. A section on COVID relate projects was also included. The full programme can be found in the appendix.

Work is underway to align the plan with the SMART Objectives identified in the SST Reports and subsequent operational plan, which will align and help formulate the IMTP.



3.10 STUDENT SELECTED COMPONENTS (SSCS) AT VELINDRE CANCER CENTRE

Cardiff School of Medicine offers a range of opportunities to tailor learning and study specific aspects in depth. As well as intercalating and opportunities to study abroad, there are hundreds of Student Selected Components (SSCs) from which to choose.
For those students with a real interest in oncology this offers an opportunity to work closely with an oncology consultant. There is also the opportunity to work collaboratively with oncologists and clinicians in other hospitals, e.g. surgeons, gastroenterologists, radiologists. Past students have had their work published in scientific journals and have presented their work in International Meetings.

The Clinical Audit Department inducts and supervises the 3rd, 4th and 5th year medical students (SSC) each year; 13 year 3 students attended for SSC projects during 2019-20. Unfortunately their time at Velindre did not proceed as planned due to the COVID pandemic and students were asked to undertake a literature review instead. In addition 17 year 4 students were also planning to attend, however with the COVID-19 pandemic, these projects were also changed to literature reviews.

3.11 MULTI-DISCIPLINARY CLINICAL EFFECTIVENESS MEETINGS APRIL 2020 TO MARCH 2021

The clinical effectiveness meetings are multi-disciplinary forums to present the results and learning from work carried out within each SST. The programmes include work on clinical governance principles such as clinical audit, service development, service evaluation etc. The meetings are also used as an opportunity to discuss and highlight national and local issues.

All the Clinical Effectiveness meetings between April 2020 to March 2021 were cancelled due to COVID-19. Preparations are underway to convert these meetings into virtual presentations.

3.12 SITE /SERVICE SPECIFIC TEAMS (SST)

The SST's key roles are to provide a forum for multi-disciplinary service planning, development, audit and research in tumour site and service specific issues, providing recommendations to Velindre Cancer Centre on required service changes and approaches to realising these. They are also required to be accountable for the delivery of excellent, efficient, equitable and safe tumour specific service by VCC and to monitor quality and timeliness of services according to national standards.

3.12.1 BREAST SITE SPECIFIC TEAM

3.12.1.1 Breast Clinical Audit Activity

Complete	Active	Discontinued	On hold
5	8	1	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.1.2 National Audits and Continuous Monitoring

5.12.1.2.1 The National Audit of Breast Cancer in Older Patients (NABCOP) was established in April 2016. It assesses the processes of care and outcomes for women aged over 70 years compared with women 50-69 years. NABCOP's results will help NHS breast cancer services in England and Wales to benchmark and improve the care delivered to these women. It is run

by the Association of Breast Surgery and the Clinical Effectiveness Unit at the Royal College of Surgeons of England and is commissioned by HQIP.

3.12.1.2.2 The Secondary Breast Cancer Multidisciplinary Forum (SBCMDF) continually collects data to support the service in evaluating outcomes and patient care. A business case has been submitted for a Breast SST Data Quality Specialist to support this work.

3.12.1.3 Areas of good practice and improvement

3.12.1.3.1 An evaluation of the effect of an app to introduce and practice deep inspiration breath hold technique on patient anxiety levels at first pre-treatment appointment for breast radiotherapy

The aim of the app introduced by the researcher has been to provide information and the opportunity to prepare in advance for Deep Inspiration Breath Hold radiotherapy with the hope that it may reduce anxiety and improve patient experience and also potentially reduce time needed in the scanner and on treatment.

The study has confirmed that even in a small cohort of patients anxiety levels are varied and it was difficult to prove any significant effect on these through use of the app. There are many reasons for anxiety in cancer patients and this study was not designed to reach the root cause of these. Of note was the experience of situational anxiety at scan and treatment from patients who experienced low general anxiety.

In terms of patient experience the app produced high engagement with the qualitative comments with many positive responses. In particular preparation, information and the opportunity for patients to take ownership over their experience by practising before attending for planning and treatment was valued with app users reporting slightly higher overall experience scores than those not using the app.

The DIBH experience was also evaluated with most patients managing comfortably and overall satisfaction scores high amongst both app users and non app users. Respondents praised staff highly and valued the supportive and informative service highlighting the importance of providing holistic care to all with the app an enhancement rather than a replacement of current services.

The value of the app during times of remote consultation was acknowledged and areas for improvement included more specific information needs relating to the process of DIBH and the potential benefit of raising awareness of the app amongst patients and staff, particularly at consent and planning stages. Improvement suggestions will be taken forward with relevant staff groups. The app is a convenient way to provide patients with an additional resource for support at an anxious time in their cancer treatment.

Suggestions for improvement related to more specific information around the depth and length of breath hold required.

3.12.1.3.2 Review of observation period required following subcutaneous Herceptin

The current VCC subcutaneous (SC) Herceptin guideline specifies to observe the patient post 1st dose SC Herceptin®, (unless already established on maintenance IV Herceptin®), for 120 minutes, and 30 minutes after their 2nd dose. Following previous audits this observation period is already reduced from the SPC guidelines which states to observe the patient for 6 hours following cycle and 2 hours after subsequent cycles. It is believe that these guidelines are based on reactions observed after patients are given IV Herceptin® rather than SC.

Of the 157 patients reviewed, it was reported that 1 patient had a “small red area on neck, small urticarial” which was noticed during the end of the 2 hour observation, otherwise all vital signs were normal. This was treated and responded well to piriton and Hydrocortisone. Based on our study of 156 patients who had no signs of adverse reaction during observation, this gives a 0.6% chance of a minor reaction.

Based on these findings from the audit of Velindre patients and supporting evidence from other audits it is proposed that the post-observation time 1st dose SC Herceptin® be changed from 2 hours to 30 minutes, with no monitoring for subsequent cycles. This would improve patients experience and reduce chair time

3.12.1.4 Posters and publications

Axillary surgery after neo-adjuvant systemic therapy in patients with operable breast cancer abstract submitted Powell-Chandler, Anna1; Chopra, Shrarat1; Sabah, Yousuf1; Satherley, Lucy1; Davies, Eleri1; Goyal, Sumit1; Borley, Annabel2; Egbeare, Donna1
1University Hospital Llandough; 2Velindre Cancer Centre;

Clin Oncol (R Coll Radiol). 2021 Apr;33(4):230-240. doi: 10.1016/j.clon.2020.11.025. Epub 2020 Dec 9. Identifying Risk Factors for Anthracycline Chemotherapy-induced Phlebitis in Women with Breast Cancer: An Observational Study. Roberts R(1), Borley A(2), Hanna L(2), Dolan G(3), Ganesh S(3), Williams EM(3).

3.12.2 COLORECTAL SITE SPECIFIC TEAM

3.12.2.1 Colorectal Clinical Audit Activity

Complete	Active	Discontinued	On hold
5	2	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.2.2 National Audits and Continuous Monitoring

3.12.2.2.1 The National Bowel Cancer Audit is a collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. It aims to improve the quality of care and survival of patients with bowel cancer; it is now well established and has collected data since 2005. The National Bowel Cancer Audit is designed to provide vital information with regards to diagnosis, treatment, and outcomes; the main focus is to help make sure that people with bowel cancer receive the best care possible.

3.12.2.3 Areas of good practice and improvement

3.12.2.3.1 Colorectal ‘Support Group’ - There is currently no Support Group in the South East Wales area for people with or those affected by Colorectal/Bowel Cancer. For some time Velindre have been looking at setting up a support group and wanted to find out if this is something that people would find helpful. The survey also provided the opportunity to identify if there are any specific topics/issues that people are keen to discuss and topics that might be useful. The survey confirmed that there was a lot of interest in a colorectal support group in the area. However there were patients who felt that it wasn’t for them. The colorectal team are working on setting this up, potentially in a virtual format in the first instance.

3.12.3 GYNAECOLOGY SITE SPECIFIC TEAM

3.12.3.1 Gynaecology Clinical Audit Activity

Complete	Active	Discontinued	On hold
5	1	0	4

**Figures exclude mandatory national audits and continuous monitoring*

3.12.3.1.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site

3.12.4 HEAD & NECK SITE SPECIFIC TEAM

3.12.4.1 Head & Neck Clinical Audit Activity

Complete	Active	Discontinued	On hold
1	6	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.4.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site

3.12.4.3 Posters and publications

Aiming to publish the SSC project outcome of metastatic carcinoma of cervical lymph nodes from an unknown primary cancer: South East Wales 2007-2016; Jessica Randall, Richard Webster

3.12.5 LUNG SITE SPECIFIC TEAM

3.12.5.1 Lung Clinical Audit Activity

Complete	Active	Discontinued	On hold
2	2	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.5.2 National Audits and Continuous Monitoring

3.12.5.2.1 The National Lung Cancer Audi (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries, and varied considerably between organisations within the UK. The

audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit.

The NLCA has previously achieved outstanding levels of NHS participation with data being used to drive improvements in the quality of care for people with lung cancer. The RCP aims to build on this success by delivering a new NLCA that incorporates key advances in the field of lung cancer, diagnosis and treatment, whilst retaining the most successful elements of the previous audit.

This NLCA annual report represents the culmination of nearly 2 years of patient care and follow up, data collection, data analysis and interpretation. Its purpose is to understand the current quality of care and outcomes for patients with lung cancer, to celebrate good practice and to highlight variability, to ensure that all patients have access to the very best care

3.12.5.3 Posters and Publications

Survival Outcomes for NSCLC patients following Palliative Radiotherapy in Velindre Cancer Centre - BTOG

3.12.6 PALLIATIVE CARE SERVICE SPECIFIC TEAM

3.12.6.1 Palliative care Clinical Audit Activity

Complete	Active	Discontinued	On hold
2	1	0	1

**Figures exclude mandatory national audits and continuous monitoring*

3.12.6.2 National Audits and Continuous Monitoring

3.12.6.2.1 The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland. NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group

Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the Five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

3.12.6.2.2 All-Wales Care Decisions for the Last Days of Life Audit was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.

3.12.6.2.3 Palliative Care Outcome Scale (POS –S) audit is an evaluation tool with which we are able to assess the quality of care in palliative care patients. It assess a patient's physical, psychological and emotional symptoms, as well collecting information about their care and

support needs. These measures are uniquely developed so as to be suitable for patients with chronic/life limiting diseases such as cancer, degenerative/neurological disease, respiratory and heart failure. These assessment methods can be used in the clinical environment, in audit, research and in training purposes.

POS-s is an additional assessment tool that focuses on symptom control. This measure is particularly useful when patients have multiple symptoms and is adaptable to all clinical settings; hospital, hospice or home setting. The measures have been shown to be sensitive to changes in a patient's condition over time.

3.12.6.2.4 I Want Great Care, Independent service to allow patients to feedback their experiences. It allows patients to leave meaningful feedback on their care, say thank you and help the next patient. It's a service that is independent, secure and trusted by patients, doctors and hospitals. Feedback is provided on doctors, dentists, hospitals, GP practices, medicines, pharmacies and nursing homes to ensure problems get fixed

3.12.6.3 Areas of good practice and improvement

Surgam 2021 Awards Cardiff University: C4ME Nomination for outstanding medical student support in palliative care training & provision of excellent quality learning materials https://www.cardiff.ac.uk/medicine/courses/surgam/c4me-recognition

E-ELCA Module on End OF Life Care and DNACPR decisions: https://portal.e-lfh.org.uk/Component/Details/1939

MediWales Awards 2020: Winners of the Scaling Up Innovation NHS Award for Covid-19 Hospital Guidelines Wales
https://blogs.bmj.com/spcare/2020/12/04/the-development-and-implementation-of-a-national-covid-19-hospital-guideline-for-wales/

RCGP & Partners EOLC What Matters Most Charter and education resources
https://blogs.bmj.com/spcare/2020/12/11/new-charter-to-support-better-life-long-conversations-about-what-matters-most/#:~:text=The%20What%20Matters%20Most%20Charter,with%20a%20life%2Dlimiting%20illness.

Advance Care Planning website for NHS Wales - an online area for patients, proxy & healthcare professionals http://advancecareplan.org.uk/

Virtual Reality Palliative Care Education Project resources & library - featured in the Guardian
https://www.theguardian.com/education/2020/mar/16/it-reduces-surgical-error-can-vr-train-better-doctors

3.12.6.4 Posters and publications

Crabtree A, et al "Clinical Audit- Invaluable" Editorial in BMJ SPCare Journal https://spcare.bmj.com/content/10/2/213.abstract 10.1136/bmjspcare-2019-001981

Rietjens, J., Korfage, I. and Taubert, M. 2021. Advance care planning: the future. BMJ Supportive and Palliative Care 11, pp. 89-91. (10.1136/bmjspcare-2020-002304)

Pease N "Advance care-planning and clinical decision-making" Medicine 2020https://www.sciencedirect.com/science/article/pii/S1357303919302555

Five things this healthcare professional would like you to know about modern resuscitation. In: Lyons, A. and Winter, L. eds. We All Know How This Ends: Lessons about life and living from working with death and dying. Green Tree

Taubert, M. 2021. Forhåndsplaner for omsorg på Twitter - Advance care planning and Twitter. Presented at: Landskonferansen i Palliasjon 2021, Oslo, Norway, 3-5 March 2021.

Pease N "Palliative Care: Introduction" Medicine 2020
https://www.medicinejournal.co.uk/article/S1357-3039(19)30256-7/abstract

Taubert, M. 2021. Palliative endringer? Snu og møte det rare - 'Palliative Changes'. Presented at: Landskonferansen i Palliasjon 2021, Oslo, Norway, 3-5 March 2021.
2020

Abel, J. and Taubert, M. 2020. Coronavirus pandemic: compassionate communities and information technology. BMJ Supportive and Palliative Care 10(4), pp. 369-371. (10.1136/bmjspcare-2020-002330)

Taubert, M. and Baker, J. I. 2020. 'Do not attempt CPR' and the concept of harm. Medicine 48(10), pp. 651-652. (10.1016/j.mpmed.2020.07.016)

Taubert, M., Rietjens, J. and Korfage, I. 2020. Rocambolesco- current and future models of advance care planning. Presented at: 11th EAPC World Research Congress, Palermo, Italy, 7-9 October 2020, Vol. 34. Vol. 1_Supp. SAGE pp. 95., (10.1177/0269216320958098)

Taubert, M. 2020. Education- 'do not resuscitate me in Barbados'. BMJ Supportive and Palliative Care (10.1136/bmjspcare-2020-002446)

Taubert, M. 2020. Lights, camera, stop! What to consider when television crews come to a hospital. Royal College of Physicians Commentary Magazine Februa(1/2020), pp. 18-19.

Abel, J.et al. 2020. Advance care planning re-imagined: a needed shift for COVID times and beyond. Palliative Care and Social Practice 14 (10.1177/2632352420934491)

Media:
https://www.telegraph.co.uk/health-fitness/body/palliative-pandemic-not-yet-one-year-lockdown-end-life-doctor/

https://www.bbc.co.uk/news/uk-wales-52833504
2020 Science Museum London Lecture "Medicine Lates"
https://www.theguardian.com/music/2020/jan/27/cremate-sound-disco-inferno-song-die-funerals-death

3.12.7 UGI Site Specific Team

3.12.7.1 UGI Clinical Audit Activity

Complete	Active	Discontinued	On hold
6	3	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.7.2 National Audits and Continuous Monitoring

The National Oesophago-Gastric Cancer Audit (NOGCA) was established to investigate the quality of care received by patients with oesophago-gastric (OG) cancer in England and Wales. It aims to provide information for NHS cancer services so that they can benchmark their performance and identify areas where aspects of care could be improved. Around 13,000 people are diagnosed with OG cancer in England and Wales annually. It is the fifth most common type of cancer, and patients are often diagnosed with more advanced disease compared with other cancers.

NOGCA collects prospective data on adult patients diagnosed in England and Wales with invasive epithelial cancer of the oesophagus, gastro-oesophageal junction (GOJ) or stomach, or high-grade dysplasia (HGD) of the oesophagus.

3.12.8 UROLOGY SITE SPECIFIC TEAM

3.12.8.1 Urology Clinical Audit Activity

Complete	Active	Discontinued	On hold
6	1	1	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.8.2 National Audits and Continuous Monitoring

Prostate cancer is the most frequently diagnosed solid cancer (over 40,000 new cases each year) and the second most common cause of cancer-related death in men in the UK.1 The National Prostate Cancer Audit (NPCA) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and the Welsh Government with the aim of assessing the process of care and its outcomes in all men diagnosed with prostate cancer in England and Wales.

3.12.8.3 Areas of good practice and improvement

3.12.8.3.1 Audit of patients in VCC with newly diagnosed, low volume metastatic prostate cancer receiving radiotherapy

Stampede M1 trial confirmed an increased overall survival for this cohort of patients. Before results were published in 2018, these patients would rarely have been offered radiotherapy. However after the publication of results it was deemed beneficial to offer radiotherapy to the standard care. As a result, in 2019 an extra 46 prostate patients were treated in Velindre. Based on this data from 2019 and projected increasing patient numbers, it is expected that annually ~ 50+ patients would be added to the radiotherapy demand.
Additional patient numbers to the service impacts on the service throughout the whole radiotherapy pathway. Therefore it was advised a business case is presented to secure funding to sustain this service.

Update: Proposal of business case to seek financial support to maintain the Stampede M1 radiotherapy service in Velindre currently in discussion with Senior Management team and potentially be addressed via commissioners.

Proposed protocol for dose fractionation schedules and Volumes/Margins; It is recommended all patient groups should be included in a quality procedure to document and clearly define a consistent and standard process which will maintain treatment standards. Therefore this group of patients should be included in the QPWI 56 Prostate Joint Protocol.

STAMPEDE and HORRAD trails used different dose fractionation schedules: 55Gy/20#, 36Gy/6#, 70 Gy/35# and 57.75 Gy/20#. There was no clear evidence of improved outcome with any schedule although there is some evidence for better outcomes in STAMPEDE with the 4 weekly schedule compared to the weekly schedule.

Results showed that the majority of PPNs were treated with 60Gy/20# and the majority of SVPs were treated with 55Gy/20#. In total, the majority of patients were treated with 55Gy/20# therefore it is recommended this dose should be used at Velindre.

The majority of patients were planned with two volumes - Prostate and Prostate & SV and margins of 5mm and 10mm. Therefore it is proposed this should be taken into consideration as the standard treatment in the clinical protocol

Update: As a result of this audit the treatment fractionation schedules, volumes and margins have been added to the shared Radiotherapy prostate protocol QPWI 56.

3.12.8.3.2 Post Holistic Needs Assessment (HNA): Patient Survey urology

The baseline patient experience questionnaire provided insights of patients' concerns and their clinic experience. The concerns ranked as most important were the management of side effects, being involved in decision making and the waiting times. It is possible that patients may not always be aware of the possibility of referrals to such services as psychology or an erectile dysfunction clinic, personal experience suggests this is often the case. The picture is different after an HNA and comparable with studies examining unmet need. Results from both the HNA collection data and the patient experience questionnaires show that once concerns such as fatigue were actively discussed, patients were keen for further advice.

Following the recommendations have been implemented into the service:
The process pathway has been implemented into the additional urology sites ensuring there is protected time, staff and space.
Coordination of the HNA intervention has become the speciality of cancer support workers such as the Navigator who facilitate the process and can triage to the appropriate HCP.
An educational training pathway has been developed for Navigators to facilitate HNA, including: psychological support, communication skills, motivational interviewing and cognitive behavioural therapy

3.12.9 NEURO-ONCOLOGY SITE SPECIFIC TEAM

3.12.9.1 Neuro-Oncology Clinical Audit Activity

Complete	Active	Discontinued	On hold
3	1	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.12.9.2 National Audits and Continuous Monitoring

There are currently no national audits within this site

3.12.9.3 Areas of good practice and improvement

3.12.9.3.1 Waiting times - Clinics have merged which has alleviated clinic waiting times

3.12.10 OTHER SITES AND SERVICES

3.12.10.1 Other Sites and Service Clinical Audit Activity

Complete	Active	Discontinued	On hold
10	15	3	1

**Figures exclude mandatory national audits and continuous monitoring*

3.12.10.2 Areas of good practice and improvement

3.12.10.2.1 Measure Yourself Concerns and Wellbeing (MYCaW) Audit identified that Of the 67 MYCaW questionnaires analysed, 22 were fully completed. Concerns identified included both physical and psychological issues with pain, sleep, stress and anxiety being the concern most regularly reported. We also found that with the majority of questionnaires each concern was scored lower at the end of the treatment regimen. Concerns are scored on a scale of 0 (not bothering me at all) to 6 (bothering me greatly). Overall, scores improved by 1 to 2 points for both concerns and wellbeing suggesting that patients do feel the Complementary Therapy treatments are beneficial.

