Bundle Public Trust Board Meeting - Velindre University NHS Trust 30 September 2021

1.0 10:00 - STANDARD BUSINESS

1.1 Apologies

Led by Prof. Donna Mead (Chair)

Apologies received from:
\- Gareth Jones\, Independent Member
\- Prof\. Andrew Westwell\, Independent Member \(may attend in part\)
\- Cath O'Brien\, Interim Chief Operating Officer
\- Dr Jacinta Abraham\, Executive Medical Director

1.2 In Attendance

Led by Prof. Donna Mead (Chair)

Item 3.1 - Hilary Williams, Consultant
- Niall Thomson, Buchan Associates
- Phil Hodson, Deputy Director of Planning & Performance
- Jenny Stock, Project Manager
Item 7.1 - Mary Swiffen-Walker, WIBSS Service Manager
Item 7.5 - Alan Prosser, Interim Director of WBS
- Paul Wilkins, Interim Director of VCC
- Andrew Paramore, NHS Wales General Management Graduate Programme

1.3 Declarations of Interest

Led by Prof. Donna Mead (Chair)

2.0 CONSENT ITEMS

Led by Prof. Donna Mead (Chair)

2.1 10:10 - FOR APPROVAL

2.1.1 Minutes from the Public Trust Board meeting held on the 29th July 2021

2.1.1 Draft Minutes Public Trust Board 29_07_21 V4.docx

2.1.2 Chair's Urgent Actions Report

Led by Prof. Donna Mead (Chair)

2.1.2 Chairs Urgent Action Report.docx

2.1.3 Commitment of Expenditure Exceeding Chief Executive's Limit

Led by Matthew Bunce, Executive Director of Finance

2.1.3 Commitment of Expenditure Cover Paper.docx

2.1.3a Appendix 1 Commitment of Expenditure.docx

2.1.3b Appendix 2 Commitment of Expenditure .docx

2.1.3c Appendix 3 Commitment of Expenditure.pdf

2.1.4 Policies for Approval Report

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

2.1.4 Approved Policies Update - September 2021.docx

2.1.4.a Charitable Funds Investment Policy.docx

2.1.4b Reserce Forces Training & Mobilisation (Cymraeg).pdf

2.1.4c Reserve Forces Training & Mobilisation Policy (English).pdf

2.1.4d All Wales Secondment Policy (Cymraeg).pdf

2.1.4e All Wales Secondment Policy (English).pdf

2.1.5 Trust Seal Report

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

2.1.5 Trust Seal Report July - Sept 2021 v2.docx

2.2 10:20 - FOR NOTING

2.2.1 3 Year Integrated Medium Term Plan 2022/23 to 2025/26 – Production Timetable, Approach and Structure

2.2.1 3 Year IMTP Timetable 2022 - 2026.docx

2.2.2 WHSSC Joint Committee Briefings

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

The Welsh Health Specialised Services Committee held its latest public meeting on 7th September 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening in Welsh Health Specialised Services.

2.2.2 2021.09.07 JC Briefing v1.0.pdf

3.0 10:30 - STRATEGIC DEVELOPMENT

3.1 South East Wales Acute Oncology Service Business Case - For Approval

Led by Hiliary Williams, Consultant, Niall Thomson, Buchans Associates, Phil Hodson, Deputy Director of Planning & Performance and Jenny Stock, Project Manager

3.1 Cover Report AOS Business Case.docx

3.1a SE Wales AOS Business Case FINAL July 2021.pdf

3.1b SEW AOS Presentation.pdf

4.0 10:45 - MATTERS ARISING

4.1 Action Log

Led by Prof. Donna Mead (Chair)

4.1 Public Action Log updated for 30_09_21 V1.docx

5.0 10:55 - TRUST BOARD MEMBERS TO JOIN WELSH NHS CONFEDERATION WELLBEING FOR WALES LECTURE SERIES

Keynote Address and Keynote Speech with First Minister and Health Minister

6.0 KEY REPORTS

6.1 12:30 - Chairs Update

Led by Prof. Donna Mead (Chair)

Chair Update Report September 2021 final (003).docx

6.2 12:40 - CEO Update

Led by Steve Ham, Chief Executive

6.2 CEO Update Report September 2021 v2.docx

7.0 QUALITY, SAFETY & PERFORMANCE

7.1 12:50 - Wales Infected Blood Support Service (WIBSS) Annual Report

Led by Mary Swiffen-Walker, WIBSS Service Manager

7.1a Trust Board - Wales Infected Blood Support Scheme - Annual Report Cover Paper-Final.docx

7.1b WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS) ANNUAL REPORT 20202021 final.pdf

7.2 13:05 - Quality, Safety & Performance Committee Highlight Report

Led by Stephen Harries, Interim Vice Chair and Interim Chair of the Quality, Safety & Performance Committee

7. 2 Public Q,S&P Committee Highlight Report 16.9.21(v4).docx

7.3 13:15 - Remuneration Committee Highlight Report

Led by Prof. Donna Mead (Chair)

7.3 Remuneration Committee Highlight Report 26-08-2021.docx

7.3a Extraordinary Remuneration Committee Highlight Report - 23-09-2021.docx

7.4 13:20 - Local Partnership Forum Highlight Report

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

7.4 LPF Highlight Report 01-09-21.docx

7.5 13:30 - Delivering Excellence Performance Report Period July 2021

Led by Alan Prosser, Interim Director of WBS and Paul Wilkins, Interim Director of VCC

7.5 JULY PMF Cover Paper TRUST BOARD Septemberwj.docx

7.5b WBS PMF Report_July 2021.pdf

7.5c WOD report_July 2021.pdf

wjVCC Performance Report (Jul 2021) MASTER.docx

7.6 13:40 - Financial Report Period Ended 31st July 2021 (M4)

Led by Matthew Bunce, Executive Director of Finance

7.6 Finance Report Cover Paper.docx

7.6a M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2021.docx

7.7 13:50 - VUNHST Risk Register

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

7.7a Trust Board Risk Register updated -final.docx

7.7b TRR VS 14 updated.pdf

7.7c TRR VS 12 WBS checked.pdf

7.8 14:00 - Trust Assurance Framework

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

7.8 Trust Assurance Framework Update Cover Report.docx

7.8a Appendix A - TAF Dashboard.pdf

7.8b Appendix B - Trust Assurance Framework -v1.1 - Aug 2021.docx

8.0 STRATEGIC DEVELOPMENT

8.1 14:10 - Strategic Development Committee Highlight Report

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

8.1 Public Strategic Development Committee Highlight Report - August 2021 v1-lf_sh.docx

8.2 14:20 - BREAK

8.3 14:30 - Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Reports **Oral Updates**

Led by Stephen Harries, Interim Vice Chair and Chair of the TCS Programme Scrutiny Sub-Committee

8.4 14:40 - Transforming Cancer Services Communication & Engagement Update

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

8.4 TCS Comms and Engagement Report.docx

8.5 14:50 - Progress Report on Quarter 1 Delivery Plan

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

8.5 Progress Report on Quarter 1 Delivery Plan.docx

8.6 15:00 - Equality Ambassadors Showcase: Disability

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

8.6 Disabity Equality Presentation Sep 2021 (003).pptx cj 14 sep 21.pdf

8.7 15:10 - Pay Gender Gap Report

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

8.7 Cover Paper Gender Pay Report Sept 2021.docx

8.7a Final Draft Gender Pay Gap Report 2019-2020.docx

9.0 INTEGRATED GOVERNANCE

9.1 15:20 - Charitable Funds Committee Highlight Report

Led by Prof. Donna Mead (Chair) and Chair of the Charitable Funds Committee

Charitable Funds Committee Final Highlight Report 14 09 2021.docx

10.0 15:30 - ANY OTHER BUSINESS

Prior Approval By the Chair Required

11.0 DATE AND TIME OF THE NEXT MEETING

25th November 2021 at 10:00 – 14:30

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).

MINUTES PUBLIC TRUST BOARD MEETING – PART A

VELINDRE UNIVERSITY NHS TRUST HQ/LIVE STREAMED
29 JULY 2021 @ 10.00 AM

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

1.0.0	**STANDARD BUSINESS**	
1.1.0	**APOLOGIES** Prof Donna Mead noted apologies from Carl James, Director of Strategic Transformation, Planning & Digital, who will be represented by Stuart Morris, Chief Digital Officer	
1.2.0	**IN ATTENDANCE** Prof Donna Mead welcomed the regular attendees of the Public Trust Board and additional attendees: 1. Katrina Febry, Audit Lead Performance, Audit Wales 2. Stephen Allen, Chief Officer, Cardiff Community Health Council 3. David Cogan, Patient Liaison Representative 4. Lisa Miller, Director of Operations, Velindre Cancer Centre 5. Peter Richards, Head of Quality Assurance & Regulatory Compliance, Welsh Blood Service	

	6. Stuart Morris, Chief Digital Officer	
1.3.0	**DECLARATIONS OF INTEREST** There were no Declarations of Interest.	
2.0.0	**CONSENT ITEMS**	
2.1.0	**FOR APPROVAL**	
2.1.1	**Minutes from the Public Trust Board meeting held on the 8th June 2021** The Trust Board confirmed the minutes of the meeting of the 8th June 2021 were an accurate and true reflection.	
2.1.2	**Chair's Urgent Actions Report** The Board **CONSIDERED** and **ENDORSED** the Chairs urgent action taken between the **26th May 2021** and the **14th July 2021**.	
2.1.3	**Commitment of Expenditure Exceeding Chief Executive's Limit** The Board **APPROVED** the Commitment of Expenditure summarised in the report and supporting appendices.	
2.1.4	**Policies for Approval Report** The Trust Board **NOTED** the **'Handling Concerns Policy'** had been updated and approved by the Quality, Safety & Performance Committee.	
2.1.5	**Support for the All Wales Positron Emission Tomography Programme (PET) Programme Business Case** The Board **APPROVED** the issuing of a letter of support from Velindre University NHS Trust to accompany the Programme Business Case submission to Welsh Government.	
2.1.6	**Revisions to Velindre University NHS Trust Model Standing Orders and Standing Financial Instructions** *This agenda item was removed from the Consent agenda by Professor Donna Mead, to address a query to enable the Trust Board to approve the revised Model Standing Orders.* Prof Donna Mead explained there was possibly an error in the paper and therefore the Trust Board could only approve the item, subject to confirmation or correction of the error. The Trust Board's attention was drawn to Appendix A, which was a table provided by Welsh Government. In particular, table 19, which incorrectly states there was no tenure limit of Independent Members for the Trust, when there was an 8 year tenure limit.	

	Lauren Fear confirmed the information in the table was incorrect and that this was already in hand to feedback to Welsh Government. The Trust Board was advised that it could approve the revisions, as the correct information was included in the Trust Standing Orders document. Steve Ham confirmed this was correct. The Trust Board **APPROVED** the Revised Model SOs and SFIs.	
2.2.0	**FOR NOTING**	
2.2.1	**WHSSC Joint Committee Briefings** The Trust Board **NOTED** the Briefing from the Welsh Health Specialist Services Committee Meeting of 13th July 2021.	
2.2.2	**Infected Blood Inquiry** The Trust Board **NOTED** the content of the report.	
3.0.0	**MATTERS ARISING**	
3.1.0	**Action Log** Prof Donna Mead noted there were no action points open on the action log. The Trust Board **APPROVED** the Action Log.	
4.0.0	**PRESENTATIONS:** There were no presentations	
5.0.0	**KEY REPORTS**	
5.1.0	**Chairs Update** Prof Donna Mead presented the report to the Trust Board and highlighted the following: • An update on the Judicial Review Process was presented to the Board Briefing Session on 29th June 2021. • The awarding of the George Cross Medal to the NHS for services provided over the last 73 years and during the pandemic. • The Trust Annual General meeting was held yesterday afternoon (28th July 2021) which had been well received. • The Chair and the Chief Executive Officer had an introductory meeting with new Health Minister, who was very keen to express her thanks for all the hard work during the pandemic and has written to all members of the Trust to say thank you. The Trust Board **NOTED** the contents of the update report.	

5.2.0	**CEO Update** Steve Ham presented the Chief Executive Officer's report and highlighted the following: • There was no further update regarding the Judicial Review since the report was written. • To give his thanks to Sue Youngman and Barbara Burridge for their work as Chair and Vice-Chair of the Patient Liaison Group. David Cogan and Sian Phipps were thanked for stepping forward into these roles. Steve Ham provided an update on COVID-19 and the current situation and the impact of demand increasing across the Trust. An update on the recruitment plan was provided. Sarah Morley provided the Trust Board with statistics on staff that are self-isolating across the Trust. The Trust continues to work with all areas in line with the national approach and any new guidelines. Martin Veale requested additional information on the Green Health Wales Launch and asked if there was any funding that came with the initiative. Steve Ham explained Green Health Wales was an organic staff led initiative and provided additional information. The Trust Board **NOTED** the content of the update report.	
6.0.0	**QUALITY, SAFETY & PERFORMANCE**	
6.1.0	**Quality Safety & Performance Committee Highlight Report** Janet Pickles presented the Trust Board with a highlight report from the Quality, Safety & Performance Committee of 15th July 2021. There were no items to alert the Board, however the following key messages were highlighted for assurance and for information: • The Committee started with a Blood Donor Story and provided information on the donor story and the improvements it had led to. The Welsh Blood Service was commended for their agile way of responding to issues, as they arise. • The Committee felt that it needed more information from the NWSSP Quality & Safety Governance Report for assurance. It was planned to review their Standing Operating Procedure and review their reporting to the Committee • The Committee received the Putting Things Right Annual report and an update on Risk Register and open risks. • The Committee noted that Audit Wales are undertaking a Quality Governance Review. • An update on the implementation of the People's Charter. Prof Donna Mead acknowledged the remit and volume of work overseen by the Quality, Safety & Performance Committee and thanked Janet Pickles for Chairing this Committee. Prof Donna	

	Mead also took the opportunity to echo Janet Pickles' comments on the agile way the Welsh Blood Service has responded to a potential donor concern and improved the health screening tool as a result which is to be commended. The Trust Board highlighted how the new Quality, Safety & Performance Committee allowed items to be discussed from a triangulated perspective, which made for a more holistic approach. Nicola Williams also wished to extend her thanks to Janet Pickles for Chairing the Committee and highlighted that workforce was a triangulated theme from the number of areas discussed at the last Committee meeting. The Trust Board noted that the 15th July meeting was the last Quality, Safety & Performance Committee to be Chaired by Janet Pickles and wished to thank her for her support and also her considerable expertise brought to the Board during her tenure, as an Independent Member over the last 9 years. The Trust Board **NOTED** the contents of the report and warm thanks to Janet Pickles.	
6.2.0	**Remuneration Committee Highlight Report** Prof Donna Mead presented the report to the Trust Board, who **NOTED** the contents of the report and actions being taken.	
6.3.0	**Local Partnership Forum Highlight Report -** Sarah Morley presented the Highlight Report for the meeting held on 6th June 2021. The following key items were highlighted: • Approval of the Local Partnership Annual Report; • Received the Respect and Resolution Policy. • Received a presentation on the Health and Wellbeing work being undertaken throughout the Trust. • Received an update on progress on building partnership arrangements with Trade Union colleagues. The Trust Board **NOTED** the report.	
6.4.0	**Delivering Excellence Performance Report Period May 2021** **Velindre Cancer Service** Lisa Miller provided the Trust Board with an update on the Velindre Cancer Service performance and highlighted that the report provides further details for inpatients and the Clinical Oncology Stretch Targets (COST) waiting times, in addition the following was highlighted: • SACT targets have been met; however the narrative shows the patient numbers coming through are significantly higher and the service was well under way in recruiting for the surge capacity.	

	• Outpatient waiting time showed an improvement against target. Details were provided on the long wait, which was due to the complexity of the patient's needs and the need to see a number of professionals at the appointment. Each of the long waits are reviewed on an individual basis to ensure lessons are learnt. Prof Donna Mead requested further information on the COST targets, as this was a new national target. Dr Jacinta Abraham and Cath O'Brien provided an explanation and background to the changes, the impact for the Trust and the aim of the new target to ensure that each patient's treatment was as streamlined, efficient, as timely as possible and to capture the patient experience. Stephen Harries noted a huge amount of work had been undertaken on outpatient waiting times. Whilst many patients have an appointment via telephone and video call, many patients still attend the centre. Stephen Harries asked what the service was doing to look after patients. Lisa Miller provided an update on the approach being taken by the service. The impact of not having loved ones present during difficult times remains at the forefront of staff consideration. Dr Jacinta Abraham echoed her agreement that this was an important issue and described the approach being taken by staff to support patients during their appointments. Prof Donna Mead was pleased to hear about all the measures being taken to make this experience, as good as it can be under the circumstances. However, more was needed to reduce the length of time patients have to wait and this should be the Trust's focus. Cath O'Brien confirmed pre-COVID there was a work programme for outpatients and this was adjusted to incorporate the impact of the pandemic. A plan was underway to look at how the Service can take a systematic approach to revising all systems and processes in outpatients. Mrs Cath O'Brien agreed to ensure the Trust Board was kept updated, as the Velindre Futures Programme progresses. Steve Ham informed the Trust Board that work would be undertaken as the new guidance was released and a report would be presented to the Quality, Safety & Performance Committee and to a future Trust Board. Prof Donna Mead highlighted the missing narrative that was previously provided on areas of concerns and any mitigation actions and it would be helpful to continue to include this information. Cath O'Brien agreed to include this additional information in the report, which was currently under review. Prof Donna Mead asked if part of the triage processes considered the differences between frailty and a patient being unwell. Nicola Williams confirmed they were two very different things and work was underway with the Head of Nursing and the Senior Nurse for Safeguarding to assess what could be developed to ensure both scenarios are considered as part of the triage process. The Board discussed the impact shielding was having on the confidence of people in general in coming away from their local areas and highlighted the need to consider this as part of future	

	changes, as restrictions ease. The fact the Trust has been MRSA free for 7 years helped provide reassurance and it was noted that this was down to the excellent work and commitment of staff. **WBS** Peter Richardson highlighted the continued challenges in forecasting demand and ensuring collections keep apace. Information was provided on the occasions when there has been a need to import red cells over the May bank holidays and additional actions being undertaken on forecasting demand. Gareth Jones noted the number of quality incidents not closed appeared to have declined in number from last month and asked if this was down to the change in the reporting mechanism. Peter Richardson provided an explanation and assured the Board this would continue to be monitored and reviewed. **Workforce** Sarah Morley provided the Trust Board with an update on workforce, which included information on the: • Current position on staff isolation; • Currently levels of sickness absence • PADR levels. The Trust Board **DISCUSSED** and **REVIEWED** the contents of the performance reports.	
6.5.0	**Financial Report Period 31 May 2021 (M2)** Mark Osland presented the Financial report and provided an update on: • The budget position. • The financial plan submitted to Welsh Government. • Reimbursement of COVID costs • Operational budgets • Trust reserves position Martin Veale noted the Welsh Government suspended savings plans last year and queried if this would be repeated for this year and how pay awards would be funded. Mark Osland responded the saving schemes had not been officially suspended, but supported by additional funding from Welsh Government. In terms of pay award, confirmation from Welsh Government was awaited. The Trust Board **NOTED** the contents of the May 2021 financial report and in particular the financial performance to date, and the year-end forecast to achieve financial break-even. Prof Donna Mead highlighted that today's Trust Board would be Mark Osland's last Trust Board meeting before retiring from the Trust. Prof Donna Mead thanked Mark Osland on behalf of the	

	Trust Board for the excellent stewardship of the Trust finances and resources over the last 7 years. The Trust Board wished Mark Osland a very happy and long retirement. Steve Ham echoed his thanks and highlighted he was an important part of the team, who has provided structure and a significant contribution in achieving our financial targets. Mark Osland thanked the Board for their kind comments and wished the Trust all the best in the future and success.	
6.6.0	**VUNHST Risk Register** Lauren Fear provided the Trust with an update on the Trust Risk Register work and the developments on the Trust Assurance Framework. It was noted the report has been presented to both the Audit and Quality, Safety & Performance Committees and feedback had been received on how some additional splits could be provided for the divisions/departments. It was planned for the next Trust Board there would be two papers: • All the risks that have been transferred to the Datix V14 from V12, which meets the Board's risk appetite escalation level • A report on the Trust Assurance Framework Nicola Williams provided additional information on the graph on page 5, which highlighted an anomaly due to a difference in the WBS risk rating score and how this has transferred across to the new Datix version. Work was ongoing to resolve these differences. Stephen Allen highlighted that it would be very difficult for a member of the public to understand what the report was saying; to identify the risk and to understand how the risks were going to be managed. Lauren Fear confirmed, this was a transition paper and the report should be clear, as the transition to the new Datix version continues. Martin Veale asked if there was a timeline for when the data cleansing work was to take place, which aims to ensure that only risks are transferred that are appropriate. Lauren Fear confirmed there was not a set date, as this was currently being scoped and an update will be provided to the September Trust Board. Peter Richardson highlighted the need to reconcile the need to give assurance to the Trust Board, whilst still providing evidence for the Regulatory Bodies on the risk assessment process and this balance was considered. *Mr Steve Ham left the meeting at 11:56 am.* Gareth Jones queried if the Trust was aware of the number of open risks a Trust of our size should have. Lauren Fear confirmed she would take the opportunity to undertake a benchmark	

	exercise, as part of the project and would provide an update in the report for the next Trust Board. Prof Donna Mead appreciated work was ongoing and asked if there were risks the Board were unaware of whilst waiting for the risk register to be presented. Lauren Fear explained in terms of assurance the Annual Report provided details of the most significant risks to the organisation. This included a check on whether there was anything that had not been reported through the governance channels. The Trust Board: • **NOTED** the content of this report. • **NOTED** that work has resumed to implement a new risk process. • **NOTED** that closure of risks was being monitored and that follow up reports would be presented to the Board. If the risk register was not fully populated an update report would be provided	**Lauren Fear**
7.0.0	**STRATEGIC DEVELOPMENT**	
7.1.0	**Strategic Development Committee Highlight Report** Stephen Harries provided the highlights from the Strategic Development Committee held on 10th June 2021 and the Extraordinary meeting of 28th June 2021: • There were no items for escalation to the Board. • The Committee received an update on the ongoing development of the Acute Oncology Service and the business case. • An update was received on the WBS Infrastructure of Talbot Green business case. • An update on the Digital Health & Care records for the replacement of CANISC. • An update received from the Estates Department on the legal responsibility/ownership for the new Velindre Cancer Centre. • The Extraordinary meeting was a single agenda to consider the Integrated Medium Term Plan, which was considered and endorsed for approval. The Trust Board **NOTED** the contents of the report and actions being taken.	
7.2.0	**Transforming Cancer Services Programme Scrutiny Sub-Committee Highlight Report** Stephen Harries provided an update from the Sub-Committee meeting held on 20th July 2021 and received updates on the: • Finance report; • the risk register; • the communication and engagement plan.	

	The Trust Board **NOTED** the contents of the reports and actions being taken.	
7.3.0	**Transforming Cancer Services Communication & Engagement Update** Lauren Fear provided an update on the activities undertaken since the last meeting, including: • Stakeholder Engagement both face-to-face and via social media. • The Digital conversation through 'Velindre Matters' social channels. • The Radiotherapy Satellite Centre engagement and events. • The establishment of a Patient Engagement Steering Group, which was being chaired Hilary Jones. Prof Donna Mead thanked the Communication Team for their hard work on all the activities. Martin Veale asked what other social channels the Trust has. Lauren Fear confirmed the Velindre Matters twitter feed and Facebook page are used. It was agreed there was a need to reconsider what other channels the Trust should be using or linking into and this would be included in a future report. The Trust Board **NOTED** the report.	
7.4.0	**Equality, Diversity & Inclusion Ambassadors** Sarah Morley provided a background to this item and explained this was a new approach to equality, diversity and inclusion through our Executive Team Ambassadors and Workforce and Organisational Development Ambassadors. The purpose of the report was to outline the active measures being planned to challenge discrimination and to achieve shared ownership of the equality, diversity and inclusion agenda at all levels of the organisation. Martin Veale requested to be involved in discussions about Equality, Diversity and Inclusion (ED&I), as this work develops; this was agreed. Stephen Harries asked for further information on the ED&I pledge. It was noted the graphic on page 6 did not represent the Equality Act categories, but was an interpretation and it was agreed this needs to be updated. Prof Donna Mead noted that she had discussed this topic with Sarah Morley and it was agreed, there was a need for Board Development Sessions to be scheduled to ensure the Independent Members are kept updated and involved in this fast moving area of work. It was agreed this would be included in the Board Development Programme. Janet Pickles highlighted the need to ensure we have confidence in the language used and it would be beneficial for all if this was included in the Board Briefing Session to allow open conversations to take place.	

	The Trust Board **NOTED** the update and that Martin Veale is to be involved in developing this work.	
7.5.0	**Equality Ambassadors Showcase: Race** Dr Jacinta Abraham and Sarah Morley provided the Board with a presentation on Race Equality. Sarah Morley provided some context and background information. Dr Jacinta Abraham took the Board through the Trust's Race Profile and the activities the Trust has already undertaken, what this means for the Trust, patents, donors and staff. Sarah Morley also provided the Board with information on the next steps. *Ceri Harries, Equality & Diversity Manager joined the meeting at 12:47.* Prof Donna Mead endorsed the actions and requested that the Trust's Charity was included in this work, Sarah Morley confirmed this would happen. David Cogan asked if the work would consider patients or include Patient Liaison Group and volunteers. Sarah Morley confirmed the agenda covered patients, donors and staff and this would be included. Martin Veale highlighted the need to have representation from all sectors of society on the Board. It was noted that whilst this was out of the Trust's control, as they are a Welsh Government appointment, the Trust was planning to share the current recruitment campaign as wide as possible and Prof Donna Mead would be grateful for any assistance in supporting distributing the advert as widely as possible. The Trust Board **NOTED** the contents of the presentation. *Ceri Harris left the Trust Board meeting at 13:03.*	
8.0.0	**INTEGRATED GOVERNANCE**	
8.1.0	**Audit Committee Highlight Reports** Martin Veale provided the highlight report of the Extraordinary Audit Committee meeting held on the 8 June 2021 to receive the Annual Report and Accounts. Martin Veale first wised to echo his thanks in addition to those previously made from the Board to Mark Osland. Martin Veale highlighted the difficulties in producing the Annual Accounts whilst staff are working from home and in spite of this an excellent high quality set of accounts had been produced. Martin Veale highlighted the Committee's disquiet with Audit Wales final opinion and that there are lessons to be learnt from this. The Board has signed off the Trust's Annual Accounts. The second highlight report included for the Board was of the meeting held on the 8 July 2021.	

	It was noted this was the first meeting since the transition of NHS Wales Informatics Service to Digital Care Wales. The below key messages were highlighted: • Receipt of the Model Standing Orders and Standing Financial Instructions; • Update on Risk Register; • An update on the General Assurance Framework; • Private patient debts. ; It was noted the Structured Assessment Phase 1 Report on Operational Planning was a very positive report and there was nothing arising from this. Phase 2 was planned for the Spring 2022. The Board requested that it continues to receive updates on the private patient debts, as part of the highlight report and this was agreed by Martin Veale. The Trust Board **NOTED** the contents of the report and actions being taken.	**Mark Osland**
9.0.0	**ANY OTHER BUSINESS** Prof Donna Mead informed the Trust Board that this is Prof Donald Fraser's last meeting as an Independent Member for the Trust Board after taking the difficult decision to step down due to the unprecedented clinical demands placed on his time following the onset of the pandemic. Prof Donna Mead wished to take this opportunity to thank Prof Donald Fraser on behalf of the Trust Board for his excellent input into the Board.	
10.0.0	**DATE AND TIME OF THE NEXT MEETING** 30th September 2021 at 10 am - 3.30 pm	
11.0.0	**CLOSE** The Board was 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	30/09/2021

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	19/07/2021	Approved
Trust Board Members – Via Email	21/07/2021	Approved
Trust Board Members – Via Email	02/09/2021	Approved

ACRONYMS	
CAP2	Commercial Appointment Review
NWSSP	NHS Wales Shared Services Partnership
PQQ	Pre-qualification Questionnaire
PPE	Personal Protective Equipment

1. SITUATION/BACKGROUND

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

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

1.3 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 15 July 2021 – 17 September 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 **15 July 2021** to the **17 September 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 19 July 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 30 September 2021 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Stephen Harries, Independent Member
- Martin Veale, Independent Member
- Mark Osland, Executive Director of Finance

A number of clarifications were required and subsequently provided. No objections to approval were received.

2. Pre-qualification Questionnaire (PQQ) Evaluation Report

The Trust Board were sent an email on the 21 July 2021, inviting the Board to **APPROVE:**

- The PQQ Evaluation Report for submission to Welsh Government Commercial Appointment Review (CAP2) process.
- Invite the three successful Economic Operators to participate in the Dialogue process.

Due to the urgency of this matter, it could not wait until the 30 September 2021 Trust Board meeting.

Recommendation Approved:

- Professor Donna Mead, Chair
- Steve Ham, Chief Executive Officer
- Stephen Harries, Independent Member
- Hilary Jones, Independent Member

No objections to approval were received. It was also confirmed that the Trust appointed Legal Advisors have carried out a review of the full PQQ Evaluation Report from a reporting perspective (i.e. they have not reviewed the application of the scoring methodologies and

reconvened evaluation teams for moderation). This was as reported to the Transforming Cancer Services Scrutiny Committee on the 20 July 2021. As a result, the Board were advised that there has been some clarification to the report language and the outline of the process followed, in particular in relation to the Change of Circumstances.

3. Pre-qualification Questionnaire (PQQ) Evaluation

The Trust Board were sent an email on the 2 September 2021, inviting the Board to **APPROVE** the updated PQQ Evaluation Report for submission to Welsh Government.

Due to the urgency of this matter it could not wait until the 30 September 2021 Trust Board meeting.

Recommendation Approved:

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

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 30 September 2021 to 25 November 2021

DATE OF MEETING	30 September 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	Mark Osland, Executive Director of Finance
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance

REPORT PURPOSE	**FOR APPROVAL**

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Business Planning Group Velindre Cancer Service Senior Leadership Team	August 2021	Supported
Capital Planning & Performance Group Welsh Blood Service Senior Management Team	August 2021	Supported
Executive Management Board	September 2021	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 **30 September 2021** to **25 November 2021** are highlighted in this report.

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.

2. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Please refer to **Appendices 1 – 3** for the detailed appraisals undertaken of each of the expenditure proposals that the Trust Board is asked to **APPROVE**.

2.2 The table below provides a summary of the decisions that are sought from the September 2021 meeting of the VUNHST Board:

Appendix No.	**Division**	**Scheme / Contract Agreement Title**	**Period of Contract**	**Total Expected Maximum Value of Contract £ (Inc. VAT)**
Appendix 1	VCC	Fluoroscopy Suite Upgrade	Start: February 2022 End: January 2029	£559,000
Appendix 2	VCC	Replacement of the Brachytherapy Applicators at Velindre Cancer Centre	Start: January 2022 End: December 2024	£264,925

Appendix 3	WBS	International Stem Cell Courier Contract for WBMDR	Start: 01/11/2021 End: 31/10/2026 Option to extend for 3+1+1	£510,000

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 Appendix 1 of this report.

4. RECOMMENDATION

4.1 The Trust Board is requested to **APPROVE** the commitment of expenditure summarised within this paper and supporting appendices.

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

SCHEME TITLE	FLUOROSCOPY SUITE UPGRAGE
DIVISION / HOST ORGANISATION	Velindre Cancer Centre
DATE PREPARED	August 2021
PREPARED BY	MIKE BOOTH, RADIOLOGY MANAGER
SCHEME SPONSOR	PAUL WILKINS, DIRECTOR OF VCC

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

The fluoroscopy suite is an imaging modality in Radiology that constitutes the primary plain film (X-Ray) source but also doubles as a fluoroscopic unit where real time imaging is essential to guide interventional procedures. The current unit is now 10-years old with a guide life-span of 7-10 years. Beyond this time-span Original Equipment Manufacturers (OEM's) reduce their support with unexpected/unscheduled breakdown's taking longer to resolve due to parts/labour scarcity.

The unit is currently out-of-action (6th August 2021) awaiting parts but no scheduled delivery date has been given. The unit is though the only modality that can support fluoroscopic interventional procedures in Velindre Cancer Centre (VCC) and therefore represents a very real single point of failure for some line-placements or drainage procedures. It is also our only source of Digital X-Rays and plays a pivotal role in plain film delivery for patients attending the department.

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	February 2022
Expected End Date of Contract	January 2029
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**
	☒	☐
At the time of the last IMTP submission in 2019 it was hoped the equipment could be sustained until the new VCC. However, subsequent delays including COVID have highlighted this as a capital prioritisation for Radiology to support service delivery for the next five years.		

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 One - Do nothing and assume the unit will be viable for the next five years to NVCC. However the current 'downtime' is proving difficult to resolve with scarce essential parts available and also operates on a windows XP platform which has enabled a virus in the software requiring a full software reload. **Options Two -** Transfer all acute patients requiring Radiology fluoroscopic intervention to their local Health Board for treatment with the subsequent loss of reputation for VCC. **Options Three -** Replace as recommended to bridge the interim up-to the NVCC enabling acute intervention to continue at VCC and provide essential Plain film X-Rays, a core component of our work in Radiology.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
- Maintain acute interventional service - Maintain plain film service delivery - The new unit will hold a full seven year warranty with OEM service support guaranteeing rapid resolution of faults It will also comfortably bridge the years prior to the NVCC. - Preserve VCC reputation - Prevent transfer of Oncology patients back to HB's for intervention, historically performed on-site. - Radiology Intervention is generally a minimally invasive solution to many acute symptoms benefiting the patient without need for transfer to local HB.

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
Longer periods of breakdown and more frequent periods due to age of equipment and problems sourcing parts. Equipment critically fails mechanically or from a qualitative service perspective, driving requirement to replace in future years.	Ultrasound can be utilised for some conditions but where required, transfer for fluoroscopy to a local HB is the only solution.

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

Procurement will be through a Mini competition through the NHS Supply Chain Framework agreement, as a new contract.

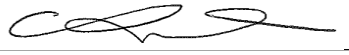
6.3 What is the approximate time line for procurement?

Welsh Government have confirmed the availability of capital monies to undertake the procurement.

Approval from the Trust Board to allow expenditure over £100,000 is expected in September 2021. After approval has been received, the project team with procurement can commence a formal tender exercise, agree a date for the upgrade which allows the radiology service to put contingency plans in place, to ensure patients can continue to be scanned. The project requires completion within the 21/22 financial year due to the funding source (Welsh Government).

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:	07/09/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£465,833**	**Including VAT (£k)** **£559,000**
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:		

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**
Cost of upgrade	£335,833	£0	£0	£0	£335,833	£403,000
Refurbishment costs of fluoroscopy suite	£10,000	£0	£0	£0	£10,000	£12,000
Maintenance contract (7-years)	Warranty period	£20,000	£20,000	£80,000	£120,000	£120,000
Overall Total	£345,833	£20,000	£20,000	£80,000	£465,833	£559,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The upgrade is being overseen by the Fluoroscopy Upgrade Project Group,

	chaired by the Planning and Performance Manager, with input from the radiology service, finance, estates and procurement. Meetings are held fortnightly, with project documentation submitted to the Divisional Senior Leadership Team (SLT) and Radiation Services Development and Delivery Group (D&D).

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:	Paul Wilkins
Signature:	
Service Area:	Director of Cancer Services
Date:	01/09/2021

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	12th August 2021
Divisional Senior Management Team	19th August 2021
Executive Management Board	6th September 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	REPLACEMENT OF THE BRACHYTHERAPY APPLICATORS AT VELINDRE CANCER CENTRE
DIVISION / HOST ORGANISATION	VCC
DATE PREPARED	JULY 2021
PREPARED BY	JANE POWELL
SCHEME SPONSOR	PAUL WILKINS, DIRECTOR, VCC

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

1. DESCRIPTION OF GOODS / SERVICES / WORKS

Brachytherapy is an essential component (along with external beam radiotherapy and chemotherapy) in the treatment of patients with gynaecological cancers. It is delivered by placing applicators inside the patient into which radioactive sources are inserted to deliver the required treatment dose of radiation.

The current CT/MR compatible applicators used for gynaecological brachytherapy will reach end of life in January 2022. The applicators have a life expectancy of 3 years or 300 uses, whichever comes first. The brachytherapy (Flexitron) treatment unit was replaced in 2018, however the applicators require more frequent replacement (every three years) due to the sterilization process between uses and exposure to radiation.

The applicators are to be supplied by a single vendor agreement as they need to be compatible with the current brachytherapy (Flexitron) treatment unit. This is a like for like replacement.

The image guided gynaecological brachytherapy service is funded by WHSSC and provides a brachytherapy service for the whole of south Wales. If the applicators are not replaced, Velindre Cancer Centre will not be able to offer brachytherapy to patients for their cancer treatment.Continuing to use the existing applicators beyond the manufacturer's end of life gives increased risks to patient and staff safety.

As mentioned, due to the irradiation and repeated sterilisation process required after each use, the applicators become more brittle and prone to damage. If an applicator were to crack or break, injury could occur to the patient or staff through laceration or stick injury. The high activity

radioactive source may become stuck in the broken/damaged applicator and be unable to retract delivering a significantly higher dose to the patient than intended and irradiating staff during its removal. This would result in a serious incident for the hospital and potential risk of litigation.

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	January 2022
Expected End Date of Contract	December 2024
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**
	☒	☐
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 brachytherapy applicators are not replaced, we will not be able to provide the image guided gynaecological brachytherapy service for South Wales, which is funded by WHSSC and is an essential component for the successful treatment of this patient cohort. **Option 2 – replace the applicators (recommended)** – this would ensure that patients will continue to receive their cancer treatment safely and allow VCC to continue offering this commissioned service. **Other options considered but not taken forward:** As part of this process, it was considered whether some applicators could be purchased in this financial year and some in the next financial year, thus splitting the cost to the Trust over two years. This was explored but not taken forward because it was confirmed that the full set of applicators is required, as the set includes applicators of different shapes and sizes, so that these can be compatible with different patient size and shape. It was also confirmed that when previous applicators have been purchased, the full set has been required.

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option
Purchasing the applicators will allow brachytherapy treatment to continue at Velindre Cancer Centre. This is a service commissioned by WHSSC and is an essential cancer treatment for gynaecological cancer 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
If the brachytherapy applicators are not replaced, we will not be able to provide the image guided gynaecological brachytherapy service for South Wales, which is funded by WHSSC and is an essential component for the successful treatment of this patient cohort.	There is no mitigation. Discontinuation of service would lead to patients being sent to centres outside Wales for treatment. Unwell patients would have to travel considerable distances for weekly treatments. Other centres are already working at full capacity, so increasing waiting times of patients from all South Wales for treatment or suboptimal treatments, both significantly impacting patient survival. . Current specialised staff would be made redundant and deskill. VCC provides the only brachytherapy service in Wales.

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

The applicators will be purchased via a Direct Award through the NHS Supply Chain Framework agreement, as applicators must be purchased from the manufacturer of the Flexitron treatment machine.

6.3 What is the approximate time line for procurement?

Once approval from the Trust Board is received for the purchase, the Direct Award can be exercised. The applicators will be delivered within 6 weeks from order.
There is no clinical downtime associated with the commissioning process for the new applicators, therefore no patient treatment will be disrupted or delayed due to the replacement.

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:	03/09/21

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k)** **£220,770**	**Including VAT (£k)** **£264,925**
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.		

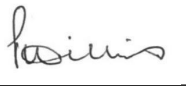
PROFILE OF EXPENDITURE

EXPENDITURE CATEGORY	**Year 1 (exc. VAT) £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**
Cost of applicators	£220,770	0	0	0	£220,770	£264,925
Overall Total	£220,770	0	0	0	£220,770	£264,925

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	The replacement is being overseen by the brachytherapy team and the Planning team at VCC, with input and approval from the VCC Business Planning Group and SLT.

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:	Paul Wilkins, Director of VCC
Signature:	
Service Area:	VCC
Date:	1.9.21

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	12th August 2021
Divisional Senior Management Team	19th August 2021
Executive Management Board	6th September 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	**International Stem Cell Courier Contract for WBMDR**
DIVISION / HOST ORGANISATION	WBMDR/WBS
DATE PREPARED	09/06/2021
PREPARED BY	Chris Harvey
SCHEME SPONSOR	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

Procurement of a courier to transport stem cells from international centres on behalf of the University hospital of Wales, Cardiff.

The full expenditure of this service is recoverable, at cost, from the University hospital of Wales.

The Welsh Bone Marrow Donor Registry [WBMDR] has a requirement to transport clinical material to Transplant Centres of WBMDR (currently UHW), form various locations throughout the world. Such transportation must comply with UK law (Human Tissue Act 2004) and WMDA guidelines.

Due to the nature of the product and the critical importance of timely delivery to the destination, transportation must be via a suitably trained courier, who will accompany the product from the time of collection at the collection centre until handover to a transplant centre representative within University Hospital of Wales (Cardiff).

Transportation of the cells by the courier must be undertaken against agreed deadlines with very little room for deviation and using specialist and validated equipment such as transport boxes utilising temperature loggers that monitor the cells from departure at the collection centre to arrival at the transplant centre.

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	01/11/2021
Expected End Date of Contract	31/10/2026
Contract Extension Options **(E.g. maximum term in months)**	3+1+1

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.
Not applicable

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 – reason for declining:

- *Catastrophic impact to patient treatment if the WBMDR were unable to facilitate the import of stem cells for welsh patients awaiting transplant*

- *National and International reputational damage which would undermine the ability to recover to normal levels of service and impact on the export of Welsh donor cells to non-Welsh patients as well as the import activities.*
- *Regulatory (HTA) licence would be put at risk*
- *Significant financial impact to the Service, WBS and the wider Trust*

Bring in-House – reason for declining

- *The logistical complexity of arranging the pick-up of stem cell from another country including arranging a volunteer courier, arranging flights including contingency flights for second day collections, arranging all border control documentation etc*
- *Identifying volunteer couriers that have the time and ability to complete the task*
- *Risk involved with transport of cells including experience at border control, reactive to bumped or cancelled flights.*
- *WBMDR staff would need to be in an on-call type situation to react to issues and problems highlighted by the volunteer courier – this could be at ANY time from the moment the courier leaves the WBS to the moment they arrive at UHW*

4. BENEFITS (Quantifiable / Non-Quantifiable)

4.1 Outline benefits of preferred option

Continue with tender process:

Benefits of this option:

- Ability to maintain stem cell provision for Welsh patients
- Removes the risk to Welsh patient treatment
- Sustainable business model
- Complies with Procurement Regulations. The Current contract was tendered for in 2012, therefore, by completing a new tender process, we will implement a compliant contract, while testing the market for Value for Money.

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 facilitate the import of stem cells in manner that complies with the Human Tissue Authority (HTA) regulations. *Extension of current contract is outside of procurement law*	*There is no mitigation that could reduce this risk as the HTA regulations are clear that any 3rd party supplier of a service is required to be held under contract or SLA.* *No Mitigation exists*

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	☐
Please click here for link to Procurement Manual for additional guidance			
6.2 Please outline the procurement strategy			
The procurement strategy is to release an open market tender, which will be published in all relevant journals, including Find a Tender and Sell2Wales.			
6.3 What is the approximate time line for procurement?			

Contracting Stage	Anticipated Date/Timescales	Responsibility
Briefing paper / Estimates return	06/05/2021	Service
Tender Issued	22/07/2021	Procurement
Tender Return	23/08/2021	Procurement
Evaluation	w/c 06/09/2021	Procurement/Service
Clarifications to Suppliers	13/09/2021	Procurement
Board Paper In	16/09/2021	Service
Board Paper Approval	30/09/2021	Board
Ratifications Out / Return	07/10/2021	Procurement
Publish Award (prior to 10 day standstill period)	21/10/2021	Procurement
Contract Start	01/11/2021	Procurement

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:	6th September 2021

7. FINANCIAL ANALYSIS

Maximum expected whole life cost relating to the award of contract	**Excluding VAT (£k) 425,000**	**Including VAT (£k) 510,000**
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:		

PROFILE OF EXPENDITURE

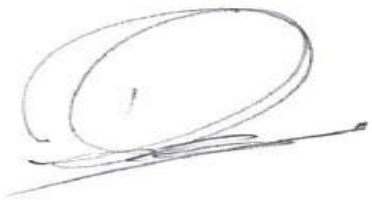
EXPENDITURE CATEGORY	Year 1 (exc. VAT) £k	Year 2 (exc. VAT) £k	Year 3 (exc. VAT) £k	Total Future Years (exc. VAT) £k	Total (exc.VAT) £k	Total (inc. VAT) £k
Revenue Budget	85,000	85,000	85,000	170,000	425,000	510,000
Overall Total	85,000	85,000	85,000	170,000	425,000	510,000

8. PROJECT MANAGEMENT (if applicable)

What are the management arrangements associated with this scheme? E.g. PRINCE 2	*Not applicable, there is no project wrap around the requirement*

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:	03/08/2021

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	05/08/2021
Divisional Senior Management Team	11/08/2021
Executive Management Board	06/09/2021

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

TRUST BOARD

APPROVED POLICIES UPDATE

DATE OF MEETING	30/09/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Emma Stephens, Head of Corporate Governance
PRESENTED BY	Emma Stephens, Head of Corporate Governance
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**
Charitable Funds Committee	14/09/2021	APPROVED
Quality, Safety & Performance Committee	15/09/2021	APPROVED

ACRONYMS	
CFC	Charitable Funds Committee
QSP	Quality, Safety & Performance Committee

1. SITUATION/BACKGROUND

1.1 In accordance with the "Policy for the Management of Policies, Procedures and other Written Control Documents", the Trust Board will receive all approved policy documents for information under the consent agenda.

1.2 The purpose of this report is for the Trust Board to note the policies that have been approved since the last report in July 2021.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Following approval at the relevant Committees the policies below were uploaded to the Trust Intranet and internet site and circulated via the policy distribution list for immediate implementation.

2.2 The list of Policies approved since the report received by the Trust Board are outlined below:

Policy Title	Policy Lead / Function	Approving Committee	Effective Date
Charitable Funds Investment Policy	Finance	Charitable Funds Committee	15 September 2021
All Wales Reserve Forces Training and Mobilisation Policy	Workforce	Quality, Safety & Performance Committee	16 September 2021
All Wales Secondment Policy	Workforce	Quality, Safety & Performance Committee	16 September 2021

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The Trust has a defined process for the management of policies and written control documents. The purpose of which is to ensure staff are aware of their responsibilities with regards to Trust policy documents and to provide a 'model' guide and consistent approach for the development, management and dissemination of the Trusts documents
RELATED HEALTHCARE	Governance, Leadership and Accountability

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

4. RECOMMENDATION

4.1 The Trust Board is asked to **NOTE** the policies that have been approved since the last report in July 2021.

Ref: CFC 004

Charitable Funds Investment Policy

Date to be reviewed:	September	**No of pages:**	11
Author job title(s):	Deputy Director of Finance		
Responsible dept /director:	Executive Director of Finance		
Approved by:	Charitable Funds Committee		
Date approved:	15 September 2021		
Effective Date (live):	15 September 2021		
Version:	4		

Date EQIA completed	7 August 2021
Documents to be read alongside this policy:	This policy should be read in conjunction with the following information: • Terms of Reference of the Investment Performance Review Sub-Committee • The Trustees Act 2000 • CC14 Charities and Investment Matters: A Guide for Trustees

Current review changes

Reviewed in accordance with the agreed policy review period.
Item 4.1 – Wording updated
Item 6.1 – Recommended cash balances have been removed
Items 8.2 and 8.3 – Wording amended/updates
Items 8.7 – Access to funds updated to reflect agreement with new investment.

Version 4 changes:

General review and update to reflect change in Trust status to 'University NHS Trust'
Item 10 Restraints on Types of Investments:
10.1 c) Companies that derive a significant proportion of their income from Fossil Fuels added to the exclusion criteria
10.1 d) investment in companies that are deemed to have an approach to risk mitigation around the issues of ethical employment considered 'Weak' by VE and paragraph to describe the organisation VE and their assessment approach

Executive Summary:
The purpose of this policy is to formalise the responsibilities of Velindre University NHS (UNHS) Trust Charitable Funds Trustees in respect of the management of charitable fund assets held by the Trust.

First operational:	Date: July 2012

Previously reviewed	June 2018			
Changes made: Yes	November 2018	June 2021		

Charitable Funds Investment Policy

Contents

Charitable Funds Investment Policy

1. Policy Statement

This policy has been prepared following the request by Velindre UNHS Trust Charitable Funds Committee to ensure that our organisation is managing appropriately and transparently the charitable funds assets and complying with all the legal regulations, guidance and best practices established by governmental and regulatory bodies.

- This policy takes into consideration
  - Maintenance of liquidity levels.
  - Investments of charitable assets.
  - Minimum level of return required.
  - Surplus funds.
  - Restraints on types of investments.
  - Pooling of investments.
  - Fund management by Investment advisors and Investment subcommittee.

2. Purpose

The purpose of this Policy is to formalise the responsibilities of the Trustees in respect of the management of the Charitable Fund's assets held by the Trust and to translate these responsibilities into an investment strategy which complies with the Trustees Act 2000 and incorporates best established practice by:

- Ensuring that when investing Charitable Funds, Trustees achieve an appropriate balance for the charity between the two objectives of:
  - Providing an income to help the charity carry out its purposes effectively in the short term; and
  - Maintaining and, if possible, enhancing the value of the invested funds, so as to enable the charity effectively to carry out its purposes in the longer term.

- Ensuring that the following standards as defined in **the Trustee Act are followed**, whether they are using the investment powers in that Act or not:
  - That the Charity is discharging its general duty of care (as described in section 1 of the Trustee Act), which is the duty to exercise such care and skill as is reasonable in the circumstances. This applies both to the use of any power of investment and

to the discharge of the specific duties which the Act attaches to the use of investment powers. A higher level of care and skill is expected of a Trustee who is or claims to be knowledgeable about or experienced in investments, or who is paid.

- Secondly, that the Charity is complying with the following **specific duties**:

  - Trustees must consider the **suitability** for their charity of any investment. This duty exists at two levels. The Trustees must be satisfied that the type of any proposed investment (e.g. a common investment fund or a deposit account) is right for their charity (including whether it is consistent with an ethical investment policy if the charity has one). They also have a duty to consider whether a particular investment of that type is a suitable one for the charity to make. Trustees should, at both levels, try to consider the whole range of investment options which are open to them; how far they should go here will, of course, depend on the amount of funds available for investment.

  - Trustees must consider the need for diversification, i.e. having different types of investment, and different investments within each type. This will reduce the risk of losses resulting from concentrating on a particular investment or type of investment. Again, how far the Trustees can go here will depend on the amount of funds available for investment.

  - Trustees must periodically review the investments of the charity. The nature and frequency of these reviews is up to the Trustees to decide, but the reviews should be proportionate to the nature and size of the charity's investment portfolio. To review too infrequently may result in losses or missed opportunities; chopping and changing investments too frequently may incur unnecessarily high levels of transaction charges. It is recommended that a review of the investments should be carried out at least once a year.

  - Before exercising any power of investment, and when reviewing the charity's investments, Trustees must obtain and consider proper advice from a suitably qualified adviser (who may be one of the Trustees), unless the size of the funds available for investment is so small that seeking investment advice would not be cost effective.

- Ensuring that the Investments Clauses defined in the Governing Document from January 1995 (Section D Trustees Powers) are followed.

3. Scope

3.1 This policy applies to all Velindre UNHS Trust Employees and Independent Members, particularly to Charitable Funds Committee Members, Investment Subcommittee Members and Investment advisors.

3.2 The term “Employees” includes all those who have a contract of employment or honorary contract with the Velindre UNHS Trust.

4. Aims and Objectives

4.1 Trustee’s objective(s) in investing its funds:
The Trustees have agreed that the Charity Committee Funds’ investment objective is to as a minimum **MAINTAIN CAPITAL** over the medium term, and to **PRESERVE CAPITAL** where an income from the Trust Investment is required; however, the priority is to maintain the value of the Trust Capital after the effect of inflation.

5. Roles and Responsibilities

5.1 The Trust Board as the Corporate Trustee Recognises its overall responsibilities for investment decisions and the need to demonstrate that they have retained overall control of decision making and have complied with their duties regarding investing Velindre UNHS Trust Charitable Funds, therefore the Trustees have agreed:

- That the Trustees and the Investment Manager are the only authorised parties able to take any decisions regarding Velindre UNHS Trust Charitable Funds Investments. These decisions have to be agreed between both parties before any action is taken.

- The Charitable Fund Committee and the Investment Performance Review Sub Committee advise the Board on the more detailed aspects of its investment policy and performance. The Terms of Reference of the Investment Performance Review Sub Committee are attached to this policy.

- The Trustees have agreed that details of their investment approach and key decision are recorded in writing in order to demonstrate that they have considered the relevant issues, taken advice appropriately and reached a reasonable decision.

- The Trustees have a formal written contract with the Investment Manager. In this agreement the Investment manager is required to follow Velindre UNHS Trust Charitable Funds Investment Policy. In this agreement the Trustees have specifically requested that The Investment Manager must not:

    - Appoint a substitute or select their own successor.
    - Reduce the normal duty of care, or places a cap on his liability for breach of contract.
    - Act in situations that might give rise to a conflict of interest unless it is reasonably necessary for them to do so.

5.2 This policy also precludes Trustees from profiting from their office.

6. Maintenance of Liquidity Levels

6.1 The Trustees shall require that a proportion of Trust Fund assets be held in immediate and short term liquid forms. These shall be:

a) Current Bank Account

The level of funds held in this account shall be as minimal as possible which is consistent with the requirement to fund all normal transactions.

b) Locally Controlled Deposit Account

The level of funds held in this account should be sufficient to provide an adequate buffer between the daily needs of the funds as financed by the current account, and the main portfolio consisting of medium and long term investments. This should obviate the necessity to prematurely liquidate assets to the potential detriment of the portfolio. The actual level will be monitored and delegated to the discretion of the Charitable Funds Investment Performance sub Committee.

c) Deposit Account Held by Investment Managers

The level of funds held in this account should be sufficient to provide a buffer between the locally held cash resources and the main portfolio. The establishment of a balance level will be delegated to the discretion of the Charitable Funds Investment Subcommittee and the Investment advisor / fund manager in managing the portfolio in total.

6.2 The Trust's officers shall be required to monitor locally held balances and commitments and inform the Investment subcommittee members and the investment manager at the earliest opportunity should it appear likely that a cash call may be required.

6.3 Investment Sub-Committee Members and Trust Officers shall be required to monitor a least every six months that the returns on Cash and cash-like investments are in line with or exceed benchmarks.

7. Investment of Charitable Assets

7.1 The Trustees must attempt to maximise the investment return on the charitable funds whilst minimising the risk to the funds themselves. Furthermore, the Trustees have a legal duty to avoid speculative forms of investment.

7.2 The Trustees Act 2000 gives to the Trustees "The General Power of Investment" where a Trustee may make any kind of investment that they could make if they were absolutely entitled to the assets of the trust. Under this Act the Trustees have to observe the following Clauses:

7.3 The general power of investment does not permit a Trustee to make investments in land other than in loans secured on land.

7.4 A person invests in a loan secured on land if he has rights under any contract under which —

(a) One person provides another with credit, and
(b) The obligation of the borrower to repay is secured on land.

7.5 In exercising any power of investment, whether arising under this Part or otherwise a Trustee must have regard to the standard investment criteria set out below:-

7.6 The Trustees must from time to time review the investments of the trust and consider whether, having regard to the standard investment criteria, they should be varied.

7.7 Before exercising any power of investment, whether arising under this Part or

otherwise, a Trustee must (unless the exception below applies) obtain and consider proper advice about the way in which, having regard to the standard investment criteria, the power should be exercised.

7.8 When reviewing the investments of the trust, a Trustee must (unless the exception applies) obtain and consider proper advice about whether, having regard to the standard investment criteria, the investments should be varied.

7.9 The exception is that a Trustee need not obtain such advice if he reasonably concludes that in all the circumstances it is unnecessary or inappropriate to do so.

7.10 Proper advice is the advice of a person who is reasonably believed by the Trustee to be qualified to give it by his ability in and practical experience of financial and other matters relating to the proposed investment.

8. Investment Risks and Profile

8.1 The Trustees recognise that all investments involve an element of risk. The level of risk that is appropriate for the Trust will be influenced by various factors, including the Trustees' attitude to risk, the Trust's capacity to afford potential investment losses and its investment objectives.

8.2 The Trustees in Order to mitigate the Capital Risk have agreed to request the investment advisor / manager to maintain a diversified portfolio of assets in order to protect the charity's investments from sudden variations in the market.

8.3 The Trustees in order to attempt minimising the risk to Velindre UNHS Trust Charitable Funds, have agreed to operate within a lower risk investment strategy, which means that investments will be skewed significantly to less volatile asset classes such as high quality investment grade corporate and sovereign bonds. Riskier assets such as equities, alternative investments and commodities may be selected but they are likely to play a less significant role.

8.4 The Trustees have determined that the purpose of the Velindre UNHS Trust Charitable Funds investment has been categorised as **GENERAL** with no specific investment purpose. The time horizon for the Trust general investment account is between 5 to 7 years.

8.5 The Trustees have requested that the Assets allocation should be distributed following the best advice from the Investment Manager and its direct effect in having a lower risk Investment strategy.

8.6 The Asset Classes allocation considered by the Trustees should include the following:

- Cash
- Sovereign Fixed Income
- Corporate Fixed Income
- Developed Market Equity
- Emerging Market Equity
- Private Equity
- Commodities
- Absolute Return

8.7 In agreement with the investment managers funds are realisable within 2 weeks.

9. Surplus Funds

9.1 Where the level of capital and income growth achieved is greater than the annual rise in the cost of living the Trustees may, at their discretion, determine to expend surpluses arising in subsequent periods or to re-invest for further income growth.