This audit highlighted that as a team, we need to improve on fully completing the outcome measures we are using and record these figures to monitor ongoing progress. We have also implemented a checklist of common symptoms and side effects to help patients identify more appropriate concerns as we finding some were reporting issues that Complementary Therapies may not have been beneficial for e.g. mouth ulcers. Also, we now have a patient satisfaction survey to be completed at the end of the treatment period to establish if they found the sessions helpful and if there is anything we could improve on as a team.

3.12.10.2.2 An audit to determine the quantity of walking aids used by the physiotherapy team across VCC demonstrated that RZF's (19) are the most frequently issued walking aid, followed by walking sticks (12) and e/c's (5). Need to set up a stock database which enables us to automatically identify when we need to order more stock. It will also enabled us to ensure we are only holding the stock we require which will free up a lot of storage space

3.12.10.2 Exploring Implementation, Barriers and Facilitators to Transfer of Care Systems in the UK aimed to describe, compare and contrast The Discharge Medicines Review (DMR) referral system, Refer-to-Pharmacy (RTP), PharmOutcomes and Help for Harry are UK transfer of care systems to highlight areas that could inform good practice recommendations. A rapid literature review was completed, and from the twenty-six sources of literature that were synthesised, three themes were identified for further exploration in semi-structured interviews with key informants: implementation, system attributes and stakeholder engagement. The key informants were purposively sampled for their role in the development and/or strategic implementation of each transfer of care system (n = 4). Audio recordings were transcribed ad verbatim and analysed both deductively and inductively. One interview was undertaken for each of the DMR, RTP and PharmOutcomes systems. Although all systems shared the same aim, differences were identified such as automated feedback for referrals, marketing

strategies and practitioner accountability. Good practice recommendations suggested in this study could be applied to the future development of such systems.

The following timely recommendations are suggested for the development, adaptation and strategic implementation of technology-supported transfer of care systems:

1. Pre-plan implementation strategies with dedicated staff, focusing on stakeholder Engagement.
2. Flexible notification systems should be developed to inform community pharmacists of patient admission and discharge, including email and USB device notifications;
3. Produce content such as videos to support patient consent for information transfer;
4. Develop methods to keep hospital and community practitioners accountable for Referrals.
5. Develop interoperability with both hospital and community IT systems to make referrals seamless.
6. Ensure post-discharge adherence-support services have broad eligibility criteria.

The use of these technologies is likely to be adopted more widely internationally with the World Health Organisation's focus on improving medication safety during transitions of care, and in the UK with the recent announcement in England of the Discharge Medicines Service [18,57]. Further work to explore stakeholder perceptions of these systems would provide more evidence of service users' perspectives.

3.12.11 COVID

3.12.11.1 COVID-19 Audit Activity

Complete	Active	Discontinued	On hold
10	17	0	0

**Figures exclude mandatory national audits and continuous monitoring*

3.13 DEATHS WITHIN 30 DAYS OF CHEMOTHERAPY

Introduction

The Wales: Clinical Audit and Outcome Reviews (Confidential Enquiries) and the NHS Wales Annual Quality Framework 2011/2012 set out how participation, and findings from national audit and outcome reviews together with a small number of Wales specific audits and other reviews will be used to measure and drive improvement in the quality of Welsh healthcare services over the next 5 years.

Background

Benefits to patients from systemic anti-cancer therapies (SACT) occur at a cost of significant toxicities that can be life threatening. In 2008 the National Confidential enquiry for patient Outcome and Death (NCEPOD) published their report of a study which examined the process of care of all patients who died within 30 days of SACT, looking for areas where their care might have been improved. It did not concentrate solely on those patients whose death may have been treatment-related.

Originally it was proposed that the study would focus on those patients in which it was thought that the toxic effects of the patient's therapy contributed to their death. Whilst this is an extremely important group of patients to study, it would only be possible to identify this cohort

of patients following close examination of individual sets of case notes. As stated above, the study included all patients who died within 30 days of systemic anti-cancer therapy and therefore included many patients who died from progressive disease as well as those who suffered iatrogenic disease. Patient management should adhere to guidelines and standards, which aim to reduce risk. This expanded study enabled NCEPOD to obtain a large dataset on patient care from which to identify remedial factors and make meaningful recommendations.

To identify remediable factors in the care of patients who received SACT which may have contributed to their death, the NCEPOD Expert Group identified five main thematic areas that would address the overall aim of the study. These were:

- The appropriateness of the decision to treat with SACT;
- The process of prescribing the anti-cancer therapy and administration of the treatment;
- The safety of the care with regard to monitoring of toxicity and management of complications;
- Communication - patient information, care pathways, protocols, guidelines, and MDT meetings; and
- Regular clinical audit with regard to process of care and clinical outcomes.

As part of the Trusts commitment to reporting on the key indicators of practice in the NHS Wales Annual Quality Framework Velindre Cancer Centre (VCC) is attempting to develop a robust mechanism to report on its deaths within 30 days of chemotherapy. Routine reports have been produced for site specific team (SST) appraisals, for consultant appraisal and revalidation, peer review and for Cancer Services as a whole.

Method

A data analysis tool was developed by the Canisc team to enable us to review all deaths within 30 days of SACT and the reporting tool within Chemocare now enables us to report on % death rate within 30 days of administration of SACT.

Inclusion criteria:

- Patients aged 16 or over
- All solid tumours and haematological malignancies
- Received intravenous, oral, subcutaneous, intravesical, Intrathecal or intraperitoneal chemotherapy, monoclonal antibodies or immunotherapy
- Died within 30 days of receiving a SACT cycle, either in hospital or in the community

The 30 day period is defined as 30 days from Day 1 of the SACT cycle immediately prior to death. If SACT is given continuously, then 30 days from the date of the last prescription.

Exclusion criteria:

- Patients under 16
- Patients receiving hormone therapy

For the purposes of the study, the definition of chemotherapy treatment includes cytotoxic drugs and biological agents, such as interferon and monoclonal antibody therapies.
% deaths within 30 days is calculated using the formula:-

$$\frac{\text{Total N}^{o}\text{ deaths within 30 days of SACT cycle per quarter}}{\text{Total N}^{o}\text{ patients starting SACT cycle per quarter}} \times 100$$

For reporting purposes, the time period is 3 monthly (quarterly) as this is in line with the NCEPOD time span (2 months data) and enables us to benchmark against other cancer centres (Marsden, Christie). Data can then be recorded on run charts or statistical process control (SPC) charts so we can observe changes over time.

Results

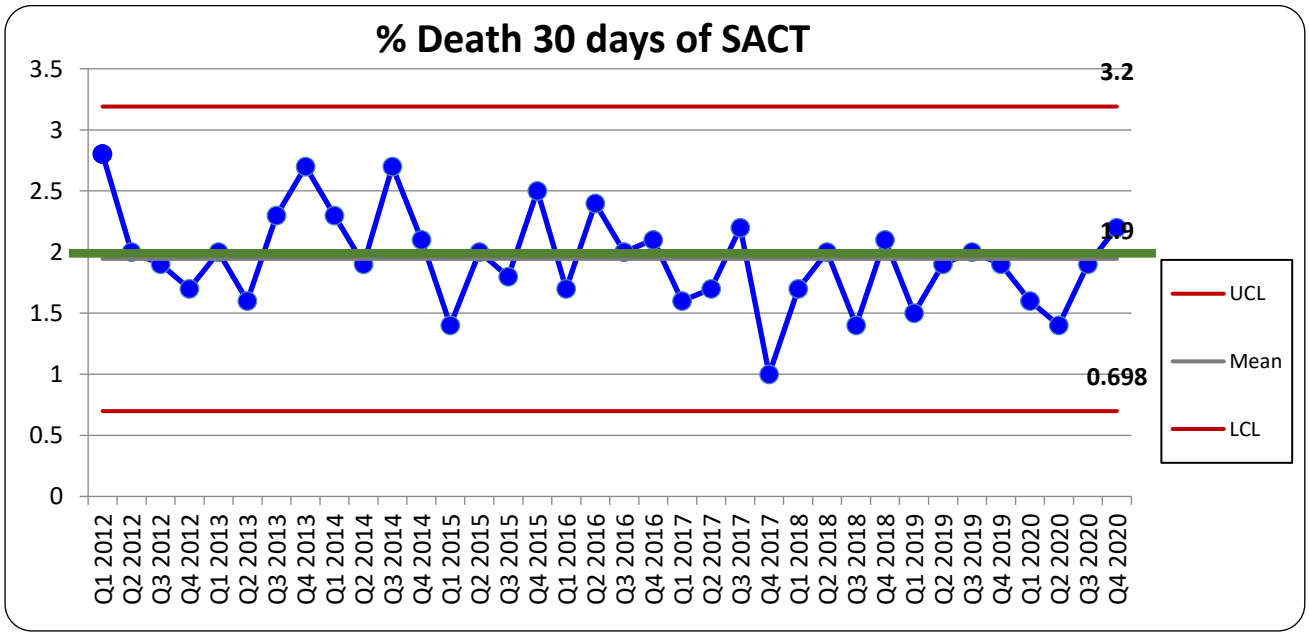
It must be acknowledged that anomalies exist due to the different methods of calculation that can be used to determine % death rate within 30 days of SACT. The NCEPOD study reviewed patients who had chemotherapy over a two month period. As data at VCC is reviewed on a quarterly basis, the rate of death within 30 days has been calculated as a percentage of individual patients who had chemotherapy prescribed during that quarter.

As previously mentioned, it must be acknowledged that this process currently requires manual intervention as the current data platforms are unable to provide all the information required. There is ongoing work with the informatics team to develop automated tools to streamline the process.

Percentage deaths by quarter

Quarter	Months	VCC Deaths	SACT	%
Q1 2019	January-March 2019	33	2197	1.5
Q2 2019	April-June 2019	42	2258	1.9
Q3 2019	July-September 2019	47	2346	2.0
Q4 2019	October-December 2019	45	2324	1.9
Q1 2020	January-March 2020	40	*2453	1.6
Q2 2020	April-June 2020	25	1689	1.5
Q3 2020	July-September 2020	40	2072	1.9
Q4 2020	October-December 2020	48	2163	2.2

*Different data analysis tool used to capture SACT moving forward



NCEPOD Benchmark

3.14 MORTALITY REVIEW APRIL 2020-MARCH 2021

In 2011 the Medical Director for Wales, sent a directive to all Health Boards and Trusts to undertake mortality reviews. This led to the forming of a collaborative under the guidance of the 1000 Lives+ team.

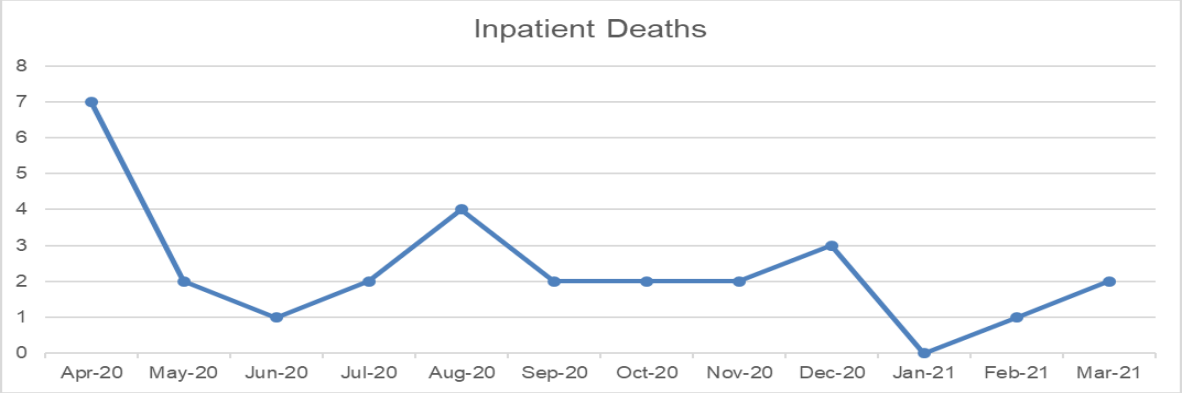
In the United Kingdom, the review of case notes from single study sites suggests that 10% of patient's experience an adverse event during inpatient management. Similar findings have been reported from studies in the US, Europe and Australia and the contributory factors can vary widely in nature. From these studies we can infer that avoidable mortality is occurring in hospitals within Wales.

Avoidable mortality can be described as deaths that should not occur given current medical knowledge and technology. The recognition that some preventable harm is occurring to patients, which can result in death, has led to a variety of methods that attempt to quantify mortality levels. Each have their advantages and disadvantages, but when used appropriately can provide an organisation with valuable insights about to areas for improvement.

A new Standard Operating Procedure (SOP) for Velindre Cancer Centre (VCC) was developed, detailing the methodology for the reviewing, recording, monitoring and referring of those who die whilst an inpatient at Velindre Hospital. This includes the standard procedures to be followed whilst providing uniformity in the process of writing, maintaining, capturing and disseminating information and data in a consistent manner in accordance with local and national guidelines, to recognize good practice and to identify areas for improvement in health care in the hospital environment and inform the appropriate individuals who can deliver the necessary changes.

Number of Inpatient Deaths:

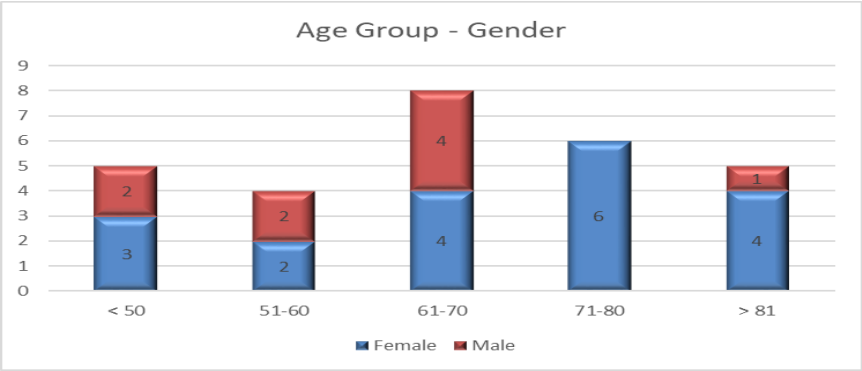
Month	Number of deaths
Apr-20	7
May-20	2
Jun-20	1
Jul-20	2
Aug-20	4
Sep-20	2
Oct-20	2
Nov-20	2
Dec-20	3
Jan-21	0
Feb-21	1
Mar-21	2



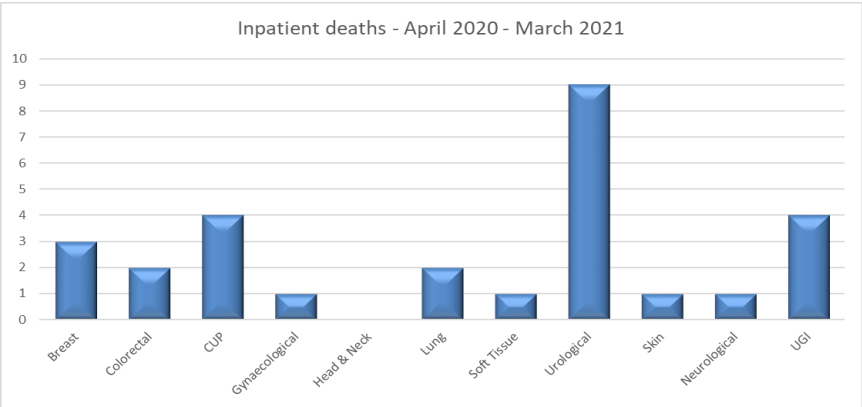
Cause of Death

	No. of patients
Covid-19, Malignant disease	8
Malignant/Metastatic disease	17
Bronchial Pneumonia	2
Septicaemia	1
Total number	28

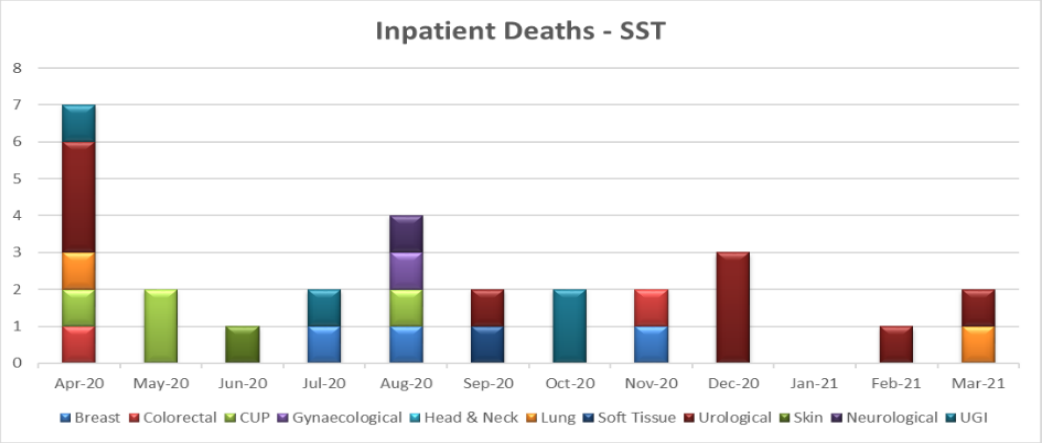
Patient Demographics



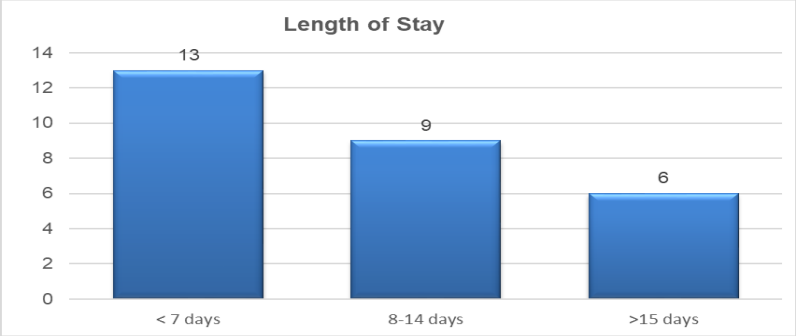
Breakdown by SST:



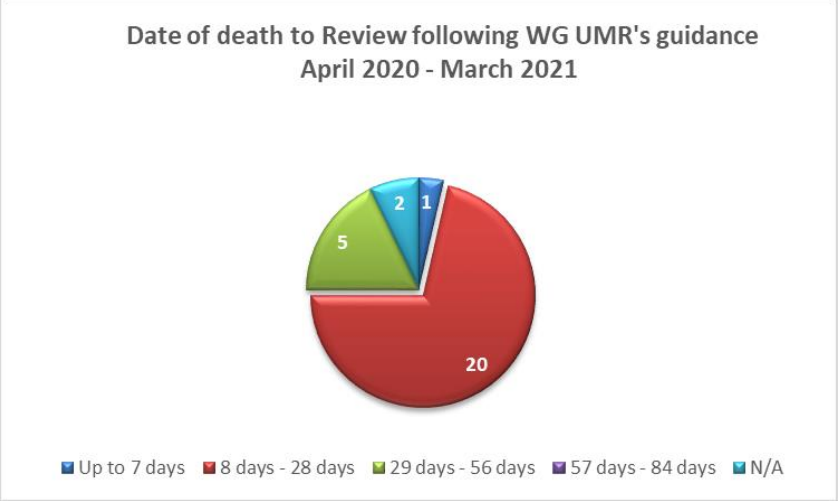
Breakdown by SST per Month:



Length of Stay



Date of Death to Date of Review



4.0 WELSH BLOOD SERVICE SUMMARY

The Welsh Blood service (WBS), as a transfusion and transplantation service does not routinely provide clinical treatment to service users, nonetheless Clinical Audit remains an essential pillar within the Clinical Governance structure to ensure that donors remain healthy and are not put at unnecessary risk. A number of clinical audit activities are embedded into WBS processes which demonstrate a commitment to sustain and improve high quality of care for all of our donors. The COVID-19 pandemic has brought new challenges to our working environment and highlighted areas of need and improvement which is reflected in some of the more recent clinical audit activities

In addition, WBS act as the system leaders for the use and administration of blood products across Wales, and the Blood Health Team have supported a number of clinical audit activities to identify and promote best practice across Health Boards in Wales.

This annual report demonstrates the consistent commitment from healthcare professionals working at the Welsh Blood Service to engage with clinical audit as a driver for change and to assure the quality of care for our donors and ultimately for the recipients of our products and services.

4.1 APPROACH TO CLINICAL AUDIT

At the Welsh Blood Service we are passionate that clinical audit should underpin everything we do as clinicians to ensure constant service/ practice evaluation and improvement focus are embedded in our day-to-day clinical practice to achieve optimal outcomes for donors, recipients and partner NHS organisations across Wales.

At the Welsh Blood Service Clinical Audit roles and responsibilities are embedded into clinical roles across the organisation. The clinical audit oversight lead role is undertaken by the Head of Quality with the support of the wider clinical service team.

4.2 SUMMARY OF AUDIT ACTIVITY 2020/21 BY DEPARTMENT/TEAM

4.2.1 NATIONAL AUDIT ACTIVITY 2020/21

4.2.1.1 For the Assessment of Individualised Risk Project. (F.A.I.R)

The Welsh Blood Service (WBS) implemented the recommendations of the FAIR (For the Assessment of Individualised Risk) project on 14 June 2021. This changed blood donor eligibility assessments for lifestyle issues from a population based risk assessment (where all individuals declaring membership of a population at increased risk of having a transfusion transmissible infection (TTI) regardless of individual circumstances are deferred) to an individual risk assessment. The successful implementation ensured that WBS remains compliant with the latest donor eligibility criteria.

The FAIR Steering Group oversaw the project and had representation from the four UK blood services, including the Welsh Blood Service, Public Health England, psychologists from the University of Nottingham, Virologists from National Health Service Blood and Transplant (NHSBT) and a variety key stakeholders including, a donor representative, a patient representative, Stonewall, The Terence Higgins Trust, Freedom to Donate.

The FAIR Project developed an evidence base for a more individualised lifestyle donor eligibility assessment to enable low risk individuals within populations at greater risk of having a TTI, to donate blood. This means that men who have sex with men (MSM) and whose individual risk is low, like male couples in long term monogamous relationships, would be able

to donate blood. This evidence base included a review of the literature (looking at behaviours that increase the likelihood of contracting a TTI), a small and large scale survey of donors assessing the type and acceptability of various question options to identify behaviours that put an individual at risk of having a TTI, staff focus groups and donor focus groups again assessing the acceptability of various question options.

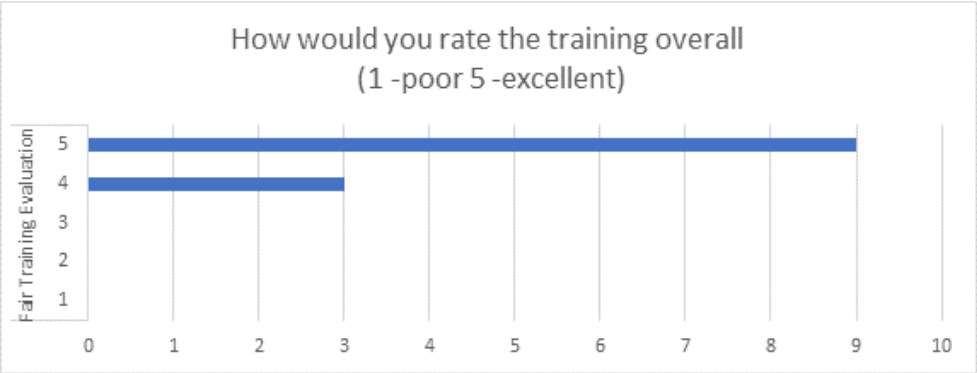
The FAIR proposal was to replace the gender based questions around sexuality with questions aimed at eliciting high risk behaviours in all individuals. Those donors who answer positively to a high risk behaviour would then be deferred for an appropriate period of time. This will defer donors whose behaviours puts them at high risk but under the current eligibility rules are still able to donate, as well as allowing donors belonging to higher risk populations but whose individual risk is low based on their behaviour, to donate.

FAIR recommendations were presented to and accepted by The UK Government Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) on 6 Oct 2020 and were ratified by the Welsh Government shortly thereafter. Subsequently a second FAIR Steering Group reviewed the "sex in areas of the world with a high HIV prevalence (Sub Saharan Africa)" question and recommended this question be removed from Donor Selection entirely – this was endorsed by SaBTO on 29 March 2021 and subsequently ratified by the Welsh Government on 16 April 2021. It was agreed that FAIR implementation day would be on World Blood Donor Day - 14 June 2021. Full report is available at https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/21001/fair_sabto_20201211.pdf .

The WBS clinical and operational teams then had a busy time gearing up for the successful implementation of FAIR. This included changes to all donor documents (SOPs, donor information leaflets, the WBS website, the online "Donor Eligibility Quiz"), communications to inform donors of the coming change in advance (pop up banners on donation sessions with accompanying explanatory leaflets), IT changes updating the Self Assessed Health History (the donor electronic questionnaire), changes to the deferrals on the donor IT system, developing and rolling out a staff training package for all donor facing staff and developing and rolling out a communications strategy to advise of the upcoming changes and mark the launch of the FAIR changes. All of this was delivered on time so FAIR was launched at WBS on 14 June 2021, as planned, and had wide media coverage.

A measure of the success of the F.A.I.R launch of can be demonstrated through:

- Appointment uptake more than doubled on 14th June with more than 1,750 donors booking to donate.
- Inbound calls rose to 287 calls with 105 bookings.
- A further 264 bookings were made from Donor Contact Centre SMS'
- Online registrations for new donors rose from 14 to 91 enrolments.
- Media coverage of donor support including married couple Carl and Martin donating as one of the first gay couples in the UK.
- Media coverage of First time donor Shane Andrews MBE
    - Media Coverage of WBS Clinical Lead Dr Stuart Blackmore and Ann Richards Education and Practice Development Lead.
    - Support from The First Minister, Mark Drakeford who celebrated the occasion by making his landmark 50th blood donation.
    - 70,000 social media accounts reached across a variety of platforms during the launch day– setting a record for the most successful June for this measure in the history of WBS.
    - Staff satisfaction survey was conducted with donor facing teams the week following FAIR launch: 100% of staff surveyed rated the training as good or excellent



4.2.1.2. Blood Health Team

During 20/21 a variety of National audits have been undertaken by the blood health team to inform the national direction of transfusion medicine.

Name of Audit/Survey	Audit Rationale	Date Completed
NCA: Medical Use of Blood	Part of the National Comparative Audit (NCA) which is a UK wide audit on the use of blood in a medical setting. All Wales data analysed and report produced for BHNOG	January 2020
PIL survey for Bevan Exemplar	Patient Information Leaflet (PIL) survey for Bevan exemplar to determine whether PIL is fit for purpose	July 2020
ICS Use Audit & Directed interviews	All Wales audit on the use of Intra-Operative Cell Salvage(ICS) as part of the BHNOG blood conservation strategy initiative	July & Oct 2020
Platelet Use in Haematology (re-audit)	All wales audit with SpRs to determine appropriate platelet requesting in Haematology	Sept 2020
NABT Practitioner survey	Audit of last Non-Medical Authorisation of Blood (NABT) cohort to ensure course fit for purpose	March 2021
SpR WBS Education Programme survey	Audit of SpRs who attended the WBS Education programme for their FRC Path exam	March 2021
Wrong Blood in Tube (WBIT)	Ongoing All Wales audit of WBITs in clinical practice	May 2021
SSA Training Audit	Audit of all 5th year medical students (approx. 400 students) who attended the transfusion training of their Senior Student Assistantship (SSA)	May 2021
Major Haemorrhage (MH) Audit Ongoing – monthly. Data to BHNOG	Ongoing All Wales audit of MH KPIs that are fed into the BHNOG quarterly	Ongoing since Jan 2020

4.2.2 WELSH BLOOD SERVICE AUDITS

4.2.2.1 Antenatal Anti D testing practice in Rh D negative women in Wales

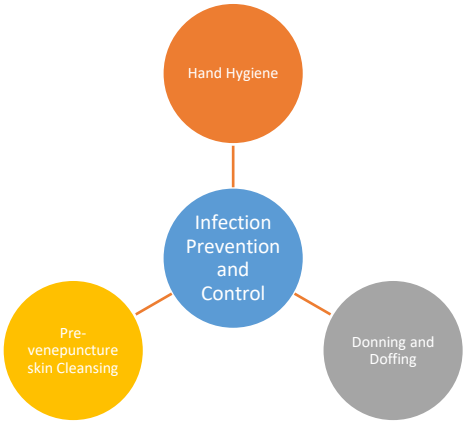
Audit Aim- Review the compliance on antenatal anti-D testing practice in Wales with the British Society for Haematology (BSH)-2016 guideline in blood grouping and red cell antibody testing in pregnancy.

Outcomes: The audit has been completed and close out report is under construction.

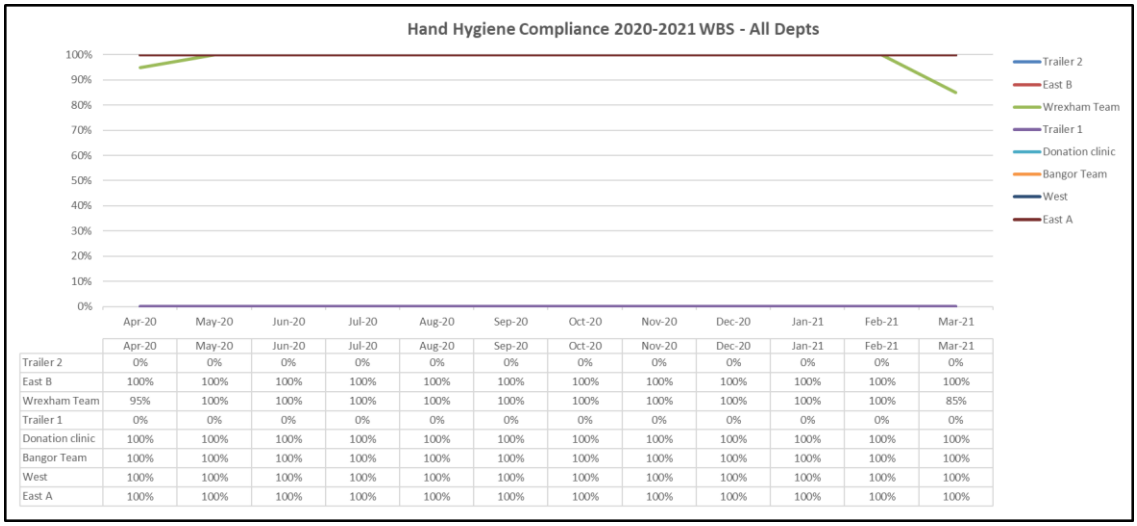
4.2.2.2 Infection Prevention and Control Audit 20/21

With the emergence of the Covid 19 pandemic Infection Prevention and Control (IPC) has been a significant focus for the Welsh Blood Service to ensure the safety of our donors, staff and recipients is maintained whilst ensuring service core functions continue.

To provide assurance that the required IPC standards have been maintained a raft of IPC audits have been undertaken within Donor Facing Clinical environments demonstrating high levels of compliance with evidence based guidance.



4.2.2.3 Hand Hygiene

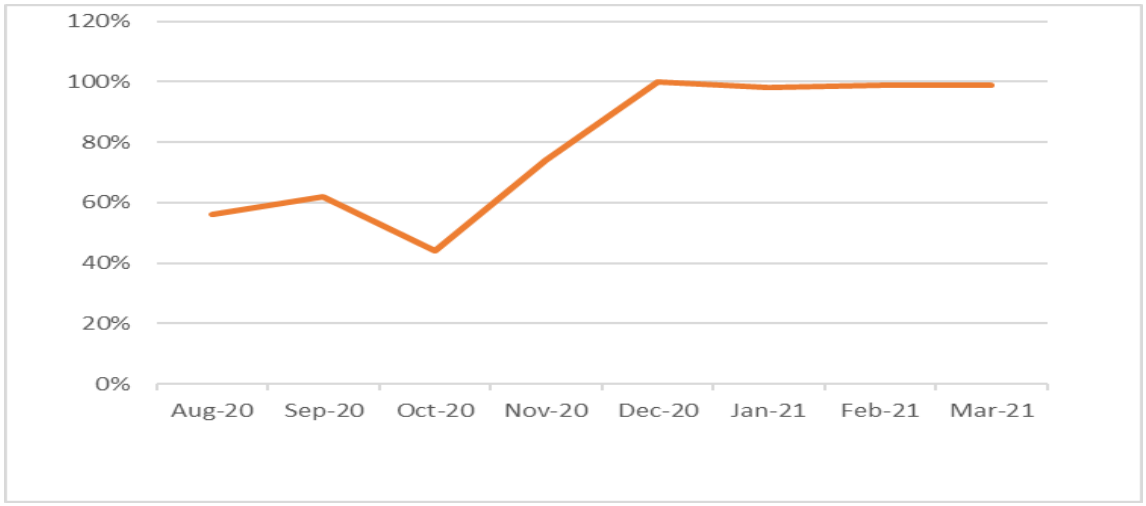


	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Trailer 2	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
East B	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Wrexham Team	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	85%
Trailer 1	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Donation clinic	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Bangor Team	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
West	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
East A	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

High levels of compliance with required hand hygiene standards remain within donor facing teams across Wales during 2020/21. As an integral part of the audit all areas of noncompliance

are discussed at the time of the audit and action plans to clearly identify and address lessons learnt are developed.

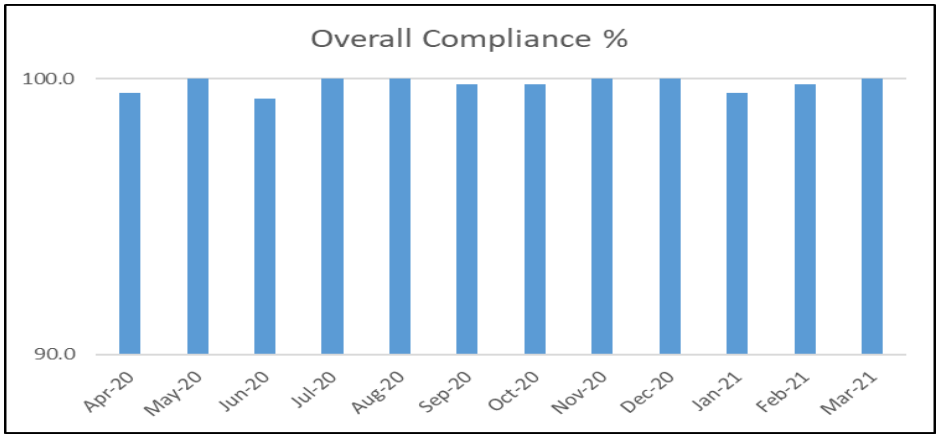
4.2.2.4 Donning and Doffing



This audit programme was introduced in August 2020 to ensure adequate compliance Public Health Guidance requirements to maximise staff and donor safety. Through the regular audit cycle incorporating both lessons learnt and required service improvements compliance has greatly improved and a variety of improvement strategies have been implemented including the implementation of IPC champion within laboratory services and annual donning and doffing training updates and assessments for all donor facing/ laboratory staff across WBS.

4.2.2.5 Venepuncture Skin Cleansing

Adequate skin cleansing practices are critical in ensuring the safety of donors, recipients and all products collected. Therefore the WBS has a robust monthly audit programme in place to ensure that required practices and standards are maintained. During 2020/ 21 compliance within all donor facing services across Wales remained high.



4.2.3 IMPROVEMENT ACTIVITY

4.2.3.1 Bacteriology Monitoring of Platelets

Stored platelet products provide an ideal environment for bacterial growth, being held at 22 degrees C. Bacterial contamination is a significant risk to recipient health and all measures must be in place to ensure risks are minimized. The most likely causes of bacterial contamination of platelets can be attribute to inadequate arm cleansing prior to venepuncture or poor IPC practices in either the collections or laboratory work areas.

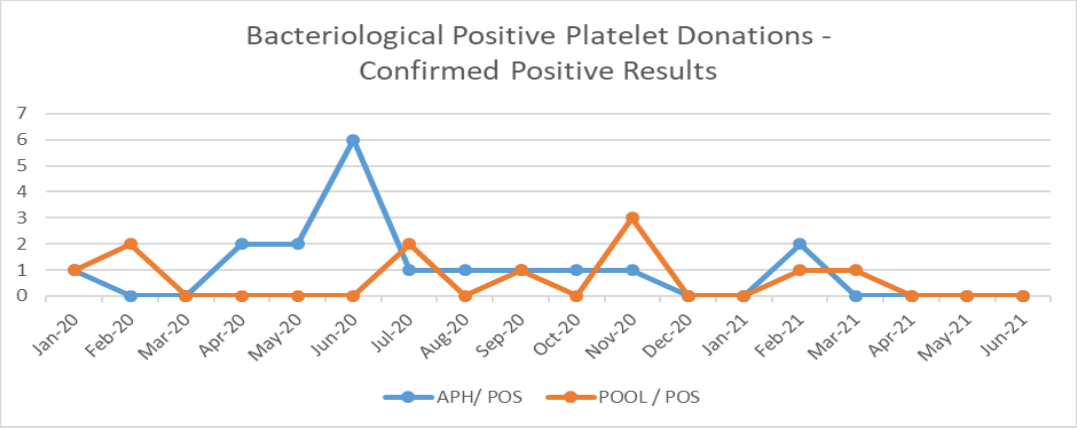
The number of bacteriological confirmed positive platelet donations identified at the Welsh Blood Service (WBS) are monitored on an ongoing basis. During January- June 2020 an increase of the number of confirmed bacteriological positive platelet donations was observed.

As a result of these increases a multidisciplinary working group was established to identify and address the causative factors.

Several Observation of Practice audits were undertaken both within the Collection Clinic and Automated Testing laboratory and as a result several areas for improvement were identified;

- Poor practice around glove use within laboratory settings
- Insufficient environmental cleaning practices within laboratory areas
- Cluttered working areas within laboratories
- Low level donning and doffing non-compliance.

Following the identification of these practice issues an action plan was developed and implemented to ensure all issues were adequately resolved and practices improved. Although the issues identified cannot be sited absolutely as the causative factor for the increase in Bacteriological Positive platelet donations there is the potential. Since the implementation of altered practices a marked decrease in positive results has been evident.



4.2.4 AUDIT PLAN FOR 2021/22

To ensure adequate standards of practice are maintained the audit programme continues.

During 2021/22, the Welsh Blood Service will continue to strive to further embed programmes of Clinical audit across the organisation to enable the continuous improvement of services to maximise donor/ recipient safety and ensure optimal high quality and evidence based practice continues to be provided.