10. Restraints on Types of Investments

10.1 This policy sets out four investment constraints namely:

a) Capital held in perpetuity shall be separately identified. This capital may not be expended until notified by the Trustees. Furthermore, the Trustees shall be bound by any constraints established in the trust document or bequest.

b) Investments shall comply with the rules and regulations of the Trustees Act 2000.

c) At the discretion of the Trustees investment in companies whose trade is inconsistent with the aims of the Velindre UNHS Trust may be expressly precluded. The Trustees may not, however, preclude investments in companies for any other reason e.g. political. **HOWEVER, SUCH EXCLUSIONS AS EXPRESSLY IDENTIFIED BY THE TRUSTEES ARE COMPANIES WHO DERIVE A SIGNIFICANT PROPORTION OF THEIR INCOME FROM FOSIL FUELS, GAMBLING, TOBACCO, ALCOHOL AND ARMOURMENT ACTIVITIES.**

d) At the discretion of the Trustees investment in companies that are deemed to have an approach to risk mitigation around the issues of ethical employment considered 'Weak' by VE. VE are an organisation that provides a risk rating in relation to the Environmental, Social & Governance (ESG) factors of a company that can be brought into the financial decision making of investors.

VE assess four areas of ethical employment (fundamental labour rights; non-discrimination; child and forced labour; social standards in the supply chain), three criteria are examined (frequency of allegation; severity of allegation; responsiveness to the issue raised). The ratings for each of the three criteria are then aggregated to give an overall rating for the company's perceived risk mitigation (advanced, robust, limited, weak).

11. Selection of Investment Managers

11.1 The Charitable Funds Committee's recommendations to the board of Trustees regarding the selection of investment manager(s) must be based on prudent due diligence procedures. A qualifying investment manager must be a registered investment advisor under the Investment Advisor Act of 1961, or a bank or insurance company which is authorised and regulated by the Financial Services Authority.

11.2 Investment Managers are to be reviewed at a minimum of five years.

11.3 A Trustee of the Velindre UNHS Trust Funds is specifically excluded from providing

investment advice, even though they may be so authorised.

12. Fund Management – Delegation of Investment Advisors

12.1 This Investment Policy has been established to act as a basis for financial advice received from the appointed financial advisor / investment manager.

12.2 The Financial advice received from Financial Advisors / Investment Manager must take into consideration the management of the main risks associated with investments such as Capital Risks, Liquidity Risks, Market Risks, Valuation Risks, Tax Risks, and Environmental, Social and Governance Risks.

12.3 The delegation of advice is subject to the conditions below:

a) Advice is compliant with the investment policy adopted by the Trustees.

b) The delegated powers may be withdrawn at any time.

c) The delegation will be reviewed at least every three years.

d) The Trustees are liable for acts or defaults of the investment advisors, since responsibility may not be delegated under the Trustees Investment Act 1961.

e) Investment managers shall be reviewed regularly regarding performance, personnel, strategy, research capabilities, organization and business matters, and other qualitative factors that may impact their ability to achieve the desired investment results.

13. Fund Management – Delegation Review

13.1 A report will be expected from the Investment Advisors demonstrating how the Trust's portfolio performance compares with movements in various published indices and other appropriate investment performance "benchmarks" on a six months basis. These investment performance indicators will be agreed between the Trustees and the Investment Advisors and should provide an assessment of both capital growth as well as income performance.

13.2 The Investment Fund Manager is also required to:

a) Provide subsidiary tax certificates for all interest and dividend payments and contract notes in respect of investment sales and purchases as soon as possible.

b) Provide a monthly statement of dividends received.

c) Provide a monthly statement of investment purchases and sales.

d) Provide a fund portfolio on a quarterly basis.

e) Hold the charity's share certificates in a wholly owned nominee company.

f) Attend the Charitable Funds Committee as and when required.

13.3 These investment reports shall be reported to the Charitable Funds Committee every six months.

14. Review

The Deputy Director of Finance will review the operation of the policy as necessary and at least every 3 years.

15. Legislation

- The Trustees Act 2000
- CC14 Charities and Investment Matters: A Guide for Trustees.
- Velindre UNHS Trust Charitable Funds Governing Document from January 1995.

16. Further Information

Further information and support is available from the Deputy Director of Finance on
Tel: 02920 316240
Mobile: 07971284383
Matthew.bunce2@wales.nhs.uk

Cymru Gyfan

Ymddiriedolaeth GIG Prifysgol Felindre

Polisi Hyfforddi a Galw i Wasanaethu gyda'r Lluoedd Wrth Gefn

GIG CYMRU NHS WALES

Sections

01

Cymru Gyfan Polisi Hyfforddi a Galw i Wasanaethu gyda'r Lluoedd Wrth Gefn

02

Atodiad 1: Person Cyswllt Dynodedig Sefydliad y GIG

03

Atodiad 2: Eithrio a Gohirio Ymfyddino

01

Cymru Gyfan Polisi Hyfforddi a Galw i Wasanaethu gyda'r Lluoedd Wrth Gefn

Cymeradwywyd gan: Fforwm Partneriaeth Cymru

Dyddiad Cyhoeddi: Mawrth 2020

CYNNWYS PAGE

01 Cymru Gyfan Polisi Hyfforddi a Galw i Wasanaethu gyda'r Lluoedd Wrth Gefn

1. Cyflwyniad Cyffredinol

1.1 Mae GIG Cymru yn cefnogi gweithwyr sy'n aelodau o'r Lluoedd wrth Gefn Gwirfoddol neu sy'n dymuno ymuno â hwy. Mae lluoedd o'r fath yn cynnwys y Llynges Frenhinol Wrth Gefn (RNR), y Morlu Brenhinol Wrth Gefn (RMR), y Fyddin wrth Gefn, y Lluoedd Awyr Wrth Gefn (RAFR ac RAuxAF), a lluoedd y cadetiaid. Bydd y polisi hwn hefyd yn gymwys i Filwyr Wrth Gefn Rheolaidd, sy'n gyn filwyr rheolaidd ac sy'n dal yn gymwys i gael eu galw i wasanaethu. Dylai aelod o'r staff gael copi o'r polisi hwn cyn gynted ag y bydd Sefydliad y GIG yn gwybod bod yr unigolyn yn filwr wrth gefn.

1.2 Rhaid i weithiwr sy'n dymuno manteisio ar ddarpariaethau'r polisi hwn hysbysu ei gyflogwr ei fod yn Filwyr Wrth Gefn drwy gysylltu â'r unigolyn dynodedig ar gyfer Sefydliad y GIG a enwir yn Atodiad 1. Bydd y person cyswllt dynodedig yn Sefydliad y GIG yn cadw rhestr o'r holl weithwyr sy'n aelodau o'r lluoedd gwirfoddol ac yn sicrhau bod rheolwr llinell yr unigolyn yn gwybod ei fod yn aelod o'r Lluoedd Wrth Gefn Gwirfoddol.

1.3 Bydd y polisi hwn hefyd yn gymwys i'r Milwyr Wrth Gefn Parodrwydd Uchel (HRR) a'r Lluoedd Ymateb i Argyfyngau Sifil Posibl (CCRF). Rhaid i aelodau o'r lluoedd wrth gefn hyn hysbysu eu cyflogwr ynglŷn â'u statws gan fod y cyfnod o rybudd cyn anfon i leoliad yn gymharol fyr. Rhaid i unigolion sy'n gweithio mwy na dau ddiwrnod yr wythnos hefyd gael caniatâd ysgrifenedig gan eu cyflogwr cyn y gallant ddal statws aelod o'r Milwyr Wrth Gefn Parodrwydd Uchel.

1.4 Mae'r hyfforddiant a roddir i Filwyr Wrth Gefn yn eu galluogi i ddatblygu sgiliau a galluoedd a all fod yn ddefnyddiol iddynt fel gweithwyr cyflogedig, ac yn fuddiol hefyd i'r cyflogwr wrth ddarparu gwasanaeth. Dylid annog aelodau staff i rannu'r rhain gyda chydweithwyr.

1.5 Bydd gwell dealltwriaeth o'r hyfforddiant a'r sgiliau sy'n cael eu datblygu yn y Lluoedd Wrth Gefn yn helpu rheolwyr sy'n cynnal cyfarfodydd Gwerthuso Perfformiad ac Adolygu Datblygiad (PADR).

2. Y Fframwaith Cyfreithiol

2.1 Yn y rhan fwyaf o achosion ni ddylai perthynas cyflogwr ag aelod o'r staff sy'n Filwr Wrth Gefn fod yn wahanol i'w berthynas ag unrhyw weithiwr arall. Er hyn, gallai statws Milwr Wrth Gefn effeithio ar weithrediadau'r sefydliad mewn rhai meysydd. Mae deddfwriaeth yn bodoli i ddiffinio'r hawliau a'r atebolrwydd sy'n gymwys i'r ddau barti.

2.2 Mae dwy brif ddeddfwriaeth sy'n ymwneud â chyflogwyr a'r Lluoedd Wrth Gefn Gwirfoddol.

- Deddf Diwygio Amddiffyn 2014 (DRA 14)
- Deddf y Lluoedd Wrth Gefn 1996 sy'n darparu'r pwerau ar gyfer galw Milwyr Wrth Gefn i wasanaethu ar sail amser llawn.
- Deddf y Lluoedd Wrth Gefn (Diogelu Cyflogaeth) 1985 sy'n darparu ar gyfer

amddiffyniad cyflogaeth i'r rhai a allai gael eu galw i wasanaethu ac ailbenodi'r rhai sy'n dychwelyd o wasanaeth milwrol i'w swyddi.

3. Cefnogaeth Ymarferol ar gyfer Hyfforddiant

3.1 Bydd Ymddiriedolaeth GIG Prifysgol F yn cefnogi gweithiwr i ddod yn filwr wrth gefn a bydd modd defnyddio gwyliau blynyddol neu ddi-dâl i gefnogi presenoldeb mewn unrhyw hyfforddiant sy'n ofynnol cyn i weithiwr ddod yn Warchodwr.

3.2 Caniateir hyd at 10 diwrnod y flwyddyn o absenoldeb â thâl i Filwyr Wrth Gefn er mwyn iddynt allu mynd i wersyll blynyddol neu ddilyn hyfforddiant parhaus cyfatebol. Dylid cymryd unrhyw absenoldeb ychwanegol sydd ei angen fel gwyliau blynyddol neu absenoldeb di-dâl.

3.3 Bydd rheolwyr llinell, i'r graddau y mae hynny'n bosibl, yn hwyluso rhestrau dyletswyddau gwaith er mwyn i weithwyr allu mynd i wersyll blynyddol neu gydymffurfio ag ymrwymiadau hyfforddiant eraill, e.e. sesiynau hyfforddi wythnosol neu ar benwythnos.

3.4 Dylai gweithwyr sy'n filwyr wrth gefn roi cymaint o rybudd ag sy'n bosibl i alluogi'r cyflogwr i gynllunio ar gyfer absenoldeb. Rhoddir caniatâd os yw'r rhybudd yn fwy na mis, a dylai gael ei roi mewn amgylchiadau eraill fel arfer. Dim ond mewn amgylchiadau eithriadol ac eithafol y bydd caniatâd sydd wedi'i roi yn cael ei ddirymu.

3.5 Dylid cyfeirio unrhyw anghydfod at y person cyswllt dynodedig i ddechrau (gweler Atodiad 1). Gall gweithwyr sy'n dal yn anfodlon ddefnyddio'r drefn gwyno.

4. Galw i Wasanaethu (Ymfyddino)

4.1 Ymfyddino yw'r broses o alw milwyr wrth gefn (i) i wasanaeth amser llawn gyda'r Lluoedd Wrth Gefn ar weithrediadau milwrol (ii) i gyflawni eu rhan yn strategaeth amddiffyn y DU. Mae Deddf y Lluoedd Wrth Gefn 1996 a Deddf Diwygio Amddiffyn 2014 yn darparu'r sail gyfreithiol ar gyfer ymfyddino. Gan ddibynnu ar ddifrifoldeb yr argyfwng rhoddid o leiaf 30 diwrnod o rybudd fel arfer. Bydd y cyfnod ymfyddino rhwng 3 a 12 mis fel arfer.

4.2 Rhaid i weithiwr sy'n dymuno gwneud gwasanaeth milwrol gwirfoddol gysylltu â'i reolwr llinell ymlaen llaw i sicrhau bod ei gyflogwr yn cytuno. Bydd unrhyw gais o'r fath yn cael ei ystyried cyn pen 5 diwrnod gwaith.

4.3 Os ceir nifer o geisiadau mewn un adran/uned cyfeirir y rhain at yr Uwch Reolwr priodol.

4.4 Os bydd unrhyw weithiwr cyflogedig yn cael galwad orfodol i wasanaethu bydd y cyflogwr (yn dilyn proses debyg i 4.2 uchod) yn penderfynu a ddylid gwneud cais i eithrio neu ohirio. Mae'r rhesymau dros eithrio yn gyfyngedig iawn a byddai'n rhaid dangos niwed difrifol i allu'r cyflogwr i ddarparu gwasanaethau. Dim ond mewn amgylchiadau eithriadol iawn y byddai'r cyflogwr yn gwneud cais am eithrio.

4.5 Mae gwybodaeth ychwanegol am eithrio a gohirio ymfyddino i'w gweld yn Atodiad 2.

5. Cymorth Ariannol i Gyflogwyr

5.1 Os bydd y cyflogwr yn wynebu costau ychwanegol pan fydd gweithiwr yn cael ei alw i wasanaethu gall wneud cais am iawndal gan y Weinyddiaeth Amddiffyn e.e.

• Costau goramser os defnyddir gweithiwr arall i wneud gwaith y Milwr Wrth Gefn.

• Unrhyw gostau hurio gweithiwr dros dro sy'n fwy nag enillion y Milwr Wrth Gefn.
• Hysbysebu am weithiwr yn lle'r Milwr Wrth Gefn neu gostau asiantaeth.
• Costau hyfforddi ar gyfer unrhyw hyfforddiant y mae ar y gweithiwr ei angen o ganlyniad i gael ei alw i wasanaethu (ni fydd y Weinyddiaeth Amddiffyn yn talu am hyfforddiant y byddem wedi ei roi beth bynnag) pan fydd y gweithiwr yn dychwelyd i'r gwaith i gyflawni ei ddyletswyddau'n iawn.

5.2 Tra bydd y Milwr Wrth Gefn ar wasanaeth, nid oes rhaid i'r cyflogwr dalu ei gyflog nac unrhyw fuddion sy'n rhan o'i gontract. Er hyn, bydd staff yn derbyn eu cyflog llawn gan y cyflogwr yn ystod eu mis cyntaf ar wasanaeth neu nes y byddant yn cael cyflog am eu mis cyntaf gan y Weinyddiaeth Amddiffyn. Bydd unrhyw gyflog dros ben a dalwyd ar ôl y dyddiad ymfyddino yn cael ei adennill pan fydd yr unigolyn yn dychwelyd i'r gwaith. Dylai'r person cyswllt dynodedig ar gyfer Sefydliad y GIG sicrhau bod yr adran gyflogau'n cael ei hysbysu bod y gweithiwr wedi cael ei alw i wasanaethu ac ar ba ddyddiad y dylai ei gyflog ddod i ben.

5.3 Er mwyn hawlio cymorth ariannol bydd y cyflogwr yn rhoi tystiolaeth ddogfennol ategol briodol i'r Weinyddiaeth Amddiffyn e.e. anfonebau.

5.4 Y dyddiad hwyraf ar gyfer cyflwyno hawliadau am gymorth ariannol, ar wahân i gymorth ariannol ar gyfer hyfforddiant, yw cyn pen pedair wythnos o'r dyddiad y mae cyfnod y Milwr wrth Gefn ar wasanaeth yn dod i ben.

6. Pensiwn y GIG tra ar Wasanaeth Gweithredol

6.1 Mae gan Filwr Wrth Gefn sy'n cael ei alw allan hawl i gadw'i aelodaeth o Gynllun Pensiwn y GIG. Bydd y Weinyddiaeth Amddiffyn yn talu cyfraniadau pensiwn y cyflogwr tra bydd yr unigolyn ar wasanaeth cyn belled bod yr unigolyn yn dal i dalu ei gyfraniadau unigol. Os bydd gweithiwr sy'n Filwr Wrth Gefn yn cael ei alw i wasanaethu bydd yn cael absenoldeb arbennig di-dâl. Byddai cyfraniadau pensiwn y gweithiwr yn cael eu cyfrifo a'u gohirio nes bydd y gweithiwr yn dychwelyd. Byddai'r rhain wedyn yn cael eu hadennill yn fisol o'r cyflog a thros yr un cyfnod ag yr oedd y gweithiwr yn absennol. Bydd y cyflogwr, ar gais y gweithiwr, yn dal i dalu cyfraniadau cyflogwr i Gynllun Pensiwn y GIG am y cyfnod ymfyddino ac yn anfonebu'r Weinyddiaeth Amddiffyn er mwyn adennill y swm hwn.

Gweler adran 12 (http://www.nhsbsa.nhs.uk/Documents/Pensions/Call_up_of_Reservists_factsheet_V2_07.13.pdf)

7. Gwyliau Blynyddol tra'n Gwasanaethu gyda'r Lluoedd

7.1 Nid oes gan Filwyr Wrth Gefn hawl i grynhoi gwyliau blynyddol tra maent ar wasanaeth ac yn cael absenoldeb di-dâl.

7.2 Bydd Milwyr Wrth Gefn yn cael cyfnod o absenoldeb 'ar ôl tymor ar ddyletswydd' y byddant yn ei grynhoi ar gyfradd o un diwrnod am bob naw diwrnod calendr a ddefnyddir (Cyfarwyddeb JSP 753 - Rheoliadau ar gyfer Ymfyddino Lluoedd Wrth Gefn y DU o wasanaeth gan y Weinyddiaeth Amddiffyn. Rhaid cymryd yr absenoldeb hwn cyn i gyfnod yr unigolyn ar wasanaeth ddod i ben.

8. Cario Gwyliau Blynyddol Drosodd

8.1 Dylid annog Milwyr Wrth Gefn i gymryd unrhyw wyliau sydd wedi crynhoi cyn ymfyddino. Os bydd gwyliau blynyddol heb ei gymryd, ni fydd modd ei gario drosodd.

9. Datblygiad Cyflog

9.1 Os bydd gweithiwr yn absennol o'i waith ar ôl ymfyddino, bydd y gwasanaeth yn cael ei ystyried yn ddi-dor ac ni fydd gweithiwr yn cael ei gosbi os yw'n digwydd yr un pryd â dyddiad ei godiad cyflog.

9.2 Dylai rheolwyr llinell sy'n cynnal cyfarfodydd Gwerthuso Perfformiad ac Adolygu Datblygiad (PADR) a / neu gyfarfodydd gwerthuso yn achos staff, fod yn ymwybodol bod y gweithgareddau Lluoedd Wrth Gefn Gwirfoddol y mae unigolyn yn ymwneud â hwy (boed drwy hyfforddiant neu ymfyddino) yn dod â sgiliau hanfodol i'r gweithle, er enghraifft arweinyddiaeth, cyfathrebu, gweithio mewn tîm a threfnu, sy'n arwain yn y pen draw at wella perfformiad yn y gweithle. Mae felly'n ymarfer da i gydnabod y sgiliau a'r galluoedd hyn mewn cyfarfodydd PADR neu gyfarfodydd gwerthuso unigolion, a chydnabod y gellir ystyried y gweithgareddau fel tystiolaeth o gyflawniad, neu eu bod mewn rhai amgylchiadau yn golygu bod unigolyn mewn sefyllfa i roi tystiolaeth o gymhwyso gwybodaeth a sgiliau. Bydd yr egwyddorion hyn hefyd yn gymwys i filwyr wrth gefn nad ydynt yn cael eu cyflogi ar Delerau ac Amodau'r Agenda ar gyfer Newid, gan ystyried ceisiadau proffesiynol, megis ailddilysu.

10. Cymorth wrth Ddychwelyd i'r Gwaith (Dadfyddino)

10.1 Gall dadfyddino fod yn gyfnod anodd, gyda Milwr Wrth Gefn Gwirfoddol yn dychwelyd i'r gwaith ar ôl cyfnod anodd ar leoliad. Er mwyn helpu i sicrhau bod gweithwyr yn ailintegreiddio'n ddirwystr yn y gweithle/tîm bydd angen ystyried:

- Yr angen i gyflwyno'r wybodaeth ddiweddaraf i'r gweithiwr ynglŷn â newidiadau a datblygiadau yn y sefydliad.
- Yr angen i gynnig hyfforddiant gloywi penodol os gofynnir amdano neu os credir bod ei angen.
- Os yw dyletswyddau'r swydd wedi newid ers i'r gweithiwr gael ei alw i wasanaethu mae'n bosibl y bydd angen cyfnod o hyfforddiant sgiliau i'w helpu ag agweddau newydd ar y swydd.
- A yw'n bosibl i'r Milwr wrth Gefn gyfarfod cydweithwyr yn anffurfiol neu'n gymdeithasol (os yw hynny'n briodol) cyn neu ar ôl dychwelyd i'r gwaith i sicrhau nad yw'n teimlo ei fod wedi colli cysylltiad, os gofynnir am hyn.
- Amser rhesymol o'r gwaith i gael triniaeth therapiwtig.

10.2 Pan fydd cyflogwr yn cael ei hysbysu gan Filwr Wrth Gefn fod arno eisiau dychwelyd i'r gwaith, rhaid i'r cyflogwr ei gyflogi yn ei hen swydd fel y nodir yn Neddf y Lluoedd Wrth Gefn (Diogelu Cyflogaeth) 1985. Os nad yw hyn yn bosibl, rhaid cynnig swydd gyfatebol iddo/iddi â'r un telerau ac amodau gwasanaeth yn unol â'r Polisi Newid Sefydliadol. Mae'r hawl i ddychwelyd i'r gwaith yn para am chwe mis ar ôl dadfyddino.

10.3 Er mwyn galluogi'r cyflogwr i gynllunio ar gyfer yr adeg pan fydd gweithiwr yn dychwelyd i'r gwaith ar ôl i'w wasanaeth milwrol ddod i ben, rhaid i Filwyr Wrth Gefn gysylltu â pherson cyswllt dynodedig y sefydliad yn ysgrifenedig, ac anfon copi i'w reolwr llinell, gan nodi'r dyddiad y bydd ar gael i ddechrau gweithio. Dylid cyfathrebu'r wybodaeth hon ddim hwyrach na thair wythnos ar ôl cwblhau'r gwasanaeth milwrol.

10.4 Rhaid hysbysu'r cyflogwr cyn gynted ag y bo modd os yw'r gweithiwr yn methu â chychwyn gweithio ar y dyddiad cytunedig oherwydd salwch neu achos rhesymol arall.

11. Adolygu

11.1 Bydd y polisi hwn yn cael ei fonitro a'i adolygu bob dwy flynedd, neu cyn hynny os bydd unrhyw newidiadau deddfwriaethol, ac yn unol â newidiadau yn y GIG.

12. Ffynonellau Cymorth Defnyddiol

Cymdeithas Lluoedd wrth Gefn a Chadetiaid Cymru

Ffôn: 02920 375746
www.wales-rcfa.org

Cyfeiriad: NHS Pensions Agency
PO Box 2269
Bolton
BL6 9JS

Ffôn: 0300 3301 346
www.nhsbsa.nhs.uk

02

Atodiad 1: Person Cyswllt Dynodedig Sefydliad y GIG

2 Atodiad 1: Person Cyswllt Dynodedig Sefydliad y GIG

Mae gan bob un o sefydliadau'r GIG gyfrifoldeb i nodi person cyswllt dynodedig. At ddibenion y polisi hwn Cyfarwyddwr Gweithlu a Datblygu Sefydliadol Sefydliad y GIG fydd y person cyswllt hwn.

Cyfrifoldeb person cyswllt dynodedig Sefydliad y GIG yw sicrhau:-

- ei fod yn gwbl ymwybodol o ddarpariaethau'r polisi hwn ac, o ganlyniad, ei fod yn gallu cynghori gweithwyr ynglŷn â'r cymorth sydd ar gael iddynt;
- ei fod yn cadw cronfa ddata gyfredol o bob Milwr Wrth Gefn sy'n gweithio yn ei faes cyfundrefnol;
- ei fod ar gael i weithio gyda'i weithiwr a rheolwr llinell y gweithiwr er mwyn sicrhau bod darpariaethau'r polisi ar gael;
- bod mecanweithiau wedi'u sefydlu i sicrhau bod yr adran gyflogau'n cael ei hysbysu bod y gweithiwr wedi cael ei alw i wasanaethu a pha bryd y dylai ei gyflog ddod i ben;
- bod mecanweithiau wedi'u sefydlu i sicrhau ei fod yn cadw mewn cysylltiad â'r gweithiwr ac yn gwneud yn siŵr ei fod yn cael yr wybodaeth ddiweddaraf am ei faes. Gallai hyn fod drwy gylchlythyr staff, negeseuon ebost cyfredol, nodiadau briffio ac yn y blaen;
- ei fod yn gweithredu fel y pwynt cyswllt cyntaf mewn unrhyw anghydfod.

03

Atodiad 2: Eithrio a Gohirio Ymfyddino

3 Atodiad 2: Eithrio a Gohirio Ymfyddino

1.1 Mae gan y cyflogwr hawl i ofyn am gael eithrio neu ohirio ymfyddino os yw'n credu y bydd y sefydliad yn dioddef niwed difrifol o ganlyniad i absenoldeb y gweithiwr.

1.2 Mae'r diffiniad o 'niwed difrifol', yn amrywio o'r naill achos i'r llall, ond mae'r canllawiau cyffredinol a nodir yn CORFA 05 yn cyfeirio'n benodol at y canlynol;

• Effaith ddifrifol o ganlyniad i golli gwerthiant, marchnadoedd, enw da neu ewyllys da neu niwed ariannol difrifol arall.
• Effaith ddifrifol ar y gallu i gynhyrchu nwyddau neu ddarparu gwasanaethau.
• Niwed amlwg i ymchwil a datblygu cynnyrch, gwasanaethau neu brosesau newydd, cyn belled na ellid atal y niwed drwy gymorth ariannol i'r cyflogwr dan CORFA 05.

1.3 Cyn y gellir ystyried eithrio neu ohirio, rhaid i'r Milwr Wrth Gefn neu'r cyflogwr gyflwyno cais, cyn pen saith niwrnod ar ôl i'r Milwr Wrth Gefn dderbyn hysbysiad ymfyddino, i Swyddog Dyfarnu'r Gwasanaeth y bydd y Milwr Wrth Gefn yn gwasanaethu ynddo. Ni ellir cyflwyno ceisiadau hwyr heb ganiatâd y Swyddog Dyfarnu a benodwyd gan y Weinyddiaeth Amddiffyn. Swyddog gwasanaethu neu un o swyddogion y Weinyddiaeth Amddiffyn fydd yn dal y swydd hon fel arfer.

Cyfeiriad: Army Adjudication Officer
Army Personnel Centre
PO Box 26703
GLASGOW G2 8YN
Ffôn: 0800 389 6585
Ffacs: 0141 224 2689
Ebost: apc-cmops-mob-so2@mod.uk

Cyfeiriad: Royal Navy and Royal Marines Adjudication Officer
West Battery (MPG-2)
Whale Island
PORTSMOUTH PO2 8BX
Ffôn: 02392 628858
Ffacs: 02392 628660
Ebost: NAVYLEGAL-RESERVESAD JSO2@MOD.UK

Cyfeiriad: Royal Air Force Adjudication Officer
Royal Air Force Adjudication Service
c/o Imjin Barracks
GLOUCESTER GL3 1HW
Ffôn: 01452 712612 ext 6107
Ffacs: 01452 510939
Ebost: aira1-adjmlbx@mod.gov.uk

1.4 Rhaid darparu'r wybodaeth a ganlyn wrth wneud cais i eithrio neu ohirio;

• Manylion personol, gan gynnwys enw llawn, cyfeiriad, rhif cyflog a rhif yswiriant cenedlaethol.
• Manylion y swydd neu'r rôl y bydd yn ei chyflawni yn y Bwrdd.
• Yr effaith y byddai ei absenoldeb yn ei gael ar y Bwrdd a/neu fusnes adrannol a/neu ddarparu gwasanaeth.
• Cyfiawnhad dros eithrio, o ran y niwed difrifol i'r Bwrdd a'r adran.

1.5 Ar ôl i'r cais ddod i law, bydd yn cael ei archwilio gan Swyddog Dyfarnu'r Gwasanaeth a fydd yn penderfynu a yw'r achos dros eithrio neu ohirio yn dderbyniol. Wrth wneud y penderfyniad hwn, bydd y Swyddog Dyfarnu'n ceisio sicrhau cydbwysedd rhwng anghenion y Bwrdd a'r adran gyflogi ar y naill law ac anghenion gweithredol y Llu Wrth Gefn y mae'r Milwr Wrth Gefn wedi'i alw iddo.

1.6 Os yw'r Bwrdd yn anfodlon â phenderfyniad Swyddog Dyfarnu'r Gwasanaeth gall gyflwyno apêl i Dribiwnlys Apêl y Lluoedd Wrth Gefn. Bydd y Swyddog Dyfarnu'n darparu gwybodaeth ynglŷn â sut i gyflwyno apêl.

1.7 Mae Tribiwnlysoedd Apêl y Lluoedd Wrth Gefn yn annibynnol ar y Weinyddiaeth Amddiffyn, ac mae penodiadau'n cael eu gwneud gan yr Ysgrifennydd Gwladol dros Faterion Cyfansoddiadol a'r Arglwydd Ganghellor. Mae pob tribiwnlys yn cynnwys cadeirydd â chymhwyster cyfreithiol a dau aelod lleyg o restr a gedwir gan y Gwasanaeth Tribiwnlysoedd Cyflogaeth.

1.8 Dylid anfon apeliadau i swyddfa'r Ysgrifennydd Tribiwnlysoedd cyn pen pum niwrnod gwaith ar ôl derbyn penderfyniad Swyddog Dyfarnu'r Gwasanaeth. Gellir ffacsio apeliadau neu eu hanfon drwy'r post dosbarth cyntaf.

Cyfeiriad: Reserve Forces Appeal Tribunal
Tribunals Service Alexandra House
14 – 22 The Parsonage
Manchester
M3 2JA

Ebost: rfat@tribunals.gsi.gov.uk

1.9 Hysbysir y cyflogwr ynglŷn â dyddiad, amser a lleoliad gwrandawiad yr apêl. Os credir bod angen hynny, mae'n bosibl y gofynnir i gyflogwyr roi gwybodaeth ychwanegol i'r Tribiwnlys i gefnogi eu hachos. Gwrandewir apeliadau fel arfer cyn pen 28 diwrnod ar ôl derbyn yr apêl, ac yn ystod y cyfnod hwnnw ni fydd y Milwr Wrth Gefn yn cael ei anfon i leoliad y tu allan i'r Deyrnas Unedig.

All Wales

Velindre NHS Trust

Reserve Forces Training and Mobilisation Policy

GIG CYMRU NHS WALES

Sections

01

All Wales Reserve Forces Training and Mobilisation Policy

Approved by: Welsh Partnership Forum

Issue Date: March 2020

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01 All Wales Reserve Forces Training and Mobilisation Policy

1. General Introduction

1.1 NHS Wales supports employees who are members of or wish to join the Volunteer Reserve Forces. These consist of the Royal Naval Reserve (RNR), the Royal Marines Reserve (RMR), the Army Reserve, the Reserve Air Forces (RAFR and RAuxAF), and cadet forces. This policy will also apply to Regular Reservists, who are ex-regulars who may retain a liability to be mobilised. A member of staff should be provided with a copy of this policy as soon as the NHS organisation is aware that the individual is a reservist.

1.2 Employees who wish to take advantage of the provisions contained within this policy must inform their employer that they are a Reservist by contacting the individual identified at Appendix 1 for their NHS Organisation. The designated contact for each NHS Organisation will keep a register of all employees who are members of the volunteer forces and will ensure that the individual's line manager is aware of their membership of the Volunteer Reserve Forces.

1.3 This policy will also apply to High Readiness Reserves (HRR) and Civil Contingency Reaction Forces (CCRF), both of whom must inform their employer of their status given the relatively short notice of deployment. High Readiness Reserves will also require written consent from their employer if they work more than two days per week before they are able to hold this status.

1.4 The training undertaken by Reservists enables them to develop skills and abilities that can be of benefit to them as employees, and to the employer in terms of service delivery. Members of staff should be encouraged to share these with colleagues.

1.5 A greater understanding of the training and skills development carried out in the Reserve Forces will assist managers in conducting PADRs.

2. The Legal Framework

2.1 In most instances an employer's relationship with a Reservist member of staff should be like that of any other employee. However, there are areas where a Reservist's status may affect the operations of the organisation. Legislation exists to define the rights and liabilities that apply to both parties.

2.2 There are two main pieces of legislation relating to employers and the Volunteer Reserve Forces.

- Defence Reform Act 2014 (DRA 14)
- The Reserve Forces Act 1996 (RFA 96) which provides the powers under which Reservists can be mobilised for full-time service.
- The Reserve Forces (Safeguard of Employment) Act 1985 (SOE 85) which provides protection of employment for those liable to be mobilised and reinstatement for those returning from mobilised service.

3. Practical Support for Training

3.1 Velindre NHS Trust will support an employee to become a reservist and provide access to annual or unpaid leave to support attendance at any training required in advance of an employee becoming a Reservist.

3.2 Paid leave of up to 10 days per year will be made available to Reservists to attend annual camp or equivalent continuous training. Any additional leave required should be taken as annual or unpaid leave.

3.3 Line managers will as far as possible facilitate work rosters to allow attendance for annual camp and other training commitments, e.g. weekly or weekend training sessions.

3.4 Reservist employees should give as much notice as possible to allow appropriate planning for absences. Permission will be granted where the notice exceeds one month and should normally be granted in other circumstances. Permission once given will not be rescinded except in exceptional and extreme circumstances.

3.5 Any disputes should be referred to the designated contact (see appendix 1) in the first instance. Employees who remain dissatisfied may thereafter use the grievance procedure.

4. Mobilisation

4.1 Mobilisation is the process of calling reservists into full-time service. (i) With the Regular Forces on the military operations (ii) To fulfil their part of the UK's defence strategy. The Reserve Forces Act 1996 and the Defence Reform Act 2014 provide the legal basis for mobilisation. Subject to the severity of the crisis there would normally be a minimum of 30 days' notice. Mobilisation will normally be for between 3 and 12 months.

4.2 An employee who wishes to volunteer for mobilisation must seek prior agreement of their employer through their line manager. Any such request will be considered within 5 working days.

4.3 Where there are multiple requests in a single department/unit these will be referred to the appropriate Senior Manager.

4.4 Where there is compulsory mobilisation of any employee the employer (following a similar process to 4.2 above) will decide whether to seek exemption or deferral. The grounds of exemption are strictly limited and would have to show serious harm to the employer's ability to provide services. The employer would only seek exemption in very exceptional circumstances.

4.5 Additional information regarding exemption and deferral from mobilisation is contained in Appendix 2.

5. Financial Assistance for Employers

5.1 Where an employee's mobilisation results in additional costs the employer may seek compensation from the MoD e.g.

- Overtime costs if another employee is used to cover the work of the Reservist.
- Any costs of hiring a temporary replacement that exceeds the Reservist's earnings.
- Advertising for replacement or agency costs.
- Training costs for any training the employee needs as a result of having been mobilised (the MoD will not pay for training that we would have carried out anyway) when they return to work to carry out their duties properly.

5.2 While the Reservist is mobilised,

the employer is not obliged to pay their salary or contractual benefits. However, staff will receive their full salary from the employer during the first month of their mobilisation or until they receive their first months pay from the MOD. The excess salary paid after the date of mobilisation will be recoverable when the individual returns to work. The designated contact for the NHS Organisation should ensure that the pay department is notified that the employee is being mobilised and the date when their pay should stop.

5.3 In order to claim financial assistance the employer will provide the Ministry of Defence with appropriate supporting documentary evidence e.g. invoices.

5.4 The latest date for submitting claims for financial assistance, other than for training, is within four weeks of the date the Reservist is demobilised.

6. NHS Pension whilst on Active Service

6.1 A Reservist who is called out is entitled to remain a member of the NHS Pension Scheme. The Ministry of Defence (MoD) will pay the employer's pension contributions whilst the individual is mobilised provided they continue to pay their individual contributions. Where mobilisation occurs, the employee will be given special unpaid leave of absence. The employee's pension contributions would be calculated and held over until the employee returns. These would then be recovered monthly from salary and over the same period as the employee was absent. The employer will continue, on request of the employee, to pay employer's contributions to the NHS Pension Scheme for the period of mobilisation and invoice the MoD to recover this amount.

See section 12 https://www.nhsbsa.nhs.uk/employer-hub/technical-guidance/pay-and-contributions

7. Annual Leave whilst Mobilised

7.1 Reservists have no entitlement to accrue annual leave whilst mobilised and on unpaid leave.

7.2 Reservists will have a period of 'post tour' leave which they accrue at the rate of one day for every nine calendar days deployed (JSP 753 Directive – Regulations for the Mobilisation of UK Reserve Forces) from the MoD. This leave must be taken before the individual is demobilised.

8. Carry Over of Annual Leave

8.1 Reservists should be encouraged to take any holiday accrued before mobilisation. However, any annual leave not taken will be carried forward.

9. Pay Progression

9.1 Where an employee is absent from work following mobilisation, the service will be considered continuous and an employee will not be penalised if it coincides with their pay step.

9.2 Line managers who carry out PADRs and / or appraisal meetings with a reservist should be made aware that the Volunteer Reserve Forces activities undertaken by an individual (either through training or mobilisation) bring essential skills into the workplace such as leadership, communication, team working and organisational ability, which ultimately lead to improved performance in the workplace. It is therefore good practice that we recognise these skills and abilities in an individual's PADR or appraisal meeting and acknowledge that

the activities can be regarded as evidence of achievement or in some circumstances contribute towards an individual being in a position to evidence application of knowledge and skills. These principles will also apply to reservists not employed on Agenda for Change Terms and Conditions, being mindful of professional requests, such as revalidation.

10. Support on Return to Work (Demobilisation)

10.1 Demobilisation may be a difficult time, with a Volunteer Reservist returning to work after a challenging period in deployment. Helping to ensure a smooth re-integration into the workplace/team will require consideration of:

- The need to update them on changes and developments in the organisation.
- The need to offer specific refresher training where it is sought/considered necessary.
- Where the job duties have changed since mobilisation a period of skills training may be required to assist them with new aspects of the job.
- Whether the Reservist can meet up with colleagues informally or socially (if appropriate) before or after return to work to prevent any feeling of dislocation, if this is sought.
- Reasonable time off to seek therapeutic treatment.

10.2 When an employer is advised by a Reservist that they want to return to work, the employer is obliged to employ them in their old job as stated in the Reserve Forces (Safeguard of Employment) Act 1985. Where this is not possible, they must be offered an equivalent position with the same terms and conditions of service in accordance with the Organisational Change Policy. The right to return to work lasts for six months after demobilisation

10.3 To enable the employer to plan for their return to work after their military service has ended, Reservists must advise the designated organisational contact and/or writing, copied to their line manager, the date they will be available to start work. This communication should be made no later than three weeks after the completion of military service.

10.4 The employer must be advised as soon as possible, if, due to illness or some other reasonable cause, the employee is unable to start work on the agreed date.

11. Review

11.1 This policy will be monitored and reviewed every two years or sooner in light of any legislative changes and in line with NHS changes.

12. Useful Sources of Help

Reserve Forces and Cadet Association for Wales

Tel: 02920 375746
www.wales-rcfa.org

Address: NHS Pensions Agency
PO Box 2269
Bolton
BL6 9JS

Tel: 0300 3301 346
www.nhsbsa.nhs.uk

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Appendix 1: Designated NHS Organisation Contacts

2 Appendix 1: Designated NHS Organisation Contacts

Each NHS organisation has a responsibility to identify their designated contact, however, for the purposes of this policy the responsibility will be that of each NHS organisation's Director of Workforce and Organisational Development.

It will be the role of the designated NHS Organisation contact to ensure that: -

- they are fully aware of the provisions of this policy and are therefore able to advise employees of the support available to them;
- they maintain an up to date database of all Reservists working in their organisational area;
- they are available to work with both their employee and the employee's line manager to ensure the provisions of the policy are available;
- mechanisms in place to ensure that the pay department is notified that the employee is being mobilised and the date when their pay should stop;
- mechanisms in place to ensure that they maintain contact with the employee to ensure they are kept informed about their area. This may be through the provision of a staff newsletter, update e-mails, briefing notes etc;
- they act as first contact in any disputes.

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Appendix 2: Exemption and Deferral from Mobilisation

3 Appendix 2: Exemption and Deferral from Mobilisation

1.1 The employer has the right to ask for exemption from, or deferral of, mobilisation if it is considered that the organisation will suffer serious harm because of their absence.

1.2 The definition of 'serious harm', varies from case to case, but the broad guidelines laid out in CORFA 05 specifically mention;

• Serious loss of sales, markets, reputation, goodwill or other financial harm.
• Serious impairment of the ability to produce goods or provide services.
• Demonstrable harm to research and development of new products, services or processes, provided that the harm could not be prevented by the employer receiving financial assistance under CORFA 05.

1.3 To be considered for exemption or deferral, the Reservist, or the employer, must make an application, within seven days of the Reservist being served with a mobilisation notice, to the Service Adjudication Officer (SAO) for the Service in which the Reservist will serve. Late applications can only be made with the permission of the SAO appointed by the MoD. A serving officer or MoD official normally holds this post.

Address: Army Adjudication Officer
Army Personnel Centre
PO Box 26703
GLASGOW G2 8YN
Tel: 0800 389 6585
Fax: 0141 224 2689
Email: apc-cmops-mob-so2@mod.uk

Address: Royal Navy and Royal Marines Adjudication Officer
West Battery (MPG-2)
Whale Island
PORTSMOUTH PO2 8BX
Tel: 02392 628858
Fax: 02392 628660
Email: NAVYLEGAL-RESERVESADJSO2@MOD.UK

Address: Royal Air Force Adjudication Officer
Royal Air Force Adjudication Service
c/o Imjin Barracks
GLOUCESTER GL3 1HW
Tel: 01452 712612 ext 6107
Fax: 01452 510939
Email: aira1-adjmlbx@mod.gov.uk

1.4 The following information must be provided when applying for exemption or deferral;

• Personal details including full name, address, payroll and national insurance number.
• Details of the job or role they perform within the Board.
• The effect that their absence would have on the Board and/or departmental business and/or service delivery.
• Justification for exemption in terms of the serious harm to the Board and department.

1.5 Once received, the application will be examined by the SAO who will decide if the case for exemption or deferral is acceptable. In making this decision, the SAO will seek to balance the needs of the Board and employing department against the operational needs of the Armed Forces for which the Reservist has been mobilised.

1.6 An appeal can be made to the Reserve Forces Appeal Tribunal if the Board is unhappy with the decision of the SAO. The SAO will provide information on making an appeal.

1.7 Reserve Forces Appeal Tribunals are independent of the MoD, with appointments made by the Secretary of State for Constitutional Affairs and Lord Chancellor. Each tribunal consists of a legally qualified chairperson and two lay-members drawn from a list held by the Employment Tribunals Service.

1.8 Appeals must be lodged with the office of the Secretary to the Tribunal no more than five working days after the SAO's decision is received. Appeals can be faxed or posted first class.

Address: Reserve Forces Appeal Tribunal
Tribunals Service
Alexandra House
14 – 22 The Parsonage
Manchester
M3 2JA

Email: rfat@tribunals.gsi.gov.uk

1.9 The employer will be advised of the date, time and place of the hearing of the appeal. Where considered necessary, employers may be asked to provide the Tribunal with additional information in support of their case. Appeals are normally heard within 28 days of receipt of the appeal, during which time the Reservist will not be deployed outside the United Kingdom.

Sefydliad y GIG

Ymddiriedolaeth GIG Prifysgol Felindre

Polisi Secondiad

Sections

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Sefydliad y GIG Polisi Secondiad

02

Atodiad A: Cais i ryddhau ar gyfer secondiad

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Atodiad B: Profforma cytundeb secondiad

01

Sefydliad y GIG Polisi Secondiad

Cymeradwywyd gan: Fforwm Partneriaeth Cymru

Dyddiad cyhoeddi: Gorffennaf 2021

CYNNWYS TUDALEN

01 Datganiad Polisi

1. Datganiad polisi

- **Rydym yn rhoi cleifion a defnyddwyr ein gwasanaethau yn gyntaf:** Rydym yn gweithio gyda'r cyhoedd a chleifion/defnyddwyr gwasanaethau drwy gyd-gynhyrchu, gan wneud yr hyn sydd ei angen yn unig, dim mwy, dim llai a pheidio â gwneud dim niwed. Rydym yn onest, yn agored, yn llawn empathi ac yn dosturiol. Rydym yn sicrhau ansawdd a diogelwch yn fwy na dim arall drwy ddarparu'r gofal gorau posibl ar bob achlysur.
- **Rydym yn ymdrechu i wella ein gofal:** Rydym yn gofalu am y rhai sydd â'r angen iechyd mwyaf yn gyntaf, gan wneud y defnydd mwyaf effeithiol posibl o'r holl sgiliau ac adnoddau a gan wneud ymdrech barhaus i sicrhau bod y gofal a'r gwasanaethau yr ydym yn eu darparu'n addas ar gyfer anghenion y defnyddwyr. Rydym yn integreiddio gwelliant yn ein gwaith bob dydd, trwy fod yn agored i newid yn ein holl waith, sydd hefyd yn lleihau niwed a gwastraff.
- **Rydym yn canolbwyntio ar lesiant ac atal:** Rydym yn ceisio gwella iechyd a chael gwared ag anghydraddoldebau drwy gydweithio gyda phobl Cymru i sicrhau eu llesiant heddiw ac ar gyfer y blynyddoedd a'r cenedlaethau i ddod.
- **Rydym yn myfyrio ar ein profiadau ac yn dysgu:** Rydym yn buddsoddi mewn dysgu a datblygu. Rydym yn gwneud penderfyniadau sy'n fanteisiol i gleifion a defnyddwyr ein gwasanaethau drwy ddefnyddio adnoddau, systemau ac amgylcheddau sy'n caniatáu i ni weithio'n fedrus, yn ddiogel ac yn effeithiol. Rydym yn ddyfeisgar, yn addasu ac yn lleihau amrywiadau amhriodol gan ystyried y sylfaen briodol o dystiolaeth i'n harwain.
- **Rydym yn gweithio mewn partneriaeth ac fel tîm:** Rydym yn gweithio gydag unigolion gan gynnwys cleifion, cydweithwyr a sefydliadau eraill; gan ymfalchïo yn ein gwaith, gwerthfawrogi a pharchu ein gilydd, bod yn onest ac yn agored a gwrando ar gyfraniad eraill. Rydym yn ceisio datrys anghytundeb yn effeithiol ac yn gyflym, ac nid ydym yn goddef bwlio neu erledigaeth o unrhyw glaf, defnyddiwr gwasanaeth neu aelod o staff.
- **Rydym yn gwerthfawrogi pawb sy'n gweithio i'r GIG:** Rydym yn cefnogi'n holl gydweithwyr wrth iddynt wneud y swyddi y maent wedi cytuno i'w gwneud. Byddwn yn gofyn yn rheolaidd beth sydd ei angen arnynt i wneud eu gwaith yn well, ac yn ceisio darparu'r cyfleusterau angenrheidiol i ragori yn y gofal y maent yn ei roi. Byddwn yn gwrando ar ein cydweithwyr ac yn gweithredu ar eu hadborth a'u pryderon.

Maent wedi cael eu datblygu er mwyn helpu a chefnogi staff sy'n gweithio yn y GIG yng Nghymru.

Yr hyn sydd wrth wraidd GIG Cymru yw pobl, gweithio gyda phobl, gofalu am bobl. Mae'r Egwyddorion Craidd hyn yn disgrifio sut gallwn weithio gyda'n gilydd i sicrhau bod yr hyn rydym yn ei wneud a sut rydym yn ei wneud yn cael ei ategu gan ymdeimlad cyffredin o bwrpas y mae pob un ohonom yn ei rannu a'i ddeall.

Mae'r GIG dan bwysau parhaol i gyflenwi mwy o wasanaethau, gyda chanlyniadau gwell a chynnal a gwella ansawdd mewn cyfnod o heriau ariannol sylweddol, disgwyliadau uchel gan y cyhoedd a chyda phoblogaeth sy'n heneiddio ac yn profi lefelau uwch o gyflyrau cronig.

Datblygwyd yr egwyddorion hyn i helpu i fynd i'r afael â'r pwysau y mae'r galwadau hyn yn ei achosi i staff. Byddant yn rhoi cydbwysedd i'r ffordd rydym yn cydweithio er mwyn i ni ddibynnu llai ar y broses ac yn cael ein cynorthwyo i wneud y peth iawn trwy gael ein llywio gan yr egwyddorion hyn wrth roi polisïau a gweithdrefnau ar waith yn y gweithlu.

Fel pobl sy'n gweithio yn y gwasanaeth iechyd, bydd pob un ohonom yn defnyddio'r egwyddorion hyn i'n cefnogi i gyflawni ein gwaith, gydag ymrwymiad parhaus tuag at y rheiny sy'n defnyddio ein gwasanaethau, mewn cyfnod o newid cyson.

Mae'r Egwyddorion yn rhan o ymrwymiad parhaus i gryfhau gwerthoedd cenedlaethol a lleol a fframweithiau ymddygiad sydd eisoes wedi'usefydlu ledled Byrddau Iechyd ac Ymddiriedolaethau.

Datblygwyd yr Egwyddorion mewn partneriaeth â chynrychiolwyr o blith y cyflogwyr a'r staff.

Defnyddir yr Egwyddorion i greu dull mwy syml a chyson o ran rheoli materion yn ymwneud â chyflogaeth yn y gweithle.

2. Cyflwyniad

Nodau ac amcanion y polisi yw:

2.1 Darparu cyngor, cymorth ac arweiniad clir i reolwyr a gweithwyr ynghylch eu rôl/rolau wrth reoli'r broses gymeradwyo secondiad a rheoli'r prosesau yn ymwneud â'r secondiad hwnnw wedi hynny.

2.2 Darparu dull cost-effeithiol, teg a chyfartal o ddarparu profiad gwaith a chyfleoedd datblygu i weithwyr y tu hwnt i'w maes gwaith arferol a/neu sefydliad y GIG gan sicrhau bod yr anghenion lefelau staff tymor byr i ganolig ar gyfer darparu'r gwasanaeth wedi'u bodloni.

2.3 Dylid darllen y polisi ar y cyd â'r Polisi Newid Sefydliadol, lle bo'n briodol.

Mae Ymddiriedolaeth GIG Prifysgol Felind yn ymrwymo i gyflenwi gwasanaeth o ansawdd uchel. Er mwyn gwneud hyn, mae sefydliad y GIG yn cydnabod ei gyfrifoldeb i hyfforddi a datblygu staff i gyflawni eu potensial, er mwyn bodloni anghenion y gwasanaeth. Mae secondiadau yn werthfawr o ran datblygiad a chynnydd staff ac ar gyfer mynd i'r afael ag angen tymor byr i benodi rhywun ar gyfer swydd.

Buddion i sefydliad y GIG:

- Cadw staff.
- Defnyddio potensial yn y gweithlu i ymgymryd â phrosiectau a amlygir, efallai nad oes modd cyfiawnhau penodiad newydd ar eu cyfer ac efallai y byddai'n anodd eu cyflawni o fewn amserlen dderbyniol.
- Yn ystod cyfnod o newid sefydliadol, efallai byddai secondiad yn helpu'r GIG i sicrhau parhad y gwasanaeth.
- Cynorthwyo anghenion datblygu gweithwyr unigol er lles y tîm neu sefydliad y GIG yn ei gyfanrwydd yn y tymor hir, fel y cytunwyd ac amlygwyd trwy'r broses Adolygiad Gwerthuso a Datblygu Perfformiad (AGDP).
- Mae staff medrus sy'n meddu ar wybodaeth fanwl am bolisïau a gweithdrefnau Sefydliad y GIG ar gael yn syth.
- Cynnal safonau'r gwasanaeth a ddarperir e.e. trwy lenwi bwlch ar gyfer cyfnodau o salwch tymor hir, absenoldeb mamolaeth neu saib gyrfa ac ati.
- Gall secondiad roi cyfle i feithrin cysylltiadau agosach â'r sefydliad sy'n derbyn y gweithiwr.

Buddion i Weithwyr:

• Darparu cyfleoedd i unigolion sydd o bosibl yn ystyried newid eu llwybr gyrfa. Mae hyn yn caniatáu i'r unigolyn a sefydliad y GIG asesu pa mor addas ydynt ar gyfer newid o'r fath.

• Rhoi cyfle i fodloni anghenion datblygu y cytunwyd arnynt gyda'r gweithiwr a'r rheolwr llinell, ac sydd o bosibl wedi'u hamlygu trwy'r broses AGDP.

• Rhoi cyfle i gael profiad gwaith a allai gyfrannu at ddatblygiad personol ac o ran gyrfa.

• Rhoi cyfle i staff brofi diwylliant gwahanol a gwahanol ffyrdd o weithio.

3. Egwyddorion

3.1 Mae'r polisi hwn yn seiliedig ar yr egwyddorion arweiniol canlynol, y dylid eu hystyried yn ystod pob cam o'r secondiad:

• Anghenion y sefydliad(au)
• Lefelau sefydlu adrannol presennol/a ddisgwylir
• Bydd staff yn cael eu cynorthwyo i gael mynediad i secondiadau sy'n fuddiol i ddatblygiad gyrfaol a phroffesiynol
• Bydd y broses o ddarparu cyfle secondiad yn dilyn proses deg sy'n trin pob gweithiwr yn gyfartal
• Tegwch i staff, rheolwyr a chydweithwyr.

3.2 Rhaid i'r aelod staff, y rheolwr llinell/ sefydliad a'r rheolwr/sefydliad sy'n derbyn y gweithiwr gytuno ar secondiadau.

3.3 Ni ddylid defnyddio secondiadau yn lle trefniadau contractiol eraill ar gyfer staff.

3.4 Mae'n ofynnol i'r unigolyn, y sefydliad sy'n cyflogi'r unigolyn a'r sefydliad lletyol gadw mewn cysylltiad trwy gydol cyfnod y secondiad. Rhaid i unrhyw unigolyn sydd ar secondiad gael gwybod am unrhyw newidiadau sylweddol i'w adran neu rôl barhaol. Mae'n ofynnol i'r unigolyn a'r sefydliad lletyol roi'r wybodaeth ddiweddaraf i'r cyflogwr o ran yr amgylchiadau, e.e. os ydynt yn ceisio unrhyw amrywiad i'w cytundeb secondiad.

3.5 Bydd cyfleoedd secondiad yn cael eu monitro i bennu a oes angen ystyried camau cadarnhaol i fynd i'r afael ag anghyfartaledd.

4. Cwmpas y polisi

4.1 Dylai cyfleoedd secondiad fod ar gael i'r holl aelodau staff, a rhoddir ystyriaeth ddifrifol i bob cais. Fodd bynnag, efallai y bydd gofynion gweithrediadol neu'r gwasanaeth yn arwain at wrthod cais am ryddhau.

4.2 Mae gweithdrefnau ar wahân yn berthnasol o ran secondiad staff meddygol a deintyddol. Mae modd cael cyngor ar y gweithdrefnau hyn gan adrannau'r Gweithlu a Datblygu Sefydliadol.

5. Diffiniadau

5.1 Secondiad

- Mae secondiad yn digwydd pan fydd gweithiwr yn cael ei drosglwyddo dros dro o'i swydd barhaol i swydd arall, naill ai yn yr un sefydliad neu mewn sefydliad arall, a disgwylir iddo ddychwelyd i'w hen swydd ar ddiwedd y secondiad. Efallai y bydd rhai telerau contractiol yn amrywio yn ystod cyfnod y secondiad, hynny yw, cyflog, gweithle, oriau gwaith ayyb. Bydd telerau ac amodau'r swydd barhaol yn parhau fel yr oeddent cyn y secondiad.

Ni ddylid drysu rhwng secondiad a symud dros dro i fand uwch. Ni ddylid drysu chwaith rhwng secondiad a chytundeb rhwng y rheolwr a'r unigolyn i alluogi'r unigolyn hwnnw i ymgymryd â darn o

waith neu brosiect am gyfnod penodol, sy'n gymesur â'i radd a'i sgiliau neu brofiad ac ati.

5.2 Y sefydliad secondio (Cyflogwr) yw prif gyflogwr / cyflogwr parhaol yr unigolyn a'r sefydliad lletyol yw'r sefydliad lle bydd yr unigolyn yn gweithio yn ystod y secondiad.

6. Mathau o secondiadau a all godi

6.1 Mewnol

Mae secondiadau mewnol yn digwydd pan fydd aelod staff yn mynd ar gyfnod secondiad yn ei sefydliad. Gallai hyn fod yn yr un adran/cyfarwyddiaeth, neu mewn maes arall yn sefydliad y GIG. Bydd y swyddi hyn yn cael eu hysbysebu yn unol â pholisïau a gweithdrefnau'r sefydliad, oni bai y cytunir ynghylch amgylchiadau eithriadol gydag adran y Gweithlu a Datblygu Sefydliadol, mewn partneriaeth â chynrychiolwyr y staff.

6.2 GIG allanol

Mae secondiadau allanol y GIG yn digwydd pan fydd aelod staff yn mynd ar gyfnod secondiad gyda sefydliad arall y GIG.

6.3 Allanol heb fod yn y GIG

Efallai y bydd cyfleoedd secondiad allanol ar gael y tu allan i'r GIG mewn nifer o sefydliadau/sectorau, e.e.

- Gwasanaethau Cymdeithasol, adrannau eraill mewn awdurdodau lleol;
- Sefydliadau addysg;
- Senedd Cymru;
- Cwmnïau yn y sector preifat sy'n ymwneud ag iechyd

7. Hyd

Fel arfer, dylai secondiadau fod am leiafswm o dri mis ac uchafswm o bedair blynedd.

Weithiau bydd secondiad yn cael ei sefydlu i ddechrau am gyfnod byrrach, ond wrth i'r amgylchiadau newid, efallai y bydd y partïon am ei estyn. Pan fydd gofyniad y sefydliad lletyol ar gyfer y swydd secondiad yn mynd i fod am fwy na phedair blynedd, dylai'r sefydliad lletyol gael sgwrs gyda'r cyflogwr ynghylch a ellir cadw swydd barhaol y secondai ar agor. Os na ellir cadw swydd barhaol y secondai ar agor, yna dyma'r opsiynau sydd ar gael:

- Cynnig y swydd i'r gweithiwr naill ai ar sail barhaol neu dymor penodol; neu
- Ddychwelyd y gweithiwr i'w rôl barhaol.