APPENDIX 1

Velindre Cancer Centre

Clinical Audit Project Progress

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
National Audits								
6.2	National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	NABCOP Annual Report			Ongoing (Annual)
3.1	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	NLCA Annual Report			Ongoing (Annual)
3.1	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	NPCA Annual Report			Ongoing (Annual)
3.1	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	NOGCA Annual Report			Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	NBoCA Annual Report			Ongoing (Annual)
3.1	UK National Audit of Care at the End of Life (NACEL) Audit	NHS Benchmarking project	SPCT	National Audit	NACEL Second round Report		We are participating in the next UK wide scheduled audit and evaluation and Mark Taubert is leading on this	Ongoing
Continuous Monitoring – Quality and Safety and Must Do's								
6.3	All Wales Patient experience framework	To evaluate patients experience at VCC to identify areas from improvement	Patient Experience	Users views	Patient experience is on hold no report available.	N/A	N/A	Ongoing (Monthly)
3.5 4.2	Audit of all Wales consent form 4 (best interests)	To identify if consent form 4 was used appropriately and ascertain completeness	Clinical Audit Dept.	Clinical risk	This will be included in the consent form audit.			Ongoing (Annual)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	All-Wales Care Decisions for the Last Days of Life Audit	Care Decisions for the Last Days of Life guidance was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.	Palliative Care	National guidance	April 2018 – March 2019 VCC had 81% usage of care decisions guidance, for the first 6 months of April 2019 – March 2020 our usage is 63%, I think this partly reflects the changes within the inpatient unit since the opening of the assessment unit and the increased acuity of patients who are admitted to the inpatient unit. There is also sometimes a reliance on the palliative care team to make the decision that the patient is in the last days/ hours of life and to complete the paperwork (even if the patient has already been reviewed by the ward team or their own oncology team). This can create delays in completing the paperwork particularly during the times when the palliative care team are not on site or are seeing pts elsewhere in the hospital.	Areas for improvement	Relaunch The All wales education package for CDG after it's been updated by Dr Fiona Rawlinson and Cardiff University also suggest it becomes part of induction and also nurses ongoing PADR. Direct junior Dr to the learning resources and do some follow up with them. Identify one palliative link nurse for each end of the ward and perhaps also have some link nurses by night. We can include them in updating, education, spending time with PC team and invite them to the 6 monthly care decisions meetings.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.5 4.2	Consent Audit	To identify if consent forms are available to view and to ascertain completeness of the information	CAD	Clinical risk	The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. The percentages were in the high nineties in the majority of cases, however improvements are required to ensure 100% compliance in future.	Areas for improvement	Identify current practice with regards to how consent forms are processed to Clarify which consent forms should be used Provide education training Future aspirations to implement electronic consent Annual audit to	Complete
2.1	Sepsis	TBC	Quality & Safety CAD	Patient Safety	This is included in the sepsis six	N/A	N/A	Included below
2.1	Escalation of Care	TBC	Quality & Safety CAD	Patient Safety	Included in DTOC	N/A	N/A	Included below
3.1	Secondary Breast Cancer Multidisciplinary Forum (SBCMDF)	To evaluate the SBCMDF service and outcomes	Breast Team	Key Indicator of Practice	Business case for data coordinator is being submitted.	N/A	N/A	Ongoing
3.1	Immunotherapy for Adjuvant melanoma	To obtain toxicity and outcome data in the adjuvant setting	Melanoma CNS	Key indicator of practice	Data collection ongoing			Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1 3.2 4.1 6.2	Palliative Care Outcome Scale (POS –S) audit	Evaluation of the use the POS-S system compared to the National guidelines	Palliative care Team	National	POS-S symptoms have consistently improved over a 7 day period (day 0, day 3 and day 5-7 evaluation). On occasion, some patient's nausea has worsened but this may have been due to the initiation of SACT agents during inpatient stay. Velindre palliative care patient's symptoms improved across the board. POS_S also remains a gold-standard evaluation framework, which may be replaced in future by i_POS or OAKE.	Areas of good practice	Continue 'Hard-POS_S ' evaluation but may be worth doing every 2 years rather than each year	Ongoing (Annual)
6.3	I Want Great Care	Independent service to allow patients to feedback their experiences.	Palliative care Team	Users views	Since COVID -19 started (March 2020) no iWGC questionnaires have been completed. But this will restart once Covid-19 visiting restrictions are lifted and admin staff can go back to filling in with patients and their kin. Respect of Covid-19 hygiene and visiting restrictions	Area of good practice	Restart once restrictions lift. End of Life Care Board are reviewing different methods of Patient Feedback for palliative Care across Wales	Ongoing
6.3 4.2	Prostate Post treatment Seminar – Patient Survey	To evaluate patient feedback to improve the sessions	Urology CNS	Users Views	Seminars we stopped during COVID and the team are looking to establish virtual seminars moving forward.	Areas of good practice and Areas for improvement	Establish Virtual seminars	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3 4.2	Immunotherapy workshop: feedback form	To evaluate patient feedback to improve the sessions	Melanoma CNS	Users Views	The immunotherapy workshop sessions were very well received by all patients, family members, carers or friends that attended. Due to COVID sessions were put on hold. There will be virtual session developed and also a DVD/digital solution	Areas of good practice and Areas for improvement	Create virtual session Create DVD/digital solution	Ongoing (Annual)
3.1	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Awaiting report			Ongoing (6 Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.6	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy Team	National Guidelines	Awaiting report			Ongoing (Monthly)
2.2	Pressure Ulcers	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	There were 18 Velindre acquired pressure ulcers during the finical year. None of which were reported to Welsh Government as a serious incident	Areas of good practice	The Pressure Ulcer Scrutiny Panel is responsible for monitoring the implementation of any agreed actions or recommendations.	Ongoing (Monthly)
2.3	Slips/Trips/ Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	There were 24 Velindre inpatients falls during the finical year, the majority of which were unavoidable. No falls were reported to Welsh Government as a serious incident	Areas of good practice Areas for improvement	The Falls Scrutiny Panel is responsible for monitoring the implementation of any agreed actions or recommendations.	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.5	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	This audit has highlighted that nursing staff are completing certain sections of the screening tools as per guidance, however there are several areas that need more work with differences each month.	Areas for improvement	1. Ensure a height is recorded, either measured on ward or estimated from the patient. 2. Aim to add a weekly weight to the screening tool instead of just weight charts. 3. To reinforce associated care plans for each category improving the use of food charts. 4. Follow current guidance for patients who need to be referred to the Dietitian irrespective of score. 5. Highlighting the need for Dietitian input with the audits, training for nursing staff and ongoing review of the audit tool for accurate results.	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.5	Protected Mealtimes Audit	To provide evidence to support safe effective care in relation to the health care standards	Therapies	Quality assurance	Compared to the audit in October last year, there has been some improvements, with a reduction in interruptions from others members of the MDT. Significantly more patients had a clear table, which should improve their eating environment. Additionally it was noted that 100% of patients continue to be given a hand wipe at meal times, to allow them to wash their hands prior to meals. However, improvements can be made; ensuring ward staff continue to reduce unnecessary interruptions by nursing staff during mealtimes.	Areas for improvement	1. Update to ward manager – Review the need for meal time interruptions by nursing staff. 2. Catering team/ ward staff – Ensure screen and protected meal times posters are on display for midday. 3. Ward staff to encourage patients to sit out if they can or sit upright in bed if physically able, and get dressed, to improve their meal time experience.	
2.5	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Average annual compliance 65%. All aspects of care given however paperwork not completed correctly.	Areas for improvement	Documentation issues to be discussed with ward staff	Ongoing (Monthly)
3.1	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Compliance never below 75% with sepsis bundle; For past 5 month's compliance 100%. It's worth noting that Patient numbers are lower than in DGH hence % variances. Less numbers on average than previous years. Improved communication between departments. Departments using SBAR handover which has improved handover of information Improved Stat Prescribing of antimicrobials	Areas of good practice Areas for improvement	Ongoing audit of compliance Inpatient sepsis group working on continuous quality improvement of inpatient sepsis and reporting systems	Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	NEWS audits were completed in the following areas, FFW, CIU, CRTU. CDU, RDU. All areas in which patient s were scoring, patient had been escalated appropriately and news increased as per protocol. Out of the 17 audits 3 had not be signed by a registered nurse. This is an improvement on previous audits Documentation of frequency of observations had been missed on 4 occasions	Areas of good practice Areas for improvement	Review by Unscheduled Care Task and Finish Group regarding Resuscitation Service provision for Velindre Cancer Centre. Continued improved compliance of Registered Staff to countersign NEWS charts Review of Resuscitation Service at Velindre Cancer Centre – Resuscitation Practitioner Role currently unfilled	Ongoing (Monthly)
3.1	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	100% all areas checked weekly	Area of good practice	N/A	Ongoing (Monthly)
2.4 3.1	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	Inpatient Dept. champions	Local & National Guidelines	Compliance with all elements of insertion and catheter care are audited and this has successfully been reviewed, improved and embedded by the ward night sisters. There has been 100% compliance for several months. Ongoing management supported by the All Wales Catheter Passport.	Areas of good practice	N/A	Ongoing (Weekly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.4	Visual Infusion Phlebitis (VIP) Score	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Annual average 80%, compliance improving monthly. New IV access champions on ward	Area for improvement	New IV access champions on ward	Ongoing (Daily)
2.4	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Bacteraemia rates continue to be a surveillance target and there has been a sustained reduction in HCAIv bacteraemia's reported through PHW HARP data. All Velindre Acquired bacteraemia's and Clostridium difficile cases are investigated by the multidisciplinary team using a Root Cause Analysis tool.	Areas of good practice Areas for improvement	Outcomes and lessons learnt are fed back to the patient consultants, clinical staff involved in the patients care and Infection Prevention and Control Management Group (IPCMG).	Ongoing (Monthly)
2.4	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Screening of patients occurs on admission and prior to the insertion of any invasive device. Inpatient compliance is reported weekly to the ward manager for information/action and to clinicians monthly along with the HARP data from PHW.	Areas of good practice	N/A	Ongoing (Monthly)
2.4	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	Dept. champions	Local & National Guidelines	Awaiting report			Ongoing (Weekly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
2.4	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Departments have PPE champions who are trained to assess their peers on Donning and Doffing PPE. Champions are also tasked with undertaking monthly audits of compliance in their departments. In addition the Infection Prevention and Control team undertake validation audits, the results of these are fed back monthly to the clinical areas and included in the monthly clinical feedback and the IPCMG	Areas of good practice	The results of these are fed back monthly to the clinical areas and included in the monthly clinical feedback and the IPCMG	Ongoing (Monthly)
2.9	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits etc)	Infection Prevention & Control	Local & National Guidelines	The IPCT undertake annual environmental audits of the clinical areas, this includes, sharps, linen, waste bins. Going forward the IPCT will work with departments to create a pared back audit tool for use by departments on a monthly basis.		The results will be reported through the monthly VCC IPC meeting which commence in April/May 2021.	Ongoing (Annual)
3.1 4.1 5.1	Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager	Local & National Guidelines	There was 1 delayed transfer of care during the finical year			Ongoing (Monthly)

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Breast Malignancies SST								
3.1	Pertuzumab	Evaluate the use of pertuzumab, trastuzumab and docetaxel in VCC since NICE approval, in particular ensuring that practice reflects NICE recommendations and evaluate outcomes	Medical Student	NICE Guidelines SSC project	Literature review complete audit to carried over to next FY	N/A	N/A	Complete
3.5	Re-audit ER/HER2 misreporting	To re-audit the documentation and accuracy of ER/HER2 status	Clinical Audit Dept.	Incident	Data Analysis Stage			Active March 2021
3.1	Bone only metastases in Breast Cancer	Whole body Magnetic Resonance Imaging (MRI)	Consultant	Clinical effectiveness	No longer a priority for the team, will be removed from the plan			Discontinued
3.1	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	Breast CNS	NICE Guidelines	Project set up stage			Active Oct 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.2	Tolerability of Ibrance (Palbociclib) in combination with an aromatase inhibitor in women 75 years ER+ve/ HER2-ve) metastatic breast cancer.	Real world toxicity and efficacy data is required, in an older UK population, to ensure that Ibrance (in combination with an AI) for first line treatment of metastatic oestrogen positive breast cancer is comparable to published trial data	Breast Consultant	National project	Complete – awaiting publication of national report			Complete
3.1	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SPR	NICE Guidelines/ National project	Data Collection stage			Active Proposed completion date July 2021
6.3	An evaluation of the effect of an app to introduce and practice deep inspiration breath hold technique on patient anxiety levels at first pre-treatment appointment for breast radiotherapy	A service evaluation project to measure the effectiveness of an App in reducing anxiety and improving patient experience when attending for radiotherapy using the Deep Inspiration Breath Hold technique (DIBH). The impact on scanning and treatment times was also explored.	Radiographer	User Views	Anxiety levels were varied and not significantly affected by use of the app. Scan and treatment times were not impacted by the app. Thematic analysis of the written responses demonstrated high patient satisfaction with the app in terms of preparation, information and opportunity to practise. Patients also valued supportive staff and reported high overall satisfaction with the DIBH process. The app is a potentially valuable information and practice resource which can be offered to patients alongside the existing supportive services	Both Areas of good practice Areas for improvement	Suggestions for improvement related to more specific information around the depth and length of breath hold required.	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					and is a convenient way to provide patients with additional support at an anxious time during their cancer treatment.			
3.1	Axillary surgery after neoadjuvant systemic therapy in patients with operable breast cancer	The aim of this audit is to examine the outcomes of this practice, with a particular focus on risks of local and distant recurrence	Breast Consultant	ABS Guidelines	SLNB after NACT appears to be safe. This is an evolving practice but patient selection is key; the majority of patients undergoing most appropriate surgery following post NACT imaging as a guide.	Area of good practice	N/A	Complete
3.1	Review of observation period required following subcutaneous Herceptin	Retrospective review to establish if current guidelines can be safely modified regarding the observation period after SC Herceptin	SACT Nurse	Patient safety/local concern/ VCC guidelines	Of the 157 patients, it was reported that 1 patient had a "small red area on neck, small urticarial" which was noticed during the end of the 2 hour observation, otherwise all vital signs were normal. This was treated and responded well to piriton and Hydrocortisone. Based on our study of 156 patients who had no signs of adverse reaction during observation, this gives a 0.6% chance of a minor reaction.	Area for improvement	The post-observation time 1st dose SC Herceptin® be changed from 2 hours to 30 minutes, with no monitoring for subsequent cycles. This would improve patients experience and reduce chair time.	Complete
3.1	The response rate of Systemic Treatment in HER2 positive Brain Metastases in secondary Breast Cancer	To review the chemotherapy given and the response rate within the brain in HER2 positive metastatic breast cancer patients.	Medical Student	Key indicator of practice Benchmarking	Data collection stage			Active Proposed completion date April 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	National project to assess the long term use of trastuzumab	Annabel Borley	National audit	Data collection stage			Active
3.1	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy	Develop and implement an intravenous Access decision tool for breast cancer patients about to commence systemic anti-cancer therapy	Trials Nurse	Clinical Effectiveness Service improvement	Data collection stage			Active Proposed completion date July 2022
3.1	Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neoadjuvant chemotherapy given with pegfilgrastim	This audit completes the audit cycle a previous audit was performed looking at neoadjuvant chemotherapy and neutropenic septic rates and admissions/dose delay and dose reductions	SHO Consultant	Key Indicators of Practice	Data collection stage			Active Proposed completion date May 2021
3.1	Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)	The aim of the project is to update and build upon the existing SABR database so that we can evaluate our treatment and compare to benchmark.	Medical Student	Key Indicators of Practice SSC	Data collection stage			Active Proposed completion date April 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Gynaecological Malignancies SST								
3.1	Novel anticancer drug - Niraparib and its prospect as a maintenance treatment option of relapsed ovarian cancer	To determine the progression free survival, overall survival and chemotherapy free interval. Analyse toxicity of niraparib treatments, including whether dose adjustments are required	Medical Student	SSC	Literature review complete due to COVID-19	N/A	N/A	Complete
6.3	Attitudes towards complementary and alternative medicine (CAM) in cancer care in Wales	Compare attitudes and knowledge surrounding CAM in both cancer patients and doctors	Medical Student	Users views	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Royal College of Radiologists (RCR) National audit of Vulva Cancer follow-up	To provide follow up information with regards to patients outcomes and toxicity	CAD Consultant	National Audit	Awaiting publication of National Report.			Complete
6.2	A Population study of cervical cancer patients using the Welsh Index of Multiple deprivation	To evaluate the impact of socioeconomic status on the presentation and stage of cervical cancer in a Welsh Population	Medical Student	SSC project	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Neoadjuvant chemotherapy for high grade serous ovarian / fallopian tube / primary peritoneal carcinomas	The review will look at clinical outcomes and toxicities in this patient cohort, and will look at the number of patients	SPR	National Guidelines	Awaiting report	Areas for improvement	Working with gynae team to consider re-optimisation of assessment pathway for IDS	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		receiving interval debulking surgery and the number who achieve optimal surgical de-bulking.		Key indicator of practice				
3.1	Niraperib FBC/Toxicity review	To assess patient outcomes	Pharmacy	Key indicator of practice	Lead is on long term sickness absence. Will work with audit team to re-establish			On hold
6.3	An evaluation of patient understanding and experience of bowel preparation in patients undergoing radical radiotherapy for gynaecological cancer.	The main aim is to evaluation of whether gynaecology patients understand bowel preparation for radiotherapy and whether the current information provision is adequate. improve patient care.	Radiotherapist	Users views	On hold due to COVID			On hold
6.3	Late Effects of Radiotherapy Gynae-oncology Clinic – Patient Experience	To evaluate patient's experience of the Gynae Late Effects Clinic.	Consultant	Users views	Data collection stage			Active
6.3	Scoping project Patient views on how the service should look	To get feedback from past patients about what the new Gynae-oncology physiotherapy service should look like/offer. Therefore aiming to shape the service taking into account directly patient's views and experiences.	Physiotherapist	Users views	On hold as waiting for assistance with patient engagement.			On hold

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Chaperone for any intimate examination of gynaecology patients	To audit how many patients we asked re. chaperones pre guidelines and then re-audit after the guidelines were published.	Physiotherapist	National guidelines Patient safety Local concern	Practice has changed during COVID and are now largely seeing patients virtually the need for a chaperone is significantly lower. Also not been able to complete the competencies that I proposed as an action because of this.			Oh hold
Head & Neck SST								
3.1	Use of Positron Emission Tomography (PET)	TBC	H&N Consultant	Clinical effectiveness	Literature review complete audit to carried over to next FY	N/A	N/A	Complete
3.1	Nivolumab	To look at the local data outcomes related to second line Nivolumab in Head and Neck Cancer from NICE approval of the treatment.	SPR H&N Consultant	Key indicator of practice	Data collection stage			Active July 2021
6.3	Patient satisfaction Palliative Patients	To obtain patients views with regards to the Head and Neck service	H&N CNS	Users views	Will be undertaken during 2021/22			July 2021
6.3	Nasogastric (NG) tubes patient experience	To look at thoughts and feelings after an NG tube	PSU Team	User views	Report writing stage			Active Proposed completion date July 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	30 day mortality post head and neck radiotherapy treatment.	To look more closely at the patients with less than 30 days mortality following treatment. The aim of the audit is to identify if there were indications retrospectively by looking back at bloods results and interventions to help us improve future care and early interventions	H&N Consultant H&N CNS	Key indicator of practice	Data analysis stage			Active Proposed completion date July 2021
3.1	Evaluating the accuracy of diagnostic imaging of extranodal extension of metastatic squamous cell carcinoma in cervical lymph nodes	To assess the accuracy and concordance between pre-treatment radiological reports and post-operative pathology reports for the detection of ENE of metastatic cervical lymph nodes in patients with HNSCC.	Medical Student	Clinical Effectiveness SSC	Data collection stage			Active proposed completion date April
3.1	Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	Aim is to review which method of enteral feeding; reactive NGT vs prophylactic GT provides the best outcomes for these patients by comparing practice during pre COVID 19.	H&N Consultant	Clinical effectiveness	Data collection stage			Active proposed completion date August

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	A service evaluation of the changes in the delivery of non-surgical cancer treatment for head and neck cancer patients in South-East Wales as a result of the COVID-19 pandemic	To look at the changes that were observed in the non-surgical treatment of head and neck cancers during the COVID-19 pandemic.	Medical student	Key indicator of practice	Data collection stage			Active proposed completion date April
Lung Malignancies SST								
3.1	Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SPR	Key indicator of practice	Data Collection			March 2022
3.1	Audit of patients with localised small cell lung cancer	Treatment pathways and outcomes for patients with localised small cell lung cancer treated with curative intent and palliative	SPR	Key indicator of practice	Undertake during 2021/22	N/A	N/A	July 2021
3.1	Is there an immune signature predictive of clinical outcome after surgery in lung cancer?	This project will explore whether the presence of macrophages in the tumour tissue of non-small cell lung cancer (NSCLC) patients is predictive of their long-term survival	PHD student	Key indicator of practice	Awaiting report			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	To assess toxicities encountered by patients receiving this treatment including immune related adverse events. To assess outcomes of patients receiving pembrolizumab.	SPR	VCC Guidelines Clinical Risk Local Concern	Was delayed due to COVID, waiting for confirmation if data collection will continue or if this will be discontinued as data collected previously may be outdated			Active
3.1	Survival Outcomes for NSCLC patients following Palliative Radiotherapy in Velindre Cancer Centre	Review of 30 and 90 day mortality for all patients who had emergency or palliative radiotherapy in Velindre Cancer Centre between January and June 2019.	SPR	Key indicator of practice	The 30 day mortality target was met for all patients. NSCLC patients were the predominant tumour site with a poorer prognosis at 30 and 90 days compared to all other tumour sites. Appropriate patient selection is important when deciding whether to offer hyper-fractionated treatment versus a single fraction of radiotherapy. Emergency treatment for bone metastasis should trigger involvement of the palliative care team and advance care planning. Brain metastasis not suitable for SRS are a poor prognostic sign for NSCLC patients. Supportive care would be appropriate for this patient group.	Area of good practice		Complete
3.1	Retrospective Data Collection for Lung Cancer Radiotherapy	To update data to date, looking at outcomes and other factors such as genetics and PETS	Lung Consultant Radiologist	Key indicator	Data collection stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	FDG PET Relapse Prediction in NSC Lung Cancer			Clinical Effectiveness Innovation				Proposed completion September 2022
Urology SST								
3.1	Audit of patients in VCC with newly diagnosed, low volume metastatic prostate cancer receiving radiotherapy	The project endpoint is to amalgamate results and to produce a protocol this patient group. Final numbers will evidence the capacity increase in radiotherapy and will be used to build a business case for funding to sustain future patients	Radiographer	NICE Guidelines	In 2019 an extra 46 patients were treated in VCC. Based on this data from 2019 and projected increasing patient numbers, it is expected that annually 50+ patients would be added to the radiotherapy demand. This impacts on the service throughout the whole radiotherapy pathway. Results showed that the majority of PPNs were treated with 60Gy/20# and the majority of SVPs were treated with 55Gy/20#. In total, the majority of patients were treated with 55Gy/20# therefore it is recommended this dose should be used at Velindre	Areas for improvement	A business case is presented to secure funding to sustain this service. It is recommended all patient groups should be included in a quality procedure to document and clearly define a consistent and standard process which will maintain treatment standards. Therefore this group of patients should be included in the QPWI 56 Prostate Joint Protocol.	Complete
3.1	Outcome of Androgen Deprivation Therapy and Docetaxel in Hormone Sensitive Metastatic Prostate Cancer	Conduct a retrospective clinical audit of survival in patients with hormone sensitive metastatic prostate cancer, treated with hormonal therapy and early docetaxel	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Treatment sequencing after upfront docetaxel in castrate refractory prostate cancer	To identify what treatments were being used to treat cancer after initial Docetaxel. To determine local drug sequencing use.	Medical student	Key indicator of practice	Estimated mean survival time from diagnosis was 92.13 months, with a 69.1 % 5-year survival. Estimated mean survival from the beginning of docetaxel treatment was 43.08 months. There was no significant difference in terms of survival between <60 and >60 age groups.	Areas of good practice Results showed a similar pattern to that of STAMPEDE trial	Future research is needed into the effectiveness of prognostic factors upon survival.	Complete
3.1	First line combination immunotherapy in advanced renal cancer	To establish overall survival and toxicity of treatments.	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Incidence of incomplete castration in patients with metastatic prostate cancer		Pharmacist		Project discontinued as was decided that no longer a priority for the service	N/A	N/A	Discontinued
3.1	A retrospective evaluation of brachytherapy treating patients with prostate cancer	To look at patient disease outcome measures assessed during cancer therapy	Medical student	SSC	Data collection stage			Active Proposed completion date April 2021
3.1	Follow Up of Patients Treated with Radical Radiotherapy: Improving outpatient clinic capacity	The aim is to improve capacity in urology follow up clinics. Our second objective is to review previous guidelines which need updating with current practice.	SPR Urology CNS	NICE Guidelines VCC Guidelines	Guidelines have been reviewed and agreed at SST	Areas for improvement	Implementation of letter follow-up and PSA tracker. Review patient experience	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
5.3	Post Holistic Needs Assessment (HNA): Patient Survey urology	To assess patient experience pre and post introduction of HNA	Urology CNS	Users views	The baseline patient experience questionnaire provided insights of patients' concerns and their clinic experience. The concerns ranked as most important were the management of side effects, being involved in decision making and the waiting times. It is possible that patients may not always be aware of the possibility of referrals to such services as psychology or an erectile dysfunction clinic, personal experience suggests this is often the case. The picture is different after an HNA and comparable with studies examining unmet need. Results from both the HNA collection data and the patient experience questionnaires show that once concerns such as fatigue were actively discussed, patients were keen for further advice.	Areas for improvement	Implement additional urology sites ensuring there is protected time, staff and space Coordination of the HNA intervention could become the Navigator who facilitate the process and can triage to the appropriate HCP. Develop education opportunities and a specific training pathway for Navigators to facilitate HNA Consider development of a disease specific HNA tool Re-audit	Complete
Palliative Care SST								
3.1	Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	To review the clinical management plans for patients referred to the CAT clinic with a confirmed diagnosis of superficial vein	Medical student	NICE Guidelines	Literature review complete due to COVID-19	N/A	N/A	April 2020

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		thrombosis and review whether we are adhering to NICE						
3.1	An evaluation of the concept of 'Natural accepted and anticipated DNACPR decision making- an evaluation'	An evaluation of the concept of 'Natural accepted and anticipated death in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision making- an evaluation'	Medical student	SSC Project	Literature review plus evaluation of last few years' data completed due to COVID-19. Also conducted a survey amongst healthcare professionals which showed that the NAAD concept is seen as helpful in decision making in the context of ceilings of treatment	NAAD is a useful concept and it is recommended in the All Wales DNACPR policy	NAAD is a useful teaching guide and will be used in DNACPR teaching	Complete
3.1	Review of treating Cancer Associated Thrombosis (CAT) in patients with primary brain tumours	To review the clinical management plans for patients referred to the CAT clinic with diagnosis of superficial vein thrombosis and review whether we are adhering to NICE guidelines.	Palliative Care team	NICE Guidelines	Need to establish new lead or SSC project			On hold
	Is primary thromboprophylaxis of palliative care cancer in-patients compliant with NICE Clinical Guideline 89 A clinical audit	To audit the risk assessment and where appropriate, the initiation of thromboprophylaxis in inpatients with cancer who are under the care of the palliative care service.	Lowri Evans	National Audit	Data collection stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Colorectal SST								
3.1	Rectal Cancer	TBC	Medical student	SSC Project	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	What happens to patients who have local relapse or progression from rectal	The project will review practice in Velindre Cancer centre and explore optimum strategies for the management of these patients. With a view to looking at future research in this area	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
6.3 4.2	Colorectal 'Support Group'	To obtain patient views on in attending a 'support-group' and to find out if there is any specific topics/issues that people are keen to discuss and topics that might be useful.	Colorectal CNS	Users Views	There was a lot of interest in a colorectal support group. However there were patients who felt that it wasn't for them.	Areas of improvement	Set up colorectal support group.	Complete
3.1	Anal cancer outcomes and relapse patterns	To examine the patterns of treatment failure in patients receiving definitive chemo radiation for anal squamous cell cancer delivered using Intensity Modulated Radiation Therapy (IMRT). This is part of a national project and will result in a future	Colorectal Consultant Consultant	National project	This series provides much-needed data on the patterns of relapse after IMRT in Anal squamous cell carcinoma (ASCC). We believe this series supports the use of the UK IMRT guidance in routine clinical care. The lower prophylactic nodal dose of 40 Gy in 28 fractions is sufficient to prevent isolated regional relapse in uninvolved nodes.	Areas of good practice	Further investigation of strategies to optimize complete response should remain a priority in Anal squamous cell carcinoma (ASCC) because the site of primary disease remains the overwhelming site of relapse	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		publication (Coordinated by Oxford group)			Due to the high rate of relapse at the primary site, strategies to optimize the radiation response, such as dose escalation, immune modulation or radiosensitization, are most likely to have an impact on disease free survival and overall survival. The treatment results compare favourably to published outcomes from similar cohorts using 3-dimensional conformal CRT.			
3.1	South Wales Adrenocortical cancer treatment and outcomes	To assess outcomes	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	SPR	Key indicator of practice Clinical Effectiveness	Data collection stage			Active
3.1	Improving communication standards of clinic letters within the colorectal service in Velindre	A focussed audit of communication standards for patients within the colorectal team to establish what we already know, that in all likelihood the situation has not changed since 2018.	Oncology GP SPR	Royal College	Data collection stage			Active Active Proposed completion date June 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		Trial the communication framework using a 'rapid cycling' method to improve the relevance and the efficiency of information input						
UGI SST								
5.1	Oesophago-gastric cancer looking at patient outcomes and in particular delays in the pathway to diagnosis and treatment.	TBC	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
5.1	Cancer outcomes – delays in diagnosis, Oesophago-gastric cancer, Sarcomas	TBC	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Evaluation of outcomes from Radical patients treated with chemo-radiotherapy for oesophageal cancer	To ascertain overall and progression free survival. To identify any toxicities of treatment	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Evaluation of outcomes from Palliative patients treated with chemo-radiotherapy for oesophageal cancer	To ascertain overall and progression free survival. To identify any toxicities of treatment	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
5.1	Understanding the causes of delayed diagnostic and treatment pathways in oesphago-gastric cancer”	To establish current practice around treatment summaries and communication with primary care.	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
5.1	Understanding the causes of delayed diagnostic and treatment pathways in oesphago-gastric cancer”	To establish current practice around treatment summaries and communication with primary care.	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Management of Oesophageal Squamous Cell Carcinoma within the UK and Ireland: A retrospective multi-centre analysis	Provide an insight into variation across the UK in the use of surgery and dCRT for the potentially curative treatment of OSCC. Review survival outcomes for CRT compared with neoadjuvant treatments plus surgery.	SPR	National Project (NOTCH)	Data collection stage			Active
6.3	Re-Audit Upper GI Patient Survey from 2014	To revaluate the patients experience of the UGI service	UGI CNS	Users views Re-audit	Data collection stage			Active Proposed completion September 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	An audit of variation in delays in the current diagnostic pathways in patients presenting with oesophageal cancer	We will look into 3 Health Boards across South-East Wales, and audit the waiting times and delays in oesophageal cancer referral treatment. We will compare this to the National Optimum Pathway, and we will then look into how this affects the prognosis of the patients.	Constant	Key indicator of practice	Data collection			Active Proposed completion April 2021
Neuro-oncology SST								
5.1	Waiting times	To evaluate current waiting times in clinic to identify where the major issues.	Neuro-oncology CNS	Key indicator of practice	No formal audit has been undertaken, however clinics have merged which has alleviated clinic waiting times	Area for improvement	Clinics have merged which has alleviated clinic waiting times	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Medical student	Clinical effectiveness	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Acute toxicity of radiotherapy for GBM	This audit will initially look at acute toxicity for conventional 3D plans and then will go onto audit the acute toxicity in patients treated with VMAT plans to see if there is any improvement.	Consultant	Key indicator of practice Clinical effectiveness	Awaiting report			
3.1	Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	To gain insight into the radiotherapy approaches currently being used across the UK, both in an adjuvant and disease recurrence setting. Data on systemic management and associated disease response will also be valuable for treating clinicians given the lack of evidence base in this area.	SPR	National Project	Data Collection stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
Sarcoma SST								
5.1	Sarcoma Pathway	To assess the pathway.	CNS	Key indicator of practice	Data collection stage.			Ongoing
Other Sites/Services								
3.1	Immunotherapy Metastatic Melanoma	To establish overall survival and toxicity of treatments.	Medical student	Key indicator of practice	Literature review complete due to COVID-19	N/A	N/A	July 2020
3.1	VAPP Project Virtual Generic pre SACT assessment clinics	To reduce capacity in consultant clinics by transferring suitable pre chemo assessment ‘s into a generic clinic.	NMP	Innovation	The VAPP project has so far assessed over 1000 patients. VAPP Clinic is self-sufficient in terms of decision making 96% of assessments take place and treatment authorised without having to refer back to the Medical team for a clinical decision. 9.4/10 patient satisfaction survey. Reduction in total number of patients in Consultant clinic.	Areas of good practice	VAPP to becomes business as usual and not a project and to expand and become sustainable.	Active
3.1	Immunotherapy	To establish overall survival and toxicity of treatments.	Medical student	SSC Project	Literature review complete due to COVID-19	N/A	N/A	Complete
3.1	Acute oncology Service	TBC	Medical student	SSC Project	Literature review complete due to COVID-19	N/A	N/A	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	NOTCH Project: A multi-centre evaluation of Acute Oncology Service (AOS) provision throughout the UK	Collect trust level data across the country to gain detailed understanding of the UK Acute oncology provision. Review the delivery of the acute oncology service quality indicators throughout the UK	SPR	National project	Did not receive reports from invites sent to AOS teams to contribute to national project from South East Wales - please discontinue / close			Discontinued
6.3	Occupational therapy: patient survey	To gain feedback with regards to the OT services provided in the drop in clinic	Occupational Therapist	Users views	Overall the patient survey has been successful. The aim is to increase the number of patient surveys completed on a weekly basis and target a wider age range. Hopefully by undertaking a greater number of surveys we can gain a better insight into patient satisfaction and areas for improvement to provide the best patient care.	Areas improvement	Increase survey numbers.	Complete
5.1	Review of Delays and Cancellations in Radiotherapy	A retrospective review of all referrals received in January 2019 is required to identify root cause of cancellations and delays which will provide an opportunity to review current pathways and adherence to process.	Radiographer/CAD	VCC guidelines	Report writing stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
5.1	A Retrospective Review Of Frequent Attending Patients With Cancer To Secondary Care Services: Planning For The Future	to evaluate the number of patients with cancer defined as frequent attenders (during a 1 year period, their reasons for attending and whether they had been referred to community palliative care services	Consultant	Service evaluation	We identified 45 patients with cancer who were defined as a FA in a 1 year period, 23 (51%) patients had presented with poorly controlled symptoms. Of the 23 patients, 14 (61%) had never been referred to palliative care. In total the 45 patients analysed accrued 50 hospital admissions 100 ED or MAU. Attendances. There is minimal research into frequent attender patients with cancer but there is a clear unmet need for the right expertise and services in the community and Emergency Department to improve the patient and family experience of repeated admissions.	Area for improvement	More work must be done to understand the reasons for repeated attendances in order to implement appropriate services in the community to prevent this	Complete
3.1	Review of nursing documentation project and Staff Survey	To ascertain completeness of inpatient documentation an obtain staff views	Ward nurse	VCC Guidelines	Awaiting report			Complete
3.1	Are BRAF results available for the patients' first oncology appointment?	To determine if we have the BRAF information at the time of meeting patients to discuss the most appropriate treatment for each patient	SHO	Patient safety Key indicator of practice Local concern	Didn't get far with this project before lead left VCC			Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Investigation & Management of iron deficiency anaemia in patients with gastrointestinal malignancy:	Use of blood transfusion, intravenous iron and oral iron	SPR	Key indicator of practice	Paused implementation of iron infusion policy due to COVID restrictions and pressures on day unit etc. To be completed later in year (May / June) with launch of prescription pathway.			Active Proposed completion June 2021
6.3	Audit on Measure yourself concerns and wellbeing questionnaire	Assess the effectiveness of complementary therapy in cancer care. We aim to use the data in order to begin a research project.	Psychology	Users views	Of the 67 MYCaW questionnaires analysed, 22 were fully completed. Concerns identified included both physical and psychological issues with pain, sleep, stress and anxiety being the concern most regularly reported. We also found that with the majority of questionnaires each concern was scored lower at the end of the treatment regimen. Concerns are scored on a scale of 0 (not bothering me at all) to 6 (bothering me greatly). Overall, scores improved by 1 to 2 points for both concerns and wellbeing suggesting that patients do feel the Complementary Therapy treatments are beneficial.	Area for improvement	To improve on fully completing the outcome measures we are using and record these figures to monitor ongoing progress.	Complete
6.3	Health Technology Wales (HTW) Patient and Carer Workshop	To run a workshop with patients/carers to understand patients' experiences and perspectives about living with the condition being studied and their use of the health technology being appraised.	Health Technology Wales	Users views	Project has been discontinued as unable to hold face to face consultations due to COVID			Discontinued

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Radiotherapy Telephone follow up service – Skin	To assess patients views regarding the telephone follow up service	Nurse specials radiographer	Users views	A number of patient's experienced skin reactions after radiotherapy. The majority were happy with the telephone led service.	Areas of good practice		Complete
5.1	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	Service Improvement team	National guidelines	Ongoing process			Active
3.1	All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	Aim to identify key clinical lessons from this period to guide local QI projects and help awareness to improve patient care currently and in case of further surge in covid19 cases.	PHD Student Consultant	Key indicator of practice Local concern Patient safety	Data collection stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Patient/carer Self-administration of sub cut injections	To identify numbers of patients attending. Ascertain if these patients could be educated and managed at home. This would reduce patient visits and footfall which at present is even more of a priority due to infection control risks.	Outpatient manager	VCC Guidelines Clinical Risk Clinical Effectiveness Patients views	This project is on hold for the time being until we can find a way of dispensing Denosumab and the resource to continue the assessments. We identified around 50% of patients willing to self-administer and go through the teaching programme. This estimate was taken in October 2020 where 55 of 101 pts agreed from their questionnaires. Due to pharmacy limited resource to dispense we hit an impasse so the next stage of setting up teaching has not gone ahead. We currently do not have the resource to continue with a chronic short staffing issue but once this is resolved we might be able to pick this back up.			On hold
5.1 3.1	Treatment Escalation Plan Quality Improvement Project Proposal	To ensure that more patients will have appropriate escalation plans put in place EARLY in their admission.	Doctor	Multi centred	Data analysis stage			Active
3.1	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	To provide assurances around antimicrobial stewardship. These measures aim to provide re-assurances that prescribing practices are in line with best practice.	Pharmacist	Key indicator of practice VCC Guidelines 1000 Lives	Data collection stage			Active Proposed completion date July 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Immuno toxicities Clinic – Patient Experience of virtual clinic during the COVID-19 Pandemic	Understanding of patient experience of a virtual (telephone) toxicity clinic during COVID-19 pandemic, to assist with future development and learning of a virtual service.	Inpatient Business Manager	Users/ Patient views	On hold lead is leaving VCC may not have the resource to undertake			Active Proposed completion date March 2022
	DPYD Health Technology Assessment Service Evaluation	To conduct a health technology assessment (cost utility analysis) of the *DPYD* genotyping service in Wales.	Consultant	National	Data collection stage			Active
	A Service Evaluation Project of the Nurse Led Paracentesis/Indwelling Peritoneal Catheter (IPC)	To evaluate the nurse led service and assess whether the service is being delivered within appropriate timeframes. This will also confirm the importance of the service going forward.	Nurse	Key indicator of practice	Data collection stage			Active Proposed completion date August 2021
3.1	Exploring the definitions of 'value' and 'value-based healthcare' in cancer care	Aims to explore how staff define value-based healthcare and what they consider to add value to patient care. This will be achieved by conducting semi-structured interviews	PHD Student	Service Evaluation	Data collection stage			Active Proposed completion September 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	How do organisations support or inhibit high reliability healthcare processes	To investigate what characteristics of Highly Reliable Organisation (HRO) are practiced within the context of healthcare management and how those practises impact on patient safety outcomes and staff	Student	Service Evaluation	Complete waiting for report to be authorised before sending.			Active Proposed completion April 2022
3.1	Exploring Implementation, Barriers and Facilitators to Transfer of Care Systems in the UK	This project aims to conduct interviews with key informants for each of the main transfer of care services available in the UK. To provide a clear picture of the implementation, barriers and facilitators of each transfer of care system.	PHD Student	Service Evaluation PHD	This is the first study to describe, compare and contrast current UK technology supported transfer of care systems Based on the discussions outlined in this paper, the following timely recommendations are suggested for the development, adaptation and strategic implementation of technology-supported transfer of care systems:	Area for improvement	1. Pre-plan implementation strategies with dedicated staff, focussing on stakeholder engagement; 2. Flexible notification systems should be developed to inform community pharmacists of patient admission and discharge, 3. Produce content such as videos to support patient consent for information transfer; 4. Develop methods to keep hospital and community practitioners accountable for referrals;	Complete Feb 2021

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Service evaluation of gardens at Velindre cancer centre	To investigate the impact of hospital gardens on health and wellbeing.	Student	Service Evaluation Users views	Hospital gardens are beneficial for health and wellbeing and that hospital gardens are an effective health intervention. Demonstrating evidence of the health and wellbeing impacts of a hospital garden is important in order to ensure that outdoor space within a hospital labelled a 'healing garden' truly warrants its name. Further research is required to support and further the findings of this research, and areas for further scholarship are suggested. 3	Areas of good practice	This study recommends that healthcare service providers consider hospital gardens a key part of their approach towards promoting health and wellbeing within healthcare facilities.	Complete
3.1	Evaluation of the Emergency Medicines Service extended community pharmacy service	To ensure that patients can access an urgent supply of their regular prescription medicines where they are unable to obtain a prescription before they need to take their next dose. To relieve pressure on urgent and emergency care services and GP of high demand.	Doctor	Service evaluation	EMS: almost completed analysis of Choose Pharmacy data, haven't managed to get any of the Health Boards to send me OOH data yet.			Active
3.1	An Evaluation of the Discharge Medicines Review service: A Secondary data analysis	This study aims to investigate the factors affecting DMR uptake and medication discrepancy rates in Wales	Doctor	Service evaluation	DMR: completed focus groups, data analysis ongoing. Rob (our PhD student who is undertaking the research) has presented results from focus groups to various boards, and we are working with a subgroup of PhDaHW to improve uptake of DMRs.			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	An audit to determine the quantity of walking aids used by the physiotherapy team across VCC	To establish which walking aids are required to be held as stock. To determine the number of each walking aid used per week. To establish minimum numbers of each walking aid required to be held as stock. To establish the most efficient method of recording stock levels.	Occupational Therapist	Service evaluation	The results of the audit show that RZF's (19) are the most frequently issued walking aid, followed by walking sticks (12) and e/c's (5). Need to set up a stock database which enables us to automatically identify when we need to order more stock. It will also enabled us to ensure we are only holding the stock we require which will free up a lot of storage space	Areas for improvement	Set up a stock database to automatically identify when we need to order more stock. Only hold stock required to free up storage space. Re-audit	Complete
3.1	Evaluation of the extended community pharmacy Independent Prescribing Service (IPS)	The aim of this project is to evaluate the pilot service. In particular, we will detail: Number of IPS consultations undertaken, Percentage of consultations where the WGPR was accessed. Percentage of patients who would have sought alternative action and nature of action. Most prescribed medication under the service	Doctor	Service evaluation	IPS: completed interviews, data collection from Choose ongoing. Results from interviews presented in Clinical Reference Group and Independent Prescribing Group, and informed next steps of wider pilot.			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Radiographer	Patient safety	Undertaking as part of a PhD at Cardiff Business School of which in the first year. Currently at the literature review stage which is to be completed by June '21.			Active Proposed completion September 2023
COVID-19 Audit/Project Programme								
3.1 5.1	Virtual consultation-study in Covid-19 era	This study is 'snapshot' study, initially proposed as pilot project in one or two tumour site specific areas, retrospectively analysing outcomes from virtual assessment (VA) clinic in a non-selective patient's cohort in VCC, including patients on follow up or on Systemic Anticancer Treatment (SACT).	Consultant	NICE PREMS Innovation	248 assessments on 148 patients (mainly CRC, single practice), Majority SACT proceeded as infusional and unaltered, 4% Assessments had subsequent unscheduled hospital admissions; 7% assessments were followed by helpline calls, 1% assessments picked up COVID-19 symptomatic patients; these had a prolonged delay in resuming treatment, 30 days Mortality rate was 2.7% (from disease progression).		Compare with National data	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	Virtual consultation-study in Covid-19 era: Patient and Staff experience	To obtain patient and staff vires with regards to their experience with virtual clinics	Consultant/Outpatients/Attend Anywhere team	Users Views	Patient survey complete. Staff survey in data analysis stage (waiting for KH to return) Retrospective data in data analysis			Active
6.3	Psychological Impact of the Coronavirus Pandemic on Trainee Wellbeing.	To ascertain the psychological impact of a pandemic on trainee well-being. Linking in with Health Education and Improvement Wales (HEIW)	SPR	Users Views	The COVID-19 pandemic had a profound effect on medical training and education and on the working lives of doctors in training. Talking to colleagues, talking to family and friends, and talking to supervisors were all shown to be important, demonstrating the importance of good communication, and team-working. Adequate supervision and support are paramount to ensure patient safety and trainee wellbeing.			Complete
3.1	The impact of COVID-19 on SACT treatment pathways	To monitor changes to treatment pathways and associated outcomes	Consultant	Key indicator of practice	Data collection stage			Active
3.1	The Impact of the Acute Phase of COVID-19 on Radiotherapy Demand in South East Wales	To monitor changes to treatment pathways and associated outcomes	SPR	Key indicator of practice	Data collection stage			Active
3.1	UK Coronavirus Cancer Monitoring Project (UKCCMP)	To track cases and outcomes of cancer patients affected by COVID-19 infection in the UK	SPR	National Project	Data collection stage			Active