8. Rhyddhau staff

8.1 Dylai unigolion sy'n dymuno cael eu rhyddhau o'u swyddi parhaol i gymryd rhan mewn cyfle secondiad lenwi'r ffurflen cais rhyddhau sydd wedi'i hatodi.

8.2 Cyn cytuno i ryddhau aelod staff ar secondiad, rhaid ystyried yr effaith ar y tîm cyfan, y gwasanaeth ac a oes angen llenwi'r swydd sy'n wag dros dro yn sgil hynny. Gellir gofyn i adran y Gweithlu a Datblygu Sefydliadol am gyngor os oes angen.

8.3 Nid oes rhaid i reolwyr gytuno i bob cais am secondiad, ond mae angen iddynt ystyried pob cais o ddifrif. Gellir gwrthod am resymau busnes gwrthrychol.

8.4 Dylai rheolwyr ystyried sawl ffactor cyn cytuno i ryddhau aelod staff, gan gynnwys:

• Anghenion datblygu sy'n codi o adolygiadau perfformiad a chynlluniau datblygu
• Ceisiadau blaenorol am secondiad
• Gofynion y gwasanaeth.

8.5 Ar ôl ystyried y pwyntiau yn 8.4, rhaid i'r rheolwr llinell gadarnhau hyd a thelerau'r secondiad yn ysgrifenedig. (Gweler adran 10)

8.6 Dylai staff drafod eu dymuniad i wneud cais am secondiad mewn egwyddor gyda'u rheolwr llinell ar y cyfle cyntaf.

9. Gwarchod swydd

9.1 Dylid cadw swydd barhaol y secondai ar agor. Os nad yw'n bosibl cadw swydd barhaol y secondai ar agor, bydd cyflogaeth amgen o'r un radd, math a statws yn cael ei geisio ar ddiwedd y secondiad, o fewn yr un gyfarwyddiaeth i ddechrau, cyn chwilio trwy gydol y sefydliad.

9.2 Os gwneir cais i ymestyn y secondiad, dylai'r mater o gadw swydd barhaol y secondai ar agor pan fydd yn dychwelyd fod yn rhan greiddiol o'r penderfyniad i ymestyn. Os nad yw'n bosibl cadw'r swydd ar agor y tu hwnt i hyd y secondiad presennol, dylid rhoi cyfle i'r gweithiwr ddychwelyd i'w swydd barhaol bryd hynny.

9.3 Os bydd newid sefydliadol yn effeithio ar strwythur yr adran yn ystod cyfnod y secondiad, rhaid i'r rheolwr llinell ymgynghori â'r secondai ar unrhyw newidiadau, a dylai gael ei ystyried yn gyfartal dan delerau'r polisi Newid Sefydliadol a dylai gael yr un hawliau a chyfleoedd.

10. Dyletswyddau a Chyfrifoldebau

10.1 Cytundeb y Secondiad

Pan gaiff unigolyn fynd ar secondiad i weithio i sefydliad arall, bydd yn parhau i gael ei gyflogi ar ei delerau ac amodau cyflogaeth arferol, ac eithrio cyflog, a all amrywio fel y bo'n briodol (hynny yw, y telerau y caiff ei gyflogi arnynt gan ei Gyflogwr). Bydd yr holl bartïon (hynny yw, y secondai, y sefydliad sy'n lletya a'r cyflogwr) yn dechrau cytundeb secondiad ysgrifenedig a fydd yn nodi'r telerau y mae'r secondiad yn seiliedig arnynt.

Mae cytundeb secondiad enghreifftiol wedi'i gynnwys yn Atodiad B.
Dylid defnyddio templed y cytundeb secondiad ar gyfer pob secondiad rhwng Byrddau Iechyd, Ymddiriedolaethau'r GIG ac Awdurdodau Iechyd Arbennig yng Nghymru. Mae templed y cytundeb yn darparu sefyllfa gytbwys rhwng pob un o gyrff GIG Cymru, gan gydnabod y bydd pob sefydliad naill ai'n sefydliad lletyol neu'n gyflogwr ar wahanol adegau.

Efallai y bydd yn ddefnyddiol i sefydliadau'r GIG ddefnyddio'r templed fel man cychwyn wrth drafod telerau secondiad gyda sefydliadau y tu allan i GIG Cymru. Fodd bynnag, dylent ystyried yn ofalus a yw'r holl ddarpariaethau'n diwallu eu hanghenion (yn enwedig o ran atebolrwydd, tâl a threfniadau ymarferol).

10.2 Rheoli'r secondai

10.2.1 Bydd y cyflogwr yn parhau i ddelio ag unrhyw faterion rheoli sy'n ymwneud â'r secondai yn ystod cyfnod y secondiad, lle bo hynny'n berthnasol yn dilyn ymgynghori â'r sefydliad lletyol.

10.2.2. Bydd y sefydliad lletyol yn darparu unrhyw wybodaeth, dogfennaeth, mynediad at ei adeiladau ac at ei weithwyr a'i gymorth (gan gynnwys ond heb fod yn gyfyngedig i roi tystiolaeth fel tyst) i'r cyflogwr ddelio ag unrhyw faterion rheoli sy'n ymwneud â'r secondai, boed hynny o dan weithdrefnau mewnol y cyflogwr neu gerbron unrhyw dribiwnlys. Bydd angen i'r sefydliad lletyol hefyd ystyried a oes angen gwiriadau cyn cyflogaeth ac, os felly, sicrhau eu bod yn cael eu cynnal mewn modd amserol.

10.2.3 Bydd gan y sefydliad lletyol reolaeth o ddydd i ddydd ar weithgareddau'r secondai ond cyn gynted ag y bo'n rhesymol ymarferol, bydd yn cyfeirio unrhyw faterion rheoli sy'n ymwneud â'r secondai sy'n dod i'w sylw at y cyflogwr.

10.2.4 Rhaid i'r sefydliad lletyol a'r cyflogwr roi gwybod i'r llall cyn gynted ag y bo'n rhesymol yn ymarferol am unrhyw fater arwyddocaol arall a all godi yn ystod cyfnod y secondiad sy'n ymwneud â'r secondai neu ei gyflogaeth.

10.2.5 Rhaid i'r secondai roi gwybod i'r cyswllt yn y sefydliad lletyol ac i'r cyswllt yn sefydliad y cyflogwr os yw'n nodi unrhyw wrthdaro buddiannau pendant neu bosibl rhwng y sefydliad lletyol a'r cyflogwr mewn perthynas â'r rôl yn ystod cyfnod y secondiad.

10.2.6 Dylai'r secondai gael ei werthuso gan y sefydliad lletyol yn dilyn trafodaethau ag unigolyn priodol o'r sefydliad lletyol a gofyn am fewnbwn priodol. Bydd y cyflogwr yn cynnal deialog reolaidd gyda'r gweithiwr. Bydd y cyflogwr yn cynnal unrhyw achosion o reoli perfformiad gyda'r sefydliad lletyol.

10.2.7 Disgwylir y bydd cyfathrebu rheolaidd a chyson rhwng y sefydliad lletyol, y cyflogwr a'r secondai, gan gynnwys cyfarfod o'r holl bartïon 8 wythnos cyn y mae'r secondiad i fod i ddod i ben.

10.2.8 Os bydd y secondai yn dod o hyd i rôl/swydd newydd, dylid rhoi rhybudd yn unol â'i rôl ar secondiad (cyfeiriwch at y cyfnod rhybudd).

11. Cyflog

11.1 Y cyflogwr parhaol ddylai dalu'r cyflog a'r treuliau (treuliau i'w cymeradwyo gan y sefydliad sy'n lletya) a dylid ail-godi'r tâl ar y sefydliad sy'n lletya i sicrhau na effeithir ar drefniadau pensiwn.

11.2 Os yw aelod staff yn cael ei warchod gan y Polisi Newid Sefydliadol pan fydd ar secondiad, dylai'r cyflog gwarchodedig hwnnw fod yn berthnasol o hyd os oes cyflog is yn y swydd ar secondiad, ar yr amod bod y secondiad yn cyd-fynd â chynllun datblygu personol yr unigolyn, er mwyn datblygu'r sgiliau a chymwyseddau angenrheidiol sy'n cynorthwyo'r unigolyn i ddychwelyd i'w radd/band presennol.

11.3 Os telir cyflog uwch na chyflog parhaol y secondai, ni fydd gwarchod tâl yn berthnasol ar ddiwedd y secondiad. Ar ddiwedd cyfnod y secondiad, bydd yr unigolyn yn dychwelyd i'w swydd barhaol, gan gynnwys cynnydd graddol a dyfarniadau tâl. Y disgwyl yw y byddai gweithiwr ar secondiad yn symud ymlaen trwy gamau cyflog yn unol â pholisi Datblygiad Cyflog Cymru Gyfan.

11.4 Cynghorir aelodau presennol Cynllun Pensiwn y GIG sydd â Statws Dosbarth Arbennig sy'n ystyried gwneud cyfnod secondiad i gael cyngor gan yr Asiantaeth Bensiynau cyn gwneud hynny i sicrhau na effeithir ar hyn.

12. Terfynu

12.1 Gellir dod â secondiad i ben yn gynnar os bydd yr holl bartïon yn cytuno â hynny.

12.2 Bydd y secondiad yn dod i ben ar ddiwedd y cyfnod a gytunwyd ac yna bydd y gweithiwr yn dychwelyd i'w swydd barhaol neu, fel y caniateir dan adran 9, i swydd ar radd a chyflog sy'n gymesur â'i swydd wreiddiol.

13. Cwblhau'r Secondiad

13.1 Pan fydd y secondiad yn dod i ben, dylai'r rheolwr llinell gynnal adolygiad i nodi sut y gellir defnyddio datblygiad yr unigolyn er budd y sefydliad a sicrhau bod yr hyn a ddysgwyd yn cael ei drosglwyddo'n llwyddiannus.

13.2 Dylai'r rheolwr llinell sicrhau bod rhaglenni sefydlu a hyfforddiant ar gael i weithwyr sy'n dychwelyd, fel sy'n briodol.

14. Anghydfodau

Os gwrthodir secondiad neu estyniad a bod y gweithiwr yn anfodlon â'r penderfyniad, dylai ddilyn y broses a nodir ym mholisi cwynion y cyflogwr (neu unrhyw bolisi sydd wedi disodli'r polisi cwynion).

15. Hyfforddi a chodi ymwybyddiaeth

Sicrheir bod pob aelod o'r staff yn ymwybodol o'r polisi hwn pan fydd yn dechrau gweithio i

Hefyd, gellir gweld copïau ar fewnrwyd

neu drwy adran y Gweithlu a Datblygu Sefydliadol. Darperir hyfforddiant fel y bo'n briodol gan ddibynnu ar gymhleth-dod y polisi.

16. Cydraddoldeb

Mae Sefydliad y GIG yn cydnabod amrywiaeth y gymuned leol a'r rhai mae'n eu cyflogi. Ein nod felly yw darparu amgylchedd diogel heb unrhyw wahaniaethu a man lle mae pob unigolyn yn cael ei drin yn deg, ag urddas ac yn briodol i'w angen.

Mae Sefydliad y GIG yn cydnabod bod cydraddoldeb yn effeithio ar bob agwedd ar ei weithrediadau o ddydd i ddydd. Aseswyd y polisi hwn gan ddefnyddio Pecyn Cymorth Asesu Effaith Canolfan Cydraddoldeb a Hawliau Dynol y GIG a chyhoeddwyd y canlyniadau ar y wefan a'u monitro'n ganolog.

17. Y Rheoliad Cyffredinol ar Ddiogelu Data 2018

Dylid trin pob dogfen sy'n cael ei chynhyrchu dan y polisi hwn, sy'n ymwneud ag unigolion y gellir eu hadnabod, fel dogfennau cyfrinachol, yn unol â Pholisi Diogelu Data

18. Deddf Rhyddid Gwybodaeth 2000

Gall holl gofnodion a dogfennau

, â rhai eithriadau cyfyngedig, gael eu datgelu dan Ddeddf Rhyddid Gwybodaeth 2000. Byddai cofnodion a dogfennau sydd wedi'u heithrio rhag cael eu datgelu, yn y rhan fwyaf o'r amgylchiadau, yn cynnwys y rhai sy'n ymwneud ag unigolion y gellir eu hadnabod sy'n codi mewn cyd-destun personél neu ddatblygu staff.
Mae gwybodaeth am gymhwyso'r Ddeddf Rhyddid Gwybodaeth yn

i'w gweld yng nghynllun cyhoeddiadau

19. Rheoli Cofnodion

Mae'r holl gofnodion a gynhyrchir dan y polisi hwn yn gofnodion swyddogol Sefydliad y GIG a byddant yn cael eu rheoli, eu storio a'u defnyddio yn unol â Pholisi Rheoli Cofnodion

20. Adolygiad

Bydd y polisi hwn yn cael ei adolygu ymhen dwy flynedd. Mae'n bosibl y bydd angen adolygiad cynharach mewn ymateb i amgylchiadau eithriadol, newid sefydliadol neu newidiadau perthnasol mewn deddfwriaeth neu ganllawiau.

21. Disgyblu

Ymchwilir i achosion o dorri'r polisi hwn a gall arwain at drin y mater fel trosedd ddisgyblaethol dan weithdrefn ddisgyblu

02

Atodiad A: Cais i ryddhau ar gyfer secondiad

2 Atodiad A: Cais i ryddhau ar gyfer secondiad

Pan fyddwch chi wedi llenwi'r ffurflen hon, dylech argraffu a llofnodi dau gopi ohoni a'i dosbarthu fel a ganlyn

Un copi i'w gadw gan yr ymgeisydd
Un copi i'w gyflwyno i'r Rheolwr Llinell a'i gadw ar y ffeil bersonol

Rhaid llenwi pob bwlch yn llawn – os na wneir hyn, bydd eich ffurflen yn cael ei hanfon yn ôl atoch, a allai beri oedi i'ch cais

Cais newydd ☐ **Estyniad** ☐ **(Ticiwch)**

ADRAN UN – I'W LLENWI GAN YR YMGEISYDD – YSGRIFENNWCH EICH ATEBION MEWN PRINT BRAS, CLIR		
Teitl: (Mr/Mrs/Miss/Ms/Dr/arall...)	Enwau cyntaf:	Cyfenw:
Swydd Bresennol:	Band:	Rhif Cofnod Staff Electronig:
Adran:	Safle:	Rhif Cyswllt (Cartref):
Rhif Cyswllt (Gwaith):	Rhif Cyswllt (Ffôn Symudol):	Cyfeiriad e-bost:
Cyfeiriad Cartref:		

CYFLE SECONDIAD
Gallai peidio â darparu'r manylion uchod yn llawn arwain at oedi wrth dderbyn cadarnhad

Teitl y Swydd:	Safle:
Sefydliad:	
Enw a Chyfeiriad y Rheolwr sy'n Derbyn:	
Hyd y Secondiad:	
O:	I:
Pwrpas y Secondiad:	
A yw'r angen i chi gymryd rhan mewn cyfle secondiad wedi'i nodi yn rhan o'r Broses Adolygu Datblygu Perfformiad?	

Nodwch sut mae'r cyfle dysgu a datblygu hwn yn berthnasol i'ch gwaith a sut bydd yn gwella eich rôl yn y gweithle.	
Llofnod	Dyddiad:

ADRAN DAU – I'W LLENWI GAN Y RHEOLWR LLINELL:		
Sut mae'r secondiad hwn yn cyd-fynd â Chynllun Datblygu Perfformiad yr ymgeisydd?		
Cymeradwywyd y secondiad:	Do:	Naddo:
Os na chafodd ei gymeradwyo, rhowch resymau pam:		
Hysbyswyd adran y gyflogres:	Do	Naddo:
Cymeradwywyd dyddiadau'r secondiad ar gyfer:	Hyd at:	Dechrau ar:
Enw'r Rheolwr (Printiwch):		Teitl:
Llofnod:		
Dyddiad:		

03

Atodiad B: Profforma cytundeb secondiad

3 Atodiad B: Profforma cytundeb secondiad

Mae'r cytundeb hwn wedi'i ddyddio

Partïon

(1) [ENW'R CYFLOGWR] o [CYFEIRIAD] (y Cyflogwr)

(2) [ENW'R SEFYDLIAD LLETYOL] o [CYFEIRIAD] (y Sefydliad Lletyol)

(3) [ENW'R GWEITHIWR] o [CYFEIRIAD] (y Gweithiwr)

Telerau y cytunwyd arnynt

1. Dehongli

1.1 Mae'r diffiniadau a'r rheolau dehongli yn y cymal hwn yn berthnasol yn y cytundeb hwn (oni bai bod y cyd-destun yn mynnu fel arall).

Dyddiad Dechrau:

Dyddiad dod i ben:

Rôl:

Cyswllt yn y Sefydliad Lletyol:

Cyswllt yn Sefydliad y Cyflogwr:

Cyflog: yn dibynnu ar godiadau cyflog graddol yn unol â'r Contract Cyflogaeth

Oriau Gwaith:

Cyfnod Rhybudd:

Lleoliad Gwaith:

Hawl i Wyliau Blynyddol:

Gwybodaeth Gyfrinachol: gwybodaeth sy'n ymwneud â busnes, cynhyrchion, materion a chyllid y parti perthnasol, sy'n gyfrinachol i'r parti perthnasol am y tro, a chyfrinachau masnach gan gynnwys, heb gyfyngiad, data technegol a gwybodaeth sy'n ymwneud â busnes y parti perthnasol neu unrhyw un o'i gyflenwyr, ei gleientiaid, ei gleifion, ei weithwyr neu'i reolwyr.

Gwybodaeth Gyfrinachol: telerau cyflogaeth rhwng y cyflogwr a'r secondai ar ddyddiad y cytundeb hwn, yn amodol ar unrhyw newidiadau i gyflog y secondai neu fuddion eraill yn unol â gweithdrefnau arferol y cyflogwr o bryd i'w gilydd.

Hawliau Eiddo Deallusol: patentau, hawliau i ddyfeisiau, hawlfraint a hawliau cysylltiedig, hawliau moesol, nodau masnach a nodau gwasanaeth, enwau busnes ac enwau parthau, hawliau o ran diwyg a sut mae cynnyrch yn edrych, ewyllys da a'r hawl i erlyn am gamgyfleu ('passing off'), hawliau i ddyluniadau, hawliau i feddalwedd gyfrifiadurol, hawliau i gronfeydd data, hawliau i ddefnyddio ac amddiffyn cyfrinachedd gwybodaeth gyfrinachol (gan gynnwys gwybod sut a chyfrinachau masnach) a'r holl hawliau deallusol eraill, ym mhob achos, p'un a ydynt wedi'u cofrestru neu heb eu cofrestru ac mae'n cynnwys pob cais a hawl i wneud cais am a derbyn, adnewyddu neu estyn hawliau i hawlio blaenoriaeth gan, hawliau o'r fath a phob hawl tebyg neu gyfwerth neu fathau o ddiogelwch sy'n bodoli neu a fydd yn bodoli yn awr neu yn y dyfodol, yn unrhyw ran o'r byd.

3 Atodiad B: Profforma cytundeb secondiad

Materion Rheoli: yr holl faterion hynny o dan y Contract Cyflogaeth sy'n gofyn am weithredu, ymchwilio a/neu benderfyniadau gan y Cyflogwr gan gynnwys yn benodol (er enghraifft yn unig a heb fod yn gyfyngedig i) arfarniadau a materion perfformiad; adolygiadau cyflog a dyfarnu taliadau a buddion eraill o dan y Contract Cyflogaeth; cyfnodau o wyliau blynyddol, absenoldeb oherwydd salwch neu wyliau eraill; absenoldeb y Secondai am unrhyw reswm arall; unrhyw gŵyn am y Secondai (p'un a fyddai hynny'n cael ei thrin o dan weithdrefn ddisgyblu'r Cyflogwr ai peidio) ac unrhyw gŵyn neu anghydfod a godwyd gan y Secondai (p'un a fyddai hynny'n cael ei drin o dan weithdrefn cwynion y Cyflogwr ai peidio).

Y Secondiad: secondiad y secondai gan y cyflogwr i'r sefydliad lletyol ar delerau'r cytundeb hwn.

Cyfnod y secondiad: y cyfnod o'r dyddiad cychwyn i'r dyddiad dod i ben, yn amodol ar ddod â'r secondiad i ben yn gynnar yn unol â thelerau'r cytundeb hwn.

1.2 Mewnosodir y penawdau yn y cytundeb hwn er hwylustod yn unig ac ni fyddant yn effeithio ar ei lunio.

1.3 Mae cyfeiriad at gyfraith benodol yn gyfeiriad ati gan ei bod mewn grym am y tro, gan ystyried unrhyw ddiwygiad, estyniad neu ailddeddfiad ac mae hefyd yn cynnwys unrhyw is-ddeddfwriaeth a wnaed oddi tani tra ei bod mewn grym.

1.4 Oni bai bod y cyd-destun yn mynnu fel arall, bydd geiriau unigol yn cynnwys geiriau lluosog a bydd geiriau lluosog yn cynnwys geiriau unigol.

1.5 Dylai'r cytundeb hwn gael ei ddarllen ochr yn ochr â Pholisi Secondiad Cymru Gyfan sydd mewn grym o bryd i'w gilydd. Os bydd unrhyw anghysondeb rhwng y ddau, bydd telerau'r cytundeb hwn yn cael blaenoriaeth.

2. Secondiad

2.1 Bydd y cyflogwr yn secondio'r secondai i'r sefydliad lletyol ar sail sy'n gyfyngedig i gyfnod y secondiad er mwyn cyflawni'r rôl.

2.2 Bydd cyfnod y secondiad yn cychwyn ar y dyddiad cychwyn a bydd yn parhau tan:

(a) Y dyddiad dod i ben; neu
(b) (bydd yn cael ei derfynu gan unrhyw barti sy'n rhoi rhybudd ysgrifenedig o ddim llai na'r cyfnod rhybudd ar unrhyw adeg; neu
(c) bydd yn cael ei derfynu yn unol â chymal 11.

3. Gwasanaethau

3.1 Bydd y secondai yn cyflawni'r rôl yn y lleoliad gwaith, neu leoliad tebyg arall yn yr ardal fel sy'n ofynnol yn rhesymol gan y sefydliad lletyol.

3.2 Efallai y bydd yn ofynnol i'r secondai deithio ar fusnes y sefydliad lletyol i leoedd (p'un ai yn y Deyrnas Unedig neu'r tu allan iddi), mewn ffyrdd ac ar achlysuron a fydd yn ofynnol gan y sefydliad lletyol o bryd i'w gilydd.

3 Atodiad B: Profforma cytundeb secondiad

3.3 Ni fydd yn ofynnol i'r secondai weithio y tu allan i'r Deyrnas Unedig am fwy na mis yn ystod y secondiad.

3.4 Oriau gwaith arferol y secondai fydd yr oriau gwaith, ac unrhyw oriau ychwanegol sy'n rhesymol ac yn angenrheidiol i gyflawni'r gwasanaethau yn iawn.

3.5 Yn ystod y secondiad, bydd y secondai yn gwneud y canlynol:

(a) neilltuo ei holl amser gweithio dan gontract, ei sylw a'i alluoedd i gyflawni'r rôl, oni bai ei fod yn methu â gweithio am resymau corfforol neu feddyliol;

(b) gwasanaethu'r sefydliad lletyol yn ffyddlon ac yn ddiwyd;

(c) peidio ag ymrwymo i unrhyw drefniant ar ran y sefydliad lletyol sydd y tu allan i'r llwybr busnes arferol neu ei ddyletswyddau arferol neu sy'n cynnwys telerau anarferol neu feichus; a

(d) chyflwyno adroddiadau o'r fath i'r cyswllt yn y sefydliad lletyol ar unrhyw faterion sy'n ymwneud â materion y sefydliad lletyol ac ar yr adegau sy'n ofynnol yn rhesymol.

4. Cyflogaeth Secondai

4.1 Bydd y contract cyflogaeth yn parhau mewn grym yn ystod cyfnod y secondiad.

4.2 Rhaid i'r secondai gydymffurfio â pholisïau a gweithdrefnau'r sefydliad lletyol, a bydd copïau ohonynt ar gael ar gais.

4.3 Ni fydd y sefydliad lletyol yn torri'r contract cyflogaeth, ac ni fydd yn ei gwneud yn ofynnol i'r secondai wneud unrhyw beth a fydd yn achosi i hyn ddigwydd, ac ni fydd gan y sefydliad lletyol unrhyw awdurdod i amrywio telerau'r contract cyflogaeth na gwneud unrhyw sylwadau i'r secondai mewn perthynas â thelerau'r contract cyflogaeth.

4.4 Bydd y sefydliad lletyol yn darparu unrhyw wybodaeth a chymorth a fydd eu hangen ar y cyflogwr er mwyn cyflawni ei rwymedigaethau fel cyflogwr y secondai.

4.5 Rhoddir gwybod i'r sefydliad lletyol am unrhyw newid yn y contract cyflogaeth yn ystod cyfnod y secondiad.

4.6 Os ystyrir bod y secondai yn cael ei gyflogi gan y sefydliad lletyol ar unrhyw adeg yn ystod neu ar ddiwedd cyfnod y secondiad, yna gall y sefydliad lletyol ddiswyddo'r secondai a bydd y cyflogwr yn cynnig cyflogaeth i'r secondai ar y telerau a oedd yn berthnasol yn union cyn y diswyddiad hwnnw.

4.7 Mae'r holl ddogfennau, llawlyfrau, caledwedd a meddalwedd a ddarperir at ddefnydd y secondai gan y sefydliad lletyol, ac unrhyw ddata neu ddogfennau (gan gynnwys copïau) a gynhyrchir, a gynhelir neu a storir ar systemau cyfrifiadurol neu offer electronig arall y sefydliad lletyol (gan gynnwys ffonau symudol), yn parhau i fod yn eiddo i'r sefydliad lletyol.

4.8 Ar ddiwedd y cytundeb hwn, ac yn ddarostyngedig i delerau'r contract cyflogaeth bob amser, ni fydd yn ofynnol i'r gweithiwr gyflawni'r rôl ar gyfer y sefydliad lletyol mwyach.

3 Atodiad B: Profforma cytundeb secondiad

5. Taliadau

5.1 Bydd y cyflogwr yn parhau i dalu cyflog y secondai ac unrhyw lwfansau, yn darparu unrhyw fuddion sy'n ddyledus i'r secondai neu ei ddibynyddion, yn gwneud unrhyw daliadau i drydydd partïon mewn perthynas â'r secondai ac yn gwneud unrhyw ddidyniadau y mae'n ofynnol iddo eu gwneud o gyflog y secondai a thaliadau eraill.

5.2 Ar ddiwedd pob mis yn ystod cyfnod y secondiad, bydd y sefydliad lletyol yn rhoi manylion unrhyw oramser ac oriau anghymdeithasol a weithiwyd gan y secondai yn ystod y mis blaenorol i'r cyflogwr, a bydd y cyflogwr yn gwneud unrhyw daliadau goramser angenrheidiol i'r secondai yn y ffordd arferol.

5.3 Bydd y sefydliad lletyol yn talu swm sy'n cyfateb i'r cyfanswm a dalwyd gan y cyflogwr i'r secondai neu mewn perthynas ag ef o dan y contract cyflogaeth, a fydd yn cynnwys, ond heb fod yn gyfyngedig i'r canlynol:

(a) y cyflog;

(b) cyfraniadau Yswiriant Gwladol a wneir gan y cyflogwr mewn perthynas â'r secondai;

(c) unrhyw daliadau goramser a wneir i'r secondai yn ystod cyfnod y secondiad ac wedi'u cymeradwyo ymlaen llaw gan y sefydliad lletyol; a

(d) chyfraniadau pensiwn a wneir gan y cyflogwr mewn perthynas â'r gweithiwr.

5.4 Bydd y secondai yn cyflwyno unrhyw dreuliau y mae'n eu hysgwyddo'n gyfan gwbl ac o reidrwydd yn ystod neu mewn cysylltiad â chyfnod y secondiad i'r sefydliad lletyol i'w cymeradwyo, bydd hyn yn ddarostyngedig i bolisi treuliau'r sefydliad lletyol bob amser. Bydd y sefydliad lletyol yn rhoi gwybod i'r cyflogwr am yr holl gostau a gymeradwyir gan y sefydliad lletyol, a bydd y cyflogwr yn ad-dalu'r secondai mewn perthynas â'r treuliau hynny. Bydd y sefydliad lletyol yn ad-dalu'r cyflogwr am unrhyw gostau o'r fath.

5.5 Bydd unrhyw symiau sy'n ddyledus i'r cyflogwr o dan y cytundeb hwn yn cronni o ddydd i ddydd a byddant yn daladwy bob mis fel ôl-daliad.

6. Rheolaeth yn ystod y secondiad

6.1 Bydd y cyflogwr yn parhau i ddelio ag unrhyw faterion rheoli sy'n ymwneud â'r secondai yn ystod cyfnod y secondiad, lle bo hynny'n berthnasol yn dilyn ymgynghori â'r sefydliad lletyol.

6.2 Bydd y sefydliad lletyol yn darparu unrhyw wybodaeth, dogfennaeth, mynediad at ei safleoedd ac at ei weithwyr a'i gymorth (gan gynnwys ond heb fod yn gyfyngedig i roi tystiolaeth fel tyst) i'r cyflogwr ddelio ag unrhyw faterion rheoli sy'n ymwneud â'r secondai, p'un ai o dan weithdrefnau mewnol y cyflogwr neu gerbron unrhyw dribiwnlys.

3 Atodiad B: Profforma cytundeb secondiad

6.3 Bydd gan y sefydliad lletyol reolaeth o ddydd i ddydd ar weithgareddau'r secondai ond cyn gynted ag y bo'n rhesymol ymarferol, bydd yn cyfeirio unrhyw faterion rheoli sy'n ymwneud â'r secondai sy'n dod i'w sylw at y cyflogwr.

6.4 Rhaid i'r sefydliad lletyol a'r cyflogwr roi gwybod i'r llall cyn gynted ag y bo'n rhesymol yn ymarferol am unrhyw fater arwyddocaol arall a all godi yn ystod cyfnod y secondiad sy'n ymwneud â'r secondai neu ei gyflogaeth.

6.5 Rhaid i'r secondai roi gwybod i'r cyswllt yn y sefydliad lletyol ac i'r cyswllt yn sefydliad y cyflogwr os yw'n nodi unrhyw wrthdaro buddiannau pendant neu bosibl rhwng y sefydliad lletyol a'r cyflogwr mewn perthynas â'r rôl yn ystod cyfnod y secondiad.

7. Gwyliau Blynyddol

7.1 Bydd y secondai yn parhau i fod yn gymwys i gael tâl salwch, tâl gwyliau ac unrhyw hawliau absenoldeb yn unol â'r contract cyflogaeth, a bydd yn parhau i fod yn ddarostyngedig i weithdrefnau cymeradwyo a hysbysu'r cyflogwr.

7.2 Bydd y secondai yn cyflwyno unrhyw geisiadau am wyliau blynyddol i'r sefydliad lletyol, yn unol â phrosesau'r sefydliad lletyol. Bydd y secondai hefyd yn rhoi gwybod i'r cyflogwr am unrhyw ddyddiadau y bydd y secondai yn eu cymryd fel gwyliau.

7.3 Bydd y secondai yn cydymffurfio â threfniadau adrodd y sefydliad lletyol os yw'r secondai yn absennol o'r gwaith am unrhyw reswm.
Yn ychwanegol, bydd yn ofynnol i'r secondai roi gwybod i'r cyflogwr am unrhyw absenoldeb.

8. Diogelu Data

8.1 Mae angen i'r cyflogwr ddarparu gwybodaeth berthnasol am y secondai i'r sefydliad lletyol mewn perthynas â'r secondiad. Yn ogystal, yn ystod y secondiad:

(a) Bydd y sefydliad lletyol yn casglu ac yn prosesu gwybodaeth sy'n ymwneud â'r secondai yn unol â hysbysiad preifatrwydd y sefydliad lletyol, sydd wedi'i atodi i'r cytundeb hwn.

(b) Bydd y secondai yn cydymffurfio â pholisi diogelu data'r sefydliad lletyol wrth drin data personol sy'n ymwneud ag unrhyw gyflogai, gweithiwr, contractwr, cwsmer, cleient, cyflenwr neu asiant y sefydliad lletyol. Bydd y secondai hefyd yn cydymffurfio â pholisi systemau TG a chyfathrebu a pholisi cyfryngau cymdeithasol y sefydliad lletyol.

(c) Gellir ymdrin â methu â chydymffurfio ag unrhyw un o'r polisïau y cyfeirir atynt yng nghymal 8.1(b) fel mater disgyblu a'i gyfeirio at y cyflogwr ac, mewn achosion difrifol, gall arwain at derfynu'r secondiad neu hyd yn oed gyflogaeth y secondai.

3 Atodiad B: Profforma cytundeb secondiad

9. Cyfrinachedd

9.1 Rhaid i'r secondai beidio â gwneud y canlynol:

(a) (ac eithrio yng nghwrs priodol gwasanaethau, fel sy'n ofynnol yn ôl y gyfraith neu fel yr awdurdodir gan y sefydliad lletyol) yn ystod cyfnod y secondiad neu ar ôl ei derfynu (sut bynnag y mae hyn yn codi) defnyddio neu gyfathrebu i unrhyw berson, cwmni neu sefydliad arall o gwbl (a bydd yn gwneud ei orau i geisio atal defnyddio neu gyfathrebu) unrhyw wybodaeth gyfrinachol sy'n ymwneud â'r sefydliad lletyol y mae'r secondai yn ei chreu, ei datblygu, ei derbyn neu ei chael yn ystod cyfnod y secondiad. Nid yw'r cyfyngiad hwn yn berthnasol i unrhyw wybodaeth sy'n gyhoeddus neu sy'n dod yn gyhoeddus, heblaw trwy ddatgeliad diawdurdod y secondai; neu

(b) wneud (heblaw er budd y sefydliad lletyol) unrhyw gofnod (p'un ai ar bapur, cof cyfrifiadur, disg neu fel arall) sy'n cynnwys gwybodaeth gyfrinachol sy'n ymwneud â'r sefydliad lletyol neu ddefnyddio cofnodion o'r fath (neu ganiatáu iddynt gael eu defnyddio) heblaw er budd y sefydliad lletyol. Bydd yr holl gofnodion o'r fath (ac unrhyw gopïau ohonynt) yn eiddo i'r sefydliad lletyol ac yn cael eu trosglwyddo i'r sefydliad lletyol gan y secondai ar ddiwedd y cytundeb hwn neu ar gais y sefydliad lletyol ar unrhyw adeg yn ystod cyfnod y secondiad.

9.2 Ni fydd unrhyw beth yn y cytundeb hwn yn atal y secondai rhag datgelu gwybodaeth y mae ganddo hawl i'w datgelu o dan Ddeddf Datgelu er Lles y Cyhoedd 1998, ar yr amod bod y datgeliad yn cael ei wneud yn unol â darpariaethau'r ddeddf honno.

9.3 Rhaid i'r cyflogwr wneud y canlynol:

(a) cadw unrhyw wybodaeth gyfrinachol sy'n ymwneud â'r sefydliad lletyol y mae'n ei chael o ganlyniad i gyfrinach y secondiad;

(b) peidio â defnyddio neu ddatgelu unrhyw wybodaeth gyfrinachol o'r fath yn uniongyrchol neu'n anuniongyrchol (neu ganiatáu iddi gael ei defnyddio neu ei datgelu), yn gyfan gwbl neu'n rhannol, i unrhyw berson heb gydsyniad ysgrifenedig ymlaen llaw gan y sefydliad lletyol;

(c) sicrhau nad oes unrhyw un yn cael mynediad i'r wybodaeth gyfrinachol ganddo, ei swyddogion, ei weithwyr na'i asiantau, oni bai ei fod wedi'i awdurdodi i wneud hynny; a

(d) rhoi gwybod i'r sefydliad lletyol ar unwaith ar ôl dod yn ymwybodol, neu'n amau, bod rhywun anawdurdodedig wedi dod yn ymwybodol o wybodaeth gyfrinachol o'r fath.

3 Atodiad B: Profforma cytundeb secondiad

10. Eiddo deallusol

10.1 Mae'r partïon yn cydnabod y bydd yr holl hawliau eiddo deallusol sy'n bodoli (neu a all fodoli yn y dyfodol) ym mhob dyfais a gwaith o'r fath sy'n ymgorffori hawliau eiddo deallusol a wneir yn gyfan gwbl neu'n rhannol gan y gweithiwr yn ystod y secondiad, wrth ei greu, yn eiddo i'r sefydliad lletyol yn awtomatig. I'r graddau nad ydynt yn eiddo i'r sefydliad lletyol yn awtomatig, bydd hawliau o'r fath yn cael eu cynnal ar sail ymddiriedaeth ar gyfer y sefydliad lletyol.

Mae'r cyflogwr a'r cyflogai yn cytuno'n brydlon i gyflawni'r holl ddogfennau a gwneud pob gweithred yn ôl yr angen i roi'r cymal hwn ar waith, ym marn resymol y sefydliad lletyol10.1.

11. Terfynu diannod

11.1 Gall y cyflogwr derfynu'r secondiad ar unwaith heb rybudd:

(a) wrth ddod â'r contract cyflogaeth i ben; neu
(b) os yw'r sefydliad lletyol yn euog o unrhyw achos o dorri telerau'r cytundeb hwn yn ddifrifol neu dro ar ôl tro ar ôl derbyn rhybudd.

Ni fydd unrhyw oedi gan y cyflogwr wrth arfer yr hawl i derfynu yn golygu ildio hawliau o'r fath.

11.2 Gall y sefydliad lletyol derfynu'r secondiad ar unwaith heb rybudd:

(a) wrth i'r contract gyflogaeth ddod i ben; neu
(b) os yw'r cyflogwr yn euog o unrhyw achos o dorri telerau'r cytundeb hwn yn ddifrifol neu dro ar ôl tro ar ôl derbyn rhybudd.

Ni fydd unrhyw oedi gan y sefydliad lletyol wrth arfer yr hawl i derfynu yn golygu ildio hawliau o'r fath.

12. Atebolrwydd

12.1 Yn ystod cyfnod y secondiad, bydd y sefydliad lletyol yn cyflawni'r holl ddyletswyddau sy'n ymwneud ag iechyd, diogelwch a lles y secondai fel pe bai'n gyflogwr iddo. Hefyd, rhaid iddo gydymffurfio â cheisiadau rhesymol y cyflogwr mewn cysylltiad â dyletswyddau'r cyflogwr mewn perthynas â'r secondai.

12.2 Mae'r sefydliad lletyol yn cydnabod nad yw'r cyflogwr yn gyfrifol am y ffordd y mae'r secondai yn darparu'r gwasanaethau ac yn hepgor yr holl hawliadau a all fod ganddo yn erbyn y cyflogwr sy'n deillio o unrhyw weithred neu esgeulustod gan y secondai wrth gyflawni'r gwasanaethau.

12.3 Bydd y sefydliad lletyol yn indemnio'r cyflogwr yn llawn ac yn sicrhau bod y cyflogwr wedi'i indemnio'n llawn bob amser yn erbyn unrhyw golled, anaf, difrod neu gostau a ddioddefwyd, a gafwyd neu a ysgwyddwyd gan:

(a) y secondai mewn perthynas ag unrhyw golled, anaf, difrod neu gostau sy'n deillio o unrhyw weithred neu esgeulustod gan y sefydliad lletyol neu ei weithwyr neu asiantau; neu

3 Atodiad B: Profforma cytundeb secondiad

(b) drydydd parti mewn perthynas ag unrhyw golled, anaf, difrod neu gostau sy'n deillio o unrhyw weithred neu esgeulustod gan y secondai wrth gyflawni'r gwasanaethau.

12.4 Bydd y sefydliad lletyol yn indemnio'r cyflogwr yn llawn ac yn sicrhau bod y cyflogwr wedi'i indemnio'n llawn bob amser yn erbyn unrhyw hawliad neu orchymyn gan y secondai sy'n deillio o'i gyflogaeth gan y cyflogwr neu ei derfynu yn ystod cyfnod y secondiad (heblaw am unrhyw honiad bod y cyflogwr wedi methu â thalu cyflog y secondai ac unrhyw lwfansau, nad yw wedi darparu unrhyw fuddion sy'n ddyledus i'r secondai na'i ddibynyddion, nad yw wedi gwneud unrhyw daliadau i drydydd partïon mewn perthynas â'r secondai na gwneud unrhyw ddidyniadau y mae'n ofynnol iddo eu gwneud o gyflog y secondai a thaliadau eraill.

13. Amrywiadau

Ni fydd unrhyw amrywiad ar y cytundeb hwn mewn grym, oni bai ei fod yn ysgrifenedig ac wedi ei lofnodi gan y partïon (neu eu cynrychiolwyr awdurdodedig).

14. Y gyfraith lywodraethol

Bydd y cytundeb hwn ac unrhyw anghydfod neu hawliad sy'n codi ohono neu mewn cysylltiad ag ef neu ei gynnwys neu ei ffurf (gan gynnwys anghydfodau neu hawliadau nad ydynt yn gontractiol) yn cael ei lywodraethu a'i ddehongli yn unol â chyfraith Cymru a Lloegr.

15. Awdurdodaeth

Mae pob parti yn cytuno, yn ddi-alw'n-ôl, y bydd gan Lysoedd Cymru a Lloegr awdurdodaeth unigryw i ddatrys unrhyw anghydfod neu hawliad sy'n deillio o'r contract hwn neu mewn cysylltiad ag ef neu ei gynnwys neu ei ffurf (gan gynnwys anghydfodau neu hawliadau nad ydynt yn gontractiol).

Gwnaed y cytundeb hwn ar y dyddiad a nodwyd ar ei ddechrau.

Llofnodwyd ar gyfer ac ar ran
[ENW'R CYFLOGWR]

.....

Dyddiad:

Llofnodwyd ar gyfer ac ar ran
[ENW'R SEFYDLIAD LLETYOL]

.....

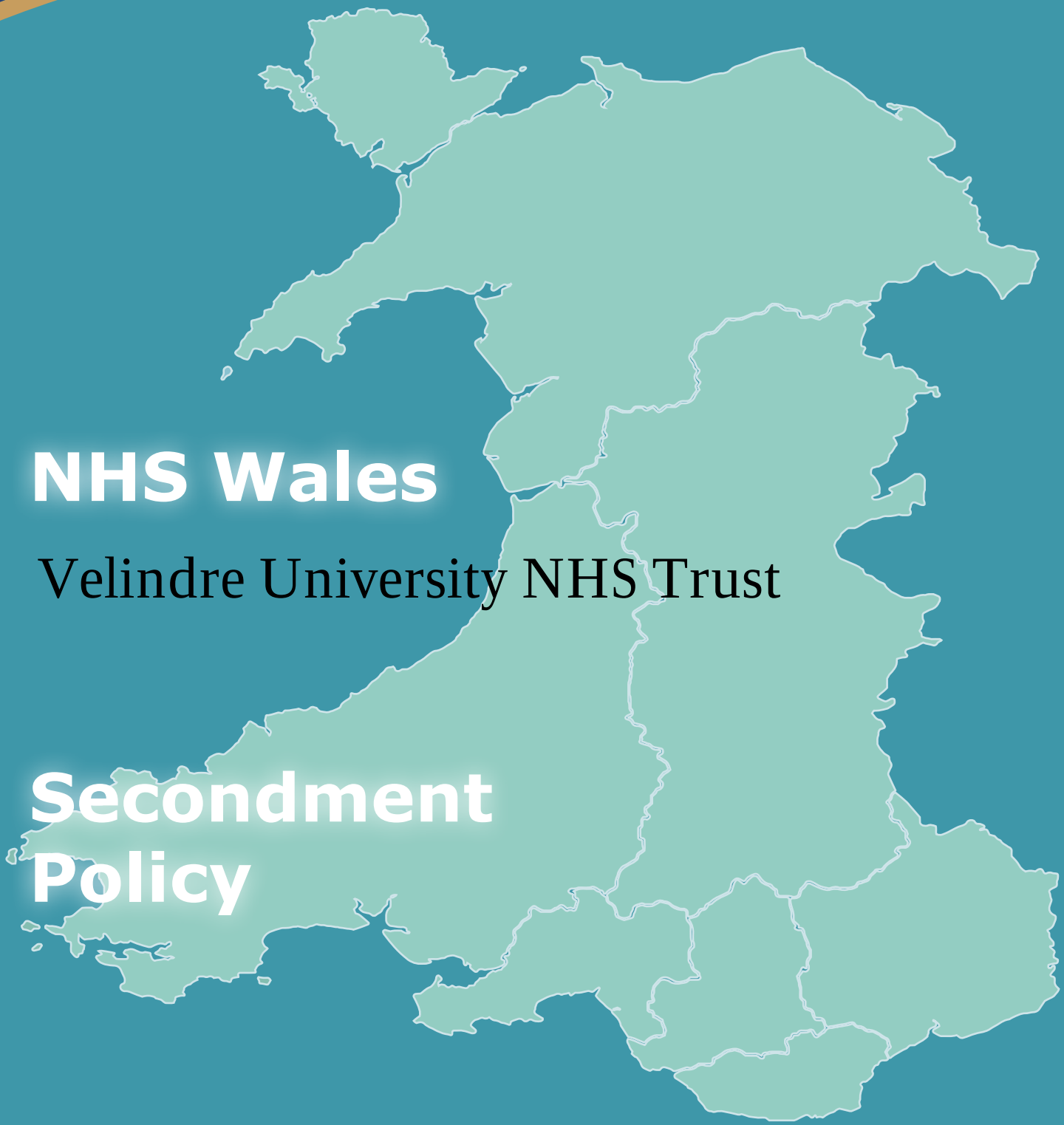
Dyddiad:

Llofnodwyd gan
[ENW'R CYFLOGAI]

.....

Dyddiad:

Dyluniwyd gan Dîm Cyfathrebu PCGC



NHS Wales

Velindre University NHS Trust

Secondment Policy

Sections

01

NHS Wales Secondment Policy

Approved by: Welsh Partnership Forum

Issue Date: July 2021

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01 Policy Statement

1. The Core Principles of NHS Wales:

- **We put patients and users of our services first:** We work with the public and patients/service users through co-production, doing only what is needed, no more, no less and trying to avoid harm. We are honest, open, empathetic and compassionate. We ensure quality and safety above all else by providing the best care at all times.
- **We seek to improve our care:** We care for those with the greatest health need first, making the most effective use of all skills and resources and constantly seeking to fit the care and services we provide to users' needs. We integrate improvement into everyday working, by being open to change in all that we do, which also reduces harm and waste.
- **We focus on wellbeing and prevention:** We strive to improve health and remove inequities by working together with the people of Wales so as to ensure their wellbeing now and in future years and generations.
- **We reflect on our experiences and learn:** We invest in our learning and development. We make decisions that benefit patients and users of our services by appropriate use of the tools, systems and environments which enable us to work competently, safely and effectively. We actively innovate, adapt and reduce inappropriate variation whilst being mindful of the appropriate evidence base to guide us.
- **We work in partnership and as a team:** We work with individuals including patients, colleagues, and other organisations; taking pride in all that we do, valuing and respecting each other, being honest and open and listening to the contribution of others. We aim to resolve disagreements effectively and promptly and we have a zero tolerance of bullying or victimization of any patient, service user or member of employees.
- **We value all who work for the NHS:** We support all our colleagues in doing the jobs they have agreed to do. We will regularly ask about what they need to do their work better and seek to provide the facilities they need to excel in the care they give. We will listen to our colleagues and act on their feedback and concerns.

They have been developed to help and support employees working in NHS Wales.

NHS Wales is about people, working with people, to care for people. These Core Principles describe how we can work together to make sure that what we do and how we do it is underpinned by a strong common sense of purpose which we all share and understand.

The NHS is continually under pressure to deliver more services, with better outcomes and maintain and increase quality against the backdrop of significant financial challenge, high levels of public expectation and with a population which is getting older and with increased levels of chronic conditions.

These principles have been developed to help address some of the pressures felt by employees in responding to these demands. They will re-balance the way we work together so we are less reliant on process and are supported to do the right thing by being guided by these principles when applying policies and procedures to the workforce.

As people working within the health service, we will all use them to support us to carry out our work with continued dedicated commitment to those using our services, during times of constant change.

The Principles are part of an ongoing commitment to strengthen the national and local values and behaviour frameworks already established across Health Boards and Trusts.

They have been developed in partnership with representatives from employers and staff side.

The Principles will be used to create a simpler and consistent approach when it comes to managing workplace employment issues.

2. Introduction

The aims and objectives of the policy are:

2.1 To provide clear advice, support and guidance to managers and employees regarding their role(s) in managing the secondment approval process and the subsequent management of processes related to the said secondment.

2.2 To provide a cost effective, fair and equitable method of providing employees with work experience and development opportunities outside of their normal area of work and/or the NHS Organisation whilst ensuring that the short to medium term staffing needs for service provision are in place.

2.3 The policy should be read in conjunction with the Organisational Change Policy, where appropriate.

The Velindre University NHS Trust is committed to the delivery of a quality service. In view of this the NHS Organisation recognises its responsibility to train and develop staff to maximise their potential, to meet the needs of the service. Secondments are valuable for staff development and progression and for addressing a short-term need to cover a post.

Benefits to the NHS Organisation:

- Retention of staff
- Utilising potential in the workforce to undertake identified projects, which may not justify a new appointment and might otherwise be difficult to achieve within an acceptable timescale.
- During a period of organisational change secondment may help the NHS Organisation to ensure continuity of service.
- Supporting the identified development needs of individual employees to the longer-term benefit of the team or NHS Organisation as a whole, as agreed and identified through the PADR process.
- Immediate availability of skilled staff with intimate knowledge of NHS Organisation policies and procedures.
- To sustain standards of service provision e.g., by covering periods of long term sickness, maternity leave or career break etc.
- A secondment may provide an opportunity to forge closer links with the recipient organisation.

Benefits to Employees:

• Providing opportunities to individuals who may have an interest in changing their career path. This allows both the individual and the NHS Organisation to assess their suitability for such a change.

• Providing an opportunity to meet development needs agreed between the employee and line manager, and which may have been identified through the PADR process.

• Providing an opportunity to experience work which could contribute to personal and career development.

• Providing an opportunity for staff to experience a different culture and different ways of working.

3. Principles

3.1 The policy is based on the following guiding principles, which should be taken into consideration during each stage of the secondment:

• The needs of the organisation(s)
• Current/expected departmental establishment levels
• Staff will be supported to access secondments that are beneficial to their career and professional development
• The process by which a secondment opportunity is provided will follow a fair process that treats every employee equally
• Fairness to staff, managers and colleagues.

3.2 Secondments must be based on mutual agreement between the member of staff, line manager/organisation and host manager/organisation.

3.3 Secondments should not be used in place of other contractual arrangements for staff.

3.4 There is a requirement on the individual and both the Employer and Host organisations to maintain communication during the period of the secondment. Any individual on secondment must be kept informed of any significant changes to their substantive department or role.
The individual and Host organisation have a requirement to keep the Employer up to date in terms of the circumstances, e.g., should they be seeking any variation to their secondment agreement.

3.5 Secondment opportunities will be monitored to inform the need to consider positive action to address inequality.

4. Scope of the policy

4.1 Secondment opportunities should be available to all staff and all requests will be given serious consideration. There may, however, be service or operational requirements which lead to an application for release being declined.

4.2 Separate procedures apply in respect of the secondment of medical and dental staff. Advice on these procedures can be obtained from Workforce and OD departments.

5. Definitions

5.1 Secondment

- Secondment occurs when an employee is transferred temporarily from their substantive post to another post either in the same or another organisation and is expected to return to their old post at the end of the secondment. Some contractual terms may vary during the period of the secondment i.e., salary, work base, hours of work etc. The terms and conditions of the substantive post will remain as they were prior to the secondment.

- Secondment is not to be confused with temporary movement into a higher band. Nor is it to be confused with an agreement between the manager and individual for that individual to undertake a time limited piece of work or project, which is commensurate with their grade and skills or experience etc.

5.2 The seconding organisation (Employer) is the individual's main/ substantive employer and the host organisation is the organisation at which the individual will work during the secondment.

6. Ways in which secondments may arise

6.1 Internal

Internal secondments occur when staff are seconded within their organisation. This can be in the same department/ directorate, or to another area of the NHS Organisation. These posts will be advertised in accordance with organisational policies and procedures, unless there are exceptional circumstances agreed with the Workforce & Organisation Development department, in partnership with staff side representation.

6.2 External NHS

External NHS secondments occur when a member of staff is seconded to another NHS Organisation.

6.3 External non-NHS

External non NHS secondment opportunities may become available in a number of organisations/sectors, e.g.

- Social Services, other local authority departments;
- Educational establishments;
- Welsh Assembly Government;
- Health related private sector companies

7. Duration

Secondments should ordinarily be for a minimum of three months and a maximum of four years.

Sometimes a secondment will initially be set up for a shorter period, but as circumstances change the parties may wish to extend it. Where the Host's requirement for the seconded post is going to last for more than four years, the host should have a conversation with the Employer about whether the Secondee's substantive post can be kept open. If the Secondee's substantive post cannot be kept open, then the options open are either:

- Offer the post to the employee on a substantive basis, either on a permanent or fixed-term basis; or

- Return the employee to their substantive role.

8. Release of staff

8.1 Individuals who wish to be released from their substantive post to take part in a secondment opportunity should complete the attached release request form.

8.2 Before agreeing to release a member of staff for a secondment, consideration must be given to the impact on the whole team, the service and the need for cover of the consequent temporary vacancy. Advice may be sought from the Workforce and OD department if necessary.

8.3 Managers are not obliged to accommodate all requests for secondments, but they are required to give serious consideration to each request. Refusals may be made on objective business grounds.

8.4 Managers should consider a number of factors when agreeing to release a member of staff including:

- Development needs arising out of individual performance reviews and development plans.
- Previous requests for secondment.
- Exigencies of the Service.

8.5 Following consideration of the points in 8.4, the length and terms of the secondment must be confirmed in writing by the line manager. (See section 10)

8.6 Staff should discuss their wish to apply for a secondment in principle with their line manager at the earliest opportunity.

9. Protection of post

9.1 The Secondee's substantive post shall be kept open. If it is not possible to keep the Secondee's substantive post open alternative employment of an equivalent grade, type and status will be sought at the end of the secondment, firstly within the same directorate before looking organisation wide.

9.2 If an extension to the secondment is sought, the issue of the Secondee's substantive post being kept open on their return should be an integral part of the decision to extend. If it is not possible to keep the post open beyond the duration of the current secondment the employee should be given the opportunity to return to their substantive post at that time.

9.3 In the event of organisational change affecting a department's establishment during the period of secondment, the secondee must be consulted on any changes by their line manager and be considered equally under the terms of the Organisational Change policy and afforded the same rights and opportunities.

10. Roles and Responsibilities

10.1 The Secondment Agreement

When an individual is seconded to work for another organisation, they will continue to be employed on their usual terms and conditions of employment with the exception of salary, which may vary as appropriate (i.e., the terms that they are employed on by their Employer). All parties (i.e., the Secondee, the Host organisation and the Employer) will enter into a written secondment agreement which will detail the terms upon which the secondment is based.

A model secondment agreement is included at Appendix B. The template Secondment Agreement should be used for all secondments between Health Boards, NHS Trusts and Special Health Authorities in Wales. The template agreement provides a balanced position as between all of the NHS bodies in Wales, recognising that at different times all organisations will be either the Host or the Employer.

NHS Organisations may find it helpful to use the template as a starting point when negotiating secondment terms with organisations outside the NHS in Wales but should carefully consider whether all of the provisions meet their needs (particularly around liability, pay and practical arrangements).

10.2 Management of the Secondee

10.2.1 The Employer shall continue to deal with any Management Issues concerning the Secondee during the Secondment Period, where relevant following consultation with the Host.

10.2.2. The Host shall provide any information, documentation, access to its premises and employees and assistance (including but not limited to giving witness evidence) to the Employer to deal with any Management Issues concerning the Secondee whether under the Employer's internal procedures or before any court of tribunal. The Host will also need to consider whether pre-employment checks are necessary and if so, ensure they are undertaken in a timely manner.

10.2.3 The Host shall have day-to-day control of the Secondee's activities but as soon as reasonably practicable shall refer any Management Issues concerning the Secondee that come to its attention to the Employer.

10.2.4 The Host and the Employer shall inform the other as soon as reasonably practicable of any other significant matter that may arise during the Secondment Period relating to the Secondee or their employment.

10.2.5 The Secondee shall notify the Host Contact and the Employer Contact if the Secondee identifies any actual or potential conflict of interest between the Host and the Employer in respect of the Role during the Secondment Period.

10.2.6 The Secondee should be appraised by the host organisation following discussions with an appropriate individual from the seconding organisation and appropriate input sought. The Employer will maintain a regular dialogue with the employee. The Employer will carry out any performance management with the host organisation.

10.2.7 There is an expectation of regular and consistent communication between the Host organisation, the Employer and the Secondee, including a meeting of all parties 8 weeks before the secondment is due to end.

10.2.8 In the event of the secondee finding a new role/job, notice should be given in line with their seconded role (refer to notice period).

11. Salary

11.1 The salary and expenses (expenses to be approved by the Host organisation) should be paid by the substantive employer and recharged to the host organisation to ensure that pension arrangements are not affected.

11.2 If a member of staff is on protection under the OCP when they are seconded, that protected salary should continue to apply if the post seconded into is on a lower salary provided that the secondment is in keeping with an individual's personal development plan, to develop the necessary skills and competencies in support of returning the individual to their current grade / band.

11.3 Where a salary in excess of the secondee's substantive salary is paid, protection of pay will not apply at the end of the secondment. At the end of the secondment period the individual will revert back to his/her substantive post including incremental rises and pay awards. The expectation is that an employee on secondment would progress through pay steps in line with the All Wales Pay Progression policy.

11.4 Existing members of the NHS Pension Scheme with Special Class Status who are considering undertaking a secondment are advised to seek advice from the Pensions Agency prior to doing so to ensure that this is not affected.