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
3.1	COVID Radiotherapy: a National Cancer Research Institute (NCRI) CTRad UK-wide initiative	COVID RT is a national initiative that aims to study the impact of COVID-19 and the recovery plan on radiotherapy patients and the radiotherapy service and help us plan for future pandemics	Consultant	National Project	Data collection stage			Active
6.3	VCC Attend Anywhere - User feedback	The VCC Attend Anywhere implementation project is part of the wider NHS Wales implementation roll out of the Attend Anywhere to all Heath Board / Trusts at both primary and secondary care levels. This work stream to ascertain the user views.	Attend Anywhere Team	Users Views	Combined with the virtual clinic project above. Will be removed from next years plan.			Active
3.1	Death within 30 days COVID/ Mortality reviews	Need to include decision making around admissions to Intensive Care Unit (ITU)	SCIF CAD	Patients safety	Mortality reviews are carried our routinely for all patients, COVID has been incorporated into this process and for death 30 days SACT, Will be removed from next year's plan.			Ongoing
3.1	Lung Radiotherapy during Coronavirus Pandemic (COVID-RT Lung)	To understand the changes in radiotherapy services for patient with lung cancer in the UK during the coronavirus pandemic Assess the outcome of operable patients	Consultant CAD	National Project	Follow-up data to be submitted later in the year			

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
6.3	PPE education and communication quality improvement project	To assess and improve communication between hospital staff regarding changes in the current PPE guidelines in VCC	SPR	Users Views	69 respondents were gathered from seven different clinical areas. Most respondents were confident in PPE use with the majority giving a score of 8/10 on a scale of one to ten, ten being most confident, and 86% scoring more than 5. The estates department were found to be most confident in PPE use with Pharmacy being the least confident. Most staff are confident in PPE use and feel guidance is communicated effectively, however, there is room for improvement.	Areas for improvement	The next stage is to implement a communication method amenable to all staff members.	Complete
6.3	Virtual Oncology SpR Teaching	To improve oncology SpR teaching Objectives. Restart oncology SpR teaching and continue throughout the COVID-19 pandemic. Improve radiotherapy training. Improve trainees' knowledge and understanding of various tumour sites	SPR	Users views Local Concern Innovation	Microsoft Teams has quickly become our platform of choice for virtual teaching. Though it was feared we would lose interactivity and human contact, the virtual world has enabled us to share local training across Wales. New approaches to keeping teaching interactive have been welcomed, including the creation of mock patients on Canisc for 'real life' case based discussion, and test cases for outlining on Prosoma. Feedback from the first virtual SpR teaching session was very positive. The Covid-19 pandemic has had a significant impact on our way of working, but it is clear that it is still possible to provide high-quality educational events in a socially distant manner. Whilst there are advantages to face-to-face teaching,	Areas of good practice	The virtual sessions have been very well received, and it is likely that at least some of the changes will become long-term features of medical education	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
	How “teachable moments” can be utilised to ensure ongoing medical education and teaching opportunities	Looking at “teachable moments” on call and on the wards – how more informal teaching can be delivered in a useful way when structured teaching is not accessible.	SPR	Innovation	Awaiting report			Complete
3.1	Outcomes of neuro-oncology for patients with intracranial tumours during COVID-19 pandemic: cohort study CovidNeuroOnc	To determine whether the COVID-19 pandemic changed the management decision in patients with newly-diagnosed or recurrent brain tumours	SPR	National Project	Data collection stage			Active
3.1	CATCH	Project run by Leeds Teaching Hospitals which aims to create a “traffic light” system for review of thorax on treatment Cone Beam Computed Tomography (CBCT) changes with the hope of identifying patients who require COVID-19 testing and potential self-isolation.	Radiotherapy	Service Evaluation	Data collection stage			Active
6.3	Supporting wellbeing at the workplace using clinical supervision	With pre and post session questionnaires we will capture junior trainee doctor’s experience with group clinical supervision and seeing whether this is	SPR	Users Views	Combined with project above			Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
		helpful with supporting wellbeing at the workplace.						
3.5 4.2	Informed consent Audit	To ensure informed consent has been document clearly and a copy included in the case notes	TBC	VCC guidelines	This will be combined with a bigger piece of work regarding consent			March 2021
3.5 6.3	Informed consent Patient feedback	To obtain patients views with regards to informed consent.	TBC	Users views	This will be combined with a bigger piece of work regarding consent			March 2021
2.4	PPE to donning and doffing	To monitor correct use of PPE	IPC Team	Patient Safety	Included above			Ongoing
2.4	Hospital acquired COVID	Collate surveillance on all HCAIs daily and capture all our target organisms and undertake investigations as required.	IPC Team	Patient Safety	Included above			Ongoing
2.4	Hand Hygiene	Collate hand hygiene audits from departmental champions as an ongoing infection prevention and control (IPC) measure	IPC Team	Patient Safety	Included in the continuous monitoring section above			Ongoing
1.1 7.1	Staff Testing	To evaluate current practice and ensure staff testing guidelines are adhered to	CAD Testing Cell	Key indicator	Regular reporting			Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
1.1 7.1	Staff COVID-19 testing Pilot questionnaire	To obtain feedback from staff involved on the staff testing pilot	Consultant CAD	Users views	Awaiting report			Complete
1.1 7.1	Staff Testing pilot	To evaluate the pilot to identify areas of good practice and improvement	CAD	Key indicator of practice	Awaiting report			Complete
3.1	Coronavirus in Cancer Patients – the South East Wales experience	Local analysis of data submitted to National audit	SHO	National audit	Overall Mortality from COVID 22.6% Similar to 28% mortality found in the initial UKCCMP paper published 28th May (The lancet). Our mortality rate maybe higher - unsure of cause of death in 17 patients. However, these numbers are unlikely to represent an accurate mortality for all cancer patients – some of these patients were already in hospital for another reason, and therefore, were already in the higher risk category. Oncological treatment within 4 weeks and COVID mortality - 20% (with 5% unsure of cause) The UKCCMP Lancet paper; mortality from receiving treatment(chemo/hormones/immunotherapy/radiotherapy/surgery/targeted therapy) within 4 weeks = 18.4%.	Area of good practice	Analyse and compare local data after for second wave.	Complete
3.1	The Impact of the COVID-19 Pandemic on South Wales' Neuro-Oncology Service	Local analysis of data submitted to National audit (*CovidNeuroOnc*) to assess the impact of the pandemic on the neuro-oncology service for patients with a newly diagnosed or recurrent brain tumour.	SPR	National	Divergence from 'pre-COVID' standard practice was identified in 16.5% of patients. 69% of changes occurred during the first 3 weeks of April Coincides with the first peak of pandemic. Period of greatest uncertainty and concern regarding chemotherapy	N/A	Comparison of South Wales' data with rest of UK Comparison of number of referrals to the neuro-oncology MDT pre- and post-COVID	Complete

HCS	Project title	Main Objectives	Lead	Selection Criteria	Results/Project progress	Area of good practice or improvement	Recommendations actions	Progress
					81% of changes occurred in cases that would have previously had surgery (biopsy /resection), 46% changed to interval monitoring 54% referred		Secondary analysis next year to assess impact of COVID-19 on patients' morbidity and overall survival	
3.1	Recovery Trial	This national clinical trial aims to identify treatments that may be beneficial for people hospitalised with suspected or confirmed COVID-19	Consultant Research Team	R&D	What have we learnt from the recovery trial: Reduce nosocomial spread, we know what treatment works and what doesn't, Recovery trial remains open if needed, access to additional, novel treatment options for IPs VCC can open and run non-Oncology focused trials. Strong legacy from Recovery Leadership	Areas of good practice		Ongoing
3.1	OnCovid (sub project - Dis-cov-er)	To describe the natural history and clinical outcomes of patients with cancer and Covid19 infection. To retrospectively describe the survival of cancer patients affected by SARS-CoV-2 infection.	Research Team	R&D	Research study			May 2022
3.1	UK-CCP	Provides data and bio specimens from the non-cancer COVID population to provide the true denominator and assess the influence of cancer and cancer treatments on COVID outcomes.	Research Team	R&D	Research study			Ongoing

APPENDIX 2

Velindre Cancer Centre

Planned Clinical Audit Programme

1st April 2021 to 31st March 2022

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
National Audits						
6.2	National Audit of Breast Cancer in Older People	National audit to assess the management of all symptomatic and screen detected breast cancers.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
3.1	UK NACEL Audit	NHS Benchmarking project	SPCT	National Audit	Ongoing (Annual)	Ongoing (Annual)

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Continuous Monitoring – Quality and Safety and Must Do's						
6.3	All Wales Patient experience framework	To evaluate patients experience at VCC to identify areas from improvement	Patient Experience Manager	Users views	Ongoing (Monthly)	Ongoing (Monthly)
3.1 3.5	Death within 30 days SACT	Review patients who die within 30 days of SACT	Clinical Audit Dept. SST's	Patient safety	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Mortality reviews	Review inpatients who die at Velindre.	SCIF Clinical Audit Dept.	Patient safety	Ongoing (Weekly)	Ongoing (Weekly)
3.5 4.2	Audit of all Wales consent form 4 (best interests)	To identify if consent form 4 was used appropriately and ascertain completeness	Clinical Audit Dept.	Clinical risk	Ongoing (Annual)	Ongoing (Annual)
3.2 3.5	All-Wales Care Decisions for the Last Days of Life Audit	Progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.	Palliative Care CNS	National guidance	Ongoing (Annual)	Ongoing (Annual)
3.5 4.2	Consent Audit	To identify if consent forms are available to view and to ascertain completeness of the information	Clinical Audit Dept.	Clinical risk	Ongoing (Annual)	Ongoing (Annual)

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3.5	Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Clinical Audit Dept.	NICE Guidance WHO	Ongoing (Annual)	Ongoing (Annual)
3.1	Secondary Breast Cancer Multidisciplinary Forum (SBCMDF)	To evaluate the SBCMDF service and outcomes	Breast Team	Key Indicator of Practice	Ongoing	Ongoing
3.1	Immunotherapy for Adjuvant melanoma	To obtain toxicity and outcome data in the adjuvant setting	Melanoma CNS	Key indicator of practice	Ongoing	Ongoing
3.1 3.2 4.1 6.2	Palliative Care Outcome Scale (POS –S) audit	Evaluation of the use the POS-S system compared to the National guidelines	Palliative Care Team	National	Ongoing (Annual)	Ongoing (Annual)
6.3	I Want Great Care	Independent service to allow patients to feedback their experiences.	Palliative Care Team	Users views	Ongoing	Ongoing
3.1	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Ongoing (6 monthly)	Ongoing (6 Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

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2.6	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards. *High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT.*	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

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2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.6	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy Team	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.2	Pressure Sores	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.3	Slips/Trips/Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.5	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.5	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)

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3.1	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
3.1	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
2.4 3.1	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
2.4	Visual Infusion Phlebitis (VIP) Score – Chemotherapy Inpatient Unit (CIU)	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula	Ward Manager	Local & National Guidelines	Ongoing (Daily)	Ongoing (Daily)
2.4	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.4	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.4	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)

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2.4	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing)	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
2.9	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits	Infection Prevention & Control	Local & National Guidelines	Ongoing (Annual)	Ongoing (Annual)
3.1 4.1 5.1	Delayed Transfer of Care (DTOC)	Tier 1 target	Nursing Ward Manager	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Breast Malignancies SST						
3.5	Re-audit ER/HER2 misreporting	To re-audit the documentation and accuracy of ER/HER2 status	Clinical Audit Dept.	Incident	June 2020	June 2021
3.1	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	Breast CNS	NICE Guidelines	January 20219	October 2021
3.1	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	To report the survival of patients diagnosed with Central Nervous System (CNS) disease secondary to Breast cancer (BC).	SPR	NICE Guidelines/ National project	February 2020	December 2021
3.1	The response rate of Systemic Treatment in HER2 positive Brain	To review the chemotherapy given and the response rate within the brain in	Medical Student	Key indicator of practice	March 2021	May 2021

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	Metastases in secondary Breast Cancer	HER2 positive metastatic breast cancer patients. To review the percentage response rate for each regimen given and the duration of that response.		Benchmarking		
3.1	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	National project to assess the long term use of trastuzumab	Consultant	National audit	February 2021	Ongoing
3.1	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy	Develop and implement an intravenous Access decision tool for breast cancer patients about to commence systemic anti-cancer therapy	Research Nurse	Clinical Effectiveness Service improvement	March 2021	Ongoing
3.1	Audit of neutropenic septic admissions and dose delay/dose reductions with FEC100-T adjuvant and neo-adjuvant chemotherapy given with pegfilgrastim	This audit completes the audit cycle a previous audit was performed looking at neo-adjuvant chemotherapy and neutropenic septic rates and admissions/ dose delay and dose reductions	SPR Consultant	Key Indicators of Practice	March 2021	May 2021
3.1	Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)	The aim of the project is to update and build upon the existing SABR database so that we can evaluate our treatment and compare to benchmark.	Medical Student	Key Indicators of Practice SSC	March 2021	May 2021
Gynaecological Malignancies SST						
3.1	Niraparib FBC/Toxicity review	To assess patient outcomes	Pharmacy	Key indicator of practice	December 2019	On hold

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6.3	An evaluation of patient understanding and experience of bowel preparation in patients undergoing radical radiotherapy for gynaecological cancer.	The main aim is to evaluation of whether gynaecology patients understand bowel preparation for radiotherapy and whether the current information provision is adequate. To improve patient care.	Radiographer	Users views	January 2020	August 2021
6.3	Late Effects of Radiotherapy Gynae-oncology – Survey	To evaluate patient's experience of the Gynae-oncology Late Effects Clinic.	Consultant	Users views	September 2020	Ongoing
6.3	Scoping project Patient views on how the service should look	To get feedback from past patients about what the new Gynae-oncology physiotherapy service should look like/ offer. Therefore aiming to shape the service taking into account directly patient's views and experiences.	Physiotherapist	Users views	September 2020	On hold
3.1	Chaperone for any intimate examination of gynaecology patients	To audit how many patients we asked re chaperones pre guidelines and then re-audit after the guidelines were published.	Physiotherapist	National guidelines Patient safety Local concern	May 2020	March 2022 Oh hold
3.1	Review of first line bevacizumab in advanced ovarian cancer in South East Wales	To review the number of patients that have received bevacizimab front line for ovarian cancer and to review the outcomes and toxicities	SPR Consultant	Clinical Effectiveness	May 2021	November 2021
3.1	Service evaluation of image guided brachytherapy	Image guided brachytherapy has been introduced into Velindre Cancer Centre in the last few years. It is important to monitor outcomes following its introduction.	Consultant	Key Indicators of Practice	April 2021	October 2021

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Head & Neck SST						
3.1	Nivolumab	To look at the local data regarding outcomes related to second line Nivolumab in Head and Neck Cancer from NICE approval of the treatment. To look at the response to treatment, previous therapy and survival data.	SPR Consultant	Key indicator of practice	April 2019	July 2021
6.3	Patient satisfaction Palliative Patients	To obtain patients views with regards to the Head and Neck service	CNS	Users views	April 2021	March 2021
6.3	Nasogastric (NG) tubes patient experience	To look at thoughts and feelings after an NG tube	PSU Team	User views	April 2020	July 2021
3.1	30 day mortality post head and neck radiotherapy treatment.	To look more closely at the patients with less than 30 days mortality following treatment. The aim of the audit is to identify if there were indications retrospectively by looking back at bloods results and interventions to help us improve future care and early interventions	Consultant SPR	Key indicator of practice	March 2020	July 2021
3.1	Evaluating the accuracy of diagnostic imaging of extranodal extension of metastatic squamous cell carcinoma in cervical lymph nodes	To assess the accuracy and concordance between pre-treatment radiological reports and post-operative pathology reports for the detection of ENE of metastatic cervical lymph nodes in patients with HNSCC.	Medical Student	Clinical Effectiveness SSC	March 2021	April 2021
3.1	Review of Enteral feeding in Head & Neck patients undergoing radical radiotherapy during COVID 19	Aim is to review which method of enteral feeding; reactive NGT vs prophylactic GT provides the best outcomes for these patients by comparing practice during pre COVID 19.	Consultant	Clinical effectiveness	February 2021	August 2021

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3.1	A service evaluation of the changes in the delivery of non-surgical cancer treatment for head and neck cancer patients in South-East Wales as a result of the COVID-19 pandemic	To look at the changes that were observed in the non-surgical treatment of head and neck cancers during the COVID-19 pandemic. Will help identify the impact of the COVID-19 pandemic on the delivery of clinical care which will have implications for the future treatment of patients	Medical Student	Key indicator of practice	March 2021	May 2021
3.1	Head and neck Oncology team, in particular focusing on surgical management/treatment strategies and the involvement of the maxillofacial teams.	To assess surgical management and treatment strategies	Medical Student	Clinical effectiveness	March 2021	May 2021
3.1	The impact on swallowing outcome of changing radiotherapy technique for the treatment of T1 and T2 glottis cancers.	To assess the impact of changing radiotherapy technique.	SPR	Clinical effectiveness	April 2021	July 2021
Lung Malignancies SST						
3.1	Audit of outcomes of patients having radical radiotherapy for NSCLC at Velindre Cancer Centre	Compare VCC outcomes to established best practice (as defined by international clinical trials) – overall survival and progression free survival	SPR	Key indicator of practice	April 2021	March 2022
3.1	Audit of patients with localised small cell lung cancer	Treatment pathways and outcomes for patients with localised small cell lung cancer treated with curative and palliative intent.	SPR	Key indicator of practice	April 2021	March 2022

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3.1 5.3	Patient support pathway from the Clinical Nurse Specialist perspective	To evaluate if patient support pathway objectives are being met Evaluate how specialist nurse based at VCC can specifically support this pathway	Lung CNS		April 2021	October 2021
3.1	Use of single agent check-point inhibitor pembrolizumab in metastatic non-small cell lung cancer	To assess toxicities encountered by patients receiving this treatment including immune related adverse events. To assess outcomes of patients receiving pembrolizumab.	SPR	VCC Guidelines Clinical Risk Local Concern	April 2019	March 2022
3.1	All Wales NSCLC genetics pathway quality improvement project	To assess current turnaround times for genetic results for NSCLC, identify gaps and improvement opportunities to reduce pathway variability and improve equity of access/turnaround times	Consultant	National guidelines, Local concern, Clinical effectiveness, Key indicator of practice	April 2021	March 2022
3.1	Retrospective Data Collection for Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	To update data to date, looking at outcomes and other factors such as genetics and PETS	Consultant Radiologist	Key indicator Clinical Effectiveness Innovation	July 2020	April 2023
Urology SST						
3.1	A retrospective evaluation of brachytherapy treating patients with prostate cancer	To look at patient disease outcome measures assessed during cancer therapy	Medical Student	SSC	April 2021	May 2021

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3.1	Changes in the delivery of treatment for patients with urological cancer during the COVID-19 initial 'peak	To monitor changes to treatment pathways and associated outcomes	Medical Student	Key indicator Clinical Effectiveness	April 2021	May 2021
3.1	Newly diagnosed hormone-sensitive metastatic prostate cancer and the impact of androgen-receptor targeted agents during the COVID 19 pandemic	To evaluate the presence and impact of toxicity of these new drugs on patients during the COVID period and how we have had to adjust drug dosages/ management plans accordingly.	Medical Student	Key indicator of practice Clinical effectiveness SSC	May 2021	July 2021
3.1	Stereotactic Ablative Radiotherapy (SABR) Metastatic prostate	To evaluate the outcomes of prostate cancer patients who have received SABR, in terms of time to biochemical progression/ time to initiation of ADT/SACT	Medical Student	Key indicator of practice SSC	May 2021	July 2021
3.1	Outcome of ADT and docetaxel for hormone-sensitive metastatic prostate cancer	To evaluate the outcomes of metastatic patients cancer patients who have received ADT and docetaxel.	Medical Student	Key indicator of practice SSC	May 2021	July 2021
6.3	Patient Survey: Urology service	To ascertain patients views regarding the urology service following changes in practice.	Urology CNS	Users views	March 2021	December 2021