12. Termination

12.1 A secondment may be terminated early by the agreement of all parties.

12.2 The secondment will terminate at the end of the agreed period and the employee will then return to their substantive post or, as allowed for under section 9, to a post on a grade and salary commensurate with his/her original post.

13. Completion of Secondment

13.1 On completion of a secondment, a review should be conducted by the line manager to identify how the individual's development can be used for the benefit of the organisation and to ensure that learning is transferred successfully.

13.2 Induction programmes and training should be made available by the line manager for returning employees, as appropriate.

14. Disputes

If a secondment or extension is refused and the employee is dissatisfied with the decision, they should follow the process set out in Employer's Grievance policy (or any policy which has replaced the Grievance policy).

15. Training and awareness raising

All staff will be made aware of this policy upon commencement with the Velindre University NHS Trust Copies can also be viewed on the Velindre University NHS Trust Intranet or obtained via the Workforce and OD department. Training will be provided as appropriate depending on the complexity of the policy.

16. Equality

NHS Organisation recognises the diversity of the local community and those that it employs. Our aim is therefore to provide a safe environment free from discrimination and a place where all individuals are treated fairly, with dignity and appropriately to their need.

NHS Organisation recognises that equality impacts on all aspects of its day to day operations. This policy was assessed using the NHS Centre for Equality and Human Rights Equality Impact Assessment Tool and the results published on the website and monitored centrally.

17. General Data Protection Regulation 2018

All documents generated under this policy that relate to identifiable individuals are to be treated as confidential documents, in accordance with the Velindre University NHS Trust Data Protection Policy.

18. Freedom of Information Act 2000

All NHS Organisations' records and documents, apart from certain limited exemptions, can be subject to disclosure under the Freedom of Information Act 2000. Records and documents exempt from disclosure would, under most circumstances, include those relating to identifiable individuals arising in a personnel or staff development context.

Details of the application of the Freedom of Information Act within the Velindre University NHS Trust may be found in the Velindre University NHS Trust publications scheme.

19. Records Management

All documents generated under this policy are official records of the NHS Organisation and will be managed and stored and utilised in accordance with the Velindre University NHS Trust Records Management Policy.

20. Review

This policy will be reviewed in two years' time. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation or guidance.

21. Discipline

Breaches of this policy will be investigated and may result in the matter being treated as a disciplinary offence under the Velindre University NHS Trust disciplinary procedure.

02

Appendix A: Application for release of secondment / secondment extension

2 Appendix A: Application for release of secondment / secondment extension

Once completed please print and sign two copies of this form and distribute as follows

One copy to be retained by applicant

One copy to be submitted to Line Manager and retained on the personal file

All fields must be completed in full, if not, your form will be returned to you which could delay your application

New application ☐ **Extension** ☐ **(Please tick)**

SECTION ONE – TO BE COMPLETED BY APPLICANT – PLEASE PRINT CLEARLY CURRENT POST		
Title: (Mr/Mrs/Miss/Ms/Dr/other...)	Forenames:	Surname:
Current Post:	Band:	ESR Number:
Department:	Site:	Contact Number (Home):
Contact Number (Work):	Contact Number (Mobile):	Email address:
Home Address:		
SECONDMENT OPPORTUNITY *Failure to provide the above details in full may delay receipt of confirmation*		
Post Title:		Base:
Organisation:		
Name and Address of Receiving Manager:		
Duration of Secondment:		
From:	To:	
Purpose of Secondment:		
Has the need for you to take part in a secondment opportunity been identified as part of the Performance Development Review Process?		

Please identify how this learning and development opportunity is relevant to your work and how it will enhance your role in the workplace?	
Signed:	To:

SECTION TWO – TO BE COMPLETED BY LINE MANAGER:		
How does this secondment align with the applicant's PDP:		
Secondment approved:	Yes:	No:
If no, please give reasons		
Payroll notified:	Yes:	No:
Secondment dates approved from:	To:	From:
Managers Name (Please print):		Title:
Signed:		
Date:		

03

Appendix B: Secondment agreement pro-forma

3 Appendix B: Secondment agreement pro-forma

This agreement is dated

Parties

(1) [EMPLOYER NAME] of [ADDRESS] (the Employer)

(2) [HOST NAME] of [ADDRESS] (the Host)

(3) [EMPLOYEE NAME] of [ADDRESS] (the Employee)

Agreed terms

1. Interpretation

1.1 The definitions and rules of interpretation in this clause apply in this agreement (unless the context requires otherwise).

Commencement Date:

Expiry Date:

Role:

Host Contact:

Employer Contact:

Salary: , subject to any incremental increases in accordance with the Employment

Contract

Working Hours:

Notice Period:

Work Location:

Annual Leave Entitlement:

Confidential Information: information relating to the business, products, affairs and finances of the relevant party for the time being confidential to the relevant party and trade secrets including, without limitation, technical data and know-how relating to the business of the relevant party or any of its suppliers, clients, patients, employees or management.

Employment Contract: the terms of employment between the Employer and the Secondee at the date of this agreement, subject to any changes in the Secondee's salary or other benefits in accordance with the Employer's usual procedures from time to time.

Intellectual Property Rights: patents, rights to inventions, copyright and related rights, moral rights, trademarks and service marks, business names and domain names, rights in get-up and trade dress, goodwill and the right to sue for passing off, rights in designs, rights in computer software, database rights, rights to use, and protect the confidentiality of, confidential information (including know-how and trade secrets) and all other intellectual property rights, in each case whether registered or unregistered and including all applications and rights to apply for and be granted, renewals or extensions of, and rights to claim priority from, such rights and all similar or equivalent rights or forms of protection which subsist or will subsist now or in the future in any part of the world.

3 Appendix B: Secondment agreement pro-forma

Management Issues: all those matters under the Employment Contract requiring action, investigation and/or decisions by the Employer including in particular (by way of illustration only and without limitation) appraisals and performance issues; pay reviews and the award of other payments and benefits under the Employment Contract; periods of annual, sick or other leave; absence of the Secondee for any other reason; any complaint about the Secondee (whether or not that would be dealt with under the Employer's disciplinary procedure) and any complaint or grievance raised by the Secondee (whether or not that would be dealt with under the Employer's grievance procedure).

Secondment: the secondment of the Secondee by the Employer to the Host on the terms of this agreement.

Secondment Period: the period from the Commencement Date to the Expiry Date, subject to early termination in accordance with the terms of this agreement.

1.2 The headings in this agreement are inserted for convenience only and shall not affect its construction.

1.3 A reference to a particular law is a reference to it as it is in force for the time being taking account of any amendment, extension, or re-enactment and includes any subordinate legislation for the time being in force made under it.

1.4 Unless the context otherwise requires, words in the singular shall include the plural and in the plural shall include the singular.

1.5 This Agreement should be read alongside the All Wales Secondment Policy as in force from time to time. In the event of any discrepancy between the two, the terms of this Agreement shall take precedence.

2. Secondment

2.1 The Employer shall second the Secondee to the Host on an exclusive basis for the Secondment Period to carry out the Role.

2.2 The Secondment Period shall commence on the Commencement Date and shall continue until:

(a) The Expiry Date; or
(b) terminated by any party giving written notice of not less than the Notice Period at any time; or
(c) terminated in accordance with clause 11.

3. Services

3.1 The Secondee shall carry out the Role at the Work Location, or such other place within its area as the Host may reasonably require.

3.2 The Secondee may be required to travel on the Host's business to such places (whether within or outside the United Kingdom) by such means and on such occasions as the Host may from time to time require.

3.3 The Secondee shall not be required to work outside the United Kingdom for more than one month during the Secondment.

3.4 The Secondee's normal working hours shall be the Working Hours, and such additional hours as are reasonable and necessary for the proper performance of the Services.

3.5 The Secondee shall during the Secondment:

(a) unless prevented by incapacity, devote the whole of their contracted working time, attention and abilities to carrying out the Role;

(b) faithfully and diligently serve the Host;

(c) not enter into any arrangement on behalf of the Host which is outside the normal course of business or their normal duties or which contains unusual or onerous terms; and

(d) promptly make such reports to the Host Contact on any matters concerning the affairs of the Host and at such times as are reasonably required.

4. Secondee's employment

4.1 The Employment Contract shall remain in force during the Secondment Period.

4.2 The Secondee shall comply with the Host's policies and procedures, copies of which will be made available on request.

4.3 The Host shall not, and shall not require the Secondee to do anything that shall, breach the Employment Contract and shall have no authority to vary the terms of the Employment Contract or make any representations to the Secondee in relation to the terms of the Employment Contract.

4.4 The Host shall provide the Employer with such information and assistance as it may reasonably require to carry out its obligations as the Secondee's employer.

4.5 Any change in the Employment Contract during the Secondment Period shall be notified to the Host.

4.6 If the Secondee is held to be employed by the Host at any time during or on termination of the Secondment Period then the Host may dismiss the Secondee and the Employer shall offer the Secondee employment on the terms that applied immediately before that dismissal.

4.7 All documents, manuals, hardware and software provided for the Secondee's use by the Host, and any data or documents (including copies) produced, maintained or stored on the Host's computer systems or other electronic equipment (including mobile phones), remain the property of the Host.

4.8 Upon the termination of this Agreement, and subject always to the terms of the Employment Contract, the Employee shall no longer be required to carry out the Role for the Host.

3 Appendix B: Secondment agreement pro-forma

5. Payments

5.1 The Employer shall continue to pay the Secondee's salary and any allowances, provide any benefits due to the Secondee or their dependants, make any payments to third parties in relation to the Secondee and make any deductions that it is required to make from the Secondee's salary and other payments.

5.2 The Host shall, at the end of each month during the Secondment Period, provide the Employer with details of any overtime and unsocial hours worked by the Secondee during the preceding month, and the Employer shall make any necessary overtime payments to the Secondee in the usual way.

5.3 The Host shall pay the Employer a sum equivalent to the total amount paid by the Employer to or in respect of the Secondee under the Employment Contract, which shall include, but is not limited to:

(a) the Salary;

(b) National Insurance contributions made by the Employer in relation to the Secondee;

(c) any overtime payments made to the Secondee during the Secondment Period and approved in advance by the Host; and

(d) Pension contributions made by the Employer in respect of the Employee.

5.4 Any wholly, exclusively and necessarily incurred expenses incurred by the Secondee during or in connection with the Secondment Period shall be submitted by the Secondee to the Host for approval, subject always to the Host's expenses policy. The Host shall notify the Employer of all expenses that are approved by the Host, and the Employer shall refund the Secondee in respect of those expenses. The Host shall reimburse the Employer for any such expenses.

5.5 Any sums due to the Employer under this agreement shall accrue from day to day and shall be payable monthly in arrears.

6. Management during the secondment

6.1 The Employer shall continue to deal with any Management Issues concerning the Secondee during the Secondment Period, where relevant following consultation with the Host.

6.2 The Host shall provide any information, documentation, access to its premises and employees and assistance (including but not limited to giving witness evidence) to the Employer to deal with any Management Issues concerning the Secondee whether under the Employer's internal procedures or before any court of tribunal.

6.3 The Host shall have day-to-day control of the Secondee's activities but as soon as reasonably practicable shall refer any Management Issues concerning the Secondee that come to its attention to the Employer.

6.4 The Host and the Employer shall inform the other as soon as reasonably practicable of any other significant matter that may arise during the Secondment Period relating to the Secondee or their employment.

6.5 The Secondee shall notify the Host Contact and the Employer Contact if the Secondee identifies any actual or potential conflict of interest between the Host and the Employer in respect of the Role during the Secondment Period.

7. Leave

7.1 The Secondee shall continue to be eligible for sick pay, holiday pay and any absence entitlements in accordance with the Employment Contract, and shall remain subject to the Employer's approval and notification procedures.

7.2 The Secondee shall submit any annual leave requests to the Host, in accordance with the Host's processes. The Secondee shall additionally notify the Employer of any dates on which the Secondee shall take holiday.

7.3 The Secondee shall comply with the Host's reporting arrangements if the Secondee is absent from work for any reason. The Secondee shall additionally be required to notify the Employer of any absence.

8. Data protection

8.1 The Employer needs to provide relevant information about the Secondee to the Host in connection with the secondment. In addition, during the secondment:

(a) The Host will collect and process information relating to the Secondee in accordance with the Host's privacy notice which is annexed to this agreement.

(b) The Secondee will comply with the Host's data protection policy when handling personal data relating to any employee, worker, contractor, customer, client, supplier or agent of the Host. The Secondee will also comply with the Host's IT and communications systems policy and social media policy.

(c) Failure to comply with any of the policies referred to in clause 8.1(b) may be dealt with as a disciplinary matter and referred to the Employer and, in serious cases, may result in the termination of the secondment or even the Secondee's employment.

3 Appendix B: Secondment agreement pro-forma

9. Confidentiality

9.1 The Secondee shall not:

(a) (except in the proper course of the Services, as required by law or as authorised by the Host) during the Secondment Period or after its termination (howsoever arising) use or communicate to any person, company or other organisation whatsoever (and shall use best endeavours to prevent the use or communication of) any Confidential Information relating to the Host that the Secondee creates, develops, receives or obtains during the Secondment Period. This restriction does not apply to any information that is or comes in the public domain other than through the Secondee's unauthorised disclosure; or

(b) make (other than for the benefit of the Host) any record (whether on paper, computer memory, disc or otherwise) containing Confidential Information relating to the Host or use such records (or allow them to be used) other than for the benefit of the Host. All such records (and any copies of them) shall be the property of the Host and shall be handed over to the Host by the Secondee on the termination of this agreement or at the request of the Host at any time during the Secondment Period.

9.2 Nothing in this agreement shall prevent the Secondee from disclosing information that they are entitled to disclose under the Public Interest Disclosure Act 1998, provided that the disclosure is made in accordance with the provisions of that Act.

9.3 The Employer shall:

(a) keep any Confidential Information relating to the Host that it obtains as a result of the Secondment secret;

(b) not use or directly or indirectly disclose any such Confidential Information (or allow it to be used or disclosed), in whole or in part, to any person without the prior written consent of the Host;

(c) ensure that no person gets access to the Confidential Information from it, its officers, employees or agents unless authorised to do so; and

(d) inform the Host immediately on becoming aware, or suspecting, that an unauthorised person has become aware of such Confidential Information.

10. Intellectual property

10.1 The Parties acknowledge that all Intellectual Property Rights subsisting (or which may in the future subsist) in all such inventions and works embodying Intellectual Property Rights made wholly or partly by the Employee during the course of the Secondment shall automatically, on creation, vest in the Host. To the extent that they do not vest automatically, such rights will be held on trust for the Host.

The Employer and the Employee agree promptly to execute all documents and do all acts as may, in the Host's reasonable opinion, be necessary to give effect to this Clause 10.1.

11. Summary termination

11.1 The Employer may terminate the Secondment with immediate effect without notice:

(a) on the termination of the Employment Contract; or
(b) if the Host is guilty of any serious or (after warning) repeated breach of the terms of this agreement.

Any delay by the Employer in exercising the right to terminate shall not constitute a waiver of such rights.

11.2 The Host may terminate the Secondment with immediate effect without notice:

(a) on the termination of the Employment Contract; or
(b) if the Employer is guilty of any serious or (after warning) repeated breach of the terms of this agreement.

Any delay by the Host in exercising the right to terminate shall not constitute a waiver of such rights.

12. Liability

12.1 During the Secondment Period, the Host shall fulfil all duties relating to the Secondee's health, safety and welfare as if it was their employer and shall comply with the Employer's reasonable requests in connection with the Employer's duties in relation to the Secondee.

12.2 The Host acknowledges that the Employer is not responsible for the way in which the Secondee provides the Services and waives all and any claims that it may have against the Employer arising out of any act or omission of the Secondee in the course of carrying out the Services.

12.3 The Host shall indemnify the Employer fully and keep the Employer indemnified fully at all times against any loss, injury, damage or costs suffered, sustained or incurred by:

(a) the Secondee in relation to any loss, injury, damage or costs arising out of any act or omission by the Host or its employees or agents; or

(b) a third party, in relation to any loss, injury, damage or costs arising out of any act or omission of the Secondee in the course of carrying out the Services.

12.4 The Host shall indemnify the Employer fully and keep the Employer indemnified fully at all times against any claim or demand by the Secondee arising out of their employment by the Employer or its termination during the Secondment Period (except for any claim that the Employer has failed to pay the Secondee's salary and any allowances, provide any benefits due to the Secondee or their dependants, make any payments to third parties in relation to the Secondee or make any deductions that it is required to make from the Secondee's salary and other payments).

13. Variation

No variation of this agreement shall be effective unless it is in writing and signed by the parties (or their authorised representatives).

14. Governing law

This agreement and any dispute or claim arising out of or in connection with it or its subject matter or formation (including non-contractual disputes or claims) shall be governed by and construed in accordance with the law of England and Wales.

15. Jurisdiction

Each party irrevocably agrees that the courts of England and Wales shall have exclusive jurisdiction to settle any dispute or claim arising out of or in connection with this agreement or its subject matter or formation (including non-contractual disputes or claims).

This agreement has been entered into on the date stated at the beginning of it.

Signed for and on behalf of
[NAME OF THE EMPLOYER]

.....

Date:

Signed for and on behalf of
[NAME OF THE HOST]

.....

Date:

Signed by
[NAME OF THE EMPLOYEE]

.....

Date:

Designed by the NWSSP Communications Team

TRUST BOARD

TRUST SEAL REPORT – JULY 2021 - SEPTEMBER 2021

DATE OF MEETING	30/09/21

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

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

REPORT PURPOSE	FOR APPROVAL

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

ACRONYMS	
TCS	Transforming Cancer Services
nVCC	New Velindre Cancer Centre
NWSSP	NHS Wales Shared Services Partnership

1. SITUATION/BACKGROUND

1.1 The contents of the Trust Board Seal Register have been approved by the Chair and the Chief Executive Officer of the Trust at every Seal request (period July - September 2021).

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

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

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

3. IMPACT ASSESSMENT

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

4. RECOMMENDATION

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

Appendix 1 – Seal Register

Date	Document Details	Signed
14 July 2021	Call Off Contract for National Project Manager Laundry Transformation Programme for North Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Project Manager Laundry Transformation Programme for South East Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Project Manager Laundry Transformation Programme for South West Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Cost Adviser Laundry Transformation Programme for North Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Cost Adviser Laundry Transformation Programme for South East Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Cost Adviser Laundry Transformation Programme for South West Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Vinci PLC and Sir Robert McAlpine (Holdings) Ltd and Velindre University NHS Trust, as the host body of NWSSP and Vinci Construction UK Ltd and Sir Robert McAlpine Ltd: Parent Company Guarantee Relating to Transforming Access to Medicines SE Hub	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call Off Contract for National Supply Chain Partner Transforming Access to Medicines SE HUB [TRAMS SE Hub] Vinci PLC and Sir Robert McAlpine (Holdings) Ltd and Velindre University NHS Trust, as the host body of NWSSP and Vinci Construction UK Ltd and Sir Robert McAlpine Ltd: Parent Company Guarantee Relating to Transforming Access to Medicines SE Hub (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
14 July 2021	Call off Contract for National Cost Adviser Transforming Access to Medicines SE Hub [TRAMS SE HUB] (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO

Date	Document Details	Signed
14 July 2021	Call of Contract for National Project Manager Transforming Access to Medicines SE Hub [TRAMS SE HUB] (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
8th August 2021	Velindre University NHS Trust and Secretary of State for Housing, Communities and Local Government, C/O Department for Health & Social Care: Underlease relating to Part Mezzanine Floor, Unit IP5 Celtic Way, Celtic Lakes, Newport, NP10 8BE (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
22nd September 2021	Interserve Group Ltd and Tilbury Douglas Construction LTD and Velindre University NHS Trust, as host body of NWSSP Shared Services Partnership: Parent Company Guarantee relating to Laundry Transformation Programme for North Wales and Call off Contract for National Supply Chain Partner, Laundry Transformation Programme for North Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
22nd September 2021	Interserve Group Ltd and Tilbury Douglas Construction LTD and Velindre University NHS Trust, as host body of NWSSP Shared Services Partnership: Parent Company Guarantee relating to Laundry Transformation Programme for South West Wales and Call off Contract for National Supply Chain Partner, Laundry Transformation Programme for South West Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
22nd September 2021	Interserve Group Ltd and Tilbury Douglas Construction LTD and Velindre University NHS Trust, as host body of NWSSP Shared Services Partnership: Parent Company Guarantee relating to Laundry Transformation Programme for South East Wales and Call off Contract for National Supply Chain Partner, Laundry Transformation Programme for South East Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
22nd September 2021	Laundry Transformation Project: Contract Execution for Business Case Writing Services (Consultant SHP) and Laundry Consultancy Service (Subconsultant: LTC Worldwde) for South West Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO

Date	Document Details	Signed
22nd September 2021	Laundry Transformation Project: Contract Execution for Business Case Writing Services (Consultant SHP) and Laundry Consultancy Service (Subconsultant: LTC Worldwide) for North Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO
22nd September 2021	Laundry Transformation Project: Contract Execution for Business Case Writing Services (Consultant SHP) and Laundry Consultancy Service (Subconsultant: LTC Worldwde) for South East Wales (x 2 copies)	Prof Donna Mead, Chair Mr. Steve Ham, CEO

TRUST BOARD

3 Year Integrated Medium Term Plan 2022/23 to 2025/26 – production timetable, approach and structure

DATE OF MEETING	30/9/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
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**
Planning and Performance Team Executive Management Board	July/August 2021 6 September 2021	NOTED NOTED

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
OMG	Operational Management Group

WBS SMT	Welsh Blood Service Senior Management Team
VCC SMT	Velindre Cancer Centre Senior Management Team
IMTP	Integrated Medium Term Plan
SDC	Strategic Development Committee
LHB	Local Health Boards
CHC	Community Health Councils

1. SITUATION/BACKGROUND

1.1 The Welsh Government has confirmed the return to a 3 year Integrated Medium Term Plan (IMTP) planning process for 2022/23 to 2025/26. More detailed planning guidance will follow, but we have received an early indication of a 31st January 2022 submission date.

1.2 The Strategic Transformation, Planning and Digital Directorate has reviewed our established IMTP development process and this paper outlines a proposed approach, IMTP structure and timetable for this year that not only meets Welsh Government 31st January 2022 deadline but also allows for comprehensive staff, Commissioner, CHC and wider stakeholder engagement.

1.3 The Welsh Government has indicated that 'Parameter Letters' giving planning assumptions and guidance will be issued in late October 2021. However, we do not believe this should delay our IMTP development plan.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The Annual (IMTP) Operational Plan for 2021/22 introduced a number of changes to the structure and content of the plan, with a focus on COVID-19 response and recovery, detailed WBS, VCC and Corporate quarterly action plans and supporting Minimum Data Set (MDS) spreadsheets.

2.2 The proposed structure and content of the IMTP for 2022/23 to 2025/26, outlined below, builds upon the good foundations of the 2021/22 plan, and will also incorporate the results of the recently launched engagement exercise, exploring our mission and vision for the future to 2032.

2.3 Our IMTP Structure and Content will broadly follow the same format as previous years with some important additions. In particular, a section outlining the results of our Equality Impact Assessment, discussions with our principal LHB Commissioners and engagement with the Community Health Council. In addition, the IMTP will follow the recently adopted VUNHST 'house style' and presentation.

IMTP 2022/23 to 2025/26 – proposed contents
Executive Summary **Part One** Overview Narrative and Our Mission, Vision and Strategic Goals Working in Partnership with Commissioners and Key Stakeholder Engagement **Part Two** 3 Year Delivery Plan for the Welsh Blood Service 3 Year Delivery Plan for the Velindre Cancer Centre **Part Three** Benefits Realisation Monitoring and Evaluation of Delivery Plans o Welsh Blood Service Quarterly Plans & Outcomes 2022/23 o Velindre Cancer Centre Quarterly Plans & Outcomes 2022/23 **Part Four** Enabling Corporate Functions o Clinical Quality and Patient and Donor Safety o Equality Impact Assessments o Workforce and Organisational Development o Digital Innovation o Research Development & Innovation o Communications, Engagement and Governance o Annual Financial Plan o Corporate Enabling Functions Quarterly Plans & Outcomes 2023/23 **Appendix** 1. Minimum Data Sets Velindre Cancer Centre (Welsh Government spreadsheets) 2. Welsh Blood Service Forecast Demand for Blood and Blood Products

2.4 Our approach to the development to the IMTP will ensure that there is an opportunity for comprehensive engagement between WBS, VCC, corporate enabling functions and with the Executive Management Board, Strategic Development Committee and the Trust Board. This will be through facilitated planning workshops and Board Development sessions.

2.5 We will also adopt an approach 'externally' that will seek to engage proactively with our LHB Commissioners, CHCs and patient/donor panels as our plan develops. The outline

development plan below envisages engagement with our LHB commissioners and CHCs on our key service priorities and developments during the period October to -December.

2.6 Our IMTP development timetable to achieve the above aims will result in a request for Trust Board approval on 28th January 2022.

2.7 It is proposed that the planning timetable should follow the stages outlined below, including clear deadlines and responsibilities for SMT, EMB, Strategic Development Committee and the Trust Board. A Trust Board development session is planned on 26th October. This will allow dedicated time for Trust Board members to input to and shape our IMTP plans.

IMTP 2022/23 to 2025/26 – production timetable	
Stage 1: Planning Assumptions and Guidance August to September 2021	
Timetable and plan structure development & contents agreed by EMB	EMB Shape 6 September 2021
Welsh Gov.t planning guidance issued in the form of 'Parameter Letters' but reasonable planning assumptions can be made	Late October 2021
Demand & Capacity – refining our forecasts	30 September 2021
VCC and WBS Divisional Reviews – future developments to shape IMTP	13 September VCC & 6 October WBS 2021
Stage 2: Plan Development Activity – September to mid December 2021	
Initial IMTP drafting WBS, VCC & Corporate	September to mid-November
Trust Board Development session – opportunity to 'shape' our plans	26th October 2021
Engage with Local Health Board Commissioners & Community Health Council	October to mid-November
Joint WBS VCC SMTs & Corp development workshops (incl. EIA)	Mid-November to mid-December
WBS, VCC and Corporate Equality Impact Assessments reviewed	Mid-November to mid-December
EMB Shape progress reviews and updates	EMB 18 Oct, 22 Nov
Trust Board and SDC briefings and updates	TB 25 Nov; SDC 7 Oct
Welsh Gov.t 2022/23 Draft Budgets published	20 December 2021
Welsh Gov.t Oversight and IMTP review IQPD meetings	Dates subject to Welsh Gov.
Stage 3: Sign off and Adoption – end December 2021 to end January 2022	
Final Draft IMTP complete for WBS VCC SMT sign off	20 December 2021 (papers 13 Dec)
Final IMTP 2022/26 iteration for EMB Shape signoff	14 January 2022

Special Strategic Development Committee final scrutiny opportunity	21 January 2022
Trust Board Briefing & Final IMTP formal approval	28 January 2022
Final submission of IMTP & MDS data 2022/26 to Welsh Gov.t	31 January 2022

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	An integrated and engaged IMTP process will help to drive forward continuous improvement in quality, safety and the overall experience of patients and donors.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the IMTP 2022/23 to 2025/26 structure, contents and production plan, based on an anticipated submission deadline of 31st January 2022.

WELSH HEALTH SPECIALISED SERVICES COMMITTEE (WHSSC)
JOINT COMMITTEE MEETING BRIEFING – SEPTEMBER 2021

The Welsh Health Specialised Services Committee held its latest public meeting on 7 September 2021. This briefing sets out the key areas of consideration and aims to ensure everyone is kept up to date with what is happening within Welsh Health Specialised Services.

The papers for the meeting can be accessed at: https://whssc.nhs.wales/joint-committee/committee-meetings-and-papers/2021-2022-meeting-papers/

1. Minutes of Previous Meetings

The minutes of the meeting held on the 13 July 2021 were **approved** as a true and accurate record of the meeting.

2. Action log & matters arising

Members **noted** the progress on the actions outlined on the action log.

3. All Wales Genetics Service Improvement

Members received an informative presentation from the Consultant Clinical Scientist and Head of the All Wales Genetics Laboratory on the work of the All Wales Medical Genomics Service (AWMGS) and the positive developments made in genomics over the last 2 years.

Members **noted** the presentation.

4. Chair's Report

Members received the Chair's Report and **noted**:

- the Chair's Year End Appraisal Review 2020-2021 with the Minister for Health & Social Services,
- that no chairs actions had been taken since the last meeting,
- the Integrated Governance Committee (IGC) held on the 10 August 2021,
- an update on discussions with Welsh Government and Cwm Taf Morgannwg University Health Board (CTMUHB) concerning WHSSC Independent Member Remuneration,
- that in future all Joint Committee "In –Committee" Reports will be shared with the NHS Wales Board Secretaries group,
- a verbal update on a request from the Chair of the NHS Wales Chairs group for the NHS Wales Board Secretaries group to review

the reporting and accountability arrangements at WHSSC and the Emergency Ambulance Services Committee (EASC).

Members **noted** the report.

5. Managing Director's Report

Members received the Managing Director's Report and **noted** updates on:

- the substantial assurance rating received for the WHSSC Cancer and Blood Programme Internal Audit Report,
- Planning undertaken in readiness for the COVID-19 Public Inquiry.

Members **noted** the report.

6. Commissioning Future New Services for Mid, South and West Wales

Members received a report to consider correspondence received from the NHS Wales Health Collaborative (Collaborative) for WHSSC to commission:

- Hepato-Pancreato-Biliary Services;
- The Hepato-Cellular Carcinoma (HCC) MDT and;
- to develop a specialist orthopaedic paediatric service specification with a view to future commissioning of the service.

A request was also received from the CEOs of Swansea Bay and Cardiff and Vale University Health Boards (HBs) on behalf of the Collaborative to commission a spinal services operational delivery network (ODN) on behalf of the six HBs in Mid, South and West Wales.

Members:
(1) **Noted** the requests received from the Collaborative Executive Group (CEG) requesting that WHSSC commissions Hepato- Pancreato-Biliary Services, the Hepato Cellular Carcinoma (HCC) MDT and develops a service specification for specialised paediatric orthopaedic surgery;
(2) **Supported** the delegation of the commissioning responsibility for HPB services and the HCC MDT services, with the required resource mapped to WHSSC;
(3) **Supported** that WHSSC develop a service specification for specialised paediatric orthopaedic surgery;
(4) **Supported** in principle the delegation of Paediatric Orthopaedic surgery commissioning, if considered appropriate by the Joint Committee, following development of the service specification, to WHSSC;
(5) **Supported** a request to commissioning health boards for approval of delegated commissioning authority to WHSSC as described above;
(6) **Noted** that the required deadline for completing the development of the Paediatric Orthopaedic Service Specification is December 2021; and
(7) **Approved** that WHSSC commission a spinal services operational delivery network (ODN) on behalf of the six Health Boards in Mid, South and West Wales. With the required funding identified and invested in through the 2022/25 Integrated Commissioning Plan.

7. WHSSC Workforce Capacity

Members received a report updating the Joint Committee on:

- requests and proposals for WHSSC to undertake new work related to services currently commissioned through Health Boards (HBs) or services which are new to Wales;
- updating the Joint Committee on workload challenges related to services currently commissioned through WHSSC,
- the range of opportunities to address the workload challenges through further development of the WHSS Team (WHSST) workforce;
- Seeking support for taking forward requests for additional investment.

Members (1) **Noted** the requests and proposals for WHSSC to undertake new work related to services currently commissioned through Health Boards (HBs) or services which are new to Wales; (2) **Noted** the workload challenges related to services currently commissioned through WHSSC; (3) **Noted** the opportunities for increasing WHSST capacity which have already been exploited; (4) **Supported** the request to Welsh Government (WG) for funding for additional project management support; (5) **Supported** the request to recharge the National Collaborative Commissioning Unit (NCCU) for increased finance support; and (6) **Supported** the inclusion of an increased DRC requirement in the 2022-2023 Integrated Commissioning Plan (ICP).

8. Recovery Planning – Quality and Outcome Improvement for Patients

Members received an informative presentation providing an update on WHSSC's approach to recovery planning with a particular emphasis on quality and outcome improvement for patients.

Members **noted** the presentation.

9. Major Trauma Priorities for in year use of Underspend and Resource Plan for 2022

Members received a report informing the Joint Committee of the current activity and performance of the Major Trauma Network, the current risks identified in the Network, the resources within the Network and how these were currently being utilised, and which sought support for underspends identified across the Network within this financial year to be used on a non-recurrent basis to address priorities identified by the Network which would be included in the Integrated Commissioning Plan (ICP).

Members discussed utilising the non-recurrent underspend across the network for priorities rather than solely in the major trauma centre. Following discussion it was agreed that a report be presented to the Management Group (MG) for further consideration.

Members (1) **Discussed** the issues in the report and requested that the proposal regarding the non-recurrent underspends, identified across the Network within this year be considered by the Management Group (MG) and that they should have delegated authority on the matter. Members accepted the principle that if the MG agreed to use the underspend within major trauma that this resource would be used across the Network; (2) **Discussed** which areas they wished to support for inclusion in the ICP and requested that further work be undertaken by MG regarding the relative priority of the proposals compared to other proposals in the plan and that their recommendations are included within the ICP for consideration by the Joint Committee

10. Review of Neonatal Cot Capacity and Neonatal Tariff
Members received a report providing an update on the number of neonatal intensive care and high dependency cots commissioned across the south Wales region, and the review of cot capacity in light of the high number of capacity transfers carried out by the transport and the neonatal tariff.

Members (1) **Supported** the proposed programme of works; (2) **Supported** the objectives of the review; (3) **Supported** the planned methodology for demand and capacity modelling; and (4) **Supported** the timelines for completion of the review.

11. Commissioning of Inherited White Matter Disorders Service (IWMDS)
Members received a report updating the Joint Committee on the development of a new Highly Specialised Service in NHS England for an Inherited White Matter Disorders Service (IWMDS), and which sought approval from the Joint Committee that WHSSC commissions the service for the population of Wales.

Members (1) **Noted** the development of a new highly specialised service for an Inherited White Matter Disorders Service (IWMDS) in NHS England; and (2) **Approved** the commissioning of the service for the population of Wales.

12. Syndrome without a Name (SWAN) Service Pilot
Members received a report requesting the ratification of the commissioning of a 2 year pilot of a Syndrome Without a Name (SWAN) service further to WHSSC receiving a request from Welsh Government.

Members (1) **Noted** the request from Welsh Government for WHSSC to commission a 2 year pilot for a Syndrome Without a Name (SWAN) service; (2) **Ratified** the commissioning of the pilot; and (3) **Approved** the intention to request that CVUHB hosts the pilot.

13. Commissioning Assurance Framework (CAF)

Members received a report which presented the Commissioning Assurance Framework (CAF) and the supporting suite of documents for final approval.

Members noted that the Integrated Commissioning Plan (ICP) 2021-2022 was presented to the Joint Committee on 09 March 2021, a final draft of the ICP was considered and approved by Joint Committee at the Extraordinary Meeting on 16 February 2021, Section 13 of the ICP outlined that a new Commissioning Assurance Framework (CAF) would be introduced in 2021-2022 which would be supported by a Performance Assurance Framework, Risk Management Strategy, Escalation Process and a Patient Engagement & Experience Framework.

Members (1) **Approved** the Commissioning Assurance Framework (CAF); (2) **Approved** the Performance Assurance Framework; (3) **Approved** the WHSSC Escalation Process; (4) **Approved** the Patient Experience & Engagement Framework; and (5) **Noted** the Risk Management Strategy which was approved by the Joint Committee in May 2021.

14. Results of Annual Committee Self-Assessment 2020-2021

Members received a report presenting the findings of the annual Committee Effectiveness Self-assessment for 2020-2021.

Members (1) **Noted** the completed actions within the Committee Effectiveness Action plan 2019- 2020; (2) **Noted** the results of the Annual Committee Effectiveness Survey 2020-2021, and the action plan for 2020-2021, to be progressed via the Integrated Governance Committee; And (3) **Received** assurance that the Annual Committee Effectiveness Self-assessment for 2020-21 has been completed and that the appropriate actions have been agreed.

15. Sub-Committee Annual Reports 2020-21

Members received the Welsh Renal Clinical Network (WRCN) and Individual Patient Funding Request (IPFR) Panel Annual Reports 2020-2021.

Members **noted** the reports.

16. Activity Reports for Month 3 2021-2022 COVID-19 Period

Members received a report that highlighted the scale of decrease in specialised services activity delivered for the Welsh population by providers in England, together with the two major supra-regional providers in South Wales.

Members **noted** the report.

17. Financial Performance Report – Month 4 2021-2022

Members received a paper the purpose of which was to provide the final outturn for the financial year. The financial position reported at Month 4 for WHSSC is a year-end outturn forecast under spend of £4,804k.

Members **noted** the report.

18. Corporate Governance Matters

Members received a report providing an update on corporate governance matters arising since the previous meeting.

Members noted that this was a new report which would feature as a standing item on the agenda going forward to provide assurance to the Joint Committee on corporate governance matters.

Members **noted** the report.

19. Other reports

Members also **noted** update reports from the following joint Sub-committees and Advisory Groups:

- Audit & Risk Committee;
- Management Group;
- Quality & Patient Safety Committee;
- Integrated Governance Committee;
- All Wales Individual Patient Funding Request Panel;
- Welsh Renal Clinical Network.

TRUST BOARD

ACUTE ONCOLOGY SERVICE

DATE OF MEETING	30 September 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jenny Stock, Principle Programme Manager
PRESENTED BY	Hilary Williams, Consultant VCC Niall Thomson, Buchans Associates
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning, Performance & Estates

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Senior Leadership Team	08/07/21	ENDORSED FOR APPROVAL
Executive Management Board	27/07/21	ENDORSED FOR APPROVAL
Strategic Development Committee	12/08/21	ENDORSED FOR APPROVAL

ACRONYMS	
AHP	Allied Health Professional
ABUHB	Aneurin Bevan University Health Board
ANP	Advanced Nurse Practitioner
AO	Acute Oncology
AOS	Acute Oncology Service
CAVUHB	Cardiff and Vale University Health Board

CCLG	Collaborative Cancer Leadership Group
CNS	Clinical Nurse Specialist
CTMUHB	Cwm Taf Morgannwg University Health Board
CUP	Confirmed Carcinoma of Unknown Primary
HB	Health Board
MDT	Multi-Disciplinary Team
MUO	Metastatic Malignancy of Undefined Primary Origin
SRO	Senior Responsible Officer
VUNHST	Velindre University NHS Trust

1. SITUATION/BACKGROUND

1.1 The purpose of this paper is to present the final South East Wales Acute Oncology Service (AOS) Business Case. It is collectively submitted as a single, regional solution to address the current gaps in the service by Aneurin Bevan University Health Board (ABUHB), Cardiff and Vale University Health Board (CAVUHB), Cwm Taf Morgannwg University Health Board (CTMUHB) and Velindre University NHS Trust (VUNHST).

1.2 The work to enhance the current AOS was commissioned by the South East Wales Collaborative Cancer Leadership Group (CCLG) in January 2020. Since then CCLG have received regular updates on progress including the draft business case in April 2021. The final business case will be received in July 2021 in parallel with the Health Board statutory governance process.

1.3 A number of strategic drivers reinforce the need to improve and enhance AOS across South East Wales including: Peer Review (2018) which identified a number of gaps in the service; the Quality Statement for Cancer (2021) which has a specific requirement under the Safety theme to ensure that fully integrated Acute Oncology Services are available in all acute hospitals; and the Nuffield Trust review (2020) of planned changes to non-surgical tertiary cancer services across South East Wales which noted the limited investment in AOS in South Wales, particularly compared to the rest of the UK, as well as the paucity of accurate data and made several recommendations on acute oncology support in Health Boards.

1.4 The business case seeks to present the compelling case for change; a robust options appraisal (supported by an independent facilitator) to assess alternative approaches to implementation; a set of financial proposals to provide organisations with an estimated level of additional investment required to secure the proposed improvements; and the benefits of that investment. Clinically led, the work has been underpinned by an extensive stakeholder engagement exercise which has drawn from a vast range of experts and professions across multiple organisations.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Acute Oncology (AO) ensures that cancer patients receive the care they need quickly and in the most appropriate setting. It brings a multitude of benefits to patients, clinicians and the wider system through improved communication, timely access to expert advice, improved patient experience and cost savings through more appropriate use of investigations, early discharge and admission avoidance.

Existing Arrangement

2.2 In South East Wales, it is estimated that, AO patients account for 10,000 admissions per year, many of whom have long lengths of stay (average of 9.4 days), which consumes a

total of 93,535 bed days. This has a significant impact on an unscheduled care system that is already under pressure.

2.3 The AOS in Wales is an outlier in comparison to other AOS services in the UK: with limited specialist nursing, the service is potentially unsustainable in terms of clinical governance requirements for nurses to work independently; the variable and inconsistent oncology advice mean there is little support to manage more complex patients; no specialist pathways to refer patients; and insufficient senior clinical time means there is very little clinical support for AOS teams and very little time for education and training.

2.4 Difficulties in coding and reliably collecting meaningful AOS data inevitably means that activity is not being accurately recorded, and the manual collection of this data, as well as the duplication to enter it into different formats and systems puts an administrative burden on nursing staff.

Business Need

2.5 The Clinical Model which sits at the heart of the Strategic Case seeks to both address the service gaps and embed positive learning from other AOS models across the UK. It shows a stronger focus on ambulatory pathways to reduce inpatient admissions and where patients do need to be admitted, timely multi-disciplinary team (MDT) reviews with appropriate specialist oncology input will support improved discharge management and reductions in length of stay.

2.6 Combining locally based nursing resources with enhanced access to specialist oncology input is key to the service, along with other elements including enhanced clinical leadership and a new, structured approach to the management of Metastatic Malignancy of Undefined Primary Origin / Confirmed Carcinoma of Unknown Primary (MUO/CUP) patients, along with access to other specialist pathways.

2.7 Underpinning the service model are a number of regional enablers, specifically digital (to ensure data collection is standardised, supports data analysis, and improves peer to peer communication) and education and training (shared learning between oncology and other medical specialties, education programmes as well as formal educational courses). Both are fundamental to the successful delivery of the clinical model and the delivery of the associated benefits.

Benefits

2.8 There are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre enable patients to access treatment at a location convenient to them.

2.9 Using empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales, and noting that the existing AOS service has already achieved some reductions in length of stay, the quantifiable benefits applied to the baseline are: 25% admission avoidance; and 10% reduction in length of stay. These have been clinically endorsed and applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity.

Figure 1: Regional Benefit Profile

ADMISSIONS AVOIDANCE	2021/22	2022/23	2023/24	2024/25
Bed day reduction	408	10,511	21,472	25,568
Beds freed Up	1	30	61	74
Benefit value at £150 / bed day	61,200	1,621,650	3,220,800	3,835,200
LENGTH OF STAY	**2021/22**	**2022/23**	**2023/24**	**2024/25**
Bed day reduction	239	3,620	5,650	7,503
Beds freed Up	0	10	16	21
Benefit value at £150 / bed day	35,850	543,000	847,500	1,125,450
TOTAL	**97,050**	**2,164,650**	**4,068,300**	**4,960,650**

Investment

2.10 The investment requirements for AOS include three 'cost pools' which cover the direct, locally managed resources in HBs; the specialist resources which predominantly come via VUNHST; and the regional support. Working collaboratively, HBs prioritised each service line to reflect their needs and priorities. These were then aligned to the specialist elements of the service model and phased. In doing so, it prioritises investment into areas of greatest need and ensures that associated benefits are delivered as early as possible in the implementation.

2.11 The investment in the specialist and regional cost pools have been apportioned using cancer incidence, with the fully implemented preferred option requiring an additional annual investment, across the three Health Boards in the region of £2.55m. It is anticipated that it will take three to four years to fully implement the proposals, with a phased build-up of resources and investment as set out below.

Figure 2: Additional investment over phases

Phase	2021/22	2022/23	2023/24	2024/25
1	468,200	1,288,000	1,535,300	1,499,400
2	-	321,800	707,100	836,400
3	-	-	123,100	215,800
Total	**468,200**	**1,609,800**	**2,365,500**	**2,551,600**

Governance

2.12 The proposed governance for the implementation and delivery of this project reflects the ongoing collaborative nature of the work undertaken. As the commissioners of this work, CCLG own the successful delivery of the project, noting that any local decisions will be made through the internal governance processes of the Health Board and Trust Executive teams. The AOS project will be strategically led by an Implementation Board, with an appointed regional Senior Responsible Officer (SRO).

2.13 The AOS Project Group will drive the operational implementation and lead on the delivery of project outcomes and benefits. It will be informed by a series of task and finish groups (with a remit to consider the operational requirements of implementation, develop job descriptions and job plans, and determine the most appropriate roll out), and the regional elements.

2.14 Crucially however, the regional governance structure also provides assurance for all Health Boards that any investment allocated to acute oncology (AO) goes to AO, through the establishment of a financial control mechanism (the AOS Financial Management Group). This group will ensure that any specialist and regional resources have clear service, implementation and deployment plans in place before funding is released, so that:

- There is alignment between the resources identified within the business case and implementation of the clinical model
- Funding will only be released into the system once there was a clear plan to deploy the required resources
- Phasing of funding reflects the speed of implementation across the region balanced against the need to ensure equity of service access
- Benefits can be measured reflecting a focus on return on investment and value based healthcare

Implementation

2.15 There are significant challenges around the implementation of a regional clinical model, across different HBs and multiple sites within those HBs. It is recognised that individual HBs have different baselines in their current AOS and therefore, different priorities. Some

elements of the implementation plan will occur at different times and be delivered in different ways, but all aspects of the clinical model should be achieved within the designated timeframe.

2.16 The phases of implementation, which take into account HB priorities and the need to deliver certain services regionally, can be found below, noting that investment is likely to run over three to four financial years. This should help maintain the regional focus of the work which can be held to account through the AOS governance, without impacting on the local operational decisions regarding the configuration of AOS across the different HBs.

2.17 The detailed plans for implementation will be developed collaboratively to ensure they reflect organisational pace and priorities, and the operational detail, particularly around the specialist service will start immediately with clinical colleagues.

Figure 3: High level implementation plan

Element	Phase 1	Phase 2	Phase 3
Nursing / AHPs	CNS recruitment plan	AHP recruitment plan	ANP recruitment plan
Oncology	Virtual support for HBs and on-site presence (including hot clinics)		
Consultant Sessions (HB)	Increased sessions to support AOS team	Specialists to support Immuno-oncology service	
MUO/CUP	New MUO/CUP service – develop pathways and establish MDT		
Immuno-oncology	*Immuno-oncology service – develop pathways and guidelines (Macmillan funding)*	Immuno-oncology service developed, MDT established	
MSCC			Scope MSCC pathways
Patient Administration	Recruit as required	Recruit as required	
Digital / Business Analysis	Discovery and design – scope baseline (process, pathways, data items, methods	Informed by outputs from phase 1.	Informed by outputs from phase 1.

Element	Phase 1	Phase 2	Phase 3
	of documentation, duplication)		
Education & training	Regional education and training programme	Regional education and training programme	Regional education and training programme
Project management	Project Manager recruited		

Conclusion

2.18 The development of this business case and the work that sits behind is the result of a multi-organisational, multi-professional collaboration across South East Wales, underpinned by strong clinical leadership and considerable stakeholder engagement. This degree of collaboration is reflected in the governance structure to support the implementation and delivery of the service, and will ensure the founding principles of equity of access and shared ownership remain central to the service.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	The enhanced AOS service will: • Increase the number of patients receiving same day emergency care • Deliver alternatives to admission for AOS patients across SE Wales • Improve timely access to advice and quality of care for acutely presenting MUO/CUP patients • Establish clear pathways in LHB for patients presenting with complications of immunotherapy • Reduce time spent in hospital for patients in last year of life with advanced cancer • Improve discharge planning and communication with community teams – to reduce length of stay and reduce readmission.
RELATED HEALTHCARE STANDARD	Choose an item.
	If more than one Healthcare Standard applies please list below: All of the above

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)
	There is a financial impact which is set out fully in the business case and appendices.

4. RECOMMENDATION

The Velindre University NHS Trust Board are requested to:

APPROVE the South East Wales Acute Oncology Business Case

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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

South East Wales
Acute Oncology Service
Business Case

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FOREWORD

The South East Wales Collaborative Cancer Leadership Group (CCLG) was established with a specific aim of providing effective system leadership for Cancer Services across South East Wales and delivering improvements in outcome and service experience for the catchment population. This is to be achieved through the building and nurturing of a sustainable, collaborative cancer community across the region.

It is recognised that, in order to achieve a transformation in outcomes and experience for patients with cancer in South East Wales, it is essential to have a coordinated and aligned approach to change across the whole cancer system. This will require leadership to address systemic barriers and challenges to improvement for Cancer Services across South East Wales. It will require the coordination of commissioning decisions and investments and facilitate the realignment of pathway resources within and between organisations.

It also requires a change in the behaviours of individuals, individual services and organisational decision makers and that attention be given to the dimensions of change including education, training, language and behaviours, research, digital and improvement science. It requires the development and deepening of trusting relationships and new ways of working. It will, importantly, require the application of the dimensions of change in a focused and coordinated manner. The Group will, therefore, be responsible for leading the required whole system changes at a regional level.

At its meeting on 8 January 2020, amongst other priorities, CCLG specifically requested that work be undertaken in developing a collaborative Acute Oncology Service (AOS) model reflecting a regional solution to be developed by the AOS Project Group along with a delivery plan (including timeline) for submission to the CCLG in September 2020. Coordinated by the AOS Multi Professional Steering Group work was undertaken over the Spring and Summer of 2020. Working with a broad range of healthcare professionals across the region and patients and carers, a model for AOS was developed, reflecting the needs across the entire patient pathway.

This was subsequently was presented to CCLG at its October 2020 meeting and garnered strong support from all members. Following this CCLG requested that partner organisations develop a single, regional business case along similar principles to the clinical model, evaluating alternative approaches to implementing the model across South East Wales, along with an assessment of the likely investment requirements and implementation timetable.

This document presents the results of the collaborative work undertaken in developing the business case and follows established investment appraisal guidance embedded within the 5 Case Model. It has been developed with extensive involvement of all organisations across South East Wales and is presented as a single, regional business case.

EXECUTIVE SUMMARY

BACKGROUND

This single, regional business case is presented on behalf of Aneurin Bevan University Health Board, Cardiff and Vale University Health Board, Cwm Taf Morgannwg University Health Board and Velindre University NHS Trust. Its purpose is to present a clear set of proposals and investment requirements to enhance Acute Oncology Services (AOS) across South East Wales. In doing so it seeks to present the compelling case for change, a robust options appraisal to assess alternative approaches to implementation, and a set of financial proposals to provide organisations with an estimated level of additional investment required to secure the proposed improvements across the anticipated 3 year timeframe to fully roll out of the clinical model. All of this has been underpinned by an extensive stakeholder engagement exercise combining organisational and professional representation.

Acute Oncology (AO) patients broadly fall into three groups: those whom a first presentation of cancer is suspected in an emergency setting; those with a known cancer who present as an emergency with complications of their treatment; and those with a known cancer who present as an emergency with cancer progression or acute complications of co-morbidities.

AO ensures that cancer patients receive the care they need quickly and in the most appropriate setting. It brings a multitude of benefits to patients, clinicians and the wider system through improved communication, timely access to expert advice, improved patient experience and cost savings through more appropriate use of investigations, early discharge and admission avoidance.[1]

Management of AO challenges the whole health and care system across South East Wales, from primary and community care to tertiary specialist service. However, the scope of this business case is the presentation, triage, assessment and management of patients in an acute setting.

CASE FOR CHANGE

In South East Wales, it is estimated that, AOS patients account for 10,000 admissions per year, many of whom have long lengths of stay (average of 9.4 days), which consumes a total of 93,535 bed days. This has a significant impact on an unscheduled care system that is already under pressure.

Further evidence of the scale and impact of AO is set out below:

- 22% of cancer diagnoses present for the first time in the unscheduled care system;

[1] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

- 80% of cancer patients presenting to emergency departments are admitted (compared to 25% of non-cancer patients);
- 20% mortality rate within 30 days of referral to AO and 70% mortality rate within 12 months of referral;
- 60% of Metastatic Malignancy of Undefined Primary Origin / Confirmed Carcinoma of Unknown Primary (MUO/CUP) patients are discussed at multiple multi-disciplinary team (MDT) meetings, 40% do not have any MDT discussion, and only 30% receive any oncology treatment;
- 60% of patients on combination immunotherapy treatment have severe autoimmune reactions;
- 80% mortality rate within 12 months following a diagnosis of Metastatic Spinal Cord Compression (MSCC).

The National Standards for AOS[2] (2016) were developed to provide a framework for NHS Wales to plan and deliver high quality services for people with cancer (either know or yet to be diagnosed) who present acutely. These standards covered four areas including: the AOS team; rapid assessment for acutely presenting patients; AOS team review of patient management; and information. A Peer Review (2018) of these standards highlighted a range of gaps in the service, including insufficient nursing and oncology presence in Health Boards across the region. This continues to be the case, making the current AOS in Wales an outlier in comparison to other AOS services in the UK: with limited specialist nursing, the service is potentially unsustainable in terms of clinical governance requirements for nurses to work independently; and the variable and inconsistent oncology advice mean there is little support to manage the more complex patients. The much needed investment in AOS would deliver a service broadly comparable to that provided by other centres (such as The Christie NHS Foundation Trust, The Clatterbridge Cancer Centre, as well as smaller sites like North Devon District Hospital) which currently have significantly more nurses per site, sessions for oncology and acute medicine, and run immunotherapy and MUO/CUP services.

A number of strategic drivers reinforce the need to improve and enhance AOS across South East Wales including: Peer Review (2018) noted above; the Quality Statement for Cancer (2021) has a specific requirement under the Safety theme to ensure that fully integrated Acute Oncology Services are available in all acute hospitals; and the Nuffield Trust review (2020) of planned changes to non-surgical tertiary cancer services across South East Wales noted the limited investment in AOS in South Wales, particularly compared to the rest of the UK, as well as the paucity of accurate data and made several recommendations on acute oncology support in Health Boards.

[2] *National Standards for Acute Oncology*. Cancer National Specialist Advisory Group. June 2016

PROPOSAL

A regional clinical model has been developed which places stronger emphasis on the specific needs of AOS patients, whilst complementing local wider unscheduled care management with a primary focus on ambulatory pathways as an alternative to inpatient admission.

Enhanced nursing will help manage initial presentations, support ambulatory pathways and act as the key worker throughout acute oncology pathway; specialist oncology advice on the ground at Health Boards will provide face to face clinical reviews, as well as education and training for the wider team. Supported by a dedicated virtual advice service, this will allow consistent and timely opinion no matter where patients are admitted. Further specialist support and local enhancements to ambulatory pathways, will mean the most vulnerable cancer patients are appropriately supported and cared for, with acute hospital admission only where absolutely necessary.

To deliver the proposed clinical model across South East Wales there is a need to invest in the service so that the current gaps can be addressed and the anticipated benefits realised. An option appraisal has been undertaken to evaluate alternative approaches to implementing the model across South East Wales along with an assessment of the likely investment requirements and associated benefits.

The fully implemented preferred option for delivering the required improvements to AOS across the region, requires additional annual investment, across the three Health Boards in the region of £2.55m. It is anticipated that it will take three to four years to fully implement the proposals, with a phased build-up of resources and investment.

EXPECTED BENEFITS

There are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them.

To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales has been used. Benchmarking with these centres demonstrates significant opportunities for admission avoidance (in the range of 40-60%) and length of stay (3–4 days). [3]

The existing AOS service has already achieved some reductions in length of stay but additional investment will support admission avoidance through staff availability (for rapid assessment of patients), oncology advice, and hot clinics, as well as some further reductions in length of stay.

[3] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Therefore, the quantifiable benefits that have been applied are 25% admission avoidance and 10% reduction in length of stay. These have been clinically endorsed and applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity.

Whilst these benefits are unlikely to be cash releasing, the analysis shown that the scale of this opportunity is in the order 30,000 bed days, or the equivalent of almost 90 freed up beds across the region, with a value of £4.5m, which if released could be used to support the needs of other service areas within acute hospital settings.

RISKS

There are significant challenges around the implementation of a regional clinical model, across different Health Boards and multiple sites within those Health Boards. The AOS remains a regional service within which there is an aspiration to secure equity of access for patients to a common service standard wherever they live and therefore a requirement to secure full implementation. However, it is recognised that Health Boards have different baseline positions in terms of current service and acute configuration, and all face challenging funding constraints which limit the ability to support service developments including AOS. Allied to this, as a largely people based service, there will be challenges in staff recruitment and deployment. To address these factors organisational specific implementation plans and associated resourcing profiles have been developed and aligned to meet each Health Boards' needs, priorities and constraints.

CONCLUSION

The development of this business case and the work that sits behind is the result of a multi-organisational, multi-professional collaboration across South East Wales, underpinned by strong clinical leadership and considerable stakeholder engagement. This degree of collaboration is reflected in the governance structure to support the implementation and delivery of the service, and will ensure the founding principles of equity of access and shared ownership remain central to the service.

Investment in AOS at this crucial time for the NHS would have a huge impact both for those patients presenting acutely with a known or as yet undiagnosed cancer, and the Health Boards receiving them.

> *"The impact upon the patient journey and quality of life is notable; particularly where progressive symptomatic needs are able to be met rapidly whilst keeping the patient in their preferred place of care beside their families."*
> *Isle of Man AOS*[4]

[4] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

INTRODUCTION

1 Introduction and Background

The purpose of this business case is to set out proposals for enhancing Acute Oncology Services (AOS) across South East Wales. Initially outlining the limitations of the existing service, it will present a clear and compelling case for change and go on to demonstrate how the proposed clinical model and preferred option for implementing this will address the identified gaps in service and deliver the required improvements and benefits. It will set out the process by which the preferred option has been selected along with the level of investment required to deliver the proposed improvements over the implementation period. Finally it will establish the organisational and delivery arrangements required to successfully implement the proposed service improvements.

The options appraisal has been developed with input from a wide range of organisational and professional stakeholders and has been facilitated by an external, independent consultant. The preferred option being put forward to the South East Wales Collaborative Cancer Leadership Group (CCLG) and Health Boards (HBs) for consideration is the result of 12 months of collaborative work with consensus being reached across multiple disciplines and multiple organisations in South East Wales.

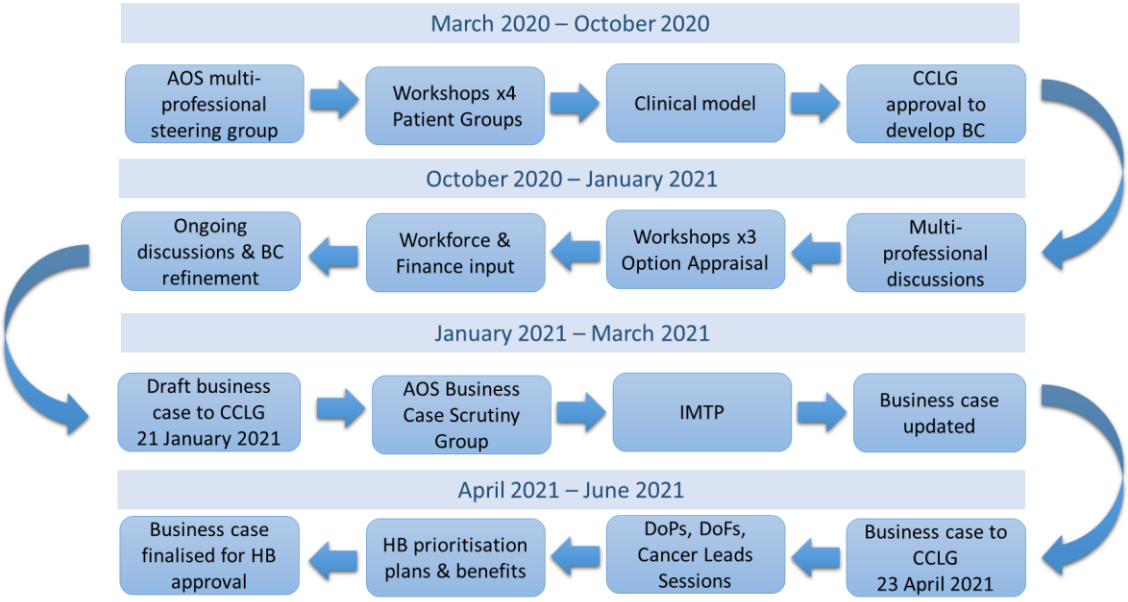
This business case is presented as a single case for the region and once endorsed by CCLG, will go through each stakeholder organisation's governance processes to secure local approval.

In developing this case it is recognised that stakeholder organisations have different starting points in terms of current baseline AOS and this will impact on the rate and sequence of implementation. However, the clinical model is premised on the dual principles of equity of access, and shared ownership and delivery. These will ensure each organisation delivers a broadly similar clinical model so that patients can expect consistency in their management and available resource irrespective of presenting location.

Management of acute oncology challenges the whole health and care system across South East Wales, from primary and community care to tertiary specialist beds. However, the scope of this business case is the presentation, triage, assessment and management of patients in an acute setting as this is a complex group of patients who would benefit significantly from improved access to acute care, with a focus on ambulatory pathways.

Commencing in the spring of 2020 a significant amount of collaborative work has taken place to develop the clinical model and translate that into a set of implementation proposals presented within this business case. The figure below is an overview of the wider reaching engagement activities that have taken place and further details of these activities is provided in Appendix A.

Figure 1: Overview of project engagement



STRATEGIC CASE

2 Introduction

The purpose of the Strategic Case is to make the case for change and to demonstrate how it provides strategic fit across the stakeholder organisations within South East Wales. Making a robust case for change requires a clear understanding of the rationale, drivers and objectives for the proposal and the associated investment by presenting a clear understanding of the existing arrangements: the Business As Usual (BAU), business needs (related problems and opportunities), potential scope (the required service coverage) and the potential benefits, risks, constraints and dependencies associated with the proposal.

2.1 Strategic Context

2.1.1 Cancer Services in South East Wales

The planning and delivery of cancer services in South East Wales is the responsibility of the three Health Boards (HBs) as part of their statutory role in addressing the health needs of the populations they serve. The three HBs in South East Wales are:

- Aneurin Bevan University Health Board (ABUHB)
- Cardiff and Vale University Health Board (CAVUHB)
- Cwm Taf Morgannwg University Health Board (CTMUHB)

A fourth HB, Powys Teaching Health Board does not formally sit within South East Wales but some of its patient population does come into ABUHB and CTM's service provision. In addition, Velindre University NHS Trust (VUNHST) provides non-surgical specialist cancer services to the region through the Velindre Cancer Centre (VCC). A map of organisation across South East Wales is provided below.

Figure 2: Map of South East Wales Health Boards and Velindre University NHS Trust

A significant proportion of patients have all of their cancer care delivered within the HBs. This is supported by VCC through the delivery of a range of outreach services including: Systemic Anti-Cancer Therapies (SACT); outpatient consultations; and Multi-Disciplinary Teams (MDTs. To further the availability and accessibility of radiotherapy services for patients across South East Wales, an Outline Business Case (OBC) for a Radiotherapy Satellite Centre based at Nevil Hall Hospital (ABUHB) has been developed and approved.

The HBs and VUNHST are supported by the Welsh Health Specialist Services Committee (WHSSC) which commissions specialist cancer services on their behalf. They also work in partnership with the All Wales Cancer Network (WCN), Public Health Wales (PHW), NHS Trusts, Community Health Councils (CHC), and voluntary and charitable organisations. More recently, the four HBs, in conjunction with VUNHST and WCN, have formed the South East Wales CCLG. The purpose of the CCLG is to provide effective system leadership for Cancer Services across South East Wales and deliver improvements in patient outcomes experience for the catchment population.

2.1.2 Acute Oncology Service in South East Wales

Acute oncology (AO) ensures that cancer patients who develop an acute cancer-related or cancer treatment related problem receive the care they need quickly and in the most appropriate setting. It brings a multitude of benefits to patients, clinicians and the wider system through improved communication, timely access to expert advice, improved patient experience and cost savings through more appropriate use of investigations, early discharge and admission avoidance.[5]

The core principles underpinning AOS have been defined as to 'promote education, awareness and early access to specialist oncology input, as well as a more integrated way or working between oncology and acute specialities within hospital trusts'.[6]

In Wales, the AOS has been in development since 2013 and aims to bring together multi-disciplinary clinical expertise to facilitate the rapid identification and appropriate prompt management of patients that present acutely. People living with cancer may need acute or emergency hospital care for a variety of reasons but an admission to acute care often heralds a change in disease trajectory and often leads to uncertainty about the future.

AOS patients broadly fall into three groups as set out below:

[5] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

[6] Jones, P, Marshall E, Young A. *Acute Oncology: Sharing Good Practice*. Macmillan, 2014

- Type 1: Acutely presenting - patients in whom a first presentation of cancer is suspected in emergency setting, including Metastatic Malignancy of Undefined primary Origin (MUO) and Confirmed Carcinoma of Unknown Primary (CUP) patients.
- Type 2: Complications of treatment – patients with known cancer (including haematological malignancies) who present as an emergency with complications of systemic anti-cancer therapy (SACT) or radiotherapy treatment, and increasingly with immune toxicity.
- Type 3: Patients with known cancer who present as an emergency with acute complications of disease and/or associated co morbidities

These patient groups are very vulnerable and often have poor outcomes either due to a delay in diagnosis and referral, multiple or sometimes unnecessary tests and interventions, and a lack of early specialist input.

Many patients will initially attend the hospital Emergency Department and Acute Surgical Unit. At the front end of emergency care pathway is normally the Medical Assessment Unit (MAU) but providing efficient and effective care to this complex patient group in a busy MAU presents a key challenge. A good working partnership between the MAU and AOS that enables rapid assessment of patients can result in significant improvement in patient care often resulting in avoided inpatient admission and re-admission.

The AOS pathway within the scope of this business case covers the patient journey from acute presentation, diagnosis, treatment through to discharge. However, there are integral elements that can, and do support patients beyond acute care including: pre-hospital triage; primary and community care that helps keep patients at home; and the optimal arrangements for the provision of specialist inpatient beds. These will be considered outside this business case.

2.2 Case for Change

2.2.1 Existing Arrangements

The current service model in South East Wales is variable both between each HB, and between sites within HBs, and collectively it has limited clinical support locally and from VUNHST.
In most HBs, the AOS service is nurse-led by Clinical Nurse Specialists (CNS), normally at a level of one nurse per acute hospital, who are on-site Monday to Friday.

The CNS supports patients and their carers through complex pathways and protocols, acting as the patient advocate. They are responsible for liaising with their local medical teams as well as linking into the on-call team in Velindre Cancer Centre (VCC) via telephone and email, and providing local AO education to other healthcare professionals. Working independently to agreed protocols they can:

- Recognise, manage and educate in broad range of oncology emergencies;

- Recognise and advise in management of suspected new diagnosis of cancer;
- Support clinical teams in decision making in malignancy unknown origin.

CNSs are supported by clinical colleagues in acute medicine, haematology and oncology. However, as there are only six allocated consultant sessions for AO across South East Wales (which are unevenly distributed), this allow very little clinical time to support the AOS team and patients.

The table below sets out the resource and associated funding for the current service in HBs.

Figure 3: Health Board AOS resources and funding

Health Board	AOS Teams (WTE)	Annual Cost
Aneurin Bevan UHB	4.10	£205,350
Cardiff & Vale UHB	4.50	£232,571
Cwm Taf Morgannwg UHB	4.70	£264,804
TOTAL LHBs	**13.30**	**£702,725**

The VCC AO teams funded remit is to provide acute inpatient care and support the oncology Assessment Unit within VCC. It runs a virtual daily multi-disciplinary team (MDT) with input from consultant oncologists, consultant radiologists, palliative care and oncology nursing to discuss these patients.

The on call doctor is available to HBs for advice but they can often be difficult to get hold of and advice can be variable, depending on their knowledge of AO, as they primarily deal with VCC patients. The table below sets out the current VCC resource and funding.

Figure 4: VCC resources and funding

Service	WTE	Annual Cost
Acute Oncology Assessment Unit & Acute Oncology MDT	8.05	£530,748
SACT Patient Support Phone Service	3.00	£77,812
TOTAL Velindre Cancer Centre	**11.1**	**£608,560**

In Wales, patients with cancer, particularly in the last months of life, frequently present acutely to emergency services on multiple occasions. Of those that die within 60 days of attending an

Emergency Department (ED), cancer is the most common diagnosis. In many instances these patients are admitted into inpatient beds and can frequently spend more than a month in hospital. Unfortunately a proportion of these patients subsequently die in the acute hospital setting. In developing this business case a range of indicators have been established, drawn from a variety of local and national sources, which demonstrate some of the challenges in managing acute oncology presentations, their impact on resources and key outcome measures. This is summarised in the table below.

Figure 5: Cancer presentations, admissions and mortality

Indicator	Findings
Emergency Department (ED) attendances with a cancer diagnosis[7]	5%
ED admissions with a cancer diagnosis[8]	25%
Cancer patients presenting to ED who are admitted **Non-cancer patients presenting to ED who are admitted 25%*	80%
Patient mortality within 30 days of referral to AO	Approx. 20%
Patient mortality within 12 months of referral to AO	Approx. 70%
Cancer diagnoses that present for the first time in the unscheduled care system	22%
Acute hospital beds are occupied by acute cancer patients[9]	10%
Emergency ambulance calls being made on behalf of people with cancer	10%
Mortality due to cancer in frequent attendance to ED	28%

In South East Wales, data collected shows the breakdown of referrals to AOS which is summarised in the table below. Although the numbers are relatively small and the data is historic, the impact on acute hospital resources can be significant. By far the biggest proportion across all organisations is 'other' which demonstrates the ongoing difficulties in coding and reliably collecting meaningful AOS data. This inevitably means that activity is not being accurately recorded and actual numbers of presentations are under stated. The manual collection of this data, as well as the duplication to enter it into different formats and systems puts an administrative burden on nursing staff.

[7] North Mersey Macmillan Project: *Urgent Care and Cancer & Cancer Care of the Elderly*, 2019

[8] *Sharing good practice Acute oncology*, Macmillan Cancer Care, 2014

[9] Mansour D, Simcock R, Gilbert D C, Acute oncology service: assessing the need and its implications, *Clinical Oncology*, 2011

Figure 6: Referrals to AOS January to December 2017

Diagnosis / Pathway	ABUHB	CVUHB	CTMUHB*	VCC
Malignancy of Unknown Origin (MUO) / Carcinoma of Unknown Primary (CUP)	66	100	31	31
Neutropenic sepsis	57	24	31	54
Metastatic Spinal Cord Compression (MSCC)	49	57	45	123
Other (no pathway)	1,518	1,660	611	816
Total	**1,690**	**1,841**	**718**	**1,024**

**Data pre-boundary change (does not include Princess of Wales Hospital, Bridgend)*

Many cancer patients are admitted as an emergency across the region and currently have an average length of stay of 9.4 days in hospital. This is often unnecessary, and for many cancer patients, home is the preferred place of care, especially when there is a poor prognosis.

Figure 7: Emergency admissions and length of stay by Health Board 2018/19

Health Board	Admissions	Mean Length of Stay	Total bed-days
ABUHB	3,860	8.3	32,203
CAVUHB	2,702	10.1	27,281
CTMUHB	3,438	9.9	34,051
Total	**10,000**	**9.4**	**93,535**

For patients with Metastatic Malignancy of Undefined Primary Origin (MUO) length of stay is even longer with an average of 25.8 days across the region in 2018. MUO refers to the broad patient group who present with metastatic cancer that do not have an immediately identifiable primary site. As there is no primary tumour identified, these patients often have no specialist team responsible for their care. In the UK, approximately 24 patients are diagnosed with a cancers of unknown primaries every day, with annual new patient case load of around 8,800.[10] In England and Wales it is the fourth most common cause of cancer death.[11] Patients often present at an advanced stage, have complex needs, undergo fragmented pathways and have poor patient experience. In about 15 - 20% of these patients, the primary site remains undetected (Confirmed Carcinoma of Unknown Primary - CUP), and overall, patients have a median survival of four to 12 months.[12] The acute presentation of this patient group often results in multiple investigations,

[10] CRUK, About cancer of unknown primary, 2017 (www.cancerresearchuk.org.uk)

[11] Metastatic Malignant disease of unknown primary origin in adults: diagnosis and management, NICE Clinical Guideline, 2010

[12] Varadhachary GR et al 2014, Stella GM et al 2012, Hainsworth JD et al 2018

and inappropriate or delayed treatment. Local analysis of CUP/MUO data (2018) demonstrated that despite the majority of new CUP/MUO referrals receiving AO input within the nationally stipulated time frame, only 30% of patients received any oncology treatment; 60% of these were discussed in multiple MDT discussions of different site specific teams; and 40% did not have any recorded MTD discussion. With no current service for these patients, the acute aspects of the MUO/CUP pathway are part of the scope of this business case.

Immunotherapy refers to treatments that use the immune system to destroy cancer. Immuno-oncology (IO) medicines are relatively new treatments which, for many patients, can achieve excellent outcomes. However, they are associated with immune-related adverse events which can have serious side effects, and are relatively unfamiliar to clinical teams.[13]

Immune-related adverse events can be unpredictable and require a very different approach to the management of toxicities related to other types of systemic anti-cancer therapy (SACT), for example, chemotherapy. Immune-related adverse events may be life threatening, potentially occurring at any time during and for up to two years post treatment. Very few patients manage their therapy without experiencing some immune-related side effects, which can include dermatologic, gastrointestinal, hepatic, endocrine, lung, renal and less common inflammatory events such as neurological and cardiac issues. It is well established that failure to recognise and instigate appropriate management for toxicity results in catastrophic consequences including unnecessary termination of treatment and patient deaths. Given the delay in toxicities, many of these patients will present as an emergency and be referred to AOS, hence the need for an IO pathway in this business case.

Metastatic Spinal Cord Compression (MSCC) is a well-recognised complication of cancer and usually presents as an oncological emergency. Life expectancy once a diagnosis of MSCC has been made is poor, with only 28% of patients surviving more than one year.[14] Early diagnosis, treatment intervention and rehabilitation is therefore necessary to prevent paralysis and to ensure the best possible outcome and quality of life.

There is currently an inequitable service, with spinal surgeons operating on MSCC in just one HB across South East Wales. Inconsistency in patient referrals, and a lack of flexibility of radiotherapy planning and treatment often means patients are admitted or require two visits.

The numbers of patients presenting with MSCC are increasing with advancing treatment techniques and as patients live longer with cancer. The outcomes for MSCC patients in South East Wales are currently below the UK average as they face delays in access to radiology, surgical opinion and radiotherapy treatment.

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[13] Good Practice Guideline for Immuno-Oncology Medicines, Royal College of Radiologists et al,

[14] NICE Clinical Guidelines, 75 *Metastatic Spinal Cord Compression: Diagnosis and Management of Patients at Risk of or with Metastatic Spinal Cord Compression*, Nov 2008

2.2.2 Business Needs

The increasing incidence of cancer in Wales (predicted to grow year on year by 1.5%[15]); the changes in clinical practice in oncology (the increased use of radical chemo-radiation); and the unprecedented step changes in the volume/pace of novel and approved anti-cancer treatment (particularly immunotherapy), has, and will continue to result in increased demand for AOS.

The Cancer National Specialist Advisory Group (CNASG) in Wales have developed a set of national standards for Acute Oncology Services (All Wales National Standards for Acute Oncology Services – June 2016) to provide a foundation for the NHS in Wales to plan and deliver effective high quality services for people with cancer, either known, or yet to be diagnosed, who present acutely to the NHS. These standards covered four areas: the AOS team; rapid assessment for acutely presenting patients; AOS team review of patient management; and information.

A Peer Review was undertaken in July 2018 to assess the existing AOS quality and performance against the standards in each HB. The all Wales summary of the findings are directly relevant to the provision of AOS in the South East. The review recognised that whilst significant progress has been made there remain some key gaps in the service which need to be addressed as part of this business case. A summary of the Peer Review findings is provided in the table below and a more detailed report is provided at Appendix B.

Figure 8: Peer Review summary against All Wales National Standards for AOS (July 2018)

Gaps in service
Insufficient oncologist presence in HBs and no specialist oncology Advanced Nurse Practitioners (ANPs) to manage more complex patients with complications of care or cancer progression
CNS presence in each site to cover core service (Mon – Fri 9am to 5pm)
No dedicated lead AOS managers in HBs
Need for additional administrator / co-ordinator time
HBs need daily access to wider dedicated consultant specialist team consisting of oncologist, palliative care consultant, Haemato-oncologist / haematologist, radiologist to help manage complex patients
Insufficient oncologist and no ANP time on site to disseminate knowledge around the management of AO through education
Insufficient oncologist and no ANP time on site to ensure clinical pathways are in place for assessment and management of all patients with complications from cancer or cancer treatment
No MUO or CUP service, supported by regular consultant oncologist support to deal with

[15] Transforming Cancer Services, Programme Business Case, VUNHST 2019

Gaps in service
concerns
No electronic access to past medical history and treatment received or access to dedicated telephone support
No automatic electronic alerts to VCC when a patient with known malignancy, or undergoing active cancer treatment, presents acutely ill to secondary care
No electronic capture of core AOS dataset at VCC or acute site

The CNSAG recognised the differing configurations and challenges across Wales, such as multiple locations and rurality, which may result in additional local requirements. However, the standards they developed describe the core requirements of AOS. Achieving the care reflected in the standards is not solely the responsibility of the acute oncology team and requires engagement and collaboration at all levels of HBs, with cross-directorate, cross-care sector and cross-boundary working.

In addition to the Peer Review there are a number of specific issues relating to AOS in South East Wales which help to further demonstrate the limitations of the existing arrangements and a focus for prioritising investment in the required service enhancements. These are outlined below.

AOS Team

The AOS CNS team model is an outlier in comparison to other AOS services in the UK with limited specialist nursing, the service is potentially unsustainable in terms of clinical governance requirements for nurses to work independently. Whilst the AOS nursing teams are effective and dynamic, the current model means nurses are working without 'wrap' of consistent medical or senior expertise. This it is a challenge clinically, particularly for them to be involved in complex cases but also for them to take forward service development and ensure they are supported in continuous professional development (CPD).

The limited clinical sessions for physicians to support AO, along with a lack of senior nursing (Advanced Nurse Practitioners - ANPs) means there has not been much support, clinical leadership, education or training for either the nursing or medical teams, and as a result, there has been limited service development since its inception in 2013.

Specialist Oncology

Although daily specialist oncology advice is available through the 'lunchtime AOS MDT meeting', there is limited take up from HBs, and it is largely used to discuss VCC patients. Outside the MDT, there is variable clinician input and support due to insufficient funded time. Often the VCC on-call doctor is the point of contact, and accessing advice can prove cumbersome and onerous for colleagues in HBs. It means that advice is often inconsistent due to a lack of acute oncology knowledge and understanding, and not always timely. There is currently no dedicated oncologist

time on site in HBs to ensure complex patients with complications from cancer or cancer treatment are assessed and managed appropriately. This also means there are no or few opportunities to disseminate knowledge through education and training.
Benchmarking with other sites such as The Christie NHS Foundation Trust and The Clatterbridge Cancer Centre demonstrate a significantly higher number of nurses per site and up to five direct clinical contact sessions for oncology consultants per site.

Admissions and length of stay

AOS can reduce admissions by providing timely expert advice and patient safety netting, facilitating same day discharge. It is a core component of ambulatory medicine services, allowing patients to receive essential care and advice without being admitted. AOS can also reduce the length of hospital stays, freeing up valuable bed space. This has been demonstrated by other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales, as noted in the table below.

Figure 9: Data from UK AOS sites on admissions and length of stay

Area of AOS	Benefit / outcome	Organisation
Acute admissions	66% of patients same day discharge after AOS established	West Suffolk Hospital[16]
Acute admissions	90% of patients same day discharge with a AO hot clinic	Royal Preston Hospital[11]
Acute admissions	61% of patients same day discharge with an acute admissions unit	VUNHST[11]
Inpatients	Reduced length of stay by 4 days after AOS established	West Suffolk Hospital[11]
Inpatients	Reduced length of stay by 3.1 days (£2m saving) after AOS established	The Clatterbridge Cancer Centre[17]
MUO/CUP	Reduced length of stay by 3.5 days with new MUO/CUP	North West Cancer Centre, Northern Ireland[18]

[16] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

[17] Neville-Webbe HL et al *The impact of a new acute oncology service in acute hospitals: experience from the Clatterbridge Cancer Centre and Merseyside and Cheshire Cancer Network*. Clinical Medicine. Dec 2013, 13(6) 565-569

[18] Dasgupta.S et al *Integration of a patient-centred MUO/CUP service within a new acute oncology service: challenges and rewards*, Future Healthcare Journal, Vol 8, No1 2021

Area of AOS	Benefit / outcome	Organisation
	service	
Immunotherapy (IO)	40% reduction in admissions after establishing service	The Clatterbridge Cancer Centre[11]

With an average length of stay of 9.4 days across the region, understanding why patients are admitted and how to prevent re-admission is crucial. Developing these skills across different professional groups will require time and investment. Competencies should include the acute medical management of unwell patients, specialist oncology knowledge (new therapies and new presentation of metastatic cancer), radiology and confidence in complex conversations. Supporting patient discharge, with input from Allied Health Professionals (AHPs) and Palliative Care teams, will also help prevent further admissions.

The Royal College of Physicians have identified the following as being essential to avoid unnecessary admissions:

- A rapid oncology assessment (within 24hrs of referral) that will identify patients who are suitable for ambulatory / outpatient-driven services;
- Management of anti-cancer therapy complications, advice on disease complications, symptom management, diagnostic pathways for new cancers and offers alternative routes to admission including access to hot / cold oncology clinics;
- A formal working relationship with community, primary care and specialist services in order to improve the quality and speed of patient discharge and to avoid admissions;
- Capacity and pathways to be in place for day-case procedures to occur, such as paracentesis or rapid-access diagnostics without inpatient admission.

Acute medicine in South East Wales has moved successfully and rapidly towards same day emergency care delivery, and there is a real opportunity by increasing engagement and sharing cancer expertise in the acute setting, that it is possible to reduce admissions, reduce length of stay, improve patient journeys and train future clinicians.

MUO / CUP

The lack of a MUO / CUP service in South East Wales means there is an unmet clinical need in the overall management of these patients. This includes ownership of these patients and defining optimal diagnostic and treatment pathways; addressing patient centred needs (anxiety, uncertainty, symptoms, quality of life, cancer related survival); health resource centred needs (multiple invasive and non-invasive investigations, length of hospital stays, readmission rates, multiple MDT discussions across different tumour sites); as well as research needs (early identification and recruitment to clinical trials).

The gap analysis identified through the Peer Review (2018) highlighted the need for a streamlined, resilient and well-resourced pathway for these patients, in accordance with national recommendations (NICE 2010) and peer review measures (NHSE 2014).

Intervention via a dedicated CUP team in several different hospitals in the UK (Sheffield Teaching Hospitals Trust, The Royal Free and Western Health and Social Care Trust) have all shown positive and measurable outcomes, with significant reductions in length of stay (3.5 -11 days), statistically significant reductions in re-admission rates and hospital deaths, and significant benefit in overall survival. Proposals to deliver a similar model of care are at the heart of this business case, as are the benefits that will accrue through its successful implementation.

Immuno-Oncology

The numbers of patients treated with immunotherapy is rising. In VCC the number of patients being treated with immunotherapy rose by 49% between 2018 and 2020, with an average of 225 patients per month by late 2020. As new drugs and new indications for drugs are licenced, including the usage of combination treatments, which have the highest rates of reaction, this rise will only get bigger.

The management of patient toxicity is complex and without specialist advice and education, patients can often be misdiagnosed or undergo inappropriate treatment. Approximately 60% of patients on combination treatments develop severe toxicities. Failure to treat promptly results in lengthier and more complex patient admissions and adverse patient outcomes, particularly in the failure to complete active therapy, resulting in reduced survival.

When The Clatterbridge Cancer Centre set up the IO service, they saw a 40% reduction in admissions after introducing a toxicity service, despite a 20% increase in the number of patients commencing treatment.

In South East Wales there is currently no pathway for these patients and the advice and access to specialist input is ad-hoc. As this is a becoming an increasingly common treatment option for cancer patients, there is a need to invest in the development of the acute pathway for patients, including the ambulatory pathway to deliver critical drugs. In doing so, this will help future proof the AOS and the increasing numbers of patients presenting with severe toxicities.

As important however, is raising awareness and educating acute care teams on this new era of drugs and their side effects. North Devon hospitals found that education and training were key to successful implementation, running weekly teaching sessions on oncological emergencies, including IO toxicities to acute teams.[19]

[19] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Metastatic Spinal Cord Compression (MSCC)

MSCC is a potentially devastating complication of cancer which requires rapid decision making by several specialists, given the risk of permanent spinal cord injury. Without a specialist single point of contact for advice and management there are delays in diagnosis and treatment, resulting in ineffective and inefficient management of patients including inappropriate diagnostic tests being carried out, increased length of stays in hospital, as well as deterioration in patient's functional ability, which reduce their prognosis and quality of life.

The Peer Review (2018) highlighted the need for a coordinator across South Wales which is in line with NICE guidance (2008), the NICE Quality Standard (2014) and as recommended in the South Wales MSCC Strategy (2016).

To date there has been no dedicated resource to co-ordinate the care and management of MSCC patients in South East Wales. The development of the MSCC pathway is crucial for timely diagnosis and treatment but will also improve system wide efficiencies, including: communication and education; clinical awareness of local MSCC pathways; and identification of risk factors of MSCC. Co-ordination of this pathway, and attendance at spinal MDTs will ensure there is greater collaboration between the AOS teams, clinical oncologists and surgeons to improve functional outcomes for patients.

2.2.3 The Quality Statement for Cancer

The Quality Statement for Cancer replaces the Cancer Delivery Plan for Wales and sets out a five year plan to improve the quality of cancer services and outcomes across Wales. Building on the work of the 2012 and 2016 Cancer Delivery Plans, the next five year phase of cancer service aims to take advantage of the widespread consensus that has emerged on priority areas, bring programmes to fruition, and maintain the national leadership and local engagement that has been achieved. This will ensure that there is a long-term and consistent approach to improving outcomes as envisaged in the Wellbeing of Future Generations Act and demonstrated by international experience.

The Quality Statement sets out a series of attributes it would like to see embedded in cancer services in Wales across a range of themes covering Equity, Safety, Effectiveness, Efficiency, Person Centredness and Timeliness. There is a specific requirement under the Safety theme to ensure that fully integrated Acute Oncology Services are available in all acute hospitals.

2.2.4 The Nuffield Review

The Nuffield Trust was commissioned by Velindre University NHS Trust to provide independent advice on the clinical model underpinning its planned changes to Velindre's cancer services contained in its Transforming Cancer Services programme.

The work assesses the proposals for the planned changes to non-surgical tertiary cancer services across South East Wales and clinical concerns raised about plans to build the new Velindre Cancer Centre on the proposed site.

Whilst the review made specific recommendations regarding the wider clinical model it also made specific reference to the management and delivery of acute oncology across South East Wales. It documented the limited investment in AOS in South Wales, particularly compared to the rest of the UK, as well as the paucity of accurate data. However, it did acknowledge the collaborative work undertaken as part of this process and many of the recommendations are directly relevant to this case and entirely consistent with the proposed direction of travel set out in this business case. In particular the review recommends that:

- Each local health board (LHB) needs to develop a plan for oncology support for unscheduled cancer patient admissions and acute oncology assessment of known cancer patients, with inpatient admission as an option. This approach will mitigate the risks for inpatients across the network.
- The development of acute oncology services in each LHB is a priority and will help support reductions in acute admissions across the network. A common dataset is required to support the planning of these services.
- Each LHB needs to ensure that there is a plan for providing oncology advice and support for patients admitted via A&E, and for acute oncology assessment of known cancer patients presenting with symptoms/toxicities, with inpatient admission provided as an option on a district general hospital site if needed. The assessment service model should provide for multi-disciplinary input, in particular from palliative care, specialist nursing and allied health professionals.

2.2.5 Spending Objectives

Having outlined the existing arrangements for delivering AOS across South East Wales, and the business needs as highlighted by the peer reviewed and local assessment of service gaps, a set of Spending Objectives were developed. These set out what the project is trying to achieve by way of intended outcomes and what needs to be achieved to deliver the necessary changes highlighted through the business needs.

The table below sets out the project spending objectives which were developed in partnership with the AOS MDT Steering Group, which has broad representation from all four of the stakeholder organisations.

Figure 10: Spending Objectives

Project Spending Objective	Description
Project Spending Objective 1	Improved patient outcomes and experience delivered consistently irrespective of presenting location
Project Spending Objective 2	To avoid unnecessary inpatient admissions but where this is necessary to reduce the average length of stay for patients admitted acutely
Project Spending Objective 3	Provide treatment for patients in the most appropriate setting that balances clinical need with personal choice
Project Spending Objective 4	Identified and improved pathways for patients presenting as MUO/CUP
Project Spending Objective 5	Improving services through better data analysis, greater focus on measuring outcomes and dissemination of knowledge around management of acute oncology across the organisation through education provision

The spending objectives will be used to support the development of the benefit criteria to be used in the non-financial aspects of the option appraisal.

2.2.6 Project scope

The scope of this project is to develop a comprehensive clinical model for acute oncology services in South East Wales covering the pathway from point of arrival in acute setting to discharge from hospital including the management of presentation, assessment, treatment and discharge. It was agreed that this would be run as a regional service across South East Wales.

It should be noted that the AOS pathway is broader than this, and includes primary and community care, as well as tertiary specialist beds, which will be considered outside of this business case.

2.2.7 AOS Clinical Model

In considering the approach to developing the clinical model considerable work has been undertaken by engaging a wider range of stakeholders through a series of workshops which incorporated patient and user input. This informed the development of the clinical model and the founding principles under which it has been developed.

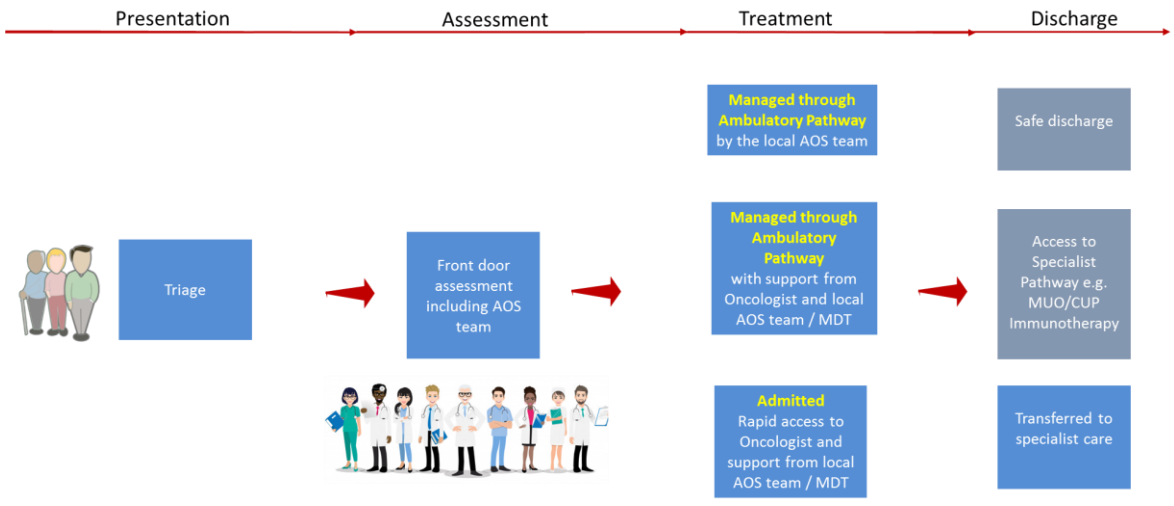
The project was established as a collaboration between Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg and Velindre to ensure a regional perspective of AOS in South East Wales was presented. Two key principles have underpinned the work in developing the clinical approach to enhancing the AOS across South East Wales, namely:

- Equity of access – irrespective of HB of residence, patients presenting to the AOS are assured of equity of access and a common service standard; and
- Shared ownership and delivery – the service model is developed jointly by the three Health Boards (Cardiff and Vale, Aneurin Bevan and Cwm Taf Morgannwg) and Velindre University NHS Trust with clarity around roles and responsibilities.

Recognising the scope of the project, the approach outlined above has developed a clinical model which sets out the key enhancements necessary in delivering the spending objectives and securing the necessary improvements in AOS across South East Wales.

As a starting point, an overview of the high level patient pathway of the project is summarised in the diagram below. This sets out the key and decision points across the patient journey through the AOS.

Figure 11: High level patient pathway

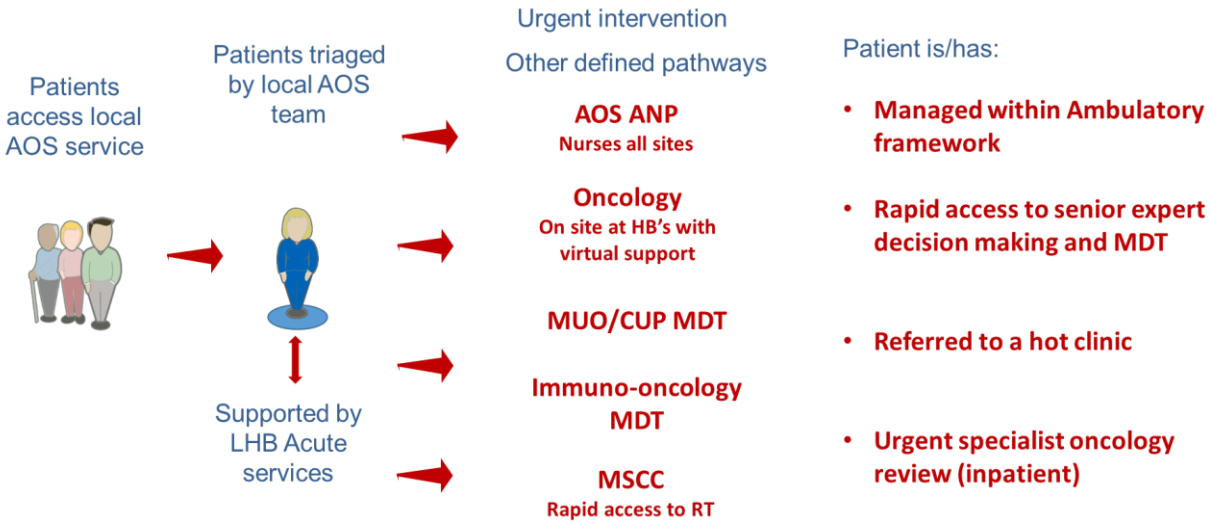


The high level pathway has been used as the foundation for developing the more detailed AOS clinical model which is summarised in the diagram below. This sets out a model which places stronger emphasis on the specific needs of AOS patients whilst complementing local wider unscheduled care management with a primary focus on ambulatory pathways as an alternative to inpatient admission. Where patients do need to be admitted, timely MDT reviews with appropriate specialist oncology input will support reductions in length of stay. It combines

locally based HB resources with enhanced access to specialist oncology input through a mix of predictable and regular physical on the ground presence and virtual support. Other elements include enhancement of specialist nursing input, a new, structured approach to the management of MUO/CUP patients along with access to other specialist pathways.

The model also recognises that timely intervention and honest conversations by AOS teams with patients and their families makes a real difference in the quality of care and patient outcome. Good working partnerships and arrangements between emergency departments, medical admission units, and acute oncology services are key underpinning elements of the model.

Figure 12: Emerging AOS Clinical Model



The areas highlighted in red show the focus of service enhancements and required investment. Further details relating to the respective elements of the proposed enhancements can be found in the table below with more detailed analysis provided in Appendix C.

Figure 13: Proposed service specifications for the enhanced AOS

Area of Investment	Service Proposal
Nursing and Allied Health Professionals	Enhanced CNSs to manage initial presentations and support ambulatory pathways to help avoid admissions, and take on the key worker role throughout acute oncology pathways; ANP senior nursing to lead AOS teams and independent decision making within areas of competency; AHP support patients and facilitate patient management and effective / timely discharge.
Consultant Sessions	Additional Clinical Lead sessions to support AOS team and provide timely senior clinical advice, and provide education and training; Consultant Palliative Care to provide specialist support to MUO/CUP MDT; and

Area of Investment	Service Proposal
	additional Consultant Radiologist time to enable enhanced access to timely radiological investigations and facilitate the rapid decision making.
Specialist Oncology Support	Enhanced HB oncology input comprising mix of physical and virtual support. HB direct time - Oncologist (named, integrated with AOS team) lead via presence on the ground at the HBs, providing face to face clinical review via ward rounds (reducing length of stay) and hot clinics (reducing admissions), education and training (delivered in HBs), and regional pathway development. Virtual Support - Complements the HB direct consultant oncologist by providing virtual touch points throughout the day for all hospitals in South East Wales, allowing consistent and timely advice no matter where patient admitted and advoiding unnecessary admissions.
MUO/CUP Service	New service for cancer patients where primary sites of tumour-origin are not immediately apparent. Consultant Oncologist - Named lead who provides expert advice to HB AOS teams (avoiding unnecessary investigations and reducing length of stay) and Chairs the MUO/CUP MDT. CNS - Key worker and point of contact for patients, providing patient education and support, with remit to develop clinical pathways and links with AOS nursing teams. Consultant Palliative Care - Support to the MUO/CUP MDT Consultant Radiologist & Pathologist - Additional time for input into MDT (as a core member) to review the treatment and care of MUO/CUP patients. Collectively, this will mean better patient experience and outcomes, as well as reducing length of stay.
Immunotherapy Toxicity Service	New service for patients with Immuno-oncology (IO) toxicities. Consultant Oncologist - Regional service lead to establish clear pathways for toxicity management, Chair the MDT, provide education with teams in all acute hospitals as well as developing ambulatory pathways to deliver critical drugs. CNS - Key worker and point of contact for patients, to liaise between primary, secondary and tertiary care, with remit to run a triage clinic and ensure prompt and early management of toxicities; work with the oncology and HB AOS teams, and provide training; manage patients on reducing steroid treatments, enabling early discharge. Consultant Specialists - Provide organ system specific toxicity advice to MDT for patients with severe and life threatening immunotherapy toxicity, improving management of complex reactions and enabling access to timely investigations. This will mean better patient experience and outcomes, as well as

Area of Investment	Service Proposal
	reducing avoidable admissions.
MSCC Pathway	Consultant Clinical Oncologist - Attend spinal MDT and improve communication between spinal surgeons and clinical oncologists. MSCC clinical co-ordination role - Attend spinal MDT and co-ordinate the care and management of MSCC across region as the single point of contact, working alongside AOS consultants and nurses and the spinal surgical team. They will provide strategic regional developments for recognition, investigation, treatment and rehabilitation of patients with MSCC. This will be better for patient experience and outcomes.
Admin support	MDT Co-ordinator (MUO/CUP and Immunotherapy Toxicity) - Provides support to MUO/CUP and Immunotherapy Toxicity MDTs. Ensures discussion conclusions are documented and communicated between organisations including VCC, LHBs and primary care. Medical Secretary - Supports the effective management and planning of patient administration including effective communication and documentation of medical reviews and advice. Administration of MDTs and hot clinics (HBs).

Underpinning the service model are a number of regional enablers, specifically digital and education and training, which are fundamental to the successful delivery of the clinical model and the delivery of the associated benefits. The digital elements include the collection of standardised, structured data using digital forms to improve patient safety, reduce duplication, support data analysis and reporting, and is a key enabler to understanding the impact of service through Patient Reported Outcome Measures (PROMS). The availability of consistent and comprehensive patient data will also support improved mechanisms for communication, facilitating seamless access to specialist advice at point of care, flag admission of diagnosed cancer patients within the region, and enable access to records across the site to facilitate specialist support.

Digital enablement also includes the ability to support virtual clinician to patient and clinician to clinician consultations and engagement. Many of the established video / voice tools are already available (e.g. Attend Anywhere, Consultant Connect and Microsoft Teams) and can be easily deployed into the proposed AOS landscape across South East Wales.

Education and training is recognised a key feature of the service. AOS bridges the gap between oncology and other medical specialties, and the possibility of this shared learning is crucial. In North Devon, weekly teaching sessions for staff working in the emergency department and MAU around oncological emergencies and immune-oncology toxicities have been core to the service.[20] In addition to this sharing of knowledge and expertise, there is a need for more formal education

[20] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

and training, particularly for nursing and to maintain the principle of equity, the proposal would be to develop a regional education and training programme.

2.2.8 Patient and staff experience

In order to demonstrate the benefit of an AOS for both patients and organisations, the following is an anonymised patient case which depicts their experience now and what it could be like with an enhanced AOS. Alongside the patient story is that of the CNS who took charge of the patient.

Figure 14: Patient experience of AOS now

I had a swelling in my neck and went to my local hospital after feeling unwell for several weeks. I had a scan and the emergency team explained they were 'worried' about it and that it showed some abnormal swellings but not much more than that and I was admitted.

The next day I met a specialist nurse who told me she would stay involved in my care until we understood what was happening, she talked to me and my family together with the ward doctor and they told me it might be cancer. The medical team organised a biopsy of the swelling but I wasn't told the results and I was still in hospital ten days later and feeling worse. I was scared and knew something was not right but too scared to ask too many questions. Everyone was so busy and they didn't seem to know what was happening to me, the specialist nurse came to visit me and told me we were waiting on the results of the biopsy to help decide what the next steps would be.

Eventually, the doctor on my ward told me the biopsy result was ready and that it was lymphoma cancer. I was given some steroids and told that they were arranging an appointment to see a cancer specialist in another hospital. By the time I saw the oncologist I was really ill and I was told I was not fit enough to be treated.

Figure 15: Patient experience of AOS in the future

I had a swelling in my neck and went to my local hospital after feeling unwell for several weeks. The emergency team I saw when I first arrived explained the swelling might be cancer and that I required further investigations, but did not need to be admitted for these. A specialist nurse came to see me in the emergency department and told me she would be acting as my Keyworker whilst I was having these investigations and gave me her contact details. I returned a couple of days later for an urgent biopsy of the swelling, whilst I was there the specialist nurse brought an oncologist to see me. They told me and my family that I probably had lymphoma. They explained what was happening and told me I could go home with an appointment to go back to a clinic and see the cancer specialist.

A week later, I saw a different oncologist who told me the results from the biopsy showed it was an "aggressive cancer" but they were booking me in for chemotherapy that day to give me the best chance to control the disease. It was obviously upsetting news but everything was done so quickly and explained to us, we always felt we knew what was happening.

Figure 16: CNS experience of AOS now and in the future

The acute team contacted me about a 70 year old lady who had presented with a large gland above her clavicle. The radiologist report suspected cancer and a biopsy was arranged. Despite my advice, for the patient to be discharged, she remained an inpatient for ten days on a medical ward waiting for the result. During this time her performance status deteriorated and she became more and more anxious. Once the result was back she was discussed at an MDT and the specialists advised starting her on steroids. She was discharged and told she would get an appointment with the oncologist in the post.

It was frustrating because I kept getting different advice from different oncologists, when I could get through. Once the patient was discharged, I had to update paper records and several different systems before I could see the next patient.

The acute team contacted me about a 70 year old lady who had presented with a large gland above her clavicle. The radiologist report suspected cancer and I met and assessed her in the emergency department. I introduced myself as her Keyworker and explained my role. I telephoned the oncologist at a time when I knew I could speak to them. They suspected lymphoma and suggested an urgent biopsy and referral to the next available clinic on site. I made sure the patient was fully informed of the plan and discharged them to return for the booked biopsy. I updated the patient records on the system once and I was free to see the next patient.

When she attended for the biopsy I was able to arrange for the oncologist to meet the patient and her family to discuss the probable diagnosis and plan.

The next week the patient returned to the onsite clinic to receive her results and treatment plan.

2.3 Anticipated benefits

A range of benefits are anticipated to accrue through the successful implementation of the proposed AOS clinical model which will be both direct and indirect as well as quantitative and qualitative.

There are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them.

Whilst some benefits will potentially free up acute hospital capacity which can be used for alternative purposes the ability to make these cash releasing will depend largely on local circumstances and the ability to disinvest in existing practices as the clinical model is rolled out. To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South East Wales have been used. Benchmarking with these centres demonstrates significant opportunities for admission avoidance (in the range of 40-60%) and reductions in length of stay (3–4 days)[21] for patients who require inpatient care. The existing AOS service has already achieved some reductions in length of stay but additional investment will support admission avoidance through staff availability (for rapid assessment of patients), oncology advice, and hot clinics, as well as some further reductions in length of stay. Therefore, the quantifiable benefits that have been applied are 25% admission avoidance and 10% reduction in length of stay respectively. These have been clinically endorsed and applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity. Further details and quantification of these benefits in relation to this business case are provided within the Economic Case section.

A summary of the anticipated benefits, beneficiaries and, critically, the proposals for assessment and measurement are set out in the table below. Further details, including the anticipated impact these benefits will have, can be found in the Benefits Realisation Plan (Appendix D).

Figure 17: Anticipated benefits of implementing AOS clinical model

Benefit	Beneficiaries	Measurement
Equal access to AOS for those in equal need	Patients, staff, Health Boards	Patients per head population, attendances linked to cancer incidence trends
Improved patient experience and better patient outcomes	Patients, staff, families, carers	PROMS

[21] *Acute oncology: Increasing engagement and visibility in acute care settings*. Royal College of Physicians. Oct 2020

Benefit	Beneficiaries	Measurement
Patients spend more time at home in their last year(s) of life	Patients, families, carers	PROMS, number of days spent in acute hospital in last year of life, patient preferred place of death, mortality rates within 30 days of treatment, palliative care contacts
More patients receive same day emergency care avoiding the need for hospital admission	Patients, Health Boards	Emergency admission rates, 30-day readmission rates, Nos of AOS patients admitted as inpatients, Nos of patients managed through ambulatory pathways, Cost per case
When admitted patients spend less time in hospital as an inpatient	Patients, staff, Health Boards	Inpatient bed days Average length of stay
Patients are not subject to unnecessary investigations or treatment	Patients, Health Boards	Numbers of investigations Patient outcomes and survival
Enhance links with other hospital based specialists / services	Patients, staff	Staff surveys, referral times
Improve effectiveness of AOS team working	Patients, staff	Staff surveys, number of patient handovers
Better professional AOS education and training	Patients, staff	Increase in critical mass of AOS team, staff surveys, retention, qualifications across the team
Digital interaction between staff / patients and staff / staff	Patients, staff, Health Boards, Velindre NHS Trust	Number of digital interactions, reduced time to access specialist opinion
Better AOS data to improve decision making & accuracy of demand and capacity forecasting	Patients, staff, Health Boards	Staff survey Reports
Efficient collection of AOS data allows for inter-operability and more clinical time spent with patients	Patients, staff	Staff survey Reports

In consideration of the development, assessment and measurement of anticipated bene fits, and ensuring they have a strong focus on outcomes the project team have been, and will continue to, work with the Value Based Healthcare teams across South East Wales and nationally in further developing our approach to benefits measurement and management.

2.3.1 Risks

Identifying, mitigating and managing the key risks is crucial to successful delivery. Without effective management of the key risks, it is likely that the project would not deliver its intended outcomes and benefits. The Management Case sets out the management of project specific risk, however, the table below sets out the key strategic risks that have been identified to date covering Business, Service and External categories.

Figure 18: AOS project risks

Risk Category	Risk Description
Business	There is a risk that there is a lack of HB support for the preferred model.
Business	There is risk that Health Boards / Commissioners do not agree to support the level of investment required to deliver the model.
Business	There is a risk that to meet the IMTP deadlines for 2021 the business does not go through due diligence and there is a delay in approvals.
Service	There is a risk that a lack of communication with key stakeholders and other disciplines means there is a lack of clinical support.
Service	There is a risk that not considering the whole AOS pathway limits the opportunities to provide a comprehensive, equitable service.
Service	There is a risk that lack of availability of appropriately trained and skilled staff limits the speed of implementation
External	There is a risk that COVID-19 will interrupt the project and take key personnel away from the project.

2.3.2 Constraints

The main constraints in relation to the AOS project are outlined in the table below.

Figure 19: AOS project constraints

Constraint	Overview
Financial constraints	The financial investment of implementing the preferred clinical model will need to be agreed with HBs.
Timescale constraints	The success of the AOS project will be dependent on inclusion in organisational IMTPs after 2021/22.
Service Capacity	The success of the AOS project will be dependent on the capacity of the service to fully implement the model in the agreed timeframe.

Constraint	Overview
Service Capacity	The success of the AOS project will be dependent on the ability to recruit to key posts.

2.3.3 Dependencies

A number of dependencies have been identified in relation to the AOS project, as outlined in the table below.

Figure 20: AOS project dependencies

Dependency	Overview
Funding Availability	Access to appropriate funding to implement the preferred clinical model.
Partnership Working	Co-production between HBs and VUNHST in the development and implementation of the model is essential to the success of the project.
Digital enablement	The need to have in place effective digital solutions to support virtual consultations / engagement and access to better clinical information / data for AOS patients
HB and CCLG Approval	The Business Case must be endorsed by the CCLG and thereafter seek approval through the HB statutory governance.
Pre implementation planning	Appropriately resourced and coordinated pre-implementation planning is critical to the successful implementation starting in 2021.
Compliance with national and UK guidelines	The AOS clinical model must comply with all relevant national and UK guidelines and recommendations.

2.4 Summary

This section of the business case has set out the background to the South East Wales Acute Oncology Service set in the context of wider cancer service delivery arrangements. It has outlined the existing arrangements for service provision and highlighted a range of gaps supported by an independent Peer Review. A set of objectives have been established to realise the benefits arising from enhanced resources and investment, and the proposed clinical model, once implemented will ensure that these benefits can be realised. Finally, a range of factors covering risks, constraints and dependencies have been identified which are critical in ensuring a successful outcome for the project.

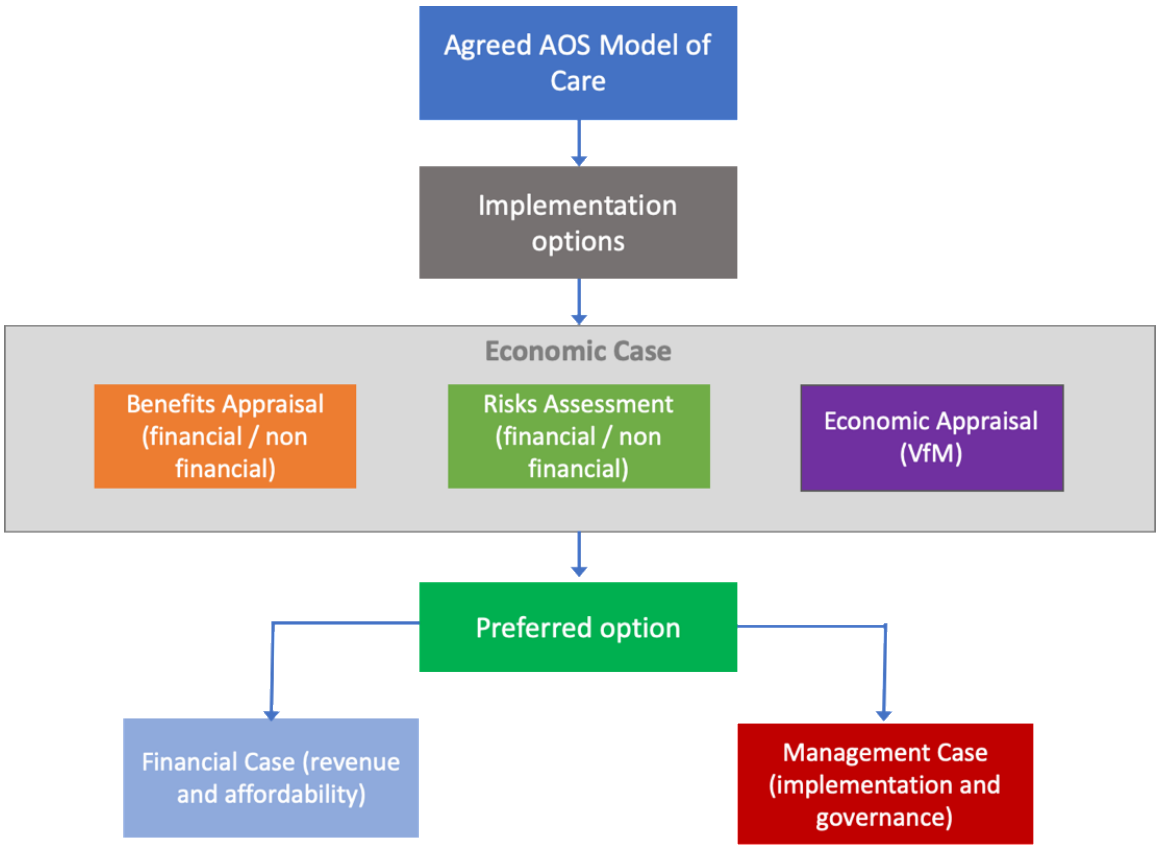
ECONOMIC CASE

3 Introduction

The purpose of the Economic Case is set out the options for implementing the Clinical Model identified within the Strategic Case and then to undertake a detailed analysis of the costs, benefits and risks of these options to ultimately identify a preferred way forward. The objective is to demonstrate the relative value for money of the options in delivering the required outcomes and services and ultimately to identify the solution which secures the optimal balance of costs, benefits and risks.

The Economic Case is set within the context of the wider Option Appraisal which translates the Acute Oncology Service clinical model into a series of alternative delivery solutions culminating in the identification of an agreed way forward. Once identified an assessment of funding and affordability (Finance Case) and deliverability (Management Case) are presented in subsequent sections of the business case. A summary of the process is provided in the diagram below.

Figure 21: AOS option appraisal



There are a number of steps involved in completing the Economic Case comprising the following:

- The process for developing the shortlist of implementation options
- The development of non-financial benefit criteria used to assess the options
- Scoring of the options against the non-financial benefit criteria
- Undertaking a non-financial risk assessment
- Assessing the monetary costs and benefits of the options over the appraisal period
- Summarising the results of the option appraisal and selecting the preferred option

The remainder of this section of the business case will outline how each of the above areas have been tacked and, critically, how stakeholders have been engaged in key aspects of the option appraisal process.

3.1 Developing the options

Options should be consistent with the project scope set out within the Strategic Case and should reflect different routes to delivering the anticipated benefits. As they reflect alternative choices it is possible to assess the differing extent to which investment objectives and associated benefits are secured, resources are applied, and risks are calibrated. As a minimum, an option that delivers the core project scope should be considered. A further option(s) that provide further optional / desirable coverage and a Do Nothing position which acts as a baseline or reference point against which improvements can be measured.

To aid with option development a framework was used to capture the key variables likely to be relevant in implementing the clinical model. These are phrased in four themes as set out below:

- **Theme 1 – Structure**: how the service would optimise combining specialist oncology expertise with locally based resources
- **Theme 2 – Configuration**: how Acute Oncology Services across SE Wales might be organised with particular emphasis on Health Board acute hospitals
- **Theme 3 – Operating**: over what time period would services be available
- **Theme 4 – Phasing**: consider a 'big bang' or phased approach and, for the latter, what might be quick wins

Using the four themes and working with a group of stakeholders from all of the South East Wales Health Boards and Velindre, representing a wide range of professional backgrounds, a short list of three options was developed. A summary is provided in the table below which also incorporates the 'quick wins' referred to above.

Figure 22: AOS option shortlist descriptions / components

Theme	Option 1 – Do Nothing (business as usual)	Option 2 – Do Minimum (Core Scope)	Option 3 – More Ambitious (desirable / optional scope)
Structure	Oncology input - daily MDT and on-call Clinical leads - one session/week	Oncologist of the day - balance of physical and virtual presence Clinical leads - additional sessions	Oncologist of the day – more physical than virtual presence Clinical leads - additional sessions with cross cover ANP – managed deployment
Configuration	Inconsistent access to AOS and variable CNS support across sites	AOS presence on all sites, appropriately resourced	Hybrid model: Inpatients (hub), ambulatory care (spoke)
Operating	Core hours but inconsistent across sites	Monday to Friday 9am -5pm	Extended day Monday to Friday 9am - 8pm
Phasing	N/A	Staged approach to implementation	Staged approach to implementation
Quick wins	N/A	MUO/CUP pathway Digital (Business Analyst)	MUO/CUP pathway Digital (Business Analyst)

In developing Options 2 and 3, certain elements were considered 'non-negotiable' as the expectation was they should be present and resourced appropriately in any implementation option, in order to meet the basic requirements of the clinical model. Specialist oncologist support is included in this but because there was a choice to be made about how this could work, it is included in the options above. A summary of the non-negotiables are provided in the table below.