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Palliative Care SST						
3.1	Review of treating CAT in patients with primary brain tumours	Our aim is review the clinical management plans for patients referred to the Cancer Associated Thrombosis clinic with a confirmed diagnosis of superficial vein thrombosis and review whether we are adhering to NICE guidelines.	Consultant	NICE Guidance	October 2019	March 2022
3.1	Is primary thromboprophylaxis of palliative care cancer in-patients compliant with NICE Clinical Guideline 89 A clinical audit	To audit the risk assessment and where appropriate, the initiation of thromboprophylaxis in inpatients with cancer who are under the care of the palliative care service.	Palliative care	National Audit	February 2021	December 2021
3.1 3.2	Symptom Control QI Project including POS-S	Evaluation of the use the POS-S within palliative care team	Medical Student	Clinical effectiveness	May 2021	July 2021
3.1 3.5	Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's wishes are respected, decisions reflect the best interest of the individual and benefits are not outweighed by burdens. A DNACPR decision is clearly recorded and communicated between health professionals.	SPR	National guidance	March 2021	December 2021
Colorectal SST						
3.1	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer	Compare the clinical effectiveness of short course Radiotherapy with long course radiotherapy. to see if there was an additional benefit of a combination of giving chemotherapy before and after short course radiotherapy	SPR Consultant	Key indicator of practice Clinical Effectiveness	September 2020	September 2021

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3.1	Improving communication standards of clinic letters within the colorectal service in Velindre	A focussed audit of communication standards for patients within the colorectal team to establish what we already know, that in all likelihood the situation has not changed since 2018.	SPR Oncology GP	Royal College	December 2020	July 2021
3.1	Rectal Simultaneous Integrated Boost (SIB)	TBC	Consultant SPR	TBC	April 2021	September 2021
3.1	Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with contact radiotherapy for rectal cancer	SPR Consultant	NICE	April 2021	September 2021
3.1	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles administered which can help us anticipate which patients are more at risk.	SACT Nurse	Clinical Risk	April 2021	September 2021
6.3 3.1	Patient support group	Support for the CRC cancer patients	CNS	Users views	April 2021	Ongoing
6.3 3.1	Recovery package and treatment summaries	To ensure all adjuvant patients receive rehab recovery package to enable rehab following completion of treatment. Treatment summary to communicate with patients and primary care – treatment given	CNS	User views Clinical effectiveness	April 2021	Ongoing

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3.1	Oxaliplatin induced peripheral neuropathy tool	Develop a tool of assessment to be piloted and accepted by the CRC SST	CNS	Clinical effectiveness	August 2021	December 2021
UGI SST						
3.1	Management of Oesophageal Squamous Cell Carcinoma within the UK and Ireland: A retrospective multi-centre analysis	Provide an insight into variation across the UK in the use of surgery and dCRT for the potentially curative treatment of OSCC. Review survival outcomes for CRT compared with neoadjuvant treatments plus surgery.	SPR	National Project (NOTCH)	October 2020	March 222
6.3	Re-Audit Upper GI Patient Survey from 2014	To revaluate the patients experience of the UGI service	CNS	Users views Re-audit	December 2020	September 2021
3.1	An audit of variation in delays in the current diagnostic pathways in patients presenting with oesophageal cancer	We will look into 3 Health Boards across South-East Wales, and audit the waiting times and delays in oesophageal cancer referral treatment. We will compare this to the National Optimum Pathway, and we will then look into how this affects the prognosis of the patients.	Medical Student	Key indicator of practice	April 2021	May 2021
3.1	Evaluation of outcomes from Palliative patients treated with chemo-radiotherapy for oesophageal cancer	To ascertain overall and progression free survival. To identify any toxicities of treatment	Medical Student	Key indicator of practice SSC	May 2021	July 2021
3.1	Evaluation of outcomes for oesophageal cancer	TBC	Medical Student	SSC	May 2021	July 2021

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Neuro-oncology SST						
3.1	Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	To gain insight into the radiotherapy approaches currently being used across the UK, both in an adjuvant and disease recurrence setting. Data on systemic management and associated disease response will also be valuable for treating clinicians given the lack of evidence base in this area.	SPR	National Project	January 2021	March 2022
3.1	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	Second-line surgery is a considerable undertaking for patients with limited life expectancies and a consideration for surgical resources. To date, our local practice has not been reviewed and doing so will allow us to better define the patient population most likely to benefit and inform our discussions with patients.	Consultant	Clinical effectiveness	May 2021	March 2021
3.1	Audit of SRS	To review outcomes of patients receiving SRS within Velindre	SPR	Key indicator of practice	May 2021	March 2021
Sarcoma SST						
5.1	Sarcoma Pathway	Working with the Welsh Cancer Network to develop and assess the pathway.	CNS	Key indicator of practice	Ongoing	Ongoing

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Other Sites/Services						
3.1	Combination immunotherapy for metastatic Melanoma and Renal cancer	To ascertain overall survival and grade of toxicities	Medical Student	Key indicator of practice	May 2021	July 2021
6.3	Audit on Measure yourself concerns and wellbeing questionnaire	Assess the effectiveness of complementary therapy in cancer care. We aim to use the data in order to begin a research project.	Psychology	Users views	December 2019	Ongoing
5.1	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	Service improvement team	National guidelines	Ongoing	Ongoing
3.1	All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	Aim to identify key clinical lessons from this period to guide local QI projects and help awareness to improve patient care currently and in case of further surge in covid19 cases.	Consultant	Key indicator of practice Local concern Patient safety	September 2020	Ongoing
5.1 3.1	Treatment Escalation Plan Quality Improvement Project Proposal	To ensure that more patients will have appropriate escalation plans put in place EARLY in their admission.	Consultant	Multi centred	September 2020	March 2022
3.1	DPYD Health Technology Assessment Service Evaluation	To conduct a health technology assessment (cost utility analysis) of the *DPYD* genotyping service in Wales.	Consultant	National	February 2021	Ongoing

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3.1	Patient/carer Self-administration of sub cut injections	To identify numbers of patients attending. Ascertain if these patients could be educated and managed at home. This would reduce patient visits and footfall which at present is even more of a priority due to infection control risks.	Outpatient Manager	VCC Guidelines Clinical Risk Clinical Effectiveness Patients views	March 2020	On Hold
6.3	Immuno toxicities Clinic – Patient Experience of virtual clinic during the COVID-19 Pandemic	Understanding of patient experience of a virtual (telephone) toxicity clinic during COVID-19 pandemic, to assist with future development and learning of a virtual service.	Inpatient Business Manager	Users/ Patient views	December 2020	March 2021
3.1	Service Evaluation Project of the Nurse Led Paracentesis Indwelling Peritoneal Catheter (IPC)	To evaluate the nurse led service and assess whether the service is being delivered within appropriate timeframes. This will also confirm the importance of the service going forward.	Nurse	Key indicator of practice	March 2021	August 2021
3.1	Exploring the definitions of ‘value’ and ‘value-based healthcare’ in cancer care	Aims to explore how staff define value-based healthcare and what they consider to add value to patient care. This will be achieved by conducting semi-structured interviews	PHD Student	Service Evaluation	March 2019	September 2022
3.1	An Evaluation of the Discharge Medicines Review service: A Secondary data analysis	This study aims to investigate the factors affecting DMR uptake and medication discrepancy rates in Wales	Doctor Cardiff & Vale	Patient safety PHD	March 2020	March 2022
3.1 5.1	CT PA requests	To create a robust pathway for suspected PE	Radiology Team		April 2021	On going

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3.1 5.1	MRI Spine requests	To create a robust pathway for suspected MSCC	Radiology Team		April 2021	On going
3.1	Evaluation of the Emergency Medicines Service extended community pharmacy service	To ensure that patients can access an urgent supply of their regular prescription medicines where they are unable to obtain a prescription before they need to take their next dose. To relieve pressure on urgent and emergency care services and general practitioner appointments at times of high demand.	Doctor Cardiff & Vale	Service evaluation	July 2020	March 2022
3.1	Evaluation of the extended community pharmacy Independent Prescribing Service (IPS)	The aim of this project is to evaluate the pilot service. In particular, we will detail: Number of IPS consultations undertaken, Percentage of consultations where the WGPR was accessed. Percentage of patients who would have sought alternative action and nature of action. Most prescribed medication under the service	Doctor Cardiff & Vale	Service evaluation	July 2020	March 2022
3.1	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Radiographer	Patient safety	May 2020	October 2023
3.1	VAPP Project Virtual Generic pre SACT assessment clinics	To reduce capacity in consultant clinics by transferring suitable pre chemo assessment ‘s into a generic clinic.	NMP	Innovation	Ongoing	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
COVID-19 Audit/Project Programme						
6.3	Virtual consultation-study in Covid-19 era: Patient and Staff experience	To obtain patient and staff vires with regards to their experience with virtual clinics	Consultant Patient Experience Outpatient Attend Anywhere	Users Views	April 2020	Ongoing
3.1	The impact of COVID-19 on SACT treatment pathways	To monitor changes to treatment pathways and associated outcomes	Consultant	Key indicator of practice	April 2020	Ongoing
3.1	The Impact of the Acute Phase of COVID-19 on Radiotherapy Demand in South East Wales	To monitor changes to treatment pathways and associated outcomes	SPR	Key indicator of practice	April 2020	Ongoing
3.1	UK Coronavirus Cancer Monitoring Project (UKCCMP)	To track cases and outcomes of cancer patients affected by COVID-19 infection in the UK	SPR	National Project	April 2020	Ongoing
3.1	COVID Radiotherapy: a National Cancer Research Institute (NCRI) CTRad UK-wide initiative	COVID RT is a national initiative that aims to study the impact of COVID-19 and the recovery plan on radiotherapy patients and the radiotherapy service and help us plan for future pandemics	Consultant	National Project	April 2020	Ongoing
3.1	Lung Radiotherapy during Coronavirus Pandemic (COVID-RT Lung)	To understand the changes in radiotherapy services for patient with lung cancer in the UK during the coronavirus pandemic	Consultant SPR	National Project	April 2020	Ongoing

HCS	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
		Assess the outcome of operable patients treated with radiotherapy during the coronavirus pandemic	CAD			
6.3	Re-audit PPE education and communication quality improvement project	To assess and improve communication between hospital staff regarding changes in the current PPE guidelines in VCC	SPR	Users Views	April 2021	December 2021
3.1	Outcomes of neuro-oncology for patients with intracranial tumours during COVID-19 pandemic: cohort study CovidNeuroOnc	To determine whether the COVID-19 pandemic changed the management decision in patients with newly-diagnosed or recurrent brain tumours	SPR	National Project	June 2020	Ongoing
3.1	CATCH	Project run by Leeds Teaching Hospitals which aims to create a “traffic light” system for review of thorax on treatment Cone Beam Computed Tomography (CBCT) changes with the hope of identifying patients who require COVID-19 testing and potential self-isolation.	Radiotherapy	Service Evaluation	June 2020	May 2021
1.1 7.1	Staff Testing	To evaluate current practice and ensure staff testing guidelines are adhered to	CAD	Key indicator	April 2020	Ongoing

APPENDIX 3

Welsh Blood Service Clinical Audit Programme 21/22

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Audit	Aim	Frequency
Venepuncture Skin Cleansing	- To prevent bacterial contamination of blood and blood products effective pre-venepuncture skin cleansing is of paramount importance. - To ensure that the arm cleansing techniques are in line With evidence base.	Monthly Quarterly Validation Audits
Points of Care	- To ensure compliance with points of care UK evidenced based donation care principles to maximise donor outcomes.	Quarterly Annual Validation Audits
Hand Hygiene	- To ensure compliance with W.H.O 5 moments of hand hygiene to maintain donor, staff and recipient safety.	Monthly Quarterly Validation Audits
Donning and Doffing	- To ensure staff safety is optimised through adherence to correct donning and doffing practices during COVID19 pandemic.	Weekly Quarterly Validation Audits

Specific Programmes of Audit 2021/22

- Development of clinical audit programme for Bone Marrow Collection Services
- Strengthen Infection Prevention and Control audits to incorporate laboratory areas
- Clinical Audit of introduction of FAIR study principles in Practice.
- The Welsh Bone Marrow Donor Registry are developing a formal plan for clinical audit which will reflect the activities that are already being undertaken and reported to regulators, and identify gaps for additional activity.

Religion and Belief in Velindre University NHS Trust

Sarah Morley

Executive Director of OD & Workforce

Executive Team Ambassador for Religion


INDIE
HORIZONS
Born
from
travellers,
for travellers!


Eid-Al-Adha
Mubarak


HAPPY
HOLI


CELEBRATE CHANUKAH

A tool in the toolbox for Wellbeing

- We draw on a team of Chaplains representing wide range of denominations and faiths
- Work closely with Palliative Care Team
- Supported colleagues during Covid
- Do lots of education for staff on spiritual care
- Trained to talk to people going through what may be the most difficult time of their life
- VCC Multi-Faith Room

What does this mean for me as the Trust Executive Ambassador for Religion

- Recognise intersectionality
- Supporting our patients, our donors and our colleagues
- Be a visible ally for Religion and Belief

What action do we need to take?

- **Leadership and accountability**: Visible involvement of diversity in leadership and zero tolerance of discrimination
- **Colleagues**: Giving staff a voice
- **Active Allyship**

Reflections from Executive Management Board

- In our society it seems awkward to talk about religion
- We need to gather greater knowledge so we can support in confidence
- We need to ask out staff how we can better support their religious needs
- We need to talk to patients and their families to understand what else we need to do
- This is one of the most important conversations at the end of life

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	25th November 2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Interim Vice-Chair and Chair of the Strategic Development Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
AOS	Acute Oncology Service
IMTP	Integrated Medium-Term Plan
JET	Joint Executive Team
MIM	Mutual Investment Model
WBS	Welsh Blood Service

1. PURPOSE

1.1 This paper has been prepared to provide the Trust Board with details of the key issues considered by the Strategic Development Committee held on 8th November 2021.

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	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Velindre @ UHW Progress Update** The Strategic Development Committee received an update regarding the Velindre @ UHW Progress. Steady progress is being made across all workstreams. The Strategic Development Committee **noted** the update. **WBS Infrastructure Programme Update** Welsh Blood Service (Talbot Green) Infrastructure Programme highlight report for October 2021 was presented to the Committee. Welsh Government allocated £150,000 to support development of the Outline Business Case, with funding to be expended in the financial year 2020/21. The programme is currently in Phase 1 (Stage 1). Progress is being made with the Supply Chain Partner, Cost Advisor and external Project Manager appointed to support the development of Outline Business Case. The Strategic Development Committee **noted** the update. **Capital Funding: Welsh Government COVID Schemes** The Capital Funding: Welsh Government COVID Schemes was presented to the Committee. An urgent request was issued to Velindre University NHS Trust from Welsh Government on 12th August 2021 outlining the availability of capital funding for the purpose of supporting COVID recovery schemes. The request was for the Trust to provide a high-level prioritised list of capital schemes that could be delivered by the end of the financial year, with a deadline for submission being close of play

	16th August 2021. The submitted schemes were highlighted during the meeting. 7 out of the 10 schemes Welsh Government agreed to fund. Each of the schemes vary in scale, complexity and budget and are time critical. The Capital Delivery Group has discussed the schemes on the 19th October 2021 and confirmed they can be delivered within 2021/2022. The Strategic Development Committee **noted** the Capital Funding: Welsh Government COVID Scheme papers.
ASSURE	**Trust Strategy: Analysis of engagement exercise** The Trust Strategy: Analysis of engagement exercise was presented to the Committee. An update was given on the feedback received regarding the mission statement, vision statement and the 5 goals. The Strategic Development Committee **noted** the presentation. **Developing Cancer System in South East Wales** The developing Cancer Systems in South East Wales presentation was presented to the Strategic Development Committee. The Collaborative Cancer Leadership Group (CCLG) aim is to improve cancer patients' outcomes and survival for the population of South East Wales. They are identifying the system-wide cancer remit across the whole end-to-end cancer pathway across South East Wales. The presentation outlines early discussions at a regional level. Following these, a draft scope for the workshop has been developed. The facilitated workshop is being planned for January 2022. The Strategic Development Committee **noted** the presentation **Nuffield Trust Recommendations: Progress** The Nuffield Trust Recommendations: Progress report was presented to the Strategic Development Committee. The Strategic Development Committee **noted** the progress.
INFORM	There were no items identified to Inform the Trust Board.

APPENDICES	None.

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	21st September 2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 21st September 2021.

1.2 This is not considered a full update on the Programme but a high level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**TCS Finance Report** An update was given on the August finance report. The financial risks were identified in respect of a projected revenue year-end overspend of £30k. It was confirmed that conversations are being held to agree how to manage the current financial position. The IRS forecast has been added as a new risk due to a projected year-end capital overspend. Meetings have been arranged to deal with this. The Sub-Committee **Noted** the Paper. **TCS Programme Risk Register** An update was received on the risk register, it illustrates the risks across the programme in terms of the risks emerging from each project. There have been several changes in terms of risk and risk score updates. A few issues have been raised but these are all being managed and updated. Any of the risks which have a current rating of 12 which are reported to Programme Board and at Scrutiny Committee have all been added to Datix and we are continuing to measure the risk register and information in Datix remains accurate. The Sub-Committee **Noted** the Paper. **Projects 1 & 2 - Minecraft for Education Competition Update** An update was given on the Minecraft for Education Competition. The young ambassadors will have the opportunity to work with the design team. The winner announcements and media opportunities are planned for 1st October. The Sub-Committee **Noted** the update.

ASSURE	**Projects 1 & 2 - Integrated Assurance & Approvals Plan (IAAP)** An update was received on the IAAP, which is an integral part of the overall governance and assurance arrangements. This update included a schedule summarising the agreed approval arrangements for each of the main deliverables, within overall Board & Committee structures. The Sub-Committee **Noted** the update. **Nuffield Trust Recommendations: Progress** An update on progress with the Nuffield Trust Recommendation was received. **Communications & Engagement** An update was given on communication and engagements. The Committee noted the work being done with Cardiff and Vale, Partnership Boards, CCLG and development of the Regional Clinical Model.
INFORM	There were no items identified to inform the Trust Board.
APPENDICES	N/A

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	25th November 2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital
REPORT PURPOSE	FOR NOTING

ACRONYMS	
OBC	Outline Business Case
FBC	Full Business Case
TCS	Transforming Cancer Services
WG	Welsh Government
IRS	Integrated Radiotherapy Solution
IM	Independent Member

1. PURPOSE

1.1 This paper has been prepared to provide the Board with details of the key issues considered by the Transforming Cancer Service (TCS) Programme Scrutiny Sub-Committee at its public meeting on 25th October 2021.

1.2 This is not considered a full update on the Programme but a high level record of the matters of business conducted by the TCS Programme Scrutiny Sub-Committee.

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

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

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for Alert / Escalation to the Trust Board.
ADVISE	**Finance Report** The finance report for October 2021 was received. A small revenue overspend to October 2021 was noted, with a current year-end forecast of £0.017m. This will be managed within the overall budgets. It was highlighted there is a projected year-end capital overspend of £0.124m for the Integrated Radiotherapy Solution (IRS) Project. This overspend will be managed within the wider Transforming Cancer Service Programme. The sub-committee **noted** the finance report. **TCS Programme Risk Register** The TCS Programme Risk Register report was presented. The latest risk positions for the TCS programme and projects were reviewed and discussed. Risks which relate to programme resources will be updated in the November Scrutiny Sub-Committee, and they will also be included in the financial strategy which will be going to the next Trust Board meeting. The sub-committee **noted** the finance report. **Project Delivery** Updates were received in the following papers which were **noted**: - Charity Interface - Children's & Young Persons Engagement (Minecraft) - Collaborative Centre – Update - Wellbeing & future generations Act (WBFGA) – new Velindre Cancer Centre Status report

ASSURE	**Project 4 – Radiotherapy Satellite Centre** **FBC Timeline Update** A verbal update was given on the FBC timeline. The sub-committee noted the verbal update. **Nuffield Trust Recommendations: Progress** An update on progress with the Nuffield Trust Recommendation was received. The Sub-Committee **Noted** the Paper. **Communications & Engagements** An update was given on communication and engagements. The Sub-Committee **Noted** the Paper.
INFORM	There were no items identified to inform the Trust Board.
APPENDICES	N/A

TRUST BOARD

TRANSFORMING CANCER SERVICES COMMUNICATION AND ENGAGEMENT UPDATE

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	FRANCESCA CARPANINI, SENIOR COMMUNICATIONS AND ENGAGEMENT MANAGER
PRESENTED BY	NON GWILYM, ASSISTANT DIRECTOR COMMUNICATIONS AND ENGAGEMENT
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**
nVCC project board Enabling Works project board	15 November	Noted
TCS Programme Board	16 November	Noted
TCS Programme Scrutiny Sub Committee	22 November	Noted

ACRONYMS	
nVCC	New Velindre Cancer Centre
TCS	Transforming Cancer Services
VCC	Velindre Cancer Centr

1. BACKGROUND

This paper provides the Trust Board with an update on programme communications and engagement during the course of mid-October to mid November 2021.