Figure 23: AOS option 'non negotiables'

Element	Description
CNS input	Specialist Cancer Nurse Specialists (CNSs) and associated leadership to help manage initial presentations, support ambulatory pathways and act as a key worker through the inpatient pathway
AHP support	Allied Health Professional support to Acute Oncology patients, in particular to facilitate patient management and effective / timely discharge

Element	Description
Diagnostics	Rapid access to diagnostics, particularly radiology (and pathology for MUO/CUP) to support diagnosis and on-going patient management
MUO / CUP and Immunotherapy	A structured pathway for the management of patients falling within these distinct groups of AOS patients
Admin support	To support the effective management and planning of patient administration including clinics and MDT meetings

Lastly, as part of the option development process, potential solutions across the four themes were assessed and excluded on the basis that they were not adequately aligned to the proposed clinical model (for example, 100% virtual oncology input) or that there was insufficient evidence to justify the associated use of resources and case for investment (for example, data did not support running a weekend service). The exclusions are summarised in the table below.

Figure 24: AOS option exclusions

Theme	Excluded from all implementation options
Structure	Oncology input provided on fully virtual basis with no physical presence at acute hospital sites
Configuration	Single designated / centralised AOS hospital site per Health Board
Operating	Weekend service (but allowing for urgent, on-call specialist advice)

3.2 Non-financial benefits assessment

The purpose of the non-financial benefits assessment is to consider the extent to which, on a qualitative basis, the shortlisted options meet the objectives and deliver the anticipated benefits arising from the proposed investment in AOS.

In approaching this part of the option appraisal process there was a strong desire to build on the extensive and effective engagement that was present in the development of the clinical model. In this regard the non-financial assessment incorporated a series of stakeholder workshops with representation from all of the Health Boards in South East Wales and Velindre NHS Trust as well as partner organisations including the Welsh Ambulance Service, Macmillan and the Community Health Council. Stakeholders were drawn from a wide range of professional backgrounds including Oncologists, Cancer Leads, Acute Medical representatives, Nursing, Allied Health Professionals, Palliative Care, Finance, Workforce and Planning.

3.2.1 Developing the benefit criteria

During the workshops a set of six benefit criteria were agreed that would be used to assess the three shortlisted implementation options for AOS. As indicated these reflect both the investment objectives and anticipated benefits highlighted in the Strategic Case. The definition of each criteria have been expanded to provide a more comprehensive indicator of how these would be used to assess and score the options. Further details are provided in the table below.

Figure 25: AOS benefit criteria and descriptors

Criterion	Description
Equity of access	The extent to which the option ensures that the service delivered is available and predictable irrespective of where the patient acutely presents across South East Wales. Patients should expect the range and level of resources provided to be consistent and the outcomes of their care to be at an acceptable standard.
Patient experience and outcomes	The extent to which the option supports a positive patient experience and respects the needs of the individual across the entire admitted care pathway. Patient care and safety is optimised through timely access to care and expertise that reflects where the patient is on their cancer journey and their desired outcome from the intervention. The patient and their carers feel that there has been a measurable benefit from the care received.
Effective and efficient use of resources	The extent to which the option supports optimum patient throughput at an acceptable level of quality whilst making best use of time and resources. This should ensure throughput is optimised and there are no undue delays across the patient pathway from presentation / admission to discharge. This could include avoiding admission into an acute bed and / or where this is required minimizing the amount of time spent in hospital.
MUO / CUP pathways	The extent to which the proposed solution delivers an effective and patient centred approach to the management of MUO / CUP. This would include a structured rapid referral process, a clinical management pathway, CUP/MDT membership, dedicated out-patient clinics and interaction with other professional groups involved in the management of the patient. As a minimum it would be anticipated that access would be provided to an oncologist, a palliative care physician and a specialist nurse or key worker.

Criterion	Description
Optimising the end of life journey	The extent to which the option supports the patients' last year of life and their preferred place of death. This should be optimised through timely access to care and expertise, as they transition from active treatment to best supportive care. This should be overseen by the acute oncology team working closely with Palliative Care. This will include support to family, carers or other people who are important to the patient being cared for.
Education and training	The extent to which the proposed arrangements support formal and informal education and training across all staff involved in the delivery of Acute Oncology. This should cover all professions inputting to the patient pathway from initial presentation through to discharge but also external education through interaction with primary and community health practitioners.

3.2.2 Scoring the options against the criteria

Having developed the benefit criteria these were then ranked and weighted prior to the scoring of the options to assess the extent to which stakeholders judged the options were able to meet each of the criteria. Options were scored on a scale from 0 (could hardly be worse) to 10 (could hardly be better) and the results aggregated to provide a total score for each option. A summary of the ranking, weighting and scoring assessment is provided in the table below.

Figure 26: AOS non-financial benefit scores

	BENEFIT CRITERIA	WEIGHT %	Option 1 - Do nothing		Option 2 - Do Minimum (Core Scope)		Option 3 - More Ambitious (Desirable / Optional Scope)	
		W	SCORE	W x S	SCORE	W x S	SCORE	W x S
1	Equity of access	23.3	3.0	69.8	7.0	162.8	9.0	209.3
2	Patient experience and outcomes	20.9	3.0	62.8	8.0	167.4	9.0	188.4
3	MUO / CUP pathways	18.8	1.0	18.8	8.0	150.7	8.0	150.7
4	Education and training	13.2	1.0	13.2	7.0	92.3	8.0	105.5
5	Effective and efficient use of resources	12.5	4.0	50.1	8.0	100.2	7.0	87.7
6	End of life care	11.3	1.0	11.3	7.0	78.9	8.0	90.2
	TOTAL	100.0		225.9		752.3		831.7
	RANK			3		2		1

The results of the scoring exercise show that, unsurprisingly, Option 1 – Do nothing returns a low score both at individual criteria and aggregate level with a total returning a score in the 'lower quartile'. This reflects the extent to which the gaps in the current service impact in key areas such as equity of access and patient experience. Options 2 and 3 perform significantly better reflecting the fact that both deliver the key elements of the proposed clinical model. Both options score in the 'upper quartile', indicating that they are likely to be capable of realising the investment objectives and delivering the required benefits. However, Option 3 returns a slightly higher score reflecting its additional scope including such features as extended hours and greater presence of roles such as the ANP.

A range of sensitivity tests were undertaken including applying equal weighting to all of the criteria and eliminating the scores for the highest ranked criterion – Equity of access. A summary of theses sensitivity tests is shown in the table below.

Figure 27: AOS non-financial benefit scores

Scenario	Option 1 – Do nothing	Option 2 – Do minimum	Option 3 – More ambitious
Baseline scores	225.9	752.3	831.7
Ranking	3	2	1
Equal weighting applied to criteria	216.7	750.0	816.7
Ranking	3	2	1
Exclude scores for top ranked criterion	156.2	589.5	622.4
Ranking	3	2	1

As can be seen from the analysis none of the sensitivities materially alter the relativity of the scoring or the ranking of the options in terms of their non- financial benefits.

3.3 Non-financial risk assessment

In parallel with the non-financial benefits assessment, a review and assessment of non-financial risks associated with implementing the proposed clinical model was undertaken, specifically to consider how these might differ across the shortlist of options. As was the case with the non-financial benefits assessment work with a range of stakeholders in identifying and assessing the key risks was undertaken. The outputs of this work form a part of the wider option appraisal but also help to inform the mitigation and management actions outlined in the risk management plan provided as part of the Management Case.

3.3.1 Developing the risk register

An initial risk register for AOS has been developed focusing on the key areas of risk likely to impact on the successful delivery of the proposals set out within the Strategic Case. These risks have been developed covering three key service themes, namely Strategic Risks, Planning Risks and Operating Risks – a definition of each of these areas is provided below.

- **Strategic risks**: those risks associated with the strategic context in which the project is set and managed
- **Planning risks**: those risks associated with the planning parameters / assumptions used for the project
- **Operating risks**: those risks associated with service delivery and resourcing

In terms of specific risks covered by each theme the table below provides the appropriate analysis. The approach has been to focus on key risks rather than breaking down into larger numbers of individual components - this results in a relatively small number of risk areas concentrating on factors critical to successful implementation.

Figure 28: AOS risks

Risk theme	Risk no	Risk description
Strategic	1.1	Health Boards are unable to prioritise required investment in AOS
	1.2	AOS governance is not adequate to maintain shared ownership and delivery
	1.3	Further phases of AOS model are not taken forward
Planning	2.1	Estimated revenue is unable to meet full costs of implementation
	2.2	AOS demand outstrips capacity resulting in unmet need
	2.3	A lack of adequate pre-go live planning impacts adversely on AOS implementation
Operating	3.1	Inability to access required numbers of adequately trained / skilled Oncologists
	3.2	Inability to access required numbers of adequately trained / skilled nursing staff
	3.3	Digital enablers are not of a standard required to support key elements of the solution(s)

3.3.2 Assessing the risks

All risks have been assessed to establish the likely consequences should they arise (their impact) and the likelihood of them arising (their probability). The assessment scale and associated calibration for each element of the assessment is shown in the table below.

Figure 29: Risk assessment scale

Risk consequence		Risk likelihood	
Score	Rating	Score	Rating
1	Negligible	1	Rare
2	Minor	2	Unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Extreme	5	Almost certain

The risk rating is assessed by multiplying together the likelihood and consequence scores. Risks are then classified as Red, Amber, Yellow or Green based on the chart below.

Figure 30: Risk rating

Likelihood	Potential Consequences				
	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Almost Certain (5)	Medium	High	High	Very High	Very High
Likely (4)	Medium	Medium	High	High	Very High
Possible (3)	Low	Medium	Medium	High	High
Unlikely (2)	Low	Medium	Medium	Medium	High
Rare (1)	Low	Low	Low	Medium	Medium

3.3.3 Scoring the risks to assess impact

A workshop was convened to assess the risks using the rating scale highlighted above. The assessment was initially based on a review of Option 2 – Do minimum and then a judgement made on the relative rating of the other options against this position. The results of the risk assessment are shown in the table below with each risk score and rating highlighted along with the relative position for the Do Nothing and More ambitious options.

Figure 31: Risk assessment results

Risk	Score / rating	Option 1 - Do nothing	Option 3 - More ambitious
Health Boards are unable to prioritise required investment in AOS	12	↓	↑
AOS governance is not adequate to maintain shared ownership and delivery	9	↓	↔
Further phases of AOS model are not taken forward	9	↓	↔
Estimated revenue is unable to meet full costs of implementation	9	↓	↔
AOS demand outstrips capacity resulting in unmet need	9	↑	↓
A lack of adequate pre-go live planning impacts adversely on AOS implementation	6	↓	↔
Inability to access required numbers of adequately trained / skilled Oncologists	12	↓	↑
Inability to access required numbers of adequately trained / skilled nursing staff	12	↓	↑
Digital enablers are not of a standard required to support key elements of the solution(s)	12	↔	↔

↓ Lower risk. ↔ Similar risk. ↑ Higher risk

As can be seen from the results of the risk assessment there are a number of areas where a 'High' rating has been determined (in some instances this may be greater depending on which option is pursued) indicating these could have a significant bearing on the overall success of the project. Careful mitigation measures will be required to ensure that these risks and their potential impact can be managed. Further analysis is provided as part of the Risk Management Plan highlighte d in the Management Case.

3.4 Monetary costs and benefits

This element of the Economic Cases focusses on the assessment of the quantifiable monetary costs and benefits associated with the AOS implementation options. It uses Net Present Value (NPV) analysis to establish the overall economic impact of the options across an appraisal period rather than a single financial year. This allows us to review the economic impact of the alternative AOS delivery solutions and, when combined with the non-financial elements of the options appraisal, identify the 'preferred option' to be taken forward into the Finance and Management cases.

Recognising, at this stage, there is further work to be undertaken on the detailed implementation arrangements within each stakeholder organisation, for the purposes of this business case it is necessary to develop a range of planning assumptions that underpin the estimated costs and benefits associated with each of the options. Whilst these will be subject to review and update, they do reflect the latest position with regard to dialogue between professional groupings / functions and planning and finance colleagues from all of the stakeholder organisations across South East Wales. Further analysis of costs and benefits is provided within the Financial Model which supports the business case and has been shared with relevant personnel from each of the stakeholder organisations.

3.4.1 Monetary costs

Monetary costs broadly reflect the components of the options as set out in Section 3.1 of the business case, however, the tables below sets out more detailed assumptions used to develop the analysis. Note that the resourcing assumptions are closely linked to the service specification outline in section 2.2.7 of the Strategic Case.

Figure 32: Cost analysis assumptions

Input	Assumption
Phasing	Largely reflects Health Board investment prioritisation across a series of 'Implementation Phases' (further detail provided within the Finance Case) combined with the challenges of recruitment across different staff groupings with 4 months as the minimum recruitment time. Consultant level posts are assumed to be the most difficult to recruit and phased over a longer timescale.
Demand growth	This reflects NHS Wales cancer incidence which is rising at an annual rate 1.5-2%. This has been applied to the resource requirements as a proxy for the impact of increases in AOS demand.
Oncologist input	Provides for a combination of regular and predictable physical on the ground support within the Health Board acute sites combined with virtual support via "oncologist of the day" to be available for a full working day 5 days a week. Costs include allowances for annual leave and Supporting Professional Activities (SPAs). Physical support provision incorporates an

Input	Assumption
	allowance for Education and Development to support local teams. Under the more ambitious option the level of on the ground support is expanded.
Other consultant input	This includes allowances for Clinical Leads input within the Health Boards. Allowance is also incorporated for additional resource to support enhancements to the management of immunocology toxicity through a range of specialty inputs from HBs Allowance for Consultant Palliative Care support to the CUP/MUO MDT There is also provision for additional Pathology and Radiology input to support enhanced access to diagnostics for AOS patients
Nursing input	CNS/ANP whole time equivalents (WTE) are based on each HB's assessment of requirements to meet its local implementation across its acute hospital sites. The more ambitious option allows for a longer working day, with a greater proportion of ANP input. Registered nurse and healthcare assistant to provide treatment or support in hot clinics is also incorporated.
AHP input	AHP requirements are based on each HBs assessment of requirements to meet its local implementation across its acute hospital sites. The more ambitious option allows for a longer working day and input to hot clinics.
Other clinical	This includes MSCC coordination and, for the more ambitious option only, some Therapeutic Radiography input.
Admin support	Additional Medical Secretary support reflects an estimate of requirements to support the management of MDT and hot clinics. Call handler input relates only to the more ambitious option and supports a dedicated helpline for patients and GPs
Project management	This allows for dedicated support to manage the implementation of the project across the region.
Digital	IT and business intelligence expenditure has been shaped by discussions with digital leads across the stakeholder organisations. It reflects the need for a time limited scoping study (Discovery phase) combining business analysis and system architecture to further inform requirements and a cost allowance to support the on-going requirements. This will be further developed in line with the more detailed requirements specification.
Training and education	Training and Education expenditure reflects a cost allowance to support formal support for AOS staff across the region. This is in addition to the less formal input provided through the Consultant Oncology input.

The table below provides an analysis of the yearly costs for each of the options across the categories set out in the table above and reflects a fully implemented position which is anticipated to be reached in financial year 2024/25.

Figure 33: Option expenditure analysis

Expenditure heading	Option 1 – Do Nothing £000	Option 2 – Do Minimum £000	Option 3– More Ambitious £000
Consultant Oncologists	175.4	716.9	979.2
Other Consultant input	137.2	350.9	485.9
ANPs	249.7	402.1	613.9
CNSs	446.3	995.2	1,243.7
Other Nursing	-	94.0	182.2
AHPs	98.6	679.9	979.9
Other Clinical	-	77.9	114.2
Admin support / PM	227.4	442.0	547.1
Digital (IT/Business Intelligence)*	-	150.0	166.7
Education and training	-	40.0	90.0
Total	**1,334.7**	**3,948.9**	**5,402.8**

* Includes non-recurrent scoping costs to cover 'Discovery' phase

3.4.2 Monetary benefits

As set out in the Strategic Case there are significant service quality and safety benefits for patients who have access to a structured AOS in terms of their experience and outcomes. AOS ensures continuity and consistency of care where they would otherwise experience significant delays in diagnosis and treatment. Offering specialist oncology support outside the cancer centre, enable patients to access treatment at a location convenient to them. These benefits have largely been assessed through the non-financial appraisal and their measurement incorporated within the Benefits Realisation Plan. However, In addition to these qualitative benefits there are a range of quantitative benefits arising from the implementation of the clinical model which can be assessed and measured in terms of acute hospital capacity released and ultimately valued in cash terms through the application of resource assumptions.

To help quantify the benefits, empirical evidence from other centres and systems across the UK who have successfully implemented an AOS model that reflect the proposed approach in South

East Wales has been used. Specific focus has been given to the impact of an effective AOS on avoiding admissions and, where admission is required, reducing acute length of stay. The benchmarks show us that improvements could be delivered which reflect a range of 40% - 66% of patients discharged the same day, reducing acute admissions; and where acute admission is necessary, patient length of stay has reduced by 3 to 4 days.

As part of the South East Wales AOS business case these benchmarks have been reviewed and clinical consideration given to the potential level of improvement likely to be delivered through the implementation of the proposed model – it is considered realistic to expect a 25% reduction in acute admissions combined with a 10% reduction in length of stay for patients requiring specialist inpatient care. These are then applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity.

To quantify these benefits, benchmarks have been applied to the baseline position in each Health Board to assess the potential improvement and the impact it could have in freeing up acute capacity which, if released, could be used to support the needs of other service areas within acute hospital settings. Whilst these benefits are unlikely to be cash releasing, for the purposes of the Economic Case an assessment of the cash value of these benefits has been made by applying a direct cost allowance to the bed days released which can then be translated into a value to be incorporated into the overall cost benefit analysis.

In terms of calculating the benefit associated with these improvements for each Health Board the approach set out below has been adopted. This recognises the limitations of existing AOS data capture in establishing a robust baseline, however, proxy measures using Patient Episode Data Wales (PEDW) have been used as the basis for estimating current AOS activity in acute care settings across the region. In summary the approach incorporated four stages, namely:

- Establish an AOS baseline activity position by looking at emergency admissions where cancer is within the top 3 diagnostic codes
- Apply the clinically validated improvement metrics arising from the proposed AOS arrangements within South East Wales (25% admission avoidance / 10% reduction in average length of stay). It is anticipated that a further 5% reduction in length of stay could be achieved through the more ambitious option.
- Translate the improvement potential into bed days (and capacity) released
- Apply a unit cost of £150 reflecting the potential direct cost benefits associated with the bed day reductions

A summary of the results of this analysis is provided in the table below.

Figure 34: Analysis of quantified benefits by Health Board (2018/19 baseline)

Health Board	Baseline AOS bed days	Bed days freed up			Capacity released (Beds)	Annual financial impact
		Avoided admissions	Reductions in LOS	Total		
ABUHB	32,203	8,051	2,344	10,395	30.0	£1,559,250
CAVUHB	27,281	6,820	2,011	8,831	25.5	£1,324,650
CTMUHB	34,051	8,513	2,507	11,020	31.8	£1,653,000
Total	**93,635**	**23,384**	**6,862**	**30,246**	**87.3**	**£4,536,900**

The analysis shows that, across South East Wales, the scale of this opportunity is in the order of 30,000 bed days / 90 beds, which if released could be used to support the needs of other service areas within acute hospital settings across the three Health Boards.

For the purposes of the Economic Appraisal the cashable benefits have been incorporated into the Economic Appraisal as set out below. Cash benefits are phased in a manner which reflects the profile of investment with an appropriate lag factor to recognise the timing between resource deployment and benefit realisation.

3.4.3 Cost benefit analysis results

Applying the assumptions set out above an NPV analysis has been undertaken to provide an economic cost for each of the options based on the approach set out below.

Figure 35: Economic Appraisal assumptions

Input	Assumption
Price base	All costs and benefits are priced at 2020/21 rates
Appraisal period	10 years from initial implementation starting in April 2021
Discount factor	3% in line with investment appraisal guidance

The analysis incorporates the anticipated profile of costs and benefits across the 10 year appraisal period. The Net Present Cost (NPC) for each option is presented as a quantitative assessment of the value for money associated with each option. By incorporating the non-financial benefit scores outlined in section 3.2 the net economic cost to quality score can be assessed. A summary of the analysis is provided in the table below.

Figure 36: Cost / benefit analysis

Heading	Option 1 – Do Nothing £000	Option 2 – Do Minimum £000	Option 3 – More Ambitious £000
Discounted costs	11,830	29,559	42,291
Discounted benefits	-	29,517	38,170
Net present cost (NPC)	11,830	42	4,121
Non-financial benefit score	225.9	752.3	831.7
NPC per benefit point	52.4	0.1	5.0

This shows that across the appraisal period, of the two options other than the Do Nothing, Option 2 – Do Minimum delivers the best balance of monetary costs and benefits returning an overall neutral ratio of economic costs to benefits. When incorporating the non-financial benefit scores it also delivers the best ratio of net economic costs to quality benefits.

3.5 Options appraisal summary

Having concluded the non-financial and financial aspects of the option appraisal process, an overview of each of the shortlisted implementation options can be provided. A summary of the option appraisal is provided in the tables below. Advantages and disadvantages summarise the assessment of the extent to which the option will deliver the main benefits (Section **Non-financial benefits assessment** refers) and incur the main risks (Section **Non-financial risk assessment** refers). Conclusion indicates if the option is likely to meet the **Spending Objectives** and additional requirements set out in the Strategic Case.

Figure 37: Summary of option appraisal

OPTION 1	Do Nothing – Business as Usual (BAU)
Description	*This maintains the existing arrangements for AOS*
Net Economic Cost	*£11,830k (£52.4k per non-financial benefit point). Reflects existing investment with no additional benefits*
Advantages	*Relatively low economic cost when compared with other options and lower overall risk.*
Disadvantages	*Does not support the Spending Objectives as indicated by the non-financial benefits score being in the lower quartile. Does not deliver any additional monetary benefits.*
Conclusion	*Does not meet the Spending Objectives nor deliver the proposed clinical model.*

	Does not address the service gaps as identified in the Peer Review.
OPTION 2	**Do minimum**
Description	*This delivers the core scope of the project and the AOS clinical model on a phased basis recognising the challenges around staff recruitment. Addresses gaps in service as identified in the Peer Review. Consistent with the recommendations of the Nuffield Review*
Net Economic Cost	*£42k (£0.1k per non-financial benefit point). Reflects benefits arising from capacity freed up through avoided admissions and reductions in length of stay*
Advantages	*Supports the Spending Objectives as indicated by the non-financial benefits score being in the upper quartile. Delivers significant non-cash releasing monetary benefits and potential to free up resources for other service priorities*
Disadvantages	*Risk profile shows mainly medium risks with some assessed as high requiring careful management.*
Conclusion	*Meets the Spending Objectives for the project*
OPTION 3	**More ambitious**
Description	*This delivers the core scope of the project and the AOS clinical model on a phased basis recognising the challenges around staff recruitment. Addresses gaps in service as identified in the Peer Review. Consistent with the recommendations of the Nuffield Review. It delivers some additional scope including an extended working day which provides for some additional benefits.*
Net Economic Cost	*£4,121 k (£5.0k per non-financial benefit point). Reflects benefits arising from capacity freed up through avoided admissions and reductions in length of stay*
Advantages	*Supports the Spending Objectives as indicated by the non-financial benefits score being in the upper quartile.*
Disadvantages	*Risk profile shows mainly high risks with some assessed as medium requiring careful management.*
Conclusion	*Meets the Spending Objectives for the project*

3.6 Recommended option

Using the results of the option appraisal summary set out above the option that offers the best overall combination of costs and benefits and is best able to meet the project spending objectives is Option 2 – Do Minimum. At this point in time, and for the purposes of this business case, Option 2 – Do Minimum will be taken forward into the Finance and Project Management sections of the business case to demonstrate how it will be funded and implemented.

3.7 Summary

The Economic Case has allowed a set of options to be developed providing different solutions to implementing the AOS clinical model and subsequently assessed their value for money through an option appraisal incorporating non-financial and financial elements. Following a robust process involving a wide range of stakeholders combining organisational and professional perspectives a preferred option has been identified with is Option 2 – Do Minimum - this approach to implementing the AOS clinical model meets the following:

- Supports the key Spending Objectives
- Addresses key gaps in service identified by independent peer review
- Delivers the best combination of costs, benefits and risks

FINANCIAL CASE

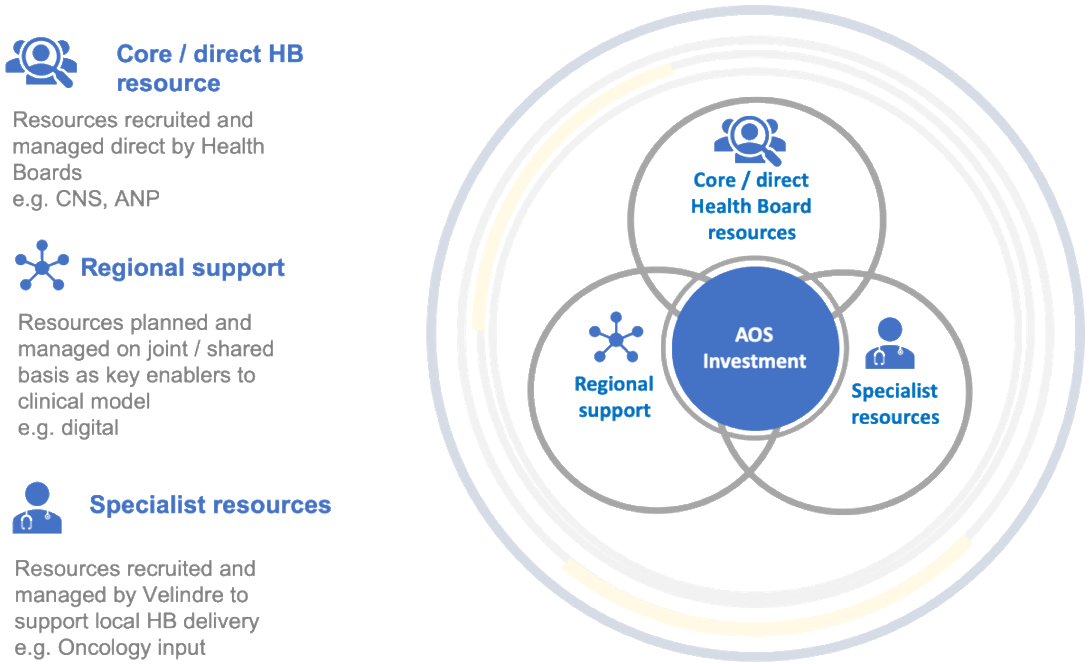
4 Introduction

The purpose of the Financial Case is to demonstrate the affordability of the preferred option, both in the context of the financial profile and funding consequences and the implications for South East stakeholder organisation's financial plans. This section of the business case sets out the following:

- Arrangements for phasing the proposed investment across the implementation period for the preferred option
- Revenue analysis for preferred option for years 1 to 4 against baseline AOS costs
- The proposed approach to apportioning costs / investment to Health Boards
- The estimated impact of the proposed AOS investment by stakeholder organisation
- Details of further work to be undertaken post business case

In developing the Finance Case it is recognised that the investment requirements cover a range of 'cost pools' including locally managed, regional and specialist support. As such funding arrangements need to reflect the likely combination of direct Health Board investment with expanded commissioning arrangements to secure the full range of resources required to successfully implement the proposed service arrangements. This is illustrated in the diagram below.

Figure 38: AOS cost and funding components



4.1 Phasing of investment

In order to implement the proposed clinical model in a manner which is both deliverable and affordable it is necessary to assign a degree of priority to the AOS service lines and associated investment requirements. Working closely with stakeholders from the partner organisations a phased approach has been negotiated which reflects the individual needs of the Health Boards balanced against the challenges in delivering the specialist elements of the service model. It also seeks to priorities investment into areas of greatest need and to ensure that associated benefits are delivered as early as possible in the implementation. In practical terms, phases will not be discrete and there may well be a degree of overlap in their implementation.

As part of this process, working closely with key stakeholders, a three phase approach to implementation has been developed and the service priorities aligned to these which can then be used to profile the associated resources and investment.

Although there are different organisational viewpoints there is a broad consensus on prioritisation, particularly in relation to what should be incorporated within Phase 1. Where organisational priorities are different and this related to the directly managed cost pool it is entirely practical to reflect this in local implementation. However, where there are differences in the priority associated with services which are part of specialist / regional arrangements this presents some practical challenges if organisations wish to operate at different speeds. Although some differences have emerged from the dialogue it has been possible to develop a set of assumptions that can be used to shape investment requirements for all aspects of the proposed service solution.

For the purposes of the business case the table below sets out how investment priorities have been mapped into phases.

Figure 39: AOS investment prioritisation

Area of investment / service line	Phase 1	Phase 2	Phase 3
Clinical Nurse Specialists	✓		
Specialist Oncology (virtual)	✓		
Specialist Oncology (on site)	✓		
MUO / CUP service	✓		
Patient administration	✓		
Project management	✓		
Digital (discovery phase)	✓		

Area of investment / service line	Phase 1	Phase 2	Phase 3
Allied Health Professionals		✓	
Immunotherapy Toxicity		✓	
Advance Nurse Practitioners			✓
MSCC Pathway			✓

4.2 Revenue analysis

By using the assumptions set out in the table above it is possible to show how the investment requirements map out across the proposed service lines and phases of implementation and the additional investment required. These can then be mapped to financial years up to 2024/25 when it is anticipated the model will be fully implemented. Note the mapping to financial years takes into account lead times to implement (particularly in relation to recruitment) the relevant part of the service solution. This analysis is shown in the tables below.

Figure 40: AOS additional investment profile by service line £000

Cost heading	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Clinical Nurse Specialists	107.8	367.3	445.0	445.0
Oncologist support	51.3	246.5	426.4	471.7
Other consultant input	19.7	72.8	102.7	119.2
AHPs	30.3	231.6	499.0	581.3
ANPs	29.7	59.4	113.7	152.4
Other nursing	4,.3	35.9	82.5	94.0
MUO / CUP	51.8	155.5	155.6	155.6
Immuotherapy Toxicity	0	110.0	142.6	142.6
MSCC	0	0	52.4	89.9
Admin support	26.0	85.5	100.2	103.9
Regional investment*	147.2	245.3	245.4	196.2
Total additional investment	468.2	1.609.8	2,365.5	2,551.6

• *Includes Project Manager, Digital and Education and Training some of which id non recurrent*

Figure 41: AOS additional investment by phase £000

Phase	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Phase 1	468.2	1,288.0	1,535.3	1,499.4
Phase 2	-	321.8	707.1	836.4
Phase 3	-	-	123.1	215.8
Total	**468.2**	**1,609.8**	**2,365.5**	**2,551.6**

The analysis shows that the invest requirements are relatively modest in year 1 (2021/22) and increase thereafter in years 2 to 4 reflecting the phased implementation of the clinical model and supporting investment across the region.

4.3 Apportionment of costs and investment requirements

By way of further analysis it is useful to break down the total AOS additional investment across the three 'cost pools' highlighted in the diagram above. This shows the comparative level of additional investment in AOS and demonstrated that the Core / Direct cost pool takes up the greatest proportion of the requirement. Further details are provided in the table below.

Figure 42: AOS additional investment by cost pool £000

Cost pool	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Core / Direct	217.8	852.4	1,343.4	1,495.8
Specialist Support	103.2	512.0	777.0	859.7
Regional Support	147.2	245.4	245.4	196.2
Total additional investment	**468.2**	**1,609.8**	**2,365.5**	**2,551.6**

In terms of apportioning the additional investment required in AOS the approach recognises the different ways in which expenditure will materialise, depending on the cost pool in which they sit. In developing the business case a set of principles have been established which are aimed at securing an equitable basis for allocating investment to Health Boards reflecting both local implementation planning and likely levels of service demand. These apportionment principles for each cost pool are as follows:

- Core / Direct – apportioned directly to the Health Board based on existing expenditure and local investment intentions. This includes all ANP / CNS and AHP costs and a proportion of Other Consultant and Admin costs
- Specialist Support – where this can be reflected in measurable inputs at Health Board level e.g. 'on the ground' Oncologist time / input then this has been used to apportion costs. Other aspects including MUO / CUP and MSCC coordination are allocated on the basis of cancer incidence
- Regional support – allocated to Health Boards on the basis of cancer incidence covering Project Management costs, Digital investment and Education and Training.

Applying these principles to the AOS costs allows an analysis of the additional investment required within each organisation across South East Wales reflecting a combination of the three areas outlines above and the proposed phasing of implementation – this is shown below.

Figure 43: AOS additional Health Board investment by phase and financial year£000

Health Board / Phase	Year 1 – 2021/22	Year 2 – 2022/23	Year 3 – 2023/24	Year 4 – 2024/25
Aneurin Bevan UHB				
Phase 1	167.2	436.5	510.8	496.6
Phase 2	-	147.9	349.1	421.0
Phase 3	-	-	52.0	93.9
Total	**167.2**	**584.4**	**911.9**	**1,011.4**
Cardiff and Vale UHB				
Phase 1	180.4	537.7	669.2	658.8
Phase 2	-	49.1	70.1	70.1
Phase 3	-	-	15.2	26.1
Total	**180.4**	**586.8**	**754.4**	**755.0**
Cwm Taf UHB				
Phase 1	120.5	313.9	355.4	344.1
Phase 2	-	124.8	287.9	345.2
Phase 3	-	-	55.9	95.9
Total	**120.5**	**438.7**	**699.2**	**785.2**

It should be noted that through the established commissioning arrangements Powys Teaching Health Board would be responsible for a proportion of the required investment, however, this is unlikely to reflect a material value.

4.4 Post business case activities

Resource and cost estimates to support AOS have been developed over a relatively short period of time, however, every effort has been made to engage with clinical, planning and finance teams across the stakeholder organisations. It is recognised that further work is required to develop and refine these and to ensure that the requirements reflect local circumstances whilst recognising the need to deliver a sustainable and consistent AOS model across the region. Furthermore there is a need to ensure that the resource estimates can be developed to a level that proves adequate certainty of required investment in AOS to be incorporated within local Integrated Medium Term Plan (IMTP) development for 2021/22 and beyond.

Further work relating to the operational detail of the proposed specialist and regional services will be undertaken to ensure they accurately reflect the local organisational arrangements for delivering AOS within the Health Boards. Final investment requirements will reflect this process although maintaining equity across the region will continue to be a fundamental aspect underpinning this work.

Consideration will also need to be given to developing commissioning and financial control arrangements for the Specialist and Regional aspects of the AOS investment and specifically how these can be aligned to / incorporated within existing mechanisms. At the heart of this will be the need to ensure transparency and assurance that investment is directed to the core elements of the clinical model. Further details are provided within the Management Case section of the business case.

4.5 Summary

The Finance Case has set out the required level of additional investment in AOS to support the implementation of the preferred option identified through the Economic Case. Recognising that costs will build up in a phased manner reflecting, in particular, challenges around recruitment, the investment has been presented over a 3 to 4 year implementation period.

Further consideration needs to be given to developing and agreeing an approach to allocating costs and funding to the Health Boards in South East Wales recognising that this combines elements of direct service provision with commissioning of specialist Oncology support and other shared investment.

It is recognised that further work will be required post business case development to refine and adapt resources to reflect local circumstances and align with IMTP processes.

MANAGEMENT CASE

5 Introduction

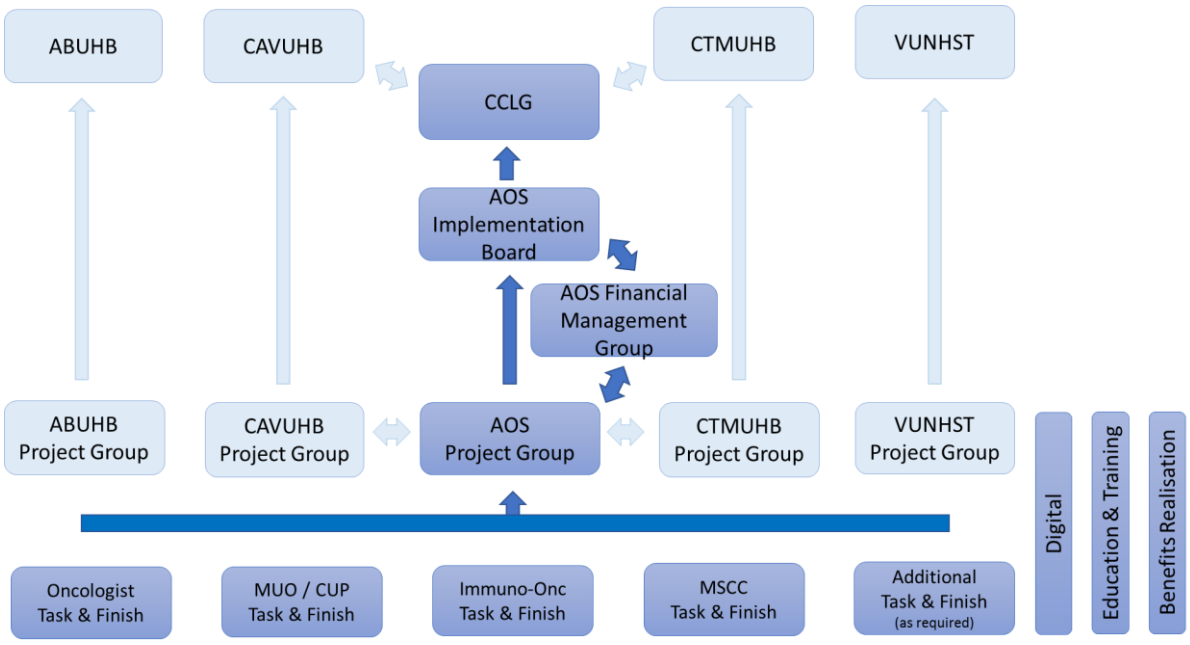
The purpose of the Management Case is to demonstrate that robust arrangements are in place for the delivery, monitoring and evaluation of the project and that the organisational stakeholders are ready and capable of delivering a successful outcome. In doing so, it sets out the governance and processes that will sit behind the implementation of the clinical model across the region. The objective is to demonstrate how the preferred option will deliver the clinical model (including realising benefits and managing risks), the approach to implementation (including change management) and the associated timescales.

5.1 Governance

The development of this business case and the work that sits behind is the result of a multi-organisational, multi-professional collaboration across South East Wales. The governance around implementation and delivery of the clinical model will continue to reflect this degree of collaboration, ensuring the founding principles of equity of access and shared ownership continue.

As the commissioners of this work, CCLG own the successful delivery of the project but HBs have the statutory authority for any investment in the service. Operationally, the project will be overseen by an AOS Implementation Board which will be supported by a Financial Management Group and AOS Project Group, which in turn will be informed by task and finish groups. Further details are provided in the supporting text and diagram below which reflects both the core AOS requirements (depicted in dark blue) and the local HB structures (depicted in light blue).

Figure 44: AOS Implementation Governance



South East Wales Collaborative Cancer Leadership Group (CCLG)

The CCLG provides effective system leadership for Cancer Services across South East Wales, in delivering improvements in outcome and service experience for the catchment population. The Group are responsible for leading whole system changes at a regional level which require the coordination of commissioning decisions and investments and facilitate the realignment of pathway resources within and between organisations. As Project Sponsor, the CCLG will provide regional oversight of the implementation of this project but will refer to HB and Trust Board teams to ensure appropriate and statutory governance is followed.

Health Board and Trust Board

Although the CCLG will provide regional oversight to the AOS project, any local decision making will need to be made through the internal governance processes of the Health Board and Trust Executive teams. HBs will have the statutory authority for any investment in both the local enhancements to AOS, as well as commissioned services from VUNHST.

AOS Implementation Board

The AOS Implementation Board will have overall responsibility for the delivery of the project. This will be a relatively small, discreet group with the Cancer Leads from the four organisations (ABUHB, CAVUHB, CTMUHB and VUNHST) as well as a number of multi-professional representatives, patient representatives and external stakeholders. They will to provide strategic

leadership to the AOS project, as well as monitor progress against the implementation plan, ensure project risks are managed appropriately and that the benefits set out in this business case are realised. The Implementation Board will receive monthly highlight reports from the AOS Project Group, and liaise with HB and Trust Board teams to ensure appropriate and statutory governance is followed.

Financial Management Group

As noted in the Finance Case the investment requirements for AOS have been categorised into three areas: direct (resources under the direct management of HBs); regional (resources supporting the region such as digital, education and training, and project management); and specialist (resources largely deployed by VUNHST, predominantly specialist oncology support).

In order to support the regional and specialist elements it is proposed that an AOS Financial Management Group is established, operating within a robust financial control mechanism, to provide financial scrutiny, and manage and monitor the flow of investment for specialist and regional resources, ensuring that resources are released appropriately once firm deployment plans are in place. This group will have financial representatives from the HBs and act on behalf of these organisations. It will ensure that:

- There is alignment between the resources identified within the business case and implementation of the clinical model
- Funding will only be released into the system once there was a clear plan to deploy the required resources
- Phasing of funding reflects the speed of implementation across the region balanced against the need to ensure equity of service access
- Benefits can be measured reflecting a focus on return on investment and value based healthcare

AOS Project Group

The AOS Implementation Board will be supported by an AOS Project Group which will include advisors and leads from the HBs across a number disciplines (clinical and nursing), as well as project and business support. This group will drive the operational implementation of an enhanced AOS across the region, lead the delivery of project outcomes and benefits, escalate project risks and issues to the Board, and facilitate effective communication and engagement across the region and organisations. The regional and cross cutting elements of the service will also report directly into the Project Group.

Health Board / VUNHST AOS Project Groups

There will be direct, local enhancements to AOS in each HB and these will need to be managed separately by them, ensuring they are in line with the principles of the clinical model of equity of access and shared ownership. Effective and ongoing communication and engagement with each

of the four organisations is crucial. Having these in place (either through existing or new groups) so that the Project Group can feed into and receive information from them, will be key in managing progress against the plan. HB leads sitting on the AOS Project Group will be responsible for this two-way communication but will be supported by the project team.

AOS Task and Finish Groups

Task and finish groups will be established with a remit to refine service models and pathways for each area of investment. They will consider the operational requirements to implement, develop job descriptions and job plans, and determine the most appropriate roll out. The outputs of these groups will be passed up through the AOS governance structure for approval, after which the investment will be released.

Most of the task and finish groups will be clinically led but all will have regional representation, and will draw on expertise from other areas as appropriate. Although they will be established as separate groups, there will some shared themes and possibly resources between the groups and this will be the responsibility of the Project Group to ensure these links are maintained and coordinated appropriately.

Cross-cutting Groups

There are some elements of implementation which will cover multiple elements of the service and will need to both feed into and take information from the task and finish groups and local HB/Trust groups. These areas, such as digital, education and training, and benefits realisation will also inform the AOS Project Group to ensure the outputs across the multiple groups are aligned and consistent.

5.2 Project Management

Successful implementation of the clinical model will require project management input for the co-ordination of the Delivery Groups and their outputs, reporting progress against the plan, as well as escalation of risks and issues. Of particular importance is the close collaboration and liaison with HB colleagues.

The project team will include a Programme Manager who has responsibility for the delivery of the project, making sure it is delivering against the plan, to time and within budget; and a Project Manager who will be responsible for the day to day running of the project with a particular focus on the delivery groups.

Figure 45: Roles and Responsibilities

Role	Name	Responsibility
Senior Responsible Officer (SRO)	To be identified (CCLG)	The SRO is accountable for the success of the AOS implementation project. The SRO owns the vision for the AOS project and is required to provide clear

Role	Name	Responsibility
(Chair - Implementation Board)		leadership and direction.
Project Director (Chair – Project Group)	To be identified	The Project Director reports to the SRO and is operationally accountable for project delivery of the AOS project. They will provide leadership and are responsible for enabling effective project delivery.
Clinical Leads (Implementation Board)	Ian Williamson (ABUHB) Meriel Jenney (CAVUHB) Calum Forrester-Paton (CTMUHB) Hilary Williams (VUNHST)	The Clinical Leads will be responsible for providing leadership within their organisations, and ensuring a clinical focus is maintained in all aspects of the project and that patient experience and quality is always a primary consideration.
Programme Manager	Jenny Stock	The Programme Manager has overall responsibility for the delivery of the project and ensure it is delivered to time, cost and quality. Key to this will be the efficient and effective use of project resources, and the identification and management of, interdependencies, risks and issues, and benefits delivery.
Project Manager	TBC	The Project Manager will be responsible for the day to day running of the project including support for the task and finish delivery groups.

5.3 Implementation

There are significant challenges around the implementation of a regional clinical model, across different HBs and multiple sites within those HBs. It is recognised that individual HBs have different baselines in their current AOS and therefore, different priorities. Some elements of the implementation plan will occur at different times and be delivered in different ways, but all aspects of the clinical model should be achieved within the designated timeframe.

As noted in the Financial Case, phased investment plans for each HB have been developed and these will shape the detailed implementation plans for each HB. There were strong similarities between the HB plans, most notably with nursing and oncology support prioritised for immediate investment. Other areas also recognised as key included the MUO / CUP pathway and digital enablers (which also reflected the quick wins identified in the option appraisal process). Where services are required to be delivered across the region (with investment from all three HBs to ensure equal access for patients) the decision was been made to move to that service in line with the majority view.

An overview of the regional phases is set out in the table below. In reality the phases will overlap with each other (phase 2 will start before phase 1 has been completed), and this is based on the premise that some services could take years to fully implement (such as the specialist oncology support).

Figure 46: Health Board Investment Phases

Phase 1	Phase 2	Phase 3
Clinical Nurse Specialists Specialist Oncology - Virtual Specialist Oncology – Onsite MUO/CUP Service AOS Lead (ABU) Consultant Sessions – Clinical Lead (ABU / CAV) Patient administration Education and training Digital discovery Project management	Allied Health Professionals Immunotherapy Toxicity Service Consultant Sessions – Other (CAV)	Advanced Nurse Practitioner (ABU / CTM) MSCC Pathway

Lead times for recruitment have also been applied to the investment plan, which again will be reflected in the implementation plans. The table below is a high level implementation plan and it pulls together the individual HB phasing plans into one so it remains a regional programme which can be held to account through the AOS governance.

Work to develop the operational implementation plans will be picked up by the task and finish groups and will run in parallel with the business case approval process.

Figure 47: High Level Implementation Plan

Element	Phase 1	Phase 2	Phase 3
Nursing / AHPs	CNS recruitment plan	AHP recruitment plan	ANP recruitment plan
Oncology	Virtual support for HBs and on-site presence (including hot clinics)		
Consultant Sessions	Increased sessions to support AOS team	Sessions to support Immuno-oncology service	
MUO/CUP	New MUO/CUP service – develop pathways and establish MDT		
Immuno-oncology	*Immuno-oncology service – develop pathways and guidelines (Macmillan funding)*	Immuno-oncology service developed, MDT established	
MSCC			Scope MSCC pathways
Patient Administration	Recruited as required	Recruited as required	
Digital / Business Analysis	Discovery and design – scope baseline (process, pathways, data items, methods of documentation, duplication)	Informed by outputs from phase 1.	Informed by outputs from phase 1.
Education & training	Regional education and training programme		
Project management	Project Manager recruited		

5.4 Workforce

A critical part of the implementation will be the workforce strategy. A high level workforce plan including associated costing will be developed and aligned to the clinical model.

The proposed service model will be appropriately resourced by a team of skilled nurses and AHPs, with specialist oncology support. This requires a change in the current workforce model. The intention of the workforce plan will be to ensure that an equitable service can be provided across the region, aligned with the clinical model, in order to ensure the delivery of quality and safe care and will seek to address future clinical and workforce challenges.

The high level plan will be created to capture the workforce requirements taking into account the future and existing skills and capabilities required to deliver an equitable AOS service in the short, medium and longer term. It is intended that workforce planning will support the clinical model through:

- Creating a more flexible workforce, sharing staff across locations within HB's with additional support provided by the AOS Lead and administrators;
- Developing and implementing a structure for career progression, learning and development to support succession planning and to provide wider service development of skills in acute oncology;
- The more detailed workforce plan being developed will address any future recruitment and skills gaps;
- Using the workforce flexibility to manage workload pressures within HBs;
- Retention of highly skilled and experienced staff within Specialist Oncology Services;
- Increased opportunities to develop clinical expertise - training and opportunities for medical and nursing, occupational therapists and AHP in acute oncology;
- The opportunity to develop the right skills for the future;
- Greater opportunities to share learning and best practice between teams and wider services.

Improvements to the quality of service and pathways for patients will be achieved as a result of more collaborative working appropriate services, reducing risk and improving patient experience. The challenges ahead in having a workforce that can effectively and efficiently provide care in an AOS are recognised.

Expansion of the AOS as a regional approach is an opportunity to make increased efficiencies in delivering services. The plan will help ensure that the right staff are in the right place at the right time, aligned with the long term model of care for AOS across South East Wales. Acknowledging the differences and difficulties in recruitment across the region, and to maintain the equitable and collaborative nature of the project, a regional nursing recruitment plan will be developed.

5.5 Change Management

Change can be challenging but by taking a systematic approach clinical teams will be supported in seeing where change has been affective. The change process is underpinned by a number of principles:

- Recognise the need to maximise the benefits of change for patients, who should be at the heart of the changes made;
- Take advantage of the pre-implementation phase to start the change process;
- Work in partnership with stakeholders to engage all those involved in the delivery of care in the change process;
- Focus on staff skills and development so they are both capable and empowered to deliver the service effectively and to a high quality standard.

A full Change Management Plan will be developed during the implementation phase.

5.6 Communication and Engagement

Effective communication and engagement with all stakeholders is vital in the delivery of a successful project.

The development of the clinical model and this business case has been the result of a huge amount of collaboration, with clear and effective communication key to reaching a consensus across four organisations and many professional disciplines. Continuing a high level of communication and engagement will be even more important during implementation, with an increasing number of stakeholders involved as the enhanced service is rolled out.

A communication plan will be developed during the implementation phase.

5.7 Benefits Management

Benefits management is the identification, optimisation and tracking of expected benefits from the implemented change. A benefit realisation plan will help assess whether the identified benefits set out in the Strategic Case (and below) deliver the project spending objectives (also set out in the Strategic Case) and are able to meet the agreed measures of success.

The benefit management process includes the following stages:

- Identification – selection of appropriate and significant benefits
- Planning – how, when and by whom the benefits will be delivered (ownership, accountability and timeframe)
- Deliver – successful delivery of the benefits plan
- Review – continuous improvement through incremental change or new projects

Measuring and monitoring the delivery of benefits is key in assessing the extent to which they are being delivered against the plan. A proportion of the benefits will be 'hard' or quantifiable (such as admissions and length of stay) but many will require 'soft' or qualitative measures to assess their delivery. In some instances, measurement can be achieved through existing systems and information sources. However, there is a recognition that these existing sources can be unreliable,

and in other instances there is a gap which will require new arrangements to effectively monitor them.

Given the complexity of working across the region and multiple organisations, management of the benefits throughout the life of the project will be led by the AOS Project Group. The following table sets out the anticipated benefits of implementing the AOS clinical model but further details, including the anticipated impact these benefits will have can be found in the Benefits Realisation Plan (Appendix D).

Figure 48: Anticipated benefits of implementing AOS clinical model

Benefit	Beneficiaries	Measurement
Equal access to AOS for those in equal need	Patients, staff, Health Boards	Patients per head population, attendances linked to cancer incidence trends
Improved patient experience and better patient outcomes	Patients, staff, families, carers	PROMS
Patients spend more time at home in their last year(s) of life	Patients, families, carers	PROMS, number of days spent in acute hospital in last year of life, patient preferred place of death, mortality rates within 30 days of treatment, palliative care contacts
More patients receive same day emergency care avoiding the need for hospital admission	Patients, Health Boards	Emergency admission rates, 30-day readmission rates, Nos of AOS patients admitted as inpatients, Nos of patients managed through ambulatory pathways, Cost per case
When admitted patients spend less time in hospital as an inpatient	Patients, staff, Health Boards	Inpatient bed days Average length of stay
Patients are not subject to unnecessary investigations or treatment	Patients, Health Boards	Numbers of investigations Patient outcomes and survival
Enhance links with other hospital based specialists / services	Patients, staff	Staff surveys, referral times
Improve effectiveness of AOS team working	Patients, staff	Staff surveys, number of patient handovers
Better professional AOS education and training	Patients, staff	Increase in critical mass of AOS team, staff surveys, retention, qualifications across the team
Digital interaction between staff / patients and staff / staff	Patients, staff, Health Boards, Velindre NHS	Number of digital interactions, reduced time to access specialist opinion

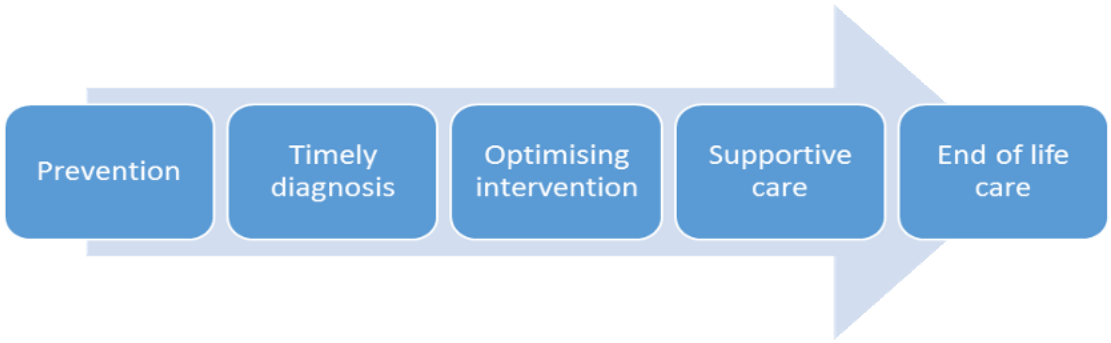
Benefit	Beneficiaries	Measurement
	Trust	
Better AOS data to improve decision making & accuracy of demand and capacity forecasting	Patients, staff, Health Boards	Staff survey Reports
Efficient collection of AOS data allows for inter-operability and more clinical time spent with patients	Patients, staff	Staff survey Reports

5.8 Value-based Healthcare approach to acute oncology

Identifying the benefits, and the approach to delivering and measuring them, are enshrined in the principles of value based healthcare (VBHC). VBHC seeks to improve the health outcomes that matter most to the people by asking people about their outcomes and creating a data-driven system which seeks to provide the timely information to citizens, clinical teams and organisations to inform the decision-making that leads to those outcomes in a way that is financially sustainable.[22]

Achieving the outcomes that matter to patients requires a population health, whole system approach as indicated below.

Figure 49: Elements of patient pathway



Although this business case considers only part of the above pathway, it is recognised in the Strategic Case that acute oncology covers the whole pathway and these elements will be picked up outside of this business case. Translating this pathway for acute oncology patients is set out below:

- Preventing acute oncological emergency presentations as far as is possible. Fully equipping patients with knowledge of what to look out for and what to do. Linking this to advance care planning so that intervention is appropriate to the patient's context and preferences.

[22] Value based Healthcare

- Clear pathways and points of contact for all professionals likely to encounter acute oncological emergencies (along with continuing education on presentations).
- Early intervention to maximise recovery and quality of life.
- Supportive care – use PROMs as assessment of symptom burden.
- Advance care planning to ensure appropriate response and palliation in the community where this is needed.

Embedding VBHC in the delivery of AOS will support benefit realisation. In doing so, it is important to think about the costs associated with as many examples of acute oncology emergency as possible, and that clinical outcomes and PROMs are considered alongside each other. There is an ongoing commitment to link the identified benefits with VBHC.

5.9 Risk Management

A risk is the possibility of a negative event occurring which adversely impact on the project. Identifying, mitigating and managing the key risks is crucial to successful delivery.

The risk management process includes the following stages:

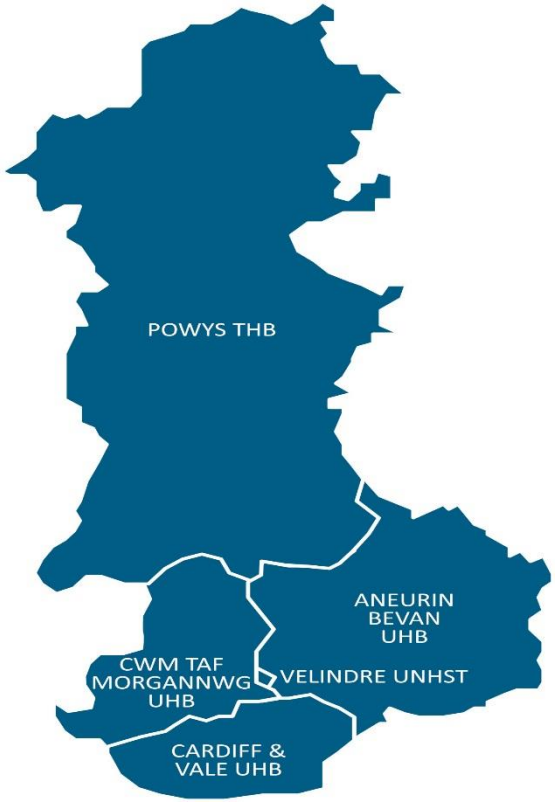
- Identification – ascertain what the possible risks are
- Assessment – determine the likelihood and impact of the risk occurring
- Control – identify ways that can reduce the likelihood and impact of the risks occurring (mitigate)
- Monitoring – review whether the situation has changed and whether the mitigation measures working

The Economic Case set out the key implementation risks, their likelihood and impact. The risks will be managed through a risk register and a full risk register can be found in Appendix E. The Project Manager is responsible for continuous review of the risks throughout the life of the project and the governance structure allows for risks to be escalated from the Project Group to the Implementation Board, who will oversee them during the life of the project.

5.10 Summary

The Management Case has set out the regional governance that will oversee the regional implementation, and the project processes, including management of risks, benefits and change. It has demonstrated that with appropriate governance structures, well developed plans and project management, the implementation of this clinical model will be successful in meeting the two core principles of equity of access and shared ownership and delivery across the region and organisations.

Improving Acute Oncology Services in South East Wales



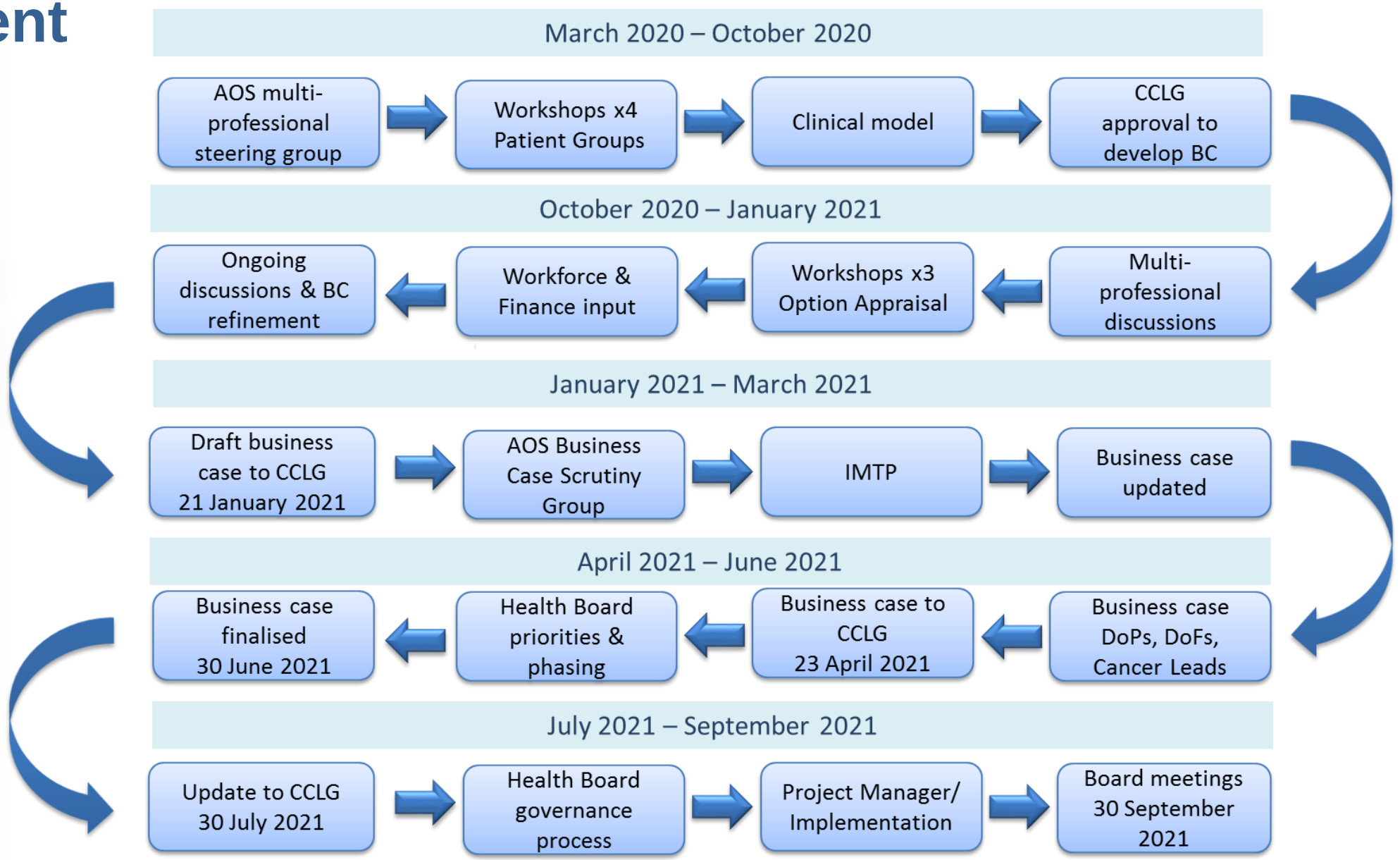
GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Caerdydd a'r Fro
Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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

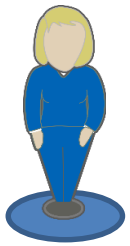
Engagement


March 2020 – October 2020
AOS multi-professional steering group
Workshops x4 Patient Groups
Clinical model
CCLG approval to develop BC
October 2020 – January 2021
Multi-professional discussions
Workshops x3 Option Appraisal
Workforce & Finance input
Ongoing discussions & BC refinement
January 2021 – March 2021
Draft business case to CCLG 21 January 2021
AOS Business Case Scrutiny Group
IMTP
Business case updated
April 2021 – June 2021
Business case DoPs, DoFs, Cancer Leads
Business case to CCLG 23 April 2021
Health Board priorities & phasing
Business case finalised 30 June 2021
July 2021 – September 2021
Update to CCLG 30 July 2021
Health Board governance process
Project Manager/ Implementation
Board meetings 30 September 2021

Clinical Model

Patients access local AOS service

Patients triaged by local AOS team



Supported by LHB Acute services

Urgent intervention

Other defined pathways

AOS ANP
Nurses all sites

Oncology
On site at HB's with virtual support

MUO/CUP MDT

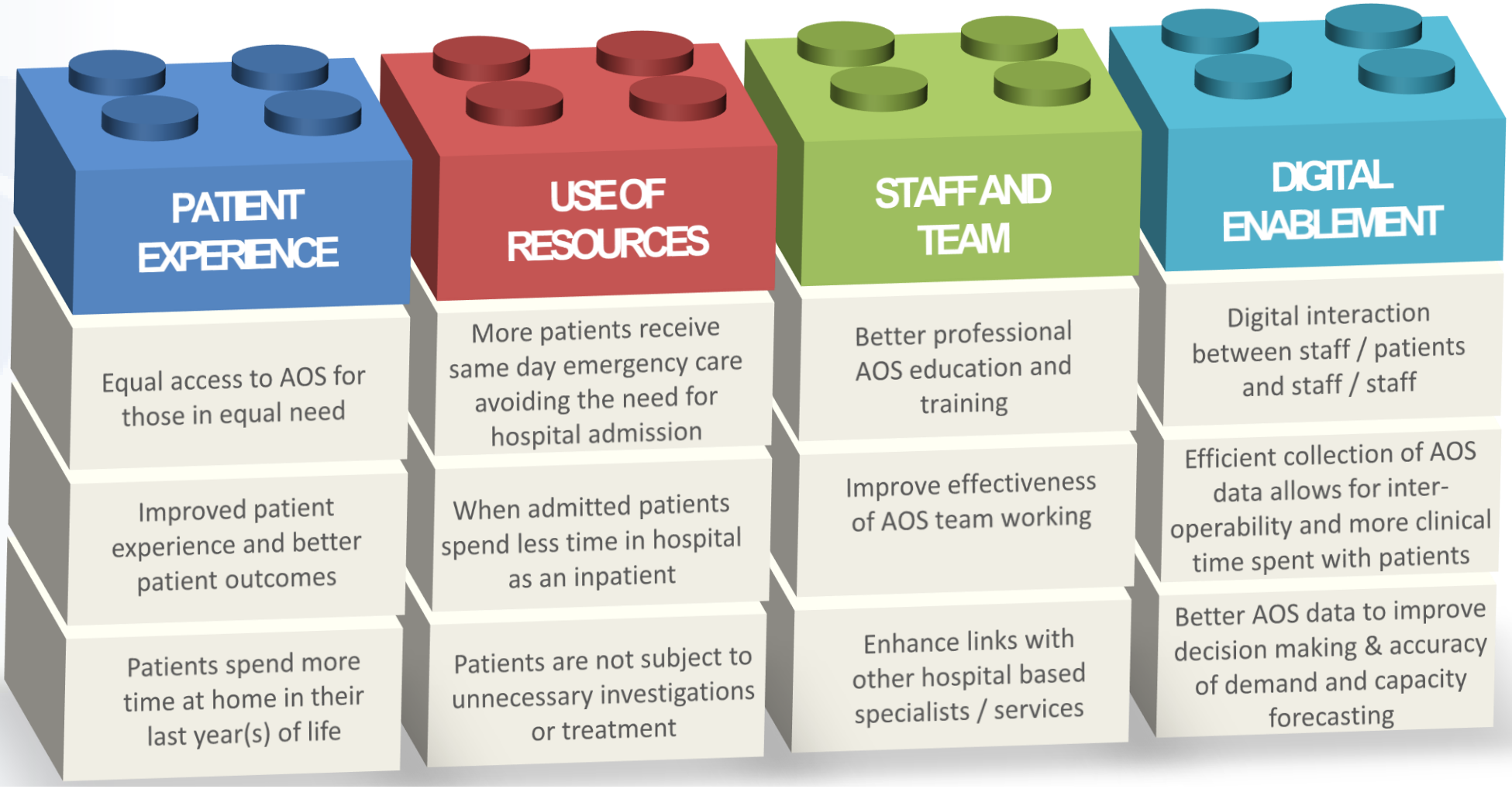
Immuno-oncology MDT

MSCC
Rapid access to RT

Patient is/has:

- **Managed within Ambulatory framework**
- **Rapid access to senior expert decision making and MDT**
- **Referred to a hot clinic**
- **Urgent specialist oncology review (inpatient)**

Anticipated key benefits



GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

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Cardiff and Vale University Health Board

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

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

Benefit Profile

ADMISSIONS AVOIDANCE	2021/22	2022/23	2023/24	2024/25
Bed day reduction	408	10,511	21,472	25,568
Beds freed Up	1	30	61	74
Benefit value at £150 / bed day	61,200	1,621,650	3,220,800	3,835,200

LENGTH OF STAY	2021/22	2022/23	2023/24	2024/25
Bed day reduction	239	3,620	5,650	7,503
Beds freed Up	0	10	16	21
Benefit value at £150 / bed day	35,850	543,000	847,500	1,125,450

TOTAL	97,050	2,164,650	4,068,300	4,960,650

Benefits of Equitable regional delivery

Meet WG goals for urgent and emergency care (for cancer)

- Reduce bed days / year / LHB
- Coordination, planning and support for people at greater risk of needing urgent or emergency care
- Rapid response in physical crisis
- SDEC – face to face assessment, diagnostics and/or treatment
- Access to clinically safe alternatives to hospital admission & expert advise (electronic safety nets to allow discharge 24/7)
- Home-first approach and reduce risk of readmission

Patient at center of decision making

- Early recognition of new/relapsed cancer – quicker route to treatment & improved outcomes
- Early recognition & resolution of treatment toxicity - improved outcomes
- Honest informed decisions with patient/family/carer's
- Avoid readmission & home first , supported by clear & accessible correspondence with community (WCP)

Economic evaluation

- 25% admission avoidance (SDEC)*
- 10% reduction in length of stay*
- Avoid unnecessary investigations and duplication

Total collective investment/benefit ratio 1:2 (1:1.94)

Deliver service specification for SEW AOS

- Standardise & deliver regional service remit e.g. malignancy unknown origin (avoid variation & improved governance)
- Education - all ED consultants and trainees, Medical Consultants and juniors on the acute rota receive essential AO training

Investment

Phase	2021/22	2022/23	2023/24	2024/25
1	468,200	1,288,000	1,535,300	1,499,400
2	-	321,800	707,100	836,400
3	-	-	123,100	215,800
Total	**468,200**	**1,609,800**	**2,365,500**	**2,551,600**

Total collective investment/benefit ratio 1:2 (1:1.94)

Investment per Health Board

ABUHB

	2021/22	2022/23	2023/24	2024/25
Total	167,250	584,382	911,880	1,011,404

CAVHB

	2021/22	2022/23	2023/24	2024/25
Total	180,421	586,809	754,563	755,007

CTMHB

	2021/22	2022/23	2023/24	2024/25
Total	120,509	438,655	699,222	785,250

Implementation

2021/22 - 202425

Phase 1	Phase 2	Phase 3
Clinical Nurse Specialist	Allied Health Professionals	Advanced Nurse Practitioner
AOS Lead (ABU)	Immunotherapy Toxicity Service	MSCC Pathway
Specialist Oncology - Virtual	Consultant Sessions (CAV)	
Specialist Oncology – On-site		
MUO/CUP Service		
Consultant Sessions (CAV)		
Patient Administration		
Digital		
Project Manager		

Next Steps & Progress

Business case governance	Progress
Business case with Health Boards and VUNHST Board for approval	30 September 2021

Implementation	Progress
Appoint a regional SRO	Under discussion
Project Manager (hosted by VUNHST)	Appointed / In post
Establish task and finish groups to refine operational implementation with specific reference to specialist elements	MUO/CUP – October Oncology – October
Establish AOS governance	October

VELINDRE UNIVERSITY NHS TRUST

UPDATE OF ACTION POINTS FROM PUBLIC TRUST BOARD MEETINGS
UPDATED as at 23 September 2021

MINUTE NUMBER	ACTION	STATUS	LEAD	DUE DATE/ STATUS
29.07.2021 PUBLIC TRUST BOARD				
6.6.0	**VUNHT Risk Register:** • Benchmark risk appetite with other organisations.	**CLOSED**	**LF**	Covered in item 8.7 on the September Trust Board agenda
8.1.0	**Audit Committee Highlight Report:** • Private Patients Debts to be a standing item on the Committee Highlight Report.	**OPEN**	**MO**	Next Audit Committee is scheduled for 14 October 2021 with the Highlight Report to be presented at the November Trust Board.

TRUST BOARD

CHAIR'S REPORT

DATE OF MEETING	30/09/2021

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

REPORT PURPOSE	FOR NOTING

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

ACRONYMS	
AQS	Advice Quality Standards
RCN	Royal College of Nursing
IPEM	Institute of Physics and Engineering in Medicine
PHW	Public Health Wales

1. SITUATION/BACKGROUND

This report provides information to the Board from the Chair for the period 30th July 2021 to 11th September. Issues addressed in this report cover the following:

- Board Briefing Sessions
- Annual General Meeting
- New Independent Member
- Vacant Independent Member post for Quality & Safety
- Correspondence from the Health Minister of Health & Social Services
- Advice Quality Standards (AQS)
- Serosurveillance 1 Year Anniversary
- Macmillan Excellence Awards
- First Institute of Physics and Engineering in Medicine (IPEM) PhD in Work Bursary
- Royal College of Nursing (RCN) Award 2021
- Graig Bike Ride

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Board Briefing Sessions

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

- Putting Things Right
- Quality Bill and the Trust's Quality Safety Framework plans
- A presentation from Cardiff & Vale University Health Board on their Strategic Programme – Shaping Our Future Hospitals

2.2 Annual General Meeting

2.3 The Chair confirmed that Velindre University NHS Trust's Annual General Meeting (AGM) had been held on 21st July 2021. The Trust's Annual Accounts and Report had been presented. The AGM had provided the Chief Executive Officer, Steve Ham, with an opportunity to provide his thoughts on the

future and the Trust's continued commitment to provide services for patients and donors, as demand recovers and as the NHS in Wales develops. The Chair would like thank everyone involved in preparing for the AGM. The AGM involved Mr Max Boyce, MBE, who introduced to AGM by reading his poem "Only the Tide went out" and also expressed his gratitude for the amazing work carried out by our staff during the pandemic which continues and Mr Ifor ap Glyn (National Poet for Wales) who wrote a poem especially for the AGM. The Chair would like to take this opportunity to thank them both for their moving poems, which conveyed the enormity of what the NHS has achieved over the past twelve months.

2.4 New Independent Member

The Chair is pleased to introduce Professor Andrew Westwell, as the Trust's new Independent Member for Universities. Professor Westwell qualified in chemistry at the University of Leeds, where he obtained his PhD in chemical synthesis in 1994. Professor Westwards has held a number of roles, which have involved undertaking research in preclinical cancer drugs and the discovery of a new clinical candidate drug and new anticancer candidates targeting advanced and resistant disease. During Professor Westwell's academic career, he has been the author/co-author of >150 publications in international scientific journals. Full details of Professor Westwell's background is available on the Trust's website. The Chair welcomed Professor Westwell to the Trust.

2.5 Vacant Independent Member post for Quality & Safety

The Chair confirmed that the vacant post to replace Mrs Janet Pickles, was currently being advertised. The Chair has had several conversations with individuals who have expressed an interest in this post. The Board will be kept update of progress on filling this vacancy. The chair would like to acknowledge the Board's thanks to Jan Pickles, one of our independent members for the last 9 years Jan's contribution to the board has been enormous and we shall miss her wise counsel.

2.6 Correspondence from the Health Minister of Health & Social Services

The Chair informed the Trust Board that she had received notification from the Eluned Morgan AS/MS on 5th August 2021, thanking the NHS for their 'incredible efforts over the last 18 months'. The letter also introduced Julie Morgan MS, as the Deputy Minister for Health & Social Services and Lynne Neagle MS, as the Deputy Minister for Mental Health and Wellbeing. The Chair would like to take this opportunity to congratulate Julie Morgan MS and Lynne Neagle MS on their new roles and looks forward to working with them in the future.

2.7 Advice Quality Standards (AQS)

The Macmillan Welfare Rights Team, who are part of the Supportive Care Team, have successfully been award the Advice Quality Standard (AQS). This is the third consecutive time the AQS has been awarded to the team, which is an amazing achievement particularly during the challenging times since the pandemic and is testament to the continued high standard of service delivered. The Chair's congratulations are sent to the team for the service provided and for continuing to drive forward improvement of advice services.

2.8 Serosurveillance 1 Year Anniversary

The Serosurveillance Project celebrates its one-year anniversary. The project was developed following work with Public Health Wales to establish Serosurveillance for COVID infection. The project has supplied over 20,000 samples to Public Health Wales (PHW) for analysis and has provided information to Welsh Government's Tactical Advisory Group to inform the national response to the COVID-19 pandemic. The Chair would like to thank all involved in the Serosuveillance Project.

2.9 Macmillan Excellence Awards

The Chair is pleased to inform the Trust Board that the Therapy Assessment Unit team have been shortlisted for the Macmillan Excellence Awards. The Trust awaits the outcome of the panel, and sends best wishes to the team for the deserved recognition.

2.10 First Institute of Physics and Engineering in Medicine (IPEM) PhD in Work Bursary

The Chair is pleased to announce that Belinda Gore, Clinical Scientist in Radiation Protection Services is the first recipient of a new PhD work bursary from the IPEM. The funding will be used to support a project to undertake research on developing an evidence-based approach to neonatal and paediatric radiation does optimisation methods. The Chair wishes Belinda Gorell every success in her research project. The Board will watch developments with interest

2.11 Royal College of Nursing (RCN) Award 2021

The Chair was pleased to announce that Diane Rees had been shortlisted for the RCN Wales, Nurse of the Year in the Health Care Support Worker Category. The award ceremony is scheduled for 10th November 2021 and the winning individual will be announced on the night of the ceremony.

2.12 Graig Bike Ride

The Chair was pleased to represent Velindre University NHS Trust at the Graig Bike Ride on 4th September 2021. There were 3 routes of 100km, 60km and 40km respectively. As of 7th September 2021 the event had raised £60,000, which will be split between Velindre University NHS Trust and the Mission to Seafarers. The event also included a gala dinner on the 3rd September 2021 at which the Chair gave a speechThis is the second Graig bike ride and planning for next year is already underway. The Chair wished to express her gratitude for the continued support and fundraising efforts during such difficult circumstances.

2.13 150 Whole Blood Donor

On the 20th September 2021, Prof Donna Mead OBE and Mr Steve Ham were delighted to have the opportunity to welcome Mr Malcolm Evans and his wife, Eileen and, in particular, to thank Mr Evans who was donating his 152nd unit of blood. Mr Evans has been donating blood for 61 years, his first donation was in July 1960. Prof Donna Mead presented Mr Evans with a specially commissioned pin badge and certificate, in recognition of his incredible support to the service. Mr Evans is the longest serving blood donor in Wales (no-one has reached the 150 milestone previously). Our research suggests that he is the longest serving blood donor in the UK. Given that each blood donation has the potential to save 3 lives, this equates to 456 lives saved by Mr Evans.

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

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

TRUST BOARD

CHIEF EXECUTIVE'S REPORT

DATE OF MEETING	30/09/2021

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
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	
nVCC	New Velindre Cancer Centre
DBS	Disclosure and Barring Service
MOU	Memorandum of Understanding
PET	Positron Emission Tomography
HIW	Health Inspectorate Wales
WHSSC	Welsh Health Specialised Services Committee

1. SITUATION/BACKGROUND

This reports provides information to the Board from the Chief Executive for the period 30th July until 11th September 2021. Issues addressed in this report cover the following;

- Welsh Governments' Joint Escalation and Intervention Arrangements
- New Velindre Cancer Centre (nVCC) Project - Competitive Dialogue
- Medical Engagement
- Command Structure for Beckton Dickinson (BD) Blood Collection Supply Issue
- Visit to the Welsh Blood Service Laboratory
- Staff Engagement on the Trust Strategy
- NHS Wales General Management and Graduate Programme
- Leading Digital Transformation Learning Academy
- Chair of Health Technology Wales
- All Wales Positron Emission Tomography (PET) Programme Business
- Appointment of Executive Director of Finance

2. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Welsh Governments' Joint Escalation and Intervention Arrangements

On the 9th August 2021, the Chief Executive Officer received confirmation from Welsh Government that following a tripartite assessment by Welsh Government, Audit Wales and Health Inspectorate Wales (HIW) a recommendation had been made to the Health Minister for Velindre University NHS Trust's status to remain unchanged as 'routine arrangements'.

2.2 New Velindre Cancer Centre (nVCC) Project - Competitive Dialogue

The Chief Executive Officer would like to inform the Trust Board that the competitive dialogue is underway following Welsh Government's approval of the Outline Business Case. The process is in week four. Week one started with overview briefing meetings; week two for legal and commercial meetings; week three covered community benefits and hospital design; and this week is focused on strategy, quality, management, to review project management and assurance processes.

2.3 Medical Engagement

Engagement with our whole clinical body remains at the core of our priorities as an Executive and as Divisional senior leadership teams.

June 2021 Medical Engagement Survey completed by 46 Trust staff. For the average of all responding medical staff, all of the ten scales were rated within the highest relative engagement compared to the external norms.

There were reductions from 2016 baseline and these will be explored in a series of structured conversations and events.

In September 2021 General Medical Council (GMC) National Training Survey results have been shared by Health Education & Improvement Wales (HEIW). HEIW wrote to congratulate the Trust for achieving such positive results. Numerous areas were identified as 'above outlier', which is a term used by the GMC to signify results that are significantly above average in particular domains, and thus denote areas of good practice. The report demonstrated that no patient safety or bullying concerns had been raised by Trainees in the 2021 survey.

2.4 Command Structure for Beckton Dickinson (BD) Blood Collection Supply Issue

The Chief Executive Officer would like to update the Board that a command structure response had been established in August to manage the supply issues. The impact for the Trust continues to be stable and the risk to service continuity has been added to the Trust risk register, following approval in Gold command, for inclusion in the next version of the register.

2.5 Visit to the Welsh Blood Service Laboratory

The Chief Executive Officer was pleased to have visited the Quality Assurance Laboratory Department of the Welsh Blood Service on 25th August 2021. The visit involved a tour of the Department and speaking to individual staff about their roles and the service, as a whole. The Chief Executive Officer would like to thank all involved for their welcome and for their time.

2.6 Staff Engagement on the Trust Strategy

The Chief Executive Officer informed the Trust Board that a series of staff session have been scheduled to provide staff with the opportunity of feeding into the Trust's plans and ambitions. On 7th September 2021 a session was held on the Trust Strategy. The Director of Strategic, Transformation Planning & Digital commenced the session by providing information on the current strategy, the Trust's aims and objectives. Staff were then given the opportunity to provide comments and feedback on the strategies being developed. The Executive Team were grateful for the time given by staff and for their willingness to be involved in these sessions. The Trust feels that it is essential for all staff to feel they have ownership of the Trust's strategy and future direction. The Board will continue to engage in the development stages, through Strategic Development Committee and Board Development Sessions, prior to Board approval of the refreshed Trust Strategy at Trust Board.

2.7 NHS Wales General Management and Graduate Programme

The Chief Executive Officer was pleased to have been asked by Health Education and Improvement Wales to speak to their current cohort of graduates, as part of their 'Meet the Leaders' programme. On the 23rd July 2021, Mr Steve Ham undertook a presentation to the graduates, which included information on Velindre University NHS Trust, his career and provided information on the wider health and social care system in Wales. There was also an opportunity for the graduates to pose questions in return. The Chief Executive Officer was pleased to have been able to spend time with the graduates, who are the future of the NHS in Wales. In addition, the Chief Executive Officer would like to welcome Andrew Paramore who has just started with the Trust for two years on the management graduate scheme.

2.8 Leading Digital Transformation Learning Academy

The Chief Executive Officer is pleased to inform the Trust Board that a collaborative partnership, between the Trust, Health Boards, and the Universities of South Wales and Trinity St David, has been successful in securing funding for a Digital Transformation Intensive Learning Academy.

Trust Officers played a key role in the delivery of the final bid submission to Welsh Government, and these officers will now form part of a Leadership Board to support the design of content for academic learning in the discipline of Digital Leadership. This content will focus on both Clinical and Non Clinical staff across NHS Wales, and beyond. The Trust Board will be kept update of progress.

2.9 Chair of Health Technology Wales

The Trust has been informed by Welsh Government that Professor Peter Groves, tenure as Chair of Health Technology Wales has been extended for three years. The Chief Executive Officer sends his congratulations to Professor Groves on his tenure extension and looks forward to continuing to work with him.

2.10 All Wales Positron Emission Tomography (PET) Programme Business

The Chief Executive Officer has been inform by Welsh Health Specialised Services Committee (WHSCC) that the All Wales PET Programme Business Case, which was presented at the 29th July 2021 Trust Board Meeting has been endorsed by Welsh Government Ministers. The next steps for the programme is to set up the Project Team including appointing the Project Senior Responsible Officers (SROs) and workstream leads and groups.

2.11 Appointment of Executive Director of Finance

The Chief Executive Officer is delighted to welcome Mr Matthew Bunce as the newly appointed Executive Director of Finance.

Mr Matthew Bunce has 30 years finance experience in a range of organisations both private sector and the NHS, working across many organisation in South Wales. The roles included providing supporting providers of primary, secondary and tertiary care as well as undertaking commissioning & partnership roles working closely with Local Authority colleagues.

Mr Matthew Bunce is proud to work for Velindre Trust and excited that to have been given the opportunity to continue his journey with the Trust as Executive Director of Finance.

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

TRUST BOARD

WALES INFECTED BLOOD SUPPORT SCHEME ANNUAL REPORT 2020/21

DATE OF MEETING	30/09/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public

PREPARED BY	Mary Swiffen-Walker, Wales Infected Blood Support Scheme Manager
PRESENTED BY	Mary Swiffen-Walker, Wales Infected Blood Support Scheme Manager
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Director of Corporate Governance & Chief of Staff

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	6/9/21	Noted

ACRONYMS:	
Wales Infected Blood Support Scheme	WIBSS
NHS Wales Shared Services Partnership	NWSSP

1. SITUATION/BACKGROUND

Established in October 2017, the Wales Infected Blood Support Scheme (WIBBS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

WIBBS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBBS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service. WIBBS currently supports 213 beneficiaries, including bereaved spouses and partners.

The structure of WIBSS is part of the Trust's model in three ways:

- NHS Wales Shared Services Partnership (NWSSP) operate the scheme, under the leadership of the Director of Planning, Performance and Informatics;
- Aspects of the service are provided by the Velindre Cancer Centre, for instance, clinical psychology and welfare rights advisors, under the leadership of the Head of Operational Service Delivery;
- A Governance Group monitors the operational management of WIBBS and provides governance, leadership, and accountability for the scheme, on behalf of the Welsh Government, through the Trust. This Governance Group is comprised of NWSSP, Velindre Cancer Centre and Welsh Government. It is chaired by the Trust's Director Corporate Governance.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Board had previously been updated on the set up of WIBBS in 2017 and 2018. Through discussions with the Governance Group, it was agreed it was important to provide a regular update to the Trust Board on this extremely important part of the Trust's business. This is the first Annual

Report that the scheme has produced and it is proposed that there is an annual update to the Trust Board based on subsequent reports.

In addition, over the coming months, the scheme, with support and oversight from the Governance Group are also working on various developments to the scheme. These have been informed both by the interaction with the Infected Blood Inquiry and the responses to the feedback received from beneficiaries in a recent questionnaire. Both are referred to in the report. Given the context of the on-going Infected Blood Inquiry, it is therefore suggested that a six-monthly report be brought to the Trust Board in Spring 2022 to update on these matters.

To also note that in August, all the parity payments, as referred to in "Key issues arising during 2020-21" have now been paid to beneficiaries, bereaved partners and spouses and the estates of those beneficiaries who have passed away, following receipt of revised Directions from Welsh Government.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Incorporated into WIBBS
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Continued guidance from Welsh Government Policy Team, informed by Welsh Government Legal teams
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	As outlined in report and to note update on parity payments in section 2

4. RECOMMENDATION

The purpose of this report is to:

- Provide an update to the Trust Board on the WIBBS in the form of the attached Annual Report, which the Board is asked to **NOTE**;
- **NOTE** the proposed annual update to the Trust Board in the form of subsequent Annual Reports and **NOTE** that for the current year, it is proposed the Director of Corporate Governance, as Chair of the Governance Group, will provide an interim update in approximately six months' time.

Cynllun Cynorthwyo Gwaed wedi'i haentio Cymru

Wales Infected Blood Support Scheme

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS)

ANNUAL REPORT 2020/2021

WALES INFECTED BLOOD SUPPORT SCHEME (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICE PARTNERSHIP
AND
VELINDRE CANCER CENTRE

ANNUAL REPORT 2020/2021

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

GIG CYMRU NHS WALES
Partneriaeth Cydwasanaethau
Shared Services Partnership

Canolfan Ganser Felindre
Velindre Cancer Centre

Cynllun Cynorthwyo Gwaed wedi'i haentio Cymru
Wales Infected Blood Support Scheme

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Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

WIBSS currently supports 213 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of our beneficiaries.

Purpose of Report

The purpose of this report is:

- **to provide an update on the finance and support services during 2020-21 as part of the Wales Infected Blood Support Scheme;**

- **to detail the work carried out by WIBSS during 2020-21;**

and

- **to look ahead to WIBSS priorities relating to 2021-22.**

Key issues arising during 2020-21

COVID-19 – The Pandemic

In March 2020 the UK entered its first lockdown, as a result of the global COVID-19 pandemic. Everybody who could work at home, was told to work at home, this included the staff at WIBSS. We successfully made this transition and operated on a "business as usual" basis.

We continued to make regular payments and to offer help and support to all our beneficiaries, many of whom were shielding as a result of their condition. We provided updates and advice on the website and were available throughout to help with any queries, provide benefit checks etc. Whilst we did need to stop home visits, we adapted to offer the well-being and counselling services, albeit remotely, over the telephone, on teams or skype calls.

Public Inquiry – The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, in particular since 1970.

In 2020/2021 we responded to a further three Rule 9 requests from the Infected Blood Inquiry. The third request received in September 2020 was the most detailed request and was for a witness statement from Alison Ramsey, Director of Planning, Performance and Informatics at NWSSP, prior to her appearance before the inquiry in May 2021.

https://www.infectedbloodinquiry.org.uk/evidence/transcript-london-thursday-20-may-2021-vaughan-gething-and-alison-ramsey

Researching the information for inclusion in the witness statement, provided WIBSS with the opportunity to take stock, to review all our procedures, documentation, communication channels etc. This review identified a few areas where we needed to update our advice and guidance to better reflect the service and some ways we could improve the service we provide.

These included ensuring all documentation was consistent and, all new procedures were incorporated into the staff guidance. We have drawn up a list of items we will address and are currently work through it to revise and edit all documentation.

Key issues arising during 2020-21

Parity across the four UK nations

When the four devolved infected blood schemes were established in 2017, three of the four operated largely to similar terms and payment rates. Scotland adopted a slightly different model. WIBSS introduced a welfare rights service, which the other schemes did not have, but the payment rates were similar to those in England and Northern Ireland.

However, on 1 April 2019, the UK Government announced additional funding for the English scheme, which allowed them to significantly increase the payments rates for their beneficiaries'. As the Welsh Government did not receive any additional funding, they were not able to increase the payments rates for WIBSS.

In July 2020 we were asked by Welsh Government to provide detailed costings of what parity would cost. We provided costings for a range of scenarios.

In March 2021 Welsh Government asked us to provide updated figures urgently. We also attended a number of meetings with officials from the four nations and from the other UK schemes in which the potential detail of a parity agreement was discussed. On 25th March 2021 Vaughan Gething announced agreement on parity had been reached and payments would be made by the end of the calendar year (December 2021).

https://gov.wales/written-statement-infected-blood-update-financial-parity

It stated, UK Treasury has announced that they will fund a number of changes to the 4 UK schemes to work towards parity. This funding will be backdated to April 2019.

beneficiaries

For our beneficiaries who currently receive ex-gratia payments delivered through our partners at the Welsh Infected Blood Support Scheme (WIBSS) the scheme will be amended as follows:

- Our regular annual ex-gratia payments will be increased to the rates currently paid in England/Scotland;
- Payments for bereaved partners will be increased to 100% of the beneficiaries payment in year 1, and 75% in year 2 and subsequent years in line with the position in Scotland;
- All the above payments are to be back dated to April 2019
- Lump sum payment to a Hepatitis C Stage1 beneficiary will increase from £20,000 to £50,000, with the additional £20,000 payable if a stage 1 beneficiary moves to stage 2. The total lump sum payable for Hepatitis C beneficiaries remains at £70,000. This is in line with Scotland and will be backdated to April 2017
- Lump sum payments for HIV (£80.5K), will change in line with England and be backdated to April 2017
- Winter fuel payments are to be paid in addition from April 2021

The other UK schemes will now follow our lead by paying the £10,000 death benefit on the death of a beneficiary.

WIBSS are currently waiting for revised Directions from Welsh Government to allow us to pay the revised rates and to introduce on-going
payment for our bereaved spouses/partners.

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG) through Velindre NHS Trust.

The WIBSS Governance Group (VCC and NWSSP) is authorised to:

- Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance Teams remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR). It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

It is empowered with the responsibility for:

- Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries budgets and provisions
- Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK
- Implementation of Welsh Government policy
- Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

Governance Group

The membership of the WIBSS Governance Group is as follows:-

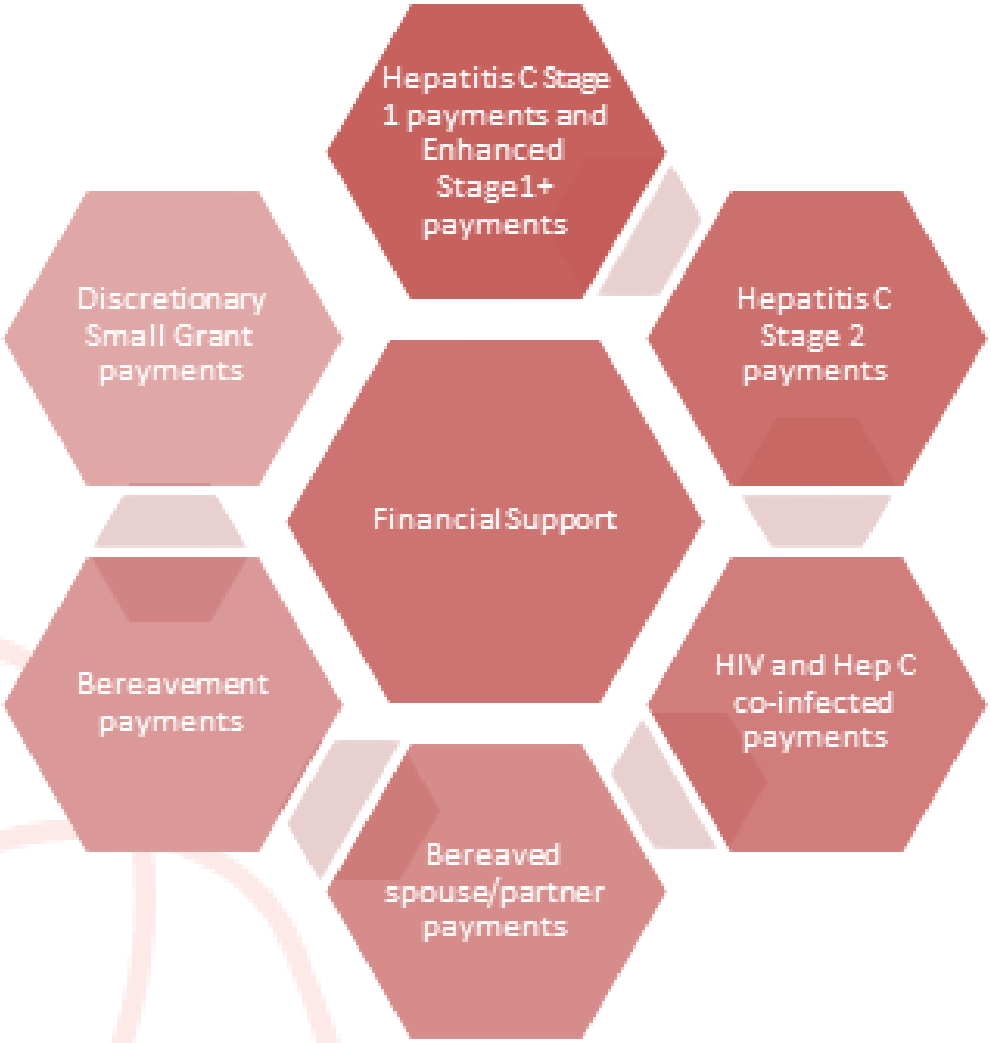
- Director of Corporate Governance, Velindre NHS Trust (Chair)
- Head of Operational Service & Delivery, VCC
- Director of Planning, Performance and Informatics
- WIBSS Service Manager
- Welsh Government Finance Representative
- Welsh Government Policy Representative
- Senior Welfare Rights Manager
- Consultant Psychologist
- Service User

Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- New Applicants to the scheme
- Members of previous legacy schemes

There are varying levels of financial support available to beneficiaries of the scheme:



Financial Support

Hepatitis C Stage 1

for those infected with hepatitis C as a result of treatment with NHS blood, blood products or tissue

Enhanced Stage 1+ payments

for Stage 1 beneficiaries whose infection, its treatment, or associated conditions, has a long-term negative impact on their ability to carry out daily activities, but is not Stage 2

Hepatitis C Stage 2

For those beneficiaries who have developed
· cirrhosis
· Primary liver cancer
· B-cell non-Hodgkin's lymphoma
· Have received a liver transplant or are on the waiting list to receive one

HIV and co-infected payments

for those infected with HIV as a result of NHS treatment before October 1985 or are co-infected with HIV and Hepatitis C Stage 1 or 2

Bereaved spouses'/partners payments

for those who are the bereaved spouse/partner of a deceased beneficiary who met one of the criteria above

Bereavement payments

paid to the bereaved spouse/partner or estate of a beneficiary, on the death of the beneficiary to assist with funeral costs etc

Discretionary Small Grant Payments

financial support the beneficiaries and bereaved spouses/partners can apply for assist with the cost of essential items or services. The grants will normally only be available to cover costs of items or services which are needed, at least indirectly, as a result of the impacts of a beneficiary's Hepatitis C or HIV infection

Financial Support

Application Process

Applications for each of the financial support elements can be made by downloading the appropriate application form at Home - WIBSS (wales.nhs.uk) or by contacting WIBSS support team, who will send an application form if preferred.

On receipt of an application it is recorded in our register of application, it will be checked to ensure that all required sections are completed by the relevant person. We also check whether the required evidence of treatment with blood products has been provided. Where it has not, the welfare team would contact the applicant and seek permission to undertake a search of clinical coding, to see it that can provide the necessary evidence.

The welfare support team will also offer help and guidance on completing the forms if this is required.

Once the completed application is submitted, the WIBSS Manager will consider the application, based on criteria set out in staff guidance and provide a recommendation to the Director of Planning, Performance and Informatics in NWSSP on whether the application should be approved. In certain circumstances, the WIBSS Manager may seek a clarity on the medical opinion contained in the application form.

If the application is successful, the WIBSS Manager will write to the applicant informing them of the outcome and welcoming them to WIBSS.

Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

During the course of 2020-21, no appeals were submitted and therefore the appeals panel was not convened.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

The appeals panel process does not cover appeals regarding the Discretionary Small Grants process. To date we have not declined any small grant applications. At the inception of WIBSS we did not think a formal appeals process was proportionate given the value of these grants. This was queried during the Infected Blood Inquiry and we therefore intend to introduce a less formal system of reconsideration of declined applications for small grants.

The proposed approach would allow an applicant unhappy with the outcome of their grant application, to resubmit it to WIBSS for reconsideration. The WIBSS Manager would arrange for the decision to be considered by somebody independent of the original decision-making process. As part of our overall review of our documentation and guidance, we will amend the small grants section to reflect these changes.

Welfare Rights Service

Application Process

We recognise that beneficiary needs may extend further than just financial assistance and therefore offer a specialist welfare rights service. This has evolved into 2 distinct areas, key worker support and the welfare rights role.

Key worker support includes:

- liaising with beneficiaries and wider family members to establish a trusting relationship and provide emotional support, outside of formal psychology and well-being referrals
- regular outbound check-ins with beneficiaries considered as vulnerable
- completion of paperwork and help to sort affairs for those unable to do so themselves.

The welfare rights service we offer is bespoke to the individual and their family. Although not exhaustive, below is a list of services we may be able to assist with:

- liaising with social workers to ensure complex beneficiary needs are met
- signposting free NHS dental care and prescription services for those eligible due to the new benefit entitlement
- chasing medical professionals seeking evidence to support applications to join WIBSS
- complete benefit and welfare checks, debt signposting, budgeting advice, navigating financial products etc.
- applying for a parking badge (Blue Badge), free bus travel and concessions.
- accessing health services, such as additional care requirements and health care transportation.

We also recognise a beneficiary's health not only impacts them, but it can also have a significant impact on those caring for them. Our welfare rights advisors can also consider the circumstances of immediate family and carers to check their entitlement to benefits which may help to improve overall financial circumstances and access to additional support requirements. The team have accreditation under Advice Quality Standards (AQS), and individually all advisors undertake continuing professional education with specialist welfare training providers.

In August 2020, the welfare rights team established a key contact within the Department of Work and Pension (DWP) policy team who has agreed to oversee DWP cases which are impacted by WIBSS funds.

The welfare rights team have intervened on behalf of several beneficiaries who had been interviewed under caution by the DWP Fraud Team. These beneficiaries had correctly, not declared their payments received from approved legacy infected blood schemes prior to WIBSS. The team has also intervened where new applications for benefits, such as pension credit and Universal Credit had been declined due to monies held from WIBSS and legacy schemes. All issues were resolved following intervention by the welfare rights advisors.

Welfare Rights Service

Case Study

Beneficiary C1

C1's late husband was a WIBSS beneficiary who sadly passed away. As a result, C1 was left managing the household finances for the first time and was struggling. She contacted the welfare rights team when she was told she could not claim Pension Credit, despite having an underlying entitlement, which had been revoked due to funds she received from WIBSS. The Welfare Rights Advisor escalated the matter to the Department of Works & Pensions (DWP) Policy Making team, detailing the legislation that allowed for WIBSS funds to be disregarded when calculating C1's entitlement.

As a result of this intervention, C1 was awarded her Pension Credit and it backdated to the date of her original claim. The Welfare Rights Advisor also identified that C1 was now also eligible for reduced council tax, free eye tests, dental care and travel concessions. C1 stated the welfare rights service had relieved some of her stress during her period of grief and was very thankful for the support.

This issue, and similar previous issues, led to the establishment of the key contact in DWP referenced above.

Psychology and Emotional Well-being Service

During 2019-20, a psychological and emotional wellbeing service specifically for WIBSS was established. From January 2020, individuals registered with WIBSS, their family members and bereaved family members have been able to access psychological assessment and treatment concerning the emotional difficulties of being given and living with a diagnosis of Hepatitis C and/or HIV.

The team are aware of the historical context and have experience of working with the emotional difficulties that have occurred as a result. This specialist psychology service, acknowledges and recognises the physical and psychological complexity and the impact on quality of life and relationships.

Introduction of the psychology and emotional well-being team has allowed WIBSS to offer an additional level of support to beneficiaries.

There are approximately 60 clients currently accessing psychological intervention from WIBSS. To date we have been able to offer an assessment and intervention to all beneficiaries and family members who have self-referred or been referred to the service. There is currently no set number of sessions offered. We operate a flexible service which reflects the need to the specific client.

The feedback we have received about the service has been overwhelmingly positive. People have been impressed with the flexibility of the service and have found talking to a therapist who is aware of the specialist context and specific issues they face is helpful and containing.

During the pandemic, the team have continued to offer the service via telephone/ video calls or face to face as preferred. The team highlighted that the theme of lack of parity was common in their clinical work and not only due to the difference in financial payments across the schemes.

Psychology and Emotional Well-being Service

There was growing awareness that the lack of parity was provoking and reinforcing feelings of anger and mistrust of the government and NHS and doubts about how the Infected Blood cases/inquiry were being managed. The psychology and emotional well-being team were noticing that such issues were causing some people secondary and continued psychological injury, and there was some evidence that some were being held within a trauma response and unable to engage in meaningful therapy relating to their infected blood experience while the issue of parity remained unresolved.

Clinical Psychologist, Caroline Coffey wrote to Welsh Government highlighting the degree of stress the issue of parity was causing beneficiaries, highlighting that the stress caused by this issue was preventing people from being able to deal effectively with other related issues they were facing. This letter was also read out during the Infected Blood Inquiry and proved to be a very powerful piece of evidence demonstrating the impact on beneficiaries.

The psychology and emotional well-being team plan to host an online event for all beneficiaries and family members to openly discuss the desire to offer a community/group level support/intervention if required, but the team would like direct input from service users on what would be appropriate and helpful. Themes of isolation, separation and difference from others often are discussed in the clinical work which supports the idea for group/community involvement but how to offer this approach is complex and needs thought and planning.

The psychology and emotional well-being team discussed the possibility of beneficiaries/clients writing testimonials about their experience of engaging in the specialist service and the impact of the therapeutic work. Several clients were keen to write and found the process of expressing their experience also therapeutic.

Beneficiaries activity 2020-21

There are 213 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31 March 2021).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	36
Hepatitis C Enhanced Stage 1+	79
Hepatitis C Stage 2	41
Hepatitis C Stage 2 Widow	2*
HIV	2
HIV & Hep C Stage 1 (Co-infected)	3
HIV & Enhanced Stage 1+ (Co-infected)	11
HIV & Hep C Stage 2	2
Bereaved spouse/partner	37

2* bereaved partners are classified under both our existing scheme of beneficiaries receiving ongoing widow's payments and under the bereaved total.

Payments Rates 2020-21

The levels of payments available to beneficiaries in 2020/21 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	£4,790
Hepatitis C Enhanced Stage 1+	£19,172
Hepatitis C Stage 2	£19,172
HIV	£19,172
HIV & Hep C Stage 1 (Co-infected)	£23,317
HIV & Enhanced Stage 1+ (Co-infected)	£37,826
HIV & Hep C Stage 2 (Co-infected)	£37,826

WIBSS pay annual payments on a monthly or quarterly basis, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. A new applicant who is Hep C Stage 1 or HIV would be entitled to a £20,000 lump sum payment. A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £50,000 lump sum payment. A new applicant who has already developed to Hepatitis C Stage 2 would receive a £70,000.

A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased beneficiary to assist with funeral costs.

WIBSS also make regular non-discretionary payments to bereaved spouses/partners/dependant relatives, equal to 75% of the rate the deceased beneficiary was on at time of death. These payments are paid for 3 years from date of death.

WIBSS Structure

The main WIBSS team consists of eight members of staff, led by the WIBSS Manager.

Alison Ramsey
Director of Planning, Performance and Informatics
NWSSP

Lisa Miller
Head of Operational Service and Delivery
Velindre Cancer Centre

Mary Swiffen-Walker
WIBSS Manager

Psychology and Well-being

Caroline Coffey
Clinical Psychologist

Julie Armytage
Counsellor

Finance

Stefan Dakovic
Finance Officer

Welfare

Hayley Price
Welfare Rights Manager, Deputy WIBSS Manager

Rebecca O'Callaghan
Welfare Rights Advisor

Sarah Ferrier
Welfare Rights Advisor

Admin Support

Ryan Clappe
Support Officer

Finance Report

The table below summarises the claims expenditure for 2020-21 with the 2019-20 comparatives. These costs include ad-hoc, widows and small grants payments.

WIBSS Claims Expenditure	2020/21	2019-20 Comparative
No. of Beneficiaries	176	175
Total Payments to Beneficiaries	£3,382,927	£2,919,251

Please note the figures above have been subject to in year movements i.e. new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the NHS Wales Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Finance Report

A summary of the running costs for 2020-21 is set out below with a 2019-20 comparative:

WIBSS Running Costs	2020/21	2019-20 Comparative
Pay	£218,749	£194,152*
Expenditure	£10,372	£6,270
Total	***£229,121***	***£200,422***

*Note the 2019-20 running cost spend is not a full comparative to 2020-21 due to the introduction of the Well-being Psychology team towards the end of 2019. 4 months of pay costs are included within the 2019/20 compared to a full year spend in 2020/21.

New Applications for Financial Support

WIBSS received 4 applications in 2020/21.

Application Type	Applications received	Outcome
Hepatitis C Stage 1	1	Accepted
Enhanced Stage 1+	1	Accepted
Hepatitis C Stage 2	1	Accepted
HIV payments	0	N/A
Move from Stage 1 to Stage 2	0	N/A
Widows application	1	Declined but accepted on receipt of additional information
Total	4	4 Accepted

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Description of key performance indicator	20/21 Target	Status
Responding to correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information requests within required deadlines	In line with Trust policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with appeals within set time limits timely basis	Once all information received, provided is 10 working days before the next Appeals Panel, 100% to be submitted to the next panel	No appeals
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date	100%
Advising WG on CPIH Uplifts and the cost implications for the next financial year	In February each year	100%

Performance Report

Description of key welfare rights indicator (no formal KPI set)	Status
Total Welfare Rights cases opened in previous 12 months	62
No of Key Worker Advice Only	34
No of welfare rights casework	28
Income Generated (Nov 17 – July 2021)	£357,091.92
Outstanding outcomes July 2021	·1 PIP renewal ·1 PIP mandatory reconsideration ·1 ESA claim ·1 Housing Benefit Claim ·1 Council Tax Reduction claim

Support and Assistance Grants Scheme

In 2020-21 we received 6 applications for a support and assistance grant. This is lower than in previous years. From speaking to beneficiaries, it seems that beneficiaries had more pressing worries and concerns regarding their health and wellbeing related to the pandemic. Also in practical terms many were shielding or isolating and may well have not wanted trades people into their homes.

The next Newsletter will contain details of the support and assistance grants that are available to beneficiaries.

Forward Look 2021 -2022

The main priority for WIBSS in 2021-2022 will be to implement the changes announced in the parity agreement made on 25th March 2021.

In addition to this, the workplan will also include the following –

- Agree a Memorandum of Understanding between Welsh Government and Velindre University NHS Trust which sets out the aims and objectives of the WIBSS service and encompasses the current working practices in WIBSS.

- Review all WIBSS documentation and guidance to ensure consistency and accuracy and to ensure it reflects all the changes introduced as a result of the parity agreement.

- To review and update the WIBSS website to reflect the parity changes and to make it more user friendly.

- Issue a Customer Satisfaction Survey to all beneficiaries, including the bereaved spouses/partners, and act on the results.

- Work with our Psychology and Emotional Wellbeing team to identify additional opportunities to support WIBSS beneficiaries e.g., through support groups.

TRUST BOARD

QUALITY, SAFETY & PERFORMANCE COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30th September 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, Independent Member
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

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 16th September 2021.

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

2. BACKGROUND

This was the sixth meeting of the Quality, Safety and Performance Committee following the establishment of a new Board Committee structure in November 2020. The Quality, Safety and Performance Committee meets on a bi-monthly basis.

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 16th September 2021.

The main theme emerging from the meeting was the ongoing challenges and pressures created by the COVID-19 pandemic and how this is impacting on the Trust's ability to deliver its core services. Members also noted the enhanced assurance they were receiving through improved reports and additional assurance mechanisms. It was recognised that this Committee is continuing to mature.

ALERT / ESCALATE	There were no items to alert or escalate to the Board.
ADVISE	**Velindre Cancer Centre Patient Story** Committee members had received and viewed in advance of the meeting the story of a patient who had been receiving treatment for quite some time at Velindre Cancer Centre. The Committee noted the inclusion of mapping the patient story against the six domains of quality and the ongoing challenge of facilitating this level of care for all patients across all of the site specific teams going forward. In particular there were some teams (breast and colorectal seeing a significantly increased number of patients). • **NHS Wales Shared Services Partnership (NWSSP) Quality & Safety Governance Report** The NWSSP Quality & Safety Governance Report was discussed that provided an overview of Operational Performance and Quality Performance (based on regulatory responsibilities to the Medicines and Healthcare products Regulatory Agency, including: ○ Reporting of errors. ○ Rejected products due to quality issues. ○ Environmental deviations. ○ Internal audit completion. ○ Ensuring documentation is kept up to date.

	The Committee was ADVISED that compliance with the areas above had been achieved for the past 6 consecutive months. • **Equality Update** The Equality, Diversity & Inclusion report was received and discussed and the following achievements were highlighted: ○ Identification of Equality Ambassador Roles, with each Executive Team member undertaking a role within specific areas, aligned to their protected characteristics. ○ The importance of staff networks over the past 18 months, with the implementation of an additional Shielding Network to understand and support staff concerns regarding shielding. ○ The attendance of a significant number of staff (285) at Virtual Pride Week.
ASSURE	• **Trust Risk Report** The Trust Risk report was discussed. The Committee received ASSURANCE that Operational and Strategic risks are being managed in line with the Trust Assurance Framework. • **2020/21 Trust Infection Prevention & Control Annual Report** The 2020-21 Trust Infection Prevention & Control Annual Report, outlining the performance, progress, activities and achievements in relation to Infection Prevention and Control across the Trust during the period 1st April 2020 to the 31st March 2021 was discussed and noted. • **Velindre Cancer Centre Divisional Report** The Velindre Cancer Centre report provided an update on key quality and safety outcomes and metrics for Velindre Cancer Centre for the period 1st April 2021 to 30th June 2021. The format of the divisional report had been structured under the headings of the six domains of Quality. The Committee received ASSURANCE that thorough reviews will be undertaken to enable improvements where themes of incidents occur.

	• **Velindre Cancer Centre Outpatient Department 15 Step Challenge Report** The Committee received the 15 Step Challenge report, providing a summary of findings / outcomes of the 15 Step Challenge conducted within the Outpatients Department of Velindre Cancer Centre on the 27th August 2021. The Committee received ASSURANCE that the main focus going forward will be around the number of areas requiring immediate attention. A recommendation report has been issued to the Cancer Centre team for consideration and updates on outstanding actions / actions undertaken will follow. • **Velindre Cancer Centre Performance Report** The Velindre Cancer Centre July 2021 Summary Performance Report was discussed. 6 targets are currently reporting as red. The Committee received ASSURANCE on arrangements for improving performance. • **Welsh Blood Service Performance Report** The Welsh Blood Service Performance report, providing an overview of performance against key metrics through to the end of July 2021 was discussed. The Committee received ASSURANCE that ongoing recruitment of new bone marrow donors will continue via a number of activities currently being progressed. • **Workforce and Organisational Development Performance Report** The Workforce and Organisational Development Performance Report was received and discussed. • **Financial Report** The Trust Finance Report, outlining the financial position and performance for the period to the end of July 2021 was received. It was noted that there are no major variances on revenue and capital budget.
INFORM	There were no items identified to inform the Board

4. RECOMMENDATION

The Trust Board is asked to **NOTE** the key deliberations and highlights from the Quality, Safety & Performance Committee held on the 16th September 2021.

TRUST BOARD

REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30/09/21

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Remuneration Committee on 26th August 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	• Nothing of note to report
ADVISE	• Nothing of note to report
ASSURE	• Nothing of note to report
INFORM	• The Remuneration Committee noted amendments to national pay arrangements in relation to staff on Agenda for Change, Medical and Dental and Senior Pay contracts. • The Committee received details of lessons learnt regarding the use of fixed term contract arrangements • The Committee discussed the remuneration of a senior manager in NWSSP.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

EXTRAORDINARY REMUNERATION COMMITTEE HIGHLIGHT REPORT

DATE OF MEETING	30th September 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Morley, Director of OD & Workforce
PRESENTED BY	Donna Mead, Chair
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Director of Organisational Development and Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	
NWSSP	NHS Wales Shared Services Partnership

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by an Extraordinary Remuneration Committee on 23rd September 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	• Nothing of note to report
ADVISE	• Nothing of note to report
ASSURE	• Nothing of note to report
INFORM	• The Committee discussed the remuneration of a senior manager in NWSSP, joined by NWSSP colleagues. The Remuneration Committee APPROVED the request for remuneration changes.
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE LOCAL PARTNERSHIP FORUM

DATE OF MEETING	30/09/21

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
PRESENTED BY	Sarah Morley, Executive Director of OD & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper had been prepared to provide the Trust Board with details of the key issues considered by the Local Partnership Forum at its meeting on the 1st September 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	• Nothing to note
ADVISE	**Violence and Aggression** • Darron Dupre presented details of the work of the Anti-Violence Collaborative and progress in supporting organisations in their implementation of the Obligatory Responses to Violence in Healthcare agreement. The Forum discussed the obligations this places on the Trust and how we are supporting and protecting staff subject to violence or aggression. **Agile Working Programme** • The meeting received details of the Agile Working Programme, its governance arrangements and the development route of the Agile Working Policy. Potential issues relating to hybrid working arrangements were discussed in particular the need to recognise individual circumstances in any arrangements that are put in place. **Velindre Futures** • The Interim Chief Operating Officer updated the LPF on progress with Velindre Futures plans and work programme including workforce design. **Partnership Working** • The LPF was advised by the Executive Director of OD and Workforce that two workshops were being arranged to develop and strengthen Partnership working arrangements in the Trust. These workshops would be facilitated by the Involvement and Participation Association (IPA) following a series of successful events at national level.
ASSURE	**3rd Party Contractor Pay** • The application of the Living Wage and differentials to Agenda for Change pay rates and their application to contracted out services was discussed and the Local Partnership Forum received an update on discussions ongoing with NHS Wales Shared Services Partnership on options to change pay rates for contracts currently in place.