The Programme Board approved the Transforming Cancer Services (TCS) Programme Communications and Engagement strategy in December 2019. The strategy emphasises the importance of good one-to-one stakeholder engagement, building positive relationships and informing our patients, staff and communities of interest.

2. ASSESSMENT

Over the reporting period we focused our efforts on:

- Strategic counsel and operational communications and engagement support for the preparation works on site ahead of ground investigation commencing in late November (summary report as attachment); this work included:

    1. Coordinating media enquiries from ITV Wales, BBC Wales, Wales Online and The National, alongside managing media on site for interviews with David Powell. Media coverage included within summary report. Overall coverage was balanced, with context provided as per information provided.
    2. Providing agreed statement from David Powell to each media outlet request alongside background information relating to permissions and context of work being undertaken.
    3. Sharing content across Velindre Matters channels and monitoring social media.
    4. Liaison with South Wales Police, Welsh Government and Cardiff Council communications
    5. Establish lines of contact with the relevant contractors

A communications and engagement lessons learned will be captured as part of a wider project lessons learned.

- Responding to correspondence from a wide range of stakeholders. There has been a significant increase in correspondence over the past month in response to the preparatory works that took place on site and the distribution of the first community newsletter. The key themes are:
    - the related permissions / licenses required,
    - awareness of the provisions in the CEMP
    - challenges in relation to the clinical model
    - 60/40 land use split

- Political stakeholder meetings – in addition to the regular meetings with the local constituency MS and MP, we have made proactive approaches to ward councillors to provide on or off site briefings relating to the works and impact on community.

- Preparation for stakeholder engagement with competitive dialogue – a new protocol guiding engagement between our stakeholders and the bidders has been developed in the spirit or open engagement while safeguarding the procurement process;

- Implementing a plan to promote clinical messaging, working towards promoting our own content to coincide with 12 months on since Nuffield

- Supporting the Velindre Minecraft Competition Green Design Workshop hosted at Down to Earth on Friday 29 October – video and images captured, alongside prize giving to attendees, runners up and winners of the competition. Artwork of winning worlds to be installed at VCC in November;

- Supporting the development of a wider value added package for socialising with staff and stakeholders.

For the next month, our priorities will be as follows:

- Implementing communications and engagement activity required to support ground survey works on site including community, stakeholder, media and staff briefings;
- To coincide with the first anniversary of the publication of the Nuffield Trust advice, implementing the clinical communications plan with accompanying promotional activity outlining the model that underpins the development of Velindre cancer service;

- Implementing the feedback plan that allows us to track and score staff and patient sentiment, understanding and idea;
- Update and publish new FAQs;
- Review the stakeholder engagement plans received from the participants as part of community benefits workstream;
- Deliver internal Green Ambitions Showcase for VCC staff to understand plans for new cancer centre and implement follow up survey / feedback process to gain further insight; this information will be shared with participants as part of competitive dialogue;
- Review and update direct action workflow following preparation works disruption to provide additional information and cover potential risks for future work being undertaken;
- Planning for the Value Added showcase in December;
- Finalise phased approach to 'I'm Involved with Velindre' campaign and begin socialising with staff and stakeholders;
- Publish next issue of Velindre Matters digital newsletter;
- Plan out topics and articles for next edition of Velindre Matters community newsletter (for January 2022) to begin drafting and approvals process;
- Support two meetings with MS and MP and local community councillors;
- Continue to maintain media briefings and information sharing with key outlets;
- Promote new content on the Velindre Matters social channels;
- Continue to monitor social media channels and advise accordingly;
- Supporting the nVCC research and development working group;
- Supporting the patient engagement framework and related activities.

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 Trust Board are recommended to **NOTE** the paper.

TRUST BOARD

AUDIT COMMITEE HIGHLIGHT REPORT

DATE OF MEETING	14/10/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Martin Veale, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance

REPORT PURPOSE	FOR NOTING

ACRONYMS	
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1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Audit Committee at its meeting held on the 14 October 2021.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Audit Committee held on the 14 October 2021:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**CLINICAL AUDIT ANNUAL REPORT** The clinical audit to be strengthened through the Quality and Safety Framework and The National Clinical Framework. A plan for Financial Year 2021-2022 and a Quality at the Centre of our Service Report are currently being worked on and will be going to Quality and Safety Committee in January 2022, and to Audit Committee following this. The report was **NOTED** and **ENDORSED** by the Audit Committee **TRUST RISK REGISTER** This report focussed on the 25s, 20s and 16s over the last few months and in this current cycle focussing on 15s. . The Trust Risk Register (Version 12 and Version 14), the actions status of individual risks and next steps were **NOTED** by the Audit Committee. Project plan is in place to manage the transition from Vs 12 to Vs 14 of Datix was **NOTED** by the Audit Committee. **EXTERNAL AUDIT:** **FINANCIAL AUDIT REPORT 2020/2021** The report sets out the recommendations from this year and 2 recommendations were set out in the report. All of these have been accepted by management and highlighted that last years' recommendations have been implemented. The Audit Committee **REVIEWED** and **NOTED** the report. **AUDIT POSITION STATEMENT 2021 – VELINDRE UNIVERSITY NHS TRUST** It was noted to the Committee that a paper will be produced in the next few weeks, about audit quality covering the standards we comply with in financial audit and the direction of travel with the performance work. The Audit Committee **REVIEWED** and **NOTED** the following reports. **INTERNAL AUDIT:** **CaNISC REPLACEMENT INTERNAL AUDIT REPORT** A reasonable assurance rating was noted to the Committee.

	WASTE MANAGEMENT INTERNAL AUDIT REPORT A reasonable assurance rating was noted to the Committee. **INFECTION PREVENTION & CONTROL INTERNAL AUDIT REPORT** A reasonable assurance rating was noted to the Committee. The Audit Committee **NOTED** the report. **DIVISIONAL REVIEW – INCIDENT MANAGEMENT INTERNAL AUDIT REPORT** A reasonable assurance rating was noted to the Committee. **DIVISIONAL REVIEW – RISK MANAGEMENT INTERNAL AUDIT REPORT** A reasonable assurance rating was noted to the Committee. **COUNTER FRAUD PROGRESS REPORT** 70.5 days of counter fraud work for VCC have been completed. During this reporting period 2 investigations have been closed and one remains open. The Audit Committee **RECEIVED** and **DISCUSSED** the Counter Fraud Progress Report for the period 1st July 2021 to 30th September 2021.
ASSURE	**INTERNAL AUDIT** **Internal Audit 2021/22 Progress Update Report** It was highlighted to the Committee they have followed up the points raised in the financial systems report from last year, which flagged issues around private patients' debts which led to that being included.
INFORM	**COUNTER FRAUD STAFFING** An advert gone out for Investigator to give more capacity for investigations.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

CHARITABLE FUNDS COMMITEE HIGHLIGHT REPORT

DATE OF MEETING	25/11/2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Professor Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Matthew Bunce, Executive Director of Finance
REPORT PURPOSE	FOR NOTING

ACRONYMS	
~	~

1. PURPOSE

This paper has been prepared to provide the Trust Board with details of the key issues and items considered by the Charitable Funds Committee at its meeting held on the 04 November 2021.

Key highlights from the meeting are reported in Section 2.

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

2. HIGHLIGHT REPORT

The following areas were highlighted for reporting to the Trust Board from the meeting of the Charitable Funds Committee held on the 04 November 2021:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**VIEW FROM A FUNDRAISER** The Committee received a presentation from Tracey Davies, Charity Ambassador, who since 2015, has committed time and energy to raising funds for Velindre, as well as being a hospital Social Worker. The Committee welcomed the opportunity to learn about Tracey's experiences of fundraising which has involved many activities, such as, sky dives, bike rides, 500 mile walks and camp outs. The Committee also learned that fundraising has enabled Tracey to visit a number of different parts of the world, including Patagonia, Machu Picchu, New Zealand, Cambodia, the Everest Base Camp, and in October 2022 this will extend to include Vietnam. The Committee were advised that to date Tracey has raised over £300,000 for Velindre and hopes to reach more than £400,000 following next year's fundraising event in Vietnam. The Committee thanked Tracey for her commitment and dedication to fundraising for Velindre and commended her passion which was inspirational. The Committee also extended their congratulations to Tracey who has recently been awarded a British Empire Medal for her fundraising work over the years. The Committee re-iterated how important it is to invite Charity ambassadors to share their experiences and hear the voice of the fundraiser at the Committee. It also provides a vital opportunity to advise our ambassadors and patrons of the key role the Committee performs in ensuring good stewardship of all funds raised. **FUNDRAISING** The Committee were advised that following the impact of the COVID 19 pandemic on fundraising activity, things have now started to improve, and September - November 2021, have been busy months for the fundraising team. The Committee were advised that the comprehensive training and development Programme to support the professional development of the fundraising team has now commenced with Health and Safety Training, and risk assessments for all fundraising events have been established. It was also noted that it was important that the digital

skills of the team be enhanced & developed in order to support delivery of the new strategy.

The Committee noted and was pleased to hear of the plans being progressed for fundraising activity over the next 12 months.

The Committee were advised of the good progress made in the development of a new 5-year strategy for the Charity and how this will seek to adopt a more proactive approach to incorporate more diverse communities within fundraising activity for Velindre. The Committee agreed that the new strategy will also consider other income models to expand its reach, including the lottery and direct debit. The Committee also noted that the need for a trading arm for the charity was being considered as part of the new strategy.

The Committee raised the importance of Independent Members and Executives attending fundraising events and wished to extend its thanks to participants and how much this is appreciated.

DEVELOPMENT OF CHARITABLE FUNDS TRUSTEE ANNUAL REPORT 2020-2021

The Committee were advised the audit of the charity accounts was due to commence the following week (w/c 8 November) and of the plans in place for the development of the Charitable Funds Trustee Annual Report for 2020 – 2021, and that the first draft will be shared with key stakeholders on the 21 November 2021. The final report is due to be completed in readiness for formal sign off at the Charitable Funds Committee Extraordinary meeting on the 22 December 2021.

The Committee were advised that this year's report will have a different look and feel designed to be more interactive and extend its reach to fundraisers. In addition, to submission to the Charity Commission by the 31 January 2022, the report is intended to feature as part of the Fundraising Annual Event planned for January 2022.

GUIDE TO PRESENTING AT CHARITABLE FUNDS COMMITTEE

The Committee were advised of the latest addition to a suite of information and support tools being developed, designed to provide guidance for individuals applying for charitable funds i.e., how to prepare and what to expect when presenting bids to the Committee. The Committee welcomed this development that will be enhanced further with a view to sign off at its next meeting.

The Committee highlighted that the scrutiny applied within the division/service areas to all bids in advance of them being submitted for consideration by the Committee needs to be strengthened, as the poor quality and incomplete responses in bids received remains a recurring theme. This is a key issue to be taken forward by the division / service areas to ensure this is addressed.

FINANCIAL POSITION

Due to the timing of the meeting the committee received the financial position to the 31st August and was provided a verbal update on the position as at the end of September.

- **Income**

The Committee noted income for the period 01 April - 31 August 2021 has overachieved against the planned target by £210,000. Income received for this period has included £199,000 in legacies, which has notably helped the year-to-date performance for that period.
The Committee noted that the total income received to the 30 September 2021 was £1,100,000 with overall income overachieving against the planned target by £300,000. It was acknowledged by the Committee that this was, down compared with the same period last year by £396,000, however this was due to a £500,000 one off donation from the Moondance foundation.

- **Expenditure**

The Committee noted for the period ending 31 August 2021, expenditure was lower than planned by £303,000. This underspend is in most cases due to timing issues due to vacancies against projects and delayed activity. The vacant Charity Director post from April to mid-June also contributes towards the underspend. Spend is expected to increase in the latter part of the year or to be deferred over future years.

The Committee noted that the total expenditure to the 30 September 2021, totalled £1,600,000, which was lower than planned for the period to date by £226,000, although was slightly higher by £39,000 when compared with the same period last year.

- **Fund balances**

Balances have decreased by £400,000 during the year because expenditure is greater than new income.

- **Investments**

The Committee noted for the period 01 April to 30 September 2021, the investment portfolio was in a positive position and increased by £248,000, which represents an increase in valuation of 4.15% during this period.

BUSINESS EXPENDITURE PROPOSALS:

The Committee **APPROVED** 1 business case request for the:

- **Advanced International Fellowship Programme Medical Training Initiative**

The Committee noted International Fellowships are a recognised mechanism of providing development opportunities for overseas medical staff to facilitate

	experience and development opportunities for individuals as they contribute to education and research in the NHS, as well as developing their own practice. The Committee agreed the request for funding for a further 2 years and the plan to advertise 2 jobs, one for this coming year and one the following year. The initiative will need to explore ways of becoming self-funding. The Committee also noted the success of Dr Chan, a current Fellow, and trainee of the scheme, on passing his final FRCR (Part B) assessment, which examines candidates on all aspects of clinical radiology against the Specialty Training Curriculum for Clinical Radiology. The Committee passed its congratulations on behalf of the Committee and the Board.
ASSURE	**BUSINESS CASE EXPENDITURE EVALUATION REPORTS:** The Committee considered 2 Business Case Expenditure Evaluation reports, which provide assurance that projects funded by the Charity have delivered or are delivering their expected outputs. This included the: • **Cloud Public WIFI Internet Services** The Committee noted the report and presentation regarding the Free WIFI Launched in 2014, and were assured that as of October 2021, the funding of WIFI is now from within the VUBHST Digital Services budget, and that Digital Health and Care Wales (DHCW) are currently looking at funding WIFI across Wales through the Welsh Government digital fund. The Committee expressed their appreciation for the service and **APPROVED** the final Business Case Expenditure Evaluation Report and were satisfied that the original objectives for the scheme had been met. • **Advanced Practitioner Physiotherapist in Oncology Gynaecological Pelvic Health report** The Committee noted that this project supports a key aim of the Trust, to add value to our services and further our understanding of value-based health care. The Committee highlighted the need to consider this in any future audit activity. The committee noted also that an exit strategy is required for when the term of charitable funds funding ends. The Committee requested that the next end of year report, increase its focus more on the outcome for patients and involve a possible economic evaluation. The Committee **APPROVED** the first end of year evaluation report for this scheme.
INFORM	**CHARITABLE FUNDS COMMITTEE TERMS OF REFERENCE** The Charitable Funds Committee **ENDORSED FOR BOARD APPROVAL** the revised Charitable Funds Committee Terms of Reference. These will be received by the Trust Audit Committee at its next meeting in January 2022 with the

	recommendation to amend the Trust Standing Orders accordingly and will subsequently be submitted to the January 2022 Trust Board for formal **APPROVAL**.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.

TRUST BOARD

BLAENAVON DATA CENTRE TRANSITION PROJECT

DATE OF MEETING	25/11/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	

PREPARED BY	David Mason Hawes, Head of Digital Delivery
PRESENTED BY	Stuart Morris, Chief Digital Officer
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	25/11/2021	

ACRONYMS	
BDC	Blaenavon Data Centre
CANISC	Cancer Information System Cymru
DHCW	Digital Health & Care Wales
NDC	Newport Data Centre
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 This paper has been produced to inform and update the Board on the work associated with the migration of national IT services and associated infrastructure out of the Blaenavon Data Centre (BDC) into a new facility in South Wales.

1.2 The paper is presented to the Trust Board for **NOTING**.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 In late 2020 Digital Health Care Wales (DHCW) confirmed plans to migrate NHS Wales IT services and associated infrastructure out of the BDC, into a new data centre facility in South Wales.

2.2 The migration of services was originally scheduled to take place over a series of weekends, from late-May 2021 to September 2021; however, this work was subsequently rescheduled to take place over nine successive weekends from 30th July 2021 to 3rd October 2021.

2.3 A Transition Batch Plan was published by DHCW, which set out which services were being moved and/or impacted over each migration weekend.

2.4 Where technically feasible, DHCW sought to use the existing resilience built into the national IT infrastructure to maintain 'uptime' for critical services. Thus, plans were put in place to operate most services from the Newport Data Centre (NDC) whilst the infrastructure was transitioned from the BDC to the new data centre. However, during the transition of these services the usual geographic resilience (failover) would not be available – as such, there is a risk to service provision should those systems encounter any issues within the NDC during the migration.

2.5 A number of Velindre University NHS Trust (VUNHST) services were either directly hosted within the BDC or were dependent on the integration / interoperability services that are supported out of that data centre.

2.6 There were specific concerns in respect of the IT infrastructure that supports the CANISC service. Whilst previous failover exercises to the NDC had been successful, the age of the

IT infrastructure that underpins the CANISC service, meant that there was an increased the risk on the migration of equipment out of BDC and into the new data centre.

2.7 The migration work was undertaken solely by colleagues in DHCW. Whilst there was no requirement on the local VUNHST Digital Services team to provide any direct support, technical staff provided testing support and regular communications were published via the weekly Trust newsletters, dedicated Digital Services communications and the DIGIT@LK newsletter.

2.8 The focus of the internal communications was to ensure affected services were prepared for *potential* disruption over the migration weekends. Working to the DHCW-published transition plan, the VUNHST Digital Services team issued the general communications alongside some more targeted engagement with key service areas, where any disruption to service provision would have a significant operational and/or clinical impact – this was broadly when key clinical systems were affected (Canisc, Hospital Pharmacy, Welsh Clinical Portal etc.).

2.9 An example of the weekly communications issued to the Service is shown in **Appendix A**.

2.10 The nine-week migration was completed successfully by DHCW, largely to plan. Whilst there was some disruption to non-critical services – for example, VUNHST access to Datix was lost for 3 days during one migration weekend – there was no downtime to critical clinical / operational systems throughout the transition period.

2.11 Some minor corrective action had to be undertaken in late-October 2021. However, again there was no material impact on VUNHST services.

2.12 DHCW confirmed that full geographical resilience was restored in respect of the CANISC service, which was successfully redeployed into the new data centre. Completion of this aspect of the work significantly reduces the risk of a prolonged or permanent loss of the CANISC service, by ensuring the service can be run from a secondary data centre in the event of a loss of service from the primary data centre (currently NDC).

2.13 At the time of writing, some equipment decommissioning activity within the BDC is ongoing; however, this does not impact on any VUNHST services.

2.14 The VUNHST Digital Services team would like to express its thanks to the DHCW Data Centre Transition Project team for their professionalism, support and communication throughout the project. Weekly progress updates from the project team, confirming minor changes to plans etc. were well received and help the VUNHST Digital Services team tailor their local communications accordingly.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	None
RELATED HEALTHCARE STANDARD	Effective Care
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	None

4. RECOMMENDATION

The Trust Board are requested to **NOTE** the contents of this report.

Appendix A – Example of Internal VUNHST Weekly Communications

Summary

Digital Health & Care Wales (DHCW) continue the migration of IT infrastructure and services out of the Blaenavon Data Centre this weekend.

Work takes place from the morning of Friday 17th September until Sunday 19th September.

Whilst there are a further two weekends of migration activity planned, the movement of equipment this weekend completes the movement of all services in use across Velindre University NHS Trust.

Services Being Moved

The table below summarises the services in use across Velindre University NHS Trust that are being moved this weekend:

Service Title	VUNHST Services Supported by this Service
Azure Application	IT services hosted on Azure (cloud) infrastructure – this includes WBS Appts. System
GovRoam*	Enables staff to work on other Trusts / HB sites to connect into NHS Wales network (WBS staff only)
Hosted Messaging Service (HMS) – Edge	Email
Identification & Collaboration Services (ICS)	Underpinning IT infrastructure which supports various national IT systems / services

Mail Routing	Email
Remote Access Service	Services that underpin VPN access into NHS Wales networks

Impact / Actions

** IMPORTANT: NO DOWNTIME FOR THESE SERVICES IS PLANNED **

During the period of the move, services will be running out of the Newport Data Centre (NDC). This means that should there be issues with the NDC during the period of the move, the usual geographical resilience will not be available and, as such, services may be temporarily unavailable.

** The **'GovRoam'** service is not geographically resilient – therefore, this service will be unavailable over the weekend. Staff working on other Trust / HB sites who use this service to connect into the NHS Wales network should utilise an alternative network and VPN (you may need to liaise with your 'host' Trust / HB to confirm which network to use).*

Services are advised to ensure departmental business continuity arrangements are robust and can be actioned should the above services become temporarily unavailable and there be a discernible impact on delivery of critical operational / clinical services as a result.

Please use the usual on-call arrangements to report any urgent issues over the weekend – i.e. x2011 / 01443 622011.

Should you have any questions about the work or its impact across VUNHST, please contact the via the Digital Services Portal or by call us on x2011.

VUNHST DIGITAL SERVICES