INFORM	• Nothing to note
APPENDICES	**NOT APPLICABLE**

TRUST BOARD

JULY PMF COVER PAPER

DATE OF MEETING	06/09/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Wayne Jenkins, Head of Planning and Performance Jeff O'Sullivan, Planning and Performance Manager
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	11.8.21	Noted
WBS PERFORMANCE REVIEW MEETING	18.8.21	Noted
VCC SLT MEETING	19.8.21	Noted
VCC PERFORMANCE REVIEW	26.8.21	Noted
EMB RUN	6.9.21	Noted

QS&P COMMITTEE	16.9.21	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 provides an update to the Trust Board with respect to Trust-wide performance against key performance metrics through to the end of July 2021 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The reports set-out performance at Velindre Cancer Centre **(*appendix 1*)** 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 18th for WBS and by the Director of Nursing, AHP's & Medical Scientists, Nicola Williams for VCC on the 26th of August 2021.

2.3 Velindre Cancer Centre:

There were 6 targets reporting as red in July's performance report (Appendix 2). Three of these were the new Clinical Oncology Sub Committee (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). The others were the National Target for waiting times for patients seen within 30 minutes of the Scheduled Appointment Times, the NEWS score for SEPSIS bundle administration and Healthcare associated infections.

We will continue to dual report on both target measures for radiotherapy, so you will see the new COSC targets being reported alongside the Royal College of Radiologists (RCR) targets.

COSC:
Since April 2021, we have been mandated by the Welsh Government to report against the 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 electronic Radiotherapy planning and scheduling systems, have been designed to respond to the original RCR targets.

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.
We will be highlighting the scope of this challenge and the potential financial support required through our IMTP submission for 2022-2025.

We are continuing to input into the development of the Trust PMF framework centrally and are looking at our existing VCC KPIs and whether they are fit for purpose as the first part of that review.

Radiotherapy Waiting Times

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.

COSC targets were red for scheduled and urgent scheduled patients. There were 345 referrals received in July 2021, this is an increase compared to June (323 referrals).

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 measure. We are continuing to report against both measures for comparison at present.

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. The radiotherapy patient pathway project has also undertaken a pilot in Head and Neck, with learning cascaded to the other tumour site teams.

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.

SACT Waiting Times

The both waiting times targets were met again for July for SACT despite record volumes requiring treatment in month.

The non-emergency patients treated within 21 days performance was the best for over 12 months with only 1 patient from 383 treated outside of 21 days (99.7% performance against 98% target). The patient was treated on day 22.

The average monthly number of patients treated pre covid was 328 per month, which was 17% lower than the July 2021 volume of 383.

All 10 of the emergency patients treated in 5 days were treated in target. The average number treated in month pre covid was 4 which was 150% down on the July 2021 volume.

The delivery of the plan developed in conjunction with Aneurin Bevan UHB focused on reopening Neville Hall SACT delivery capacity is planned for September/October 2021. At the time of writing there has been issues identified with the planned facility following an inspection visit by our SACT leadership team. A number of issues have been highlighted to the ABMU team for addressing prior to commencement of the service. These include medicines storage, access and waiting facilities for patients and medical cover.

Outpatient waiting times

This target is reporting as red as we are still not hitting the 30 minute target. It has remained steady with last month at 76%. We have had further discussion at SMT about possibly looking at splitting the targets into waits from first arriving to Phlebotomy and then the wait from Phlebotomy to seeing the consultant. The reason for this is that some patients cannot see the consultant unless they have up to date blood results and waiting for the results is adding to the delay. Normally some of these blood tests would happen in the health boards and that is still not happening. Patients have also fed back that they prefer to have blood taken at Velindre on the same day as their appointment so they are only travelling to the Centre once, especially those that live a distance away. Some patients also need blood testing on the day, so the picture is a complex one. 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.

Phlebotomy - repatriation of services

Conversations are continuing about the repatriation of services with Health Boards. The plan is to repatriate elements of phlebotomy activity to local health boards, linked to the return of outreach clinics.

Therapies

A shortage of dietetic staff due to sickness in July resulted in 3 patients not being seen within the stipulated target time for urgent outpatient referrals to be seen within 2-weeks. The department's prioritisation protocol was enacted and all patients were seen on day 1 of the third week. There was no patient harm.

A patient administrative error resulted in 1 Speech and Language Therapy patient being seen as a routine outpatient outside of the 6 week target. Actions have been taken to mitigate errors in process in the future. There was no harm to the patient as a result of this issue.

Outpatient DNA Rates

Although performance remains within the target of 5%, there has been a gradual increase over the year from a 2-3% steady state up to the current performance. We are currently clarifying the reasons behind this and in particular the impact of virtual appointments on this target. We will continue to monitor and report on this going forward.

Other areas

Falls – there were 3 falls involving 3 individual patients. Each was deemed unavoidable following investigation. In two instances, patients had attempted to mobilise unaided contrary to their care plans which were put in place following falls risk assessments on admission. In the third case, on discovery, the patient could not recall the fall. All appropriate measures had been put in place. A patient handling assessment had determined that the patient was mobile, but only with assistance and the use of a frame.

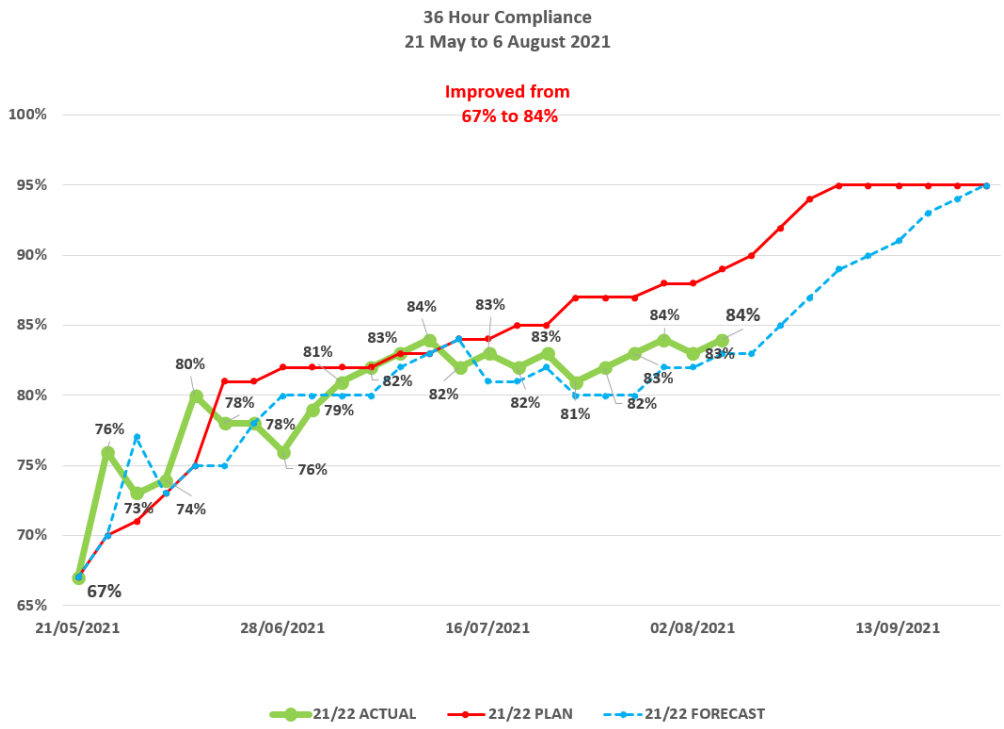
Pressure Ulcers – There were no pressure ulcers this month.

Healthcare Associated Infections – There was 1 C diff infection identified. A full root cause analysis is being undertaken. A full multi-disciplinary team panel, involving the consultant microbiologist, will consider the report and identify learning in September 2021.

SEPSIS bundle NEWS score – 1 of 5 patients receiving the SEPSIS bundle did not receive it in the timescale due to the attending doctor being called away to manage a medical emergency for resuscitation. We are reviewing the criteria for widening the cohort of professionals able to administer the required drugs to avoid this issue in the future.

SACT 36 Hour Pre Prescribing Compliance

Compliance has improved with the pre-prescribing of SACT at least 36 hours (1 working) day before the patient's SACT day case appointment. It now stands at 84%. This is a 17% increase since we started looking at this in May 2021. We have piloted an automated email with a group of consultants which informed them on a daily basis which patient(s) had not had their treatment prescribed in accordance with the timescales. This pilot was successful and the next step is for this automated email to be rolled out to all consultant staff. Subject to agreement, this will occur over the next couple of weeks.



Further detailed performance data is provided in Appendix 1

2.4 Welsh Blood Service

July's report highlights the extremely good performance that is still being delivered by the WBS Team despite the ongoing challenges of operating in a Covid environment and the overall impact that this has had on the workforce. We have maintained good stock positions with all stock groups continued to be maintained above 3 days for July and through our mutual aid agreement have exported red cells to the Scottish National Blood Transfusion Service (SNBTS) on three occasions in the month of July. We have not seen the surge in demand they've had elsewhere in the UK and the increase in demand we did have in June and July has calmed a little.

2.4.1 Recruitment of new bone marrow volunteers

148 new bone marrow volunteers were added to the Welsh Bone Marrow Donor Registry in June. Recruitment continues to be hindered by the inability to hold whole blood donation clinics in schools and Universities. But we have scheduled 7 bone marrow collections in August 2021 and 8 for September 2021, and this is in-line with our average normal of between 6 and 7 a month.

2.4.2 Quality

Incidents closed within 30 days

Performance in July has met the target position, with 96% of quality incidents closed within the required 30 days and this is a 1% improvement in performance from the previous month. The situation is being monitored and the agreed SMT action plan will remain in place to ensure that the improved performance is sustained.

Number of Concerns Received

10 concerns (0.14%) were reported within this period, 7 were managed as early resolution, and 3 were managed as formal concerns in line with Putting Things Right (PTR) regulations.

Part Bag Rates

Part bag rate remains within the required tolerance level for the third consecutive month now.

Donor Satisfaction

In July overall donor satisfaction continued to exceed target at 96.0%. In total there were 1,054 respondents who had made a full donation**.**

Failed Venepuncture Rates

The Failed Venepuncture (FVP) rate for July 2021 is within the tolerance threshold of 2%.

2.4.3 Other information

Serology Department is still under considerable pressure, both in terms of the complexity of the referrals and also in terms of the high number that are being requested out of hours, and the impact this has on staff availability the following day. We have also noticed as part of the work to develop the new performance management framework our targets are out of kilter with those across the rest of the UK, with ours being significantly shorter. We are setting up a project to look at the referral patterns from the hospitals to the reference serology laboratory and this work will be undertaken through the autumn.

Although productivity in labs is good, it is worth noting that the teams are operating under extreme pressure and stress as they are having to support the vaccine distribution process. The situation is being monitored by the Senior Management Team on an ongoing basis.

Further detailed performance data is provided in Appendix 2

3.0 Workforce & Wellbeing

Highlights for July 2021

PADRs - overall, a slight decrease on last month. WBS' compliance was 79.78% (compared to 81.74 in June 2021). VCC's compliance was 74.31% In July (compared to 76.52% in June). Hotspot areas are being worked on, in conjunction with Managers.

Sickness Absence - overall, a very slight increase in sickness this month. Sickness within WBS was 4.78% in July 2021 (compared to 4.53% in June). In VCC, sickness absence was 5.42% (compared to 5.38% in June). Sickness absence cases related to COVID are still very small and reducing month on month.

Stat and Mandatory training compliance slightly increased in July. WBS saw an increase in compliance from 92.39% in June, to 93.38% in July – please note this exceeds the 85% target. VCC also saw a slight increase from 82.45% in June, to 82.70% in July.

Job Planning – This remains relatively low, but work is ongoing within the Medical Directorate to identify ways in which to improve compliance. This remains part of a bigger piece of work within the Directorate.

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

Welsh Blood Service Monthly Report

July 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 July.
- On 3 occasions WBS exported red cells to the Scottish National Blood Transfusion Service (SNBTS) in July as part of the mutual aid support agreement. The supply consisted of: 225 O+ , 80 O-, 20 A- and 100 A- units
- All clinical demand for platelets was met, and continues to be at pre Covid levels (approx. 200 units per week), showing high levels of variability.
- There were 148 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in June. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment. In comparison to June there was also a slight reduction in appointments available resulting in a slight decline in the number of 17-30 year olds donating, in addition to a slight decline in the percentage of 17-30 year olds converted to WBMDR.
- Turnaround time Antenatal tests for July is slightly lower than June. Work continues to be prioritised based on clinical need, and all compatibility testing (>50% of referrals) was completed to the required time/date.
- Whole Blood Collection productivity is at 0.93 for July. The ongoing COVID 19 response requirement to resource the additional Triage role on donation clinics continues to affect productivity.
- The overall Part Bag Rate is at 2% for July. Part bag rate remains within the required tolerance level for the third consecutive month, whilst the Failed Venepuncture (FVP) rate for July 2021 is at at 1.43 % and is within the tolerance threshold of 2%.
- 482 new donors completed a donation in July, 7.0% of the total donations received in the month.
- In July overall donor satisfaction continued to exceed target at 96.0%. In total there were 1,054 respondents who had made a full donation, 215 were from North Wales and 809 were from South Wales
- There were 4 new apheresis donors in July 2021, making 10 new apheresis donors this quarter to date, against a quarterly target of 14.
- Increased collections and transfer of staff to support vaccine delivery, coupled with departmental vacancies continues to contribute to Processing Productivity being above target for July.
- In July 2021 approximately 7,000 donors were registered at donation clinics. 10 concerns (0.14%) were reported within this period, 7 were managed as early resolution, 3 were managed as formal concerns in line with Putting Things Right (PTR) regulations.

6 Key Performance Indicators were above the previous month's performance

4 Key Performance Indicators remained the same as the previous month's performance, 4 achieved target.

8 Key Performance Indicators were down on the previous month's performance, with 2 achieving target..

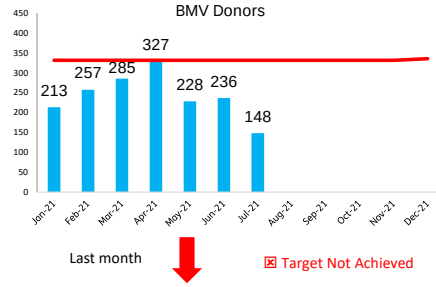
Reference Table

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

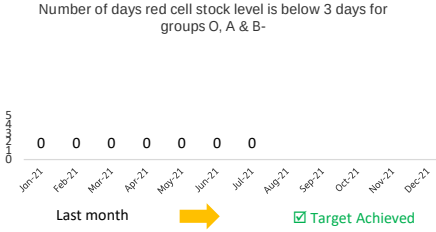
Jul-21



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 148 new bone marrow volunteers added to the Welsh Bone Marrow Donor Registry (WBMDR) in July. The inability to hold whole blood donation clinics in schools and Universities, continues to hinder recruitment of new BMV's (Bone Marrow Volunteers). The strong stock position led to an agreed decision to reduce the effort in driving high appointment uptake rate. In comparison to June there was also a slight reduction in appointments resulting in a slight decline in the number of 17-30 year olds donating alongside a slight decline in the percentage of 17-30 year olds converted to WBMDR.	The new donor recruitment and retention strategy for the WBMDR became live on 03/08/2021. Further work to raise the awareness of the public of the alternative bone marrow recruitment methods to support the desired increase in volunteers is now needed. 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 ahead of expected deferred September 2021 deadline.

Safe and Reliable Service

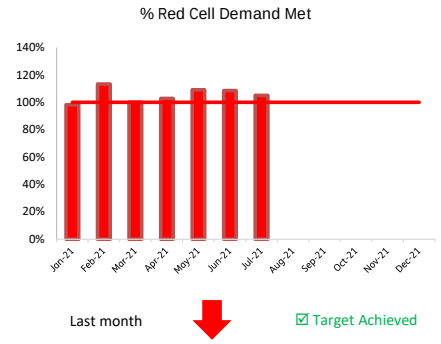
Jul-21



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 continued to be maintained above 3 days for July.	Daily Resilience meetings are held between blood collection and manufacturing teams; this forum facilitates operational actions in response to challenges in maintaining adequate stock levels in order to minimise blood shortages.	Business as Usual, reviewed daily

Safe and Reliable service

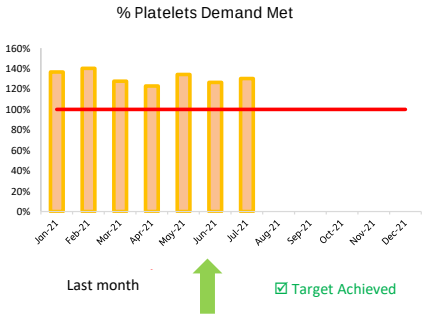
Jul-21



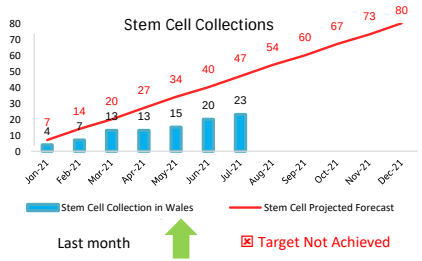
Monthly Target: 100%	SMT Lead: Jayne Davey/ Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All demand for red cells was met. Communications between the Collections and Laboratory teams continues to enable agile responses to variations of stock levels and service needs. On 3 occasions WBS exported red cells to the Scottish National Blood Transfusion Service (SNBTS) in July as part of the mutual aid support agreement. In total the supply consisted of: 225 O+ units 80 O- units 20 A- units 100 A- units This has led to a reduction in WBS total stock, however July stock levels remain above target and levels of individual groups are satisfactory.	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

Jul-21



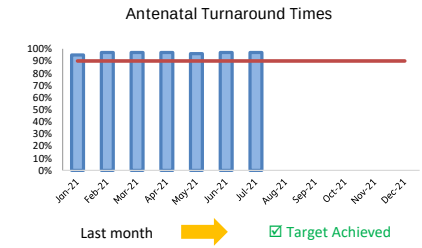
Monthly Target: 100%	SMT Lead: Jayne Davey / Tracey Rees	
What are the reasons for performance?	Actions(s) being taken to improve performance	By When
All clinical demand for platelets was met. Daily communications between the Collections and Laboratory teams enables agile responses to variations of stock levels and service needs. Platelet demand remains at pre covid levels (approx. 200 units per week) and shows high levels of variability. Changes were made to bleed instructions to support the collection of male plasma for Cryoprecipitate production. Additional production of platelets was planned to offset this change. Following success of the change, platelet production was reduced at end of July	The Ambient Overnight Hold (AONH) production process allows flexibility in the production plan for platelets. Adjustments on the weekly production are being made to better align with demand.	Business as Usual, reviewed daily



Safe and Reliable service

Jul-21

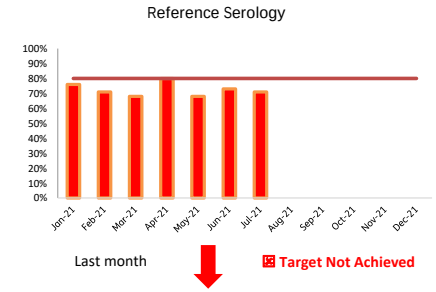
Annual Target: 80 (ave 7 per month)	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 3 Stem Cell Collections in July two via Peripheral Blood Stem Cells (PBSC) collection , and one via Bone Marrow donation. There were three cancellations at the preparation/work up stage which has impacted on collection performance for July, 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. It is anticipated the new service from VCC will 'go-live' September 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

Jul-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 July is 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

Jul-21

Monthly Target: 80%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Turnaround time for July is slightly lower than June. Work continues to be prioritised based on clinical need, and all compatibility testing (>50% of referrals) was completed to the required time/date. The workload remains high , with 242 hospital patient referrals in July2021 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.

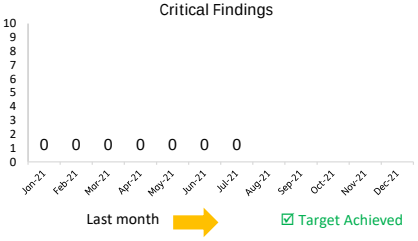
Safe and Reliable service

Jul-21

Monthly Target: 90%	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Performance in July has met the target position, with 96% of quality incidents closed within the required 30 days. This indicates an 1% improvement in performance from the previous month. The number of incidents reported in the three month rolling period has increased (102 reports, 37 more than the previous period). The number of incidents not closed within the required timeframe has increased from 3 in the previous three month rolling period to 4 in this reporting period. GMP (Good Manufactoring Practice) related incidents reported by Collection Teams are being recorded in the Datix Once for Wales System; the increase in the total number of incidents reported may be attributable to some types of low risk GMP incidents being reported individually, whereas in the past these events were monitored and only reported when a formally agreed threshold had been exceeded.	The agreed SMT action plan will remain in place to ensure that the improved performance is sustained. 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 were fully closed within a few days of reporting. It should be noted there are a small number of incidents within Datix v.12 that are still being managed to closure through the original process.	Continue with close monitoring.

Safe and Reliable service

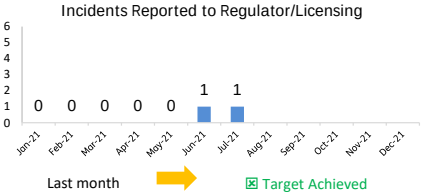
Jul-21



What are the reasons for performance?	Action(s) being taken to improve performance	By When
UKAS undertook an inspection of WBS laboratories against ISO 15189 week commencing 19th July. There were no critical or major inspection findings and no significant weaknesses identifed that presented a risk, although there were several findings that require action to improve and enhance the quality management system. The assessors have made a recommendation to the independent UKAS Decision Maker that acrreditation of the WBS Laboratories is renewed.	Required actions are defined in an action plan, being overseen by the Laboratories Business & Compliance Manager.	Evidence of action to be submitted to UKAS by 27/08/2021

Safe and Reliable service

Jul-21



Annual Target: 0	SMT Lead: Peter Richardson	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
No Serious Adverse Events (SAE) were reported to the MHRA in July. One SAE was reported to the HTA; a bone marrow collection undertaken on 7th July gave a positive microbiology culture result for Staphylococus. The root cause is under investigation. There has been no donor or patient harm as a result of this event.	The entire bone marrow collection process will be examined and reviewed to determine whether improvements can be made.	Completion is reliant on observation and review of the next bone marrow collection.

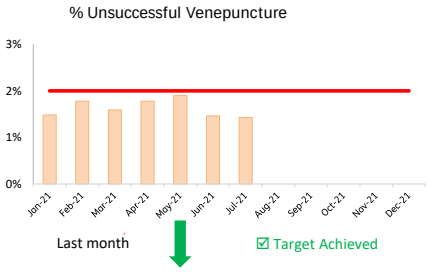
Spending Every Pound Well

Jul-21

Monthly Target: Maximum 3%	SMT Lead: Janet Birchall	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
The overall Part Bag Rate is at 2% for July following breach in April 2021. Part bag rate remains within the required tolerance level for the third consecutive month	Monitoring of part bag rates (overall and by team) continues. The first cohort of staff to take the reviewed Collections Training Programme are due to commence their training in late August 2021. This measure will continue to be closely monitored to ensure quality of care is unaffected.	Monthly monitoring and reporting continues.

Spending Every Pound Well

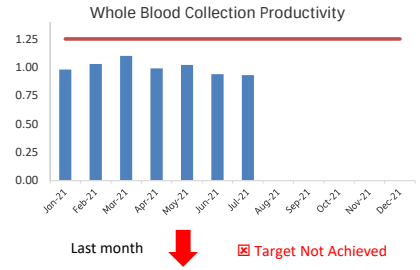
Jul-21



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 July 2021 is at at 1.43 % and remains within the tolerance threshold of 2%. FVP rates have decreased but remain higher on the Wrexham Team 2.3 % - 18 events. Operational management are undertaking a review to identify any further improvement work required within this specific team.	Ongoing monitoring of FVP rates by the team continues, with continued performance analysis taking place to evaluate trends. The north Wales Operations Manager is currently undertaking a review in relation to Wrexham raised rate, and feedback is awaited.	Monthly monitoring and reporting continue.

Spending Every Pound Well

Jul-21



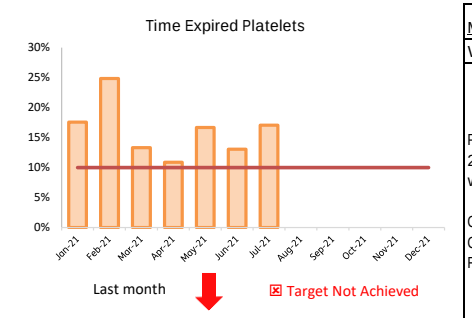
Monthly Target: 1.25	SMT Lead: Jayne Davey	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Collection productivity continues to be below target, at 0.93 for July. The ongoing COVID 19 response requirement to resource the additional Triage role on donation clinics will also continue to affect productivity. This essential element of infection prevention and control (IPC) will remain in place while COVID 19 is present in the community.	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
Increased collections and the movement of staff from Manufacturing to Hospital Services to support vaccine delivery coupled with departmental vacancies continues to contribute to this metric being above target for July.	The target will remain at its current level until the impact of covid restrictions on collections and surge planning are evaluated.	Dec-21

Spending Every Pound Well

Jul-21



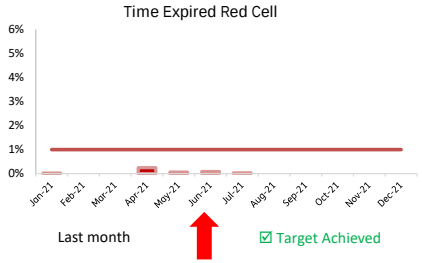
Monthly Target: Maximum 10%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
Platelet expiry was driven by production to meet variable demand in platelet issuing (200-220 p/w). This is kept under weekly review, to determine appropriate levels, in conjunction with expected demand. Changes were made to bleed instructions to support the collection of male plasma for Cryoprecipitate production, with additional production of platelets to offset this change. Following the change, platelet production was reduced at end of July.	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

Jul-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 July are at 0.2% and remain within tolerance to be below 0.5%. The causes for July's performance include: Storage : 1 Blood Press : 5 - new staff error Centrifuge : 9 - new staff / electrical issue.	Reporting and management of incidents, ongoing monitoring of losses when ocurring and lessons learned analysis takes place. The metric for July is within tolerance and represents a very low percentage of processed units.	Business as Usual, reviewed monthly

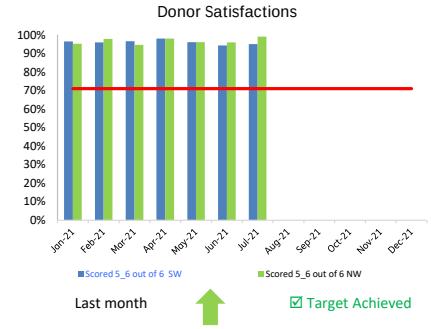
Spending Every Pound Well



Jul-21

Monthly Target: Maximum 1%	SMT Lead: Tracey Rees	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
At 0.03% the volume of time expired red cells as a percentage total of red cell bags produced per month is lower than June (0.09%) and within tolerance target of 1%. Red cell collections and demand are closely aligned with minimal wastage.	Monitoring continues	Business as usual, reviewed daily

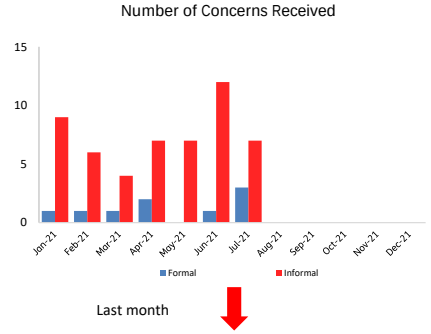
First Class Donor Experience



Jul-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 July overall donor satisfaction continued to exceed target at 96.0%. In total there were 1,054 respondents, who had made a full donation and shared their donation experience, 215 were from North Wales and 809 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

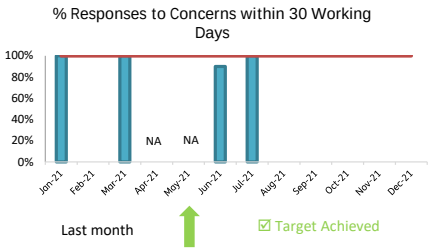


Jul-21

Target: N/A	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
In July 2021 approximately 7,000 donors were registered at donation clinics. 10 concerns (0.14%) were reported within this period, 7 were managed as early resolution, 3 were managed as formal concerns in line with Putting Things Right (PTR) regulations. Concern themes highlighted during this period include: 1) Bruising/Painful arm on cannulation, resulting in 3 concerns 2) Donor felt rushed from donation chair and queried what ocurred during vaso vagal event with loss of consciousness . 3) Volume of SMS invites 4) Staff attitude and behaviour, resulting in 2 concerns 5) Vaccinated Donors. Similar concerns have been received by other UK Blood Services and a formal response requested from JPAC with input from the MHRA to ensure consistent messaging. A response has been received and formal response to this individual is being prepared. The wider concerns expressed by members of the public relating to safety of donations received from COVID vaccinated donors has been evident upon several social media platforms. WG are aware of the situation. 6) Donor deferred at screening- donor was over 70 years of age and had made no dontation during the previous 2 years.	All concerns have been investigated and lessons learned identified and actioned as appropriate by relevant departmental managers. Actions taken to address concerns in this period include: 1) Clinical Leads to review & identify any further training needs and action as appropriate 2) Clinical Services Training Manager to complete a review of documentation practices following a Vaso Vagal event, a review of current resting times post donation, and a review of WBS Standard Operating Procedure (COL/006), introducing additional training if required. 3) Discussions with the DCC has removed the donor from the SMS list following request. A new process to allow donors to confirm appointments is being implemented enabling donors to use a self-service function as part of the modernisation of our donor contact centre. 4) Discussions with staff to take place following further investigation findings. Where required additional conversations with staff members takes place to address any lessons learned following donor feedback. 5) WBS has liaised with other UK blood services, the MHRA and JPAC (The Joint United Kingdom Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee), to establish the UK position for COVID 19 vaccines and blood transfusion. Feedback on the UK position for COVID 19 vaccines and blood transfusion will be issued to the complainant. 6) WBS will continue to make current guidelines prevent donors who do not meet donation acceptance criteria explicit across its booking platforms, including donors donating whole blood if they have not donated within last two years if aged 70 and over.	Business as usual, reviewed daily

First Class Donor Experience

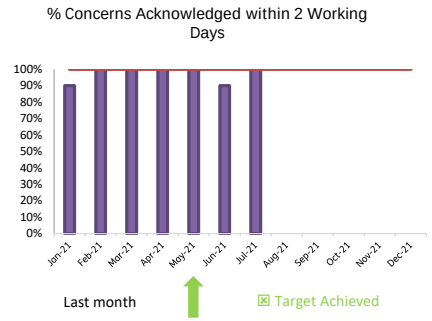
Jul-21



Monthly Target: 100%	SMT Lead: Alan Prosser	
What are the reasons for performance?	Action(s) being taken to improve performance	By When
There were 3 formal concerns received during July 2021, 1 of which remains to be compelted, but is within timeline.	Continue to monitor 30 day response compliance.	Business as Usual, reviewed daily

First Class Donor Experience

Jul-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 July 2021, were managed within timeline.	Continue to monitor concern management timescales	ongoing, reviewed daily

Workforce Monthly Report

July 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
	Jul-21	Jun-21	
PADR	73.28	75.09	85%
Sickness	4.98	4.89	3.54%
S&M Compliance	84.97	84.59	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	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
Corporate	41.28	41.59	44.35	44.07	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33
Research, Development & Innovation	70.45	69.57	71.11	75.00	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70
Transforming Cancer Services	61.54	60.00	62.50	50.00	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67
Velindre Cancer Centre	62.75	67.60	71.61	73.63	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31
Welsh Blood Service	65.11	68.69	70.22	71.46	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78
Velindre Organisations	61.92	65.67	68.61	70.02	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28
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)	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
Corporate	70.00	72.80	66.67	70.00	69.45	70.47	71.61	70.62	69.47	69.06	70.08	69.08	69.26
Research, Development & Innovation	75.96	80.79	72.41	75.71	76.73	76.25	77.45	82.50	83.73	82.59	83.08	85.69	86.00
Transforming Cancer Services	66.67	70.99	70.00	65.26	70.56	70.56	71.18	69.38	64.12	65.29	70.00	76.00	76.84
Velindre Cancer Centre	78.82	79.87	77.79	78.94	80.13	80.23	80.69	81.53	81.57	80.98	81.77	82.45	82.70
Welsh Blood Service	93.79	91.99	90.65	89.69	91.67	91.42	90.43	89.54	90.90	90.43	92.23	92.39	93.38
Velindre Organisations	82.49	82.99	80.57	81.26	85.59	82.66	82.81	83.06	83.39	82.92	84.09	84.59	84.97

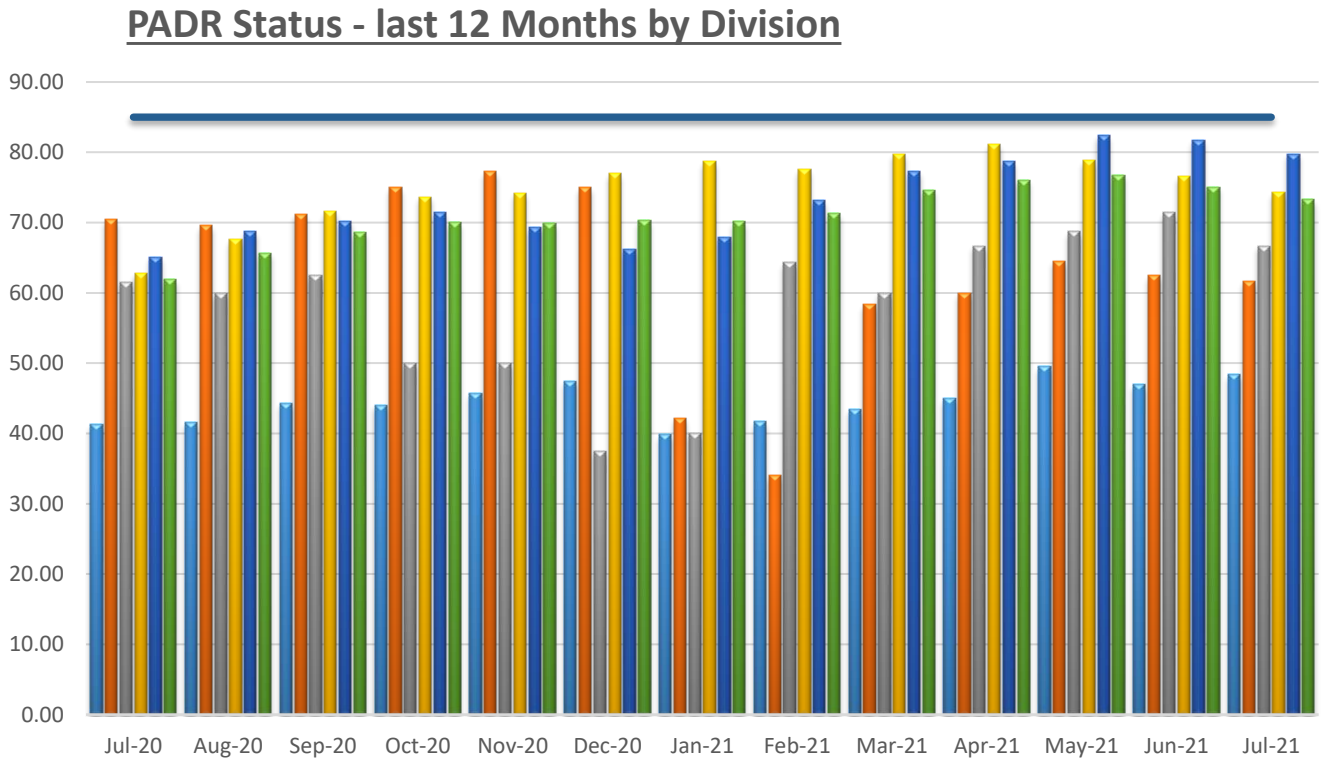
Key	0% - 3.54%		3.55% - 4.49%		4.5 % & Above								
Sickness Rolling %	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Corporate	4.91	5.20	5.38	5.40	5.19	5.21	5.26	5.16	4.87	4.62	4.54	4.46	4.36
Research, Development & Innovation	5.14	4.88	4.68	4.51	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.35
Transforming Cancer Services	3.08	2.46	2.38	2.31	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32
Velindre Cancer Centre	5.57	5.63	5.73	5.74	5.76	5.86	5.86	5.94	5.74	5.37	5.34	5.38	5.42
Welsh Blood Service	4.76	4.60	4.53	4.43	4.43	4.43	4.44	4.38	4.25	4.19	4.36	4.56	4.78
Velindre Organisations	5.21	5.21	5.25	5.22	5.21	5.27	5.27	5.28	5.08	4.82	4.84	4.89	4.98
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	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
Corporate	0.18	0.18	0.20	0.23	0.28	0.42	0.56	0.61	0.58	0.53	0.58	0.63	0.68
Research, Development & Innovation	0.18	0.21	0.31	0.35	0.36	0.43	0.45	0.46	0.42	0.35	0.44	0.45	0.45
Transforming Cancer Services	0.31	0.30	0.29	0.28	0.28	0.27	0.26	0.26	0.21	0.00	0.00	0.00	0.00
Velindre Cancer Centre	0.79	0.84	0.94	1.02	1.09	1.28	1.39	1.44	1.31	0.96	0.89	0.87	0.87
Welsh Blood Service	0.19	0.19	0.21	0.26	0.30	0.37	0.42	0.45	0.39	0.31	0.29	0.29	0.29
Velindre Organisations	0.52	0.55	0.62	0.68	0.74	0.88	0.97	1.00	0.91	0.68	0.65	0.64	0.64

Monthly Special Leave Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Non Covid Related	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
Corporate	0.41	0.40	0.42	0.39	0.38	0.37	0.30	0.23	0.17	0.11	0.05	0.04	0.06
Research, Development & Innovation	0.61	0.69	0.70	0.65	0.67	0.71	0.74	0.65	0.50	0.46	0.42	0.51	0.53
Transforming Cancer Services	0.02	0.02	0.02	0.02	0.16	0.32	0.51	0.51	0.51	0.51	0.51	0.51	0.50
Velindre Cancer Centre	0.34	0.36	0.38	0.39	0.39	0.40	0.42	0.43	0.43	0.41	0.41	0.42	0.43
Welsh Blood Service	0.52	0.53	0.54	0.58	0.57	0.62	0.63	0.61	0.61	0.57	0.59	0.58	0.58
Velindre Organisations	0.41	0.43	0.44	0.45	0.45	0.47	0.49	0.48	0.47	0.43	0.43	0.44	0.45

Monthly Special Leave Absence %	0%		0.01% - 0.49%		0.50 % & Above								
Special Leave Covid Related	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
Corporate	0.49	0.57	0.58	0.59	0.59	0.58	0.58	0.58	0.49	0.32	0.25	0.18	0.12
Research, Development & Innovation	1.82	1.97	1.96	1.94	1.99	1.98	1.96	1.95	1.45	1.04	0.76	0.49	0.21
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	1.61	1.74	1.83	1.87	1.97	2.16	2.29	2.38	2.14	1.73	1.43	1.19	1.03
Welsh Blood Service	1.22	1.32	1.39	1.45	1.52	1.63	1.74	1.79	1.70	1.39	1.14	0.93	0.79
Velindre Organisations	1.37	1.49	1.56	1.60	1.68	1.81	1.92	1.98	1.80	1.45	1.19	0.97	0.82

PADR – The Figures



	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
Corporate	41.28	41.59	44.35	44.07	45.76	47.46	39.82	41.74	43.44	45.00	49.58	47.01	48.33
Research, Development & Innovation	70.45	69.57	71.11	75.00	77.27	75.00	42.22	34.04	58.33	60.00	64.58	62.50	61.70
Transforming Cancer Services	61.54	60.00	62.50	50.00	50.00	37.50	40.00	64.29	60.00	66.67	68.75	71.43	66.67
Velindre Cancer Centre	62.75	67.60	71.61	73.63	74.23	76.98	78.68	77.53	79.78	81.07	78.88	76.52	74.31
Welsh Blood Service	65.11	68.69	70.22	71.46	69.32	66.18	67.97	73.19	77.25	78.65	82.41	81.74	79.78
Velindre Organisations	61.92	65.67	68.61	70.02	69.89	70.32	70.19	71.32	74.64	76.07	76.77	75.09	73.28
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	June Figure	Hotspot Areas	%	Comment to include reasons for change / rates high or low
PADR Compliance (85%)	73.28% ↓	75.09%	WBS - Directors Section	25% ↓	4 people in this section. 1 reported as completed. Section recently split in ESR.
			WBS - General Section	60.42% ↓	Decrease on previous month.
			WBS – Quality Assurance	80.56% ↑	Significant improvement on previous month. 4 departments remain under the target of 85%.
			WBS Collections	80.49% ↑	Slight increase from 79.6% in June 2021.
			VCC – Medical Staffing	43.33% ↑	Slight improvement on previous month.
			VCC - Clinical Audit	66.67% ↑	Improvement on previous month.
			VCC - Palliative/Chronic Pain	52.63% ↔	Same as previous month.

			Corporate	48.33% 	6 departments have compliance above 50% which is a significant improvement. The other 5 are between 0 and 40%. Workforce Operational Team have been asked to link in with departmental Managers as a matter of priority.
			RD+I	61.70% 	Decrease on last month.
			TCS	66.67% 	Decrease on last month.
			HTW	69.23% 	Increase on last month.

Action/ initiatives:

WBS

- A few areas across WBS have decreased in July.
- WTAIL and Clinical Services are reporting figures of 97.83% and 95% compliance respectively.
- Some further investigations needed into the hierarchy for Directors section. Some changes have been made in July to reporting lines which has impacted on this figure.

VCC

- Workforce business meeting undertaken with Clinical Audit (July 2021)
- Between April 2020 and April 2021 and despite suspension of medical appraisals – 30 were undertaken and completed with the rest being 'awarded missed appraisal' (AMA) status for the year. Medical Directorate continue to monitor and manage the input of appraisals into ESR to improve the overall figure however AMA has no way of being recorded in ESR or MARS.

Corporate Areas (including RD&T, HTW & TCS)

- Despite the increased compliance in most of the corporate areas, Managers are reporting that working arrangements (WFH) are making PADRs more difficult.
- Work to be undertaken in some corporate areas to ensure Managers know how to update PADR data in ESR.

Sickness Data – The Figures

	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
Corporate	4.91	5.20	5.38	5.40	5.19	5.21	5.26	5.16	4.87	4.62	4.54	4.46	4.36
Research, Development & Innovation	5.14	4.88	4.68	4.51	4.62	4.60	4.37	4.23	4.01	3.73	3.46	3.16	3.35
Transforming Cancer Services	3.08	2.46	2.38	2.31	2.24	2.46	2.41	2.41	2.01	1.34	0.88	0.41	0.32
Velindre Cancer Centre	5.57	5.63	5.73	5.74	5.76	5.86	5.86	5.94	5.74	5.37	5.34	5.38	5.42
Welsh Blood Service	4.76	4.60	4.53	4.43	4.43	4.43	4.44	4.38	4.25	4.19	4.36	4.56	4.78
Velindre Organisations	5.21	5.21	5.25	5.22	5.21	5.27	5.27	5.28	5.08	4.82	4.84	4.89	4.98
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	June Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Sickness absence (3.42%)	4.98% ↑	4.89%	WBS - Collection Service	7.19% ↑	Increase on previous month.
			WBS – Laboratory Services	7.64% ↑	Significant increase from previous months, where there has been a downward trend.
			WTAIL	5.38% ↓	Decrease on previous month.
			WBS – Quality Assurance	5.23% ↓	Very slight decrease on previous month. QA Laboratories showing both long and short term sickness of 10.81% and 4.81% respectively.
			VCC - Psychology	19.11% ↑	Significant increase in Psychology sickness from previous month. Outpatients continue to increase month on month – with a 15.85% increase over a six month period. These figures are due mainly to long term sickness cases that are being managed by departments.
			VCC - Outpatients	20.34% ↑	
			VCC – Clinical Audit	35.21% New Hotspot	
			Corporate	4.36%	0.8% Covid related absence (sickness and special leave)

					Around 50% of absence due to long term stress/anxiety/depression – a significant reduction.
			RD+I	3.35% 	Increase from June 2021.
			TCS	0.32% 	No Covid absence reported.
			HTW	3.43% 	No Covid absence reported.

Action/ initiatives:

<u>WBS</u>

- HR Operational Team continue to support mangers to resolve sickness cases.
- Hotspot areas identified to HR Operational Team to ensure timely support is offered to managers
- Some managers have engaged for support in managing some challenging cases and meetings are scheduled to take place to support and plan actions required.

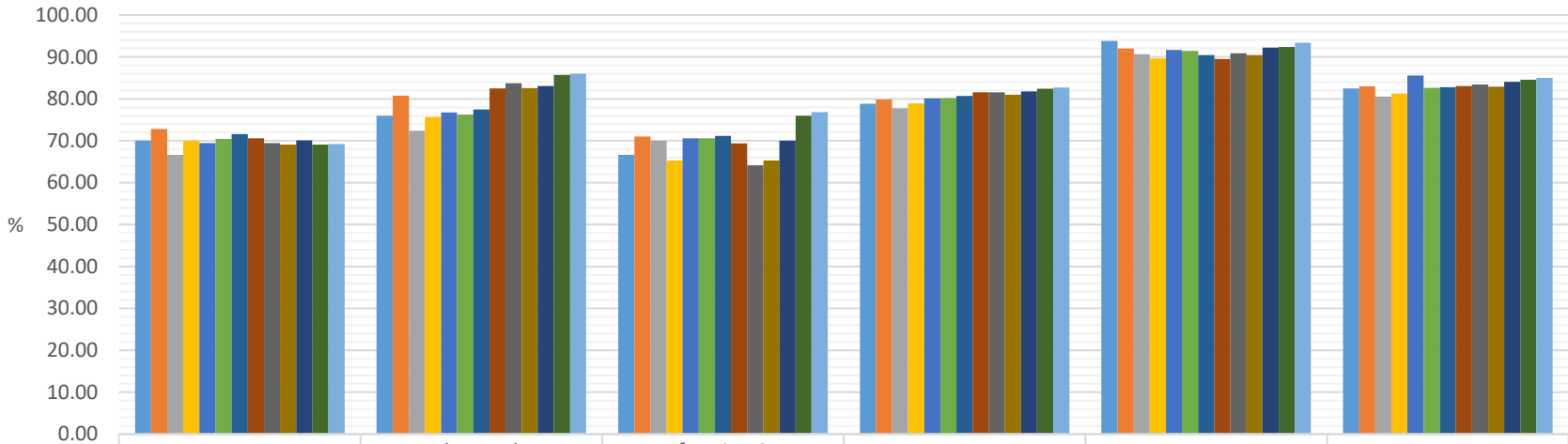
<u>VCC</u>

- Workforce and OD Operational Team to begin the process of regular sickness audits, to understand compliance of the policy and support required by management to progress cases.
- WOD Operations Team have held 121's with hotspot areas in June and July 2021 to progress LTS cases.
- Short-term sickness remains relatively low in VCC at 1.27%

Corporate Areas (including RD&T, HTW & TCS)

- Corporate has around 130 staff (headcount) across 11 departments. Between 2 and 32 staff per department so each staff member can have between 3% and 50% impact on that department's figures. Managers are engaging in Workforce conversations and acting to support staff back into work.

Statutory and Mandatory Figures – The Figures



	Corporate	Research, Development & Innovation	Transforming Cancer Services	Velindre Cancer Centre	Welsh Blood Service	Velindre Organisations
Jul-20	70.00	75.96	66.67	78.82	93.79	82.49
Aug-20	72.80	80.79	70.99	79.87	91.99	82.99
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

Statutory and Mandatory Figures – The Narrative

Performance Indicator	RAG/ Change from previous month	June Figure	Hotspot	%	Comment to include reasons for change / rates high or low
Stat & Mand Training (85%)	**84.97%** ↑	84.59%	VCC - Palliative/Chronic Pain	65.16% ↑	Increase on previous month.
			VCC - Medical Staffing	64.81% ↑	Increase on previous month.
			VCC – Operational Services	75% ↑	Increase on previous month.
			Corporate	69.26% ↑	Slight increase in compliance. All managers committed to getting staff to undertake the relevant training.
			RD&I	86% ↑	Small increase. Managers encouraging staff to complete e-learning.
			TCS	76.84%	Increase on last month.

					
			HTW	78.82% 	Small decrease on last month.

Action/ initiatives:

WBS

- As a whole, WBS is currently achieving a compliance rate of 93.38% - the aim is to maintain this level of compliance.
- Discussion has taken place with Education and Training Team re: training due in the Autumn for collections teams, hoping to ensure compliance is maintained by forward planning.

VCC

- Face to face training continues to be delivered and 50% of departments at VCC have achieved minimum compliance.
- Operational Services have appointed a new training supervisor to support staff to achieve online training and develop ICT literacy to improve compliance.

Corporate Areas (including RD&T, HTW & TCS)

- Hotspot areas being addressed up during Workforce/Management meetings.
- Issues with ESR learning portal may have impacted on compliance.

Job Planning Figures – VCC & WBS combined

Combined – VCC& WBS

Role	Assignments	With Expired Plan	% With Expired Plan	With Unsigned Plan	% With Unsigned Plan	With Current Plan	% With Current Plan
Consultant	60	27	**45.00%**	15	**25.00%**	19	**31.67%**
Specialty Doctor	12	10	**83.33%**	0	**0.00%**	2	**16.67%**
Grand Total	**72**	**37**	**51.4%**	**15**	**25.00%**	**21**	**29.17%**

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

100% compliant with their job plans – these now need to be updated on to ESR.

VCC

More job planning sessions have been arranged over the forthcoming weeks. Work will also be undertaken to ensure that all job plans are signed off in a timely manner. The figures represented above (from ESR) need to be updated by the Directorate - it has been agreed that this work will commence mid-August 2021.

SPR doctors work to educational training plans, as opposed to job plans; these are yet to be inputted in ESR.

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.

Velindre Cancer Centre Monthly Performance Report Summary Dashboard (July 2021)

			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Radiotherapy	Patients Beginning Radical Radiotherapy Within 28-Days (page 6) ***(JCCO Measure)***	Actual	91%	94%	94%	91%	92%	95%	97%	92%	89%	95%	94%	97%
		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	92%	94%	82%	91%	93%	90%	97%	90%	85%	95%	84%	82%
		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%	96%	97%	94%	93%	95%	97%	100%	97%	100%	100%	97%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Scheduled Patients Beginning Radiotherapy Within 21-Days (page 12) ***(COSC Measure)***	Actual									35%	28%	37%	35%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Urgent Scheduled Patients Beginning Radiotherapy Within 7-Days (page 12) ***(COSC Measure)***	Actual									41%	48%	40%	54%
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
	Emergency Patients Beginning Radiotherapy Within 1-Day (page 12) ***(COSC Measure)***	Actual									83%	88%	85%	82%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SACT	Patients Beginning Non-Emergency SACT Within 21-Days (page 15)	Actual	51%	58%	68%	79%	86%	79%	77%	88%	98%	98%	98%	99%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Patients Beginning Emergency SACT Within 2-Days (page 17)	Actual	50%	50%	100%	80%	100%	100%	100%	100%	100%	100%	100%	100%
		Target	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%

			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Outpatients	New Patient, other Outpatient and Chemotherapy Assessment Appointments Where Patients Were Seen Within 30 minutes of the Scheduled Appointment Times (National Target) (page 21)	Actual	Data Not Collected During Initial Pandemic Response		72%	93%	67%	66%	65%	57%	66%	79%	76%	76%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Did Not Attend (DNA) Rates	Actual	3%	2%	2%	2%	2%	3%	2%	3%	3%	4%	4%	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)	100%	95%	95%	96%	97%	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)	100%	95%	98%	96%	97%	100%	100%	100%	100%	100%	84%	94%
		Actual (Physiotherapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
		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)	88%	67%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Occupational Therapy)	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%
		Actual (Speech and Language Therapy)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%
		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	0	0	3	2	2	0	0	0	1	0	0	0
		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	0	0	1	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of VCC Inpatient Falls (page 27)	Actual (Total)	3	0	4	0	2	1	1	1	2	3	1	3

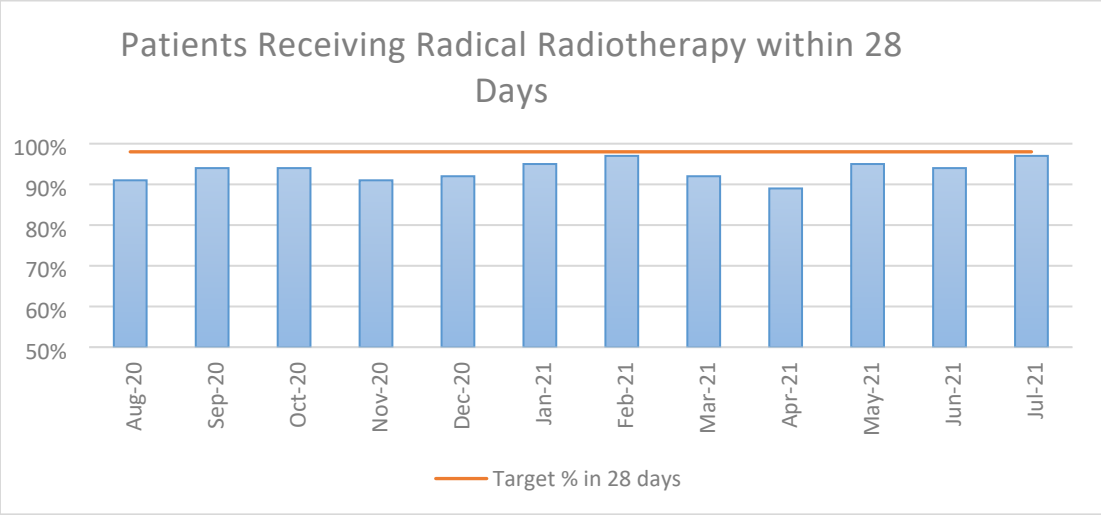
			Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
		Unavoidable	3	0	3	0	2	1	1	1	1	3	1	3
		Avoidable	0	0	1	0	0	0	0	0	1	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	Number of Delayed Transfers of Care (DToCs)	Actual	0	0	1	1	0	0	0	0	0	0	0	0
		Target	0	0	0	0	0	0	0	0	0	0	0	0
	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	77%	75%	100%	75%	100%	100%	100%	100%	100%	100%	100%	80%
		Target	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Healthcare Acquired Infections (page 31)	Actual	0	0	0	0	0	1 (*C.diff*)	0	0	0	0	0	1 (*C.diff*)
		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	72%	68%	78%	85%	Routine Reporting Currently Interrupted							
		Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%
Percentage of Episodes Clinically Coded Within 1 Month Post Episode End Date		Actual	98%	98%	98%	98%	99%	98%	98%	98%	98%	98%	98%	98%

		Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
	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 July 2021 (189) exceeded the monthly average observed in 2020-21 (177) and the number scheduled to begin treatment in July 2020 (140).
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.

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (July 2021)
Radical	223	177	229
	Patients Scheduled to Begin Treatment (July 2019)	Patients Scheduled to Begin Treatment (July 2020)	
	268	140	

189 patients referred for radiotherapy treatment with radical intent were scheduled to begin treatment in July. Of this total, 6 patients did not begin treatment within the 28 day target constituting an overall performance rate of **97%.**

The 6 patients who did not begin treatment within 28 days, commenced their treatment at the following points:

Treatment Intent	≤ 35 days	≤ 40 days
Radical (28-day target)	4	2

Summary of delays:

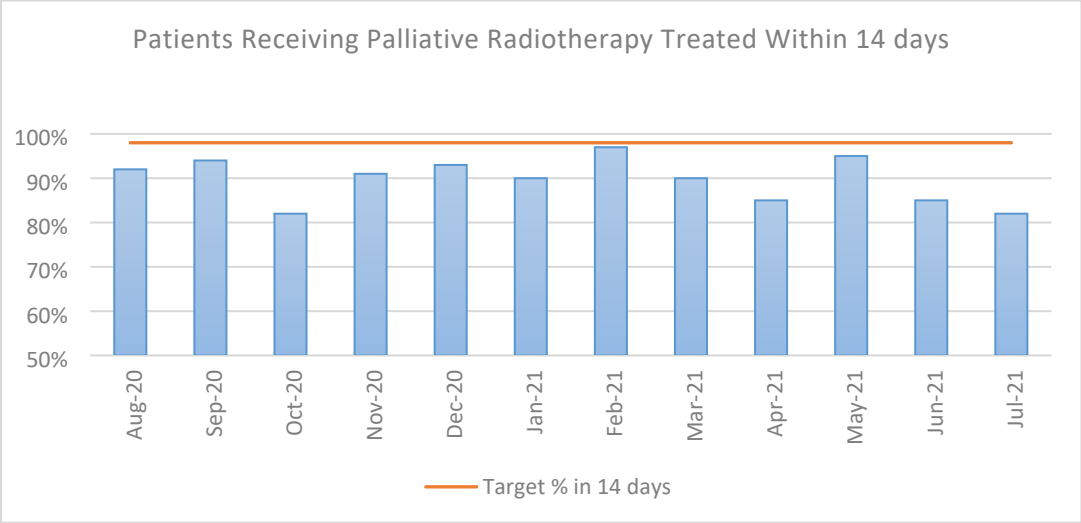
Re-scan required (3), delineation not undertaken in time to plan (1), consultant availability due to unplanned bereavement leave (2).

Action:

- Re-scan and delineation delay reasons to be reviewed with clinical team as they are a regular cause of breaches.
- Cross cover arrangements to be reviewed by SST lead in cases of unplanned absence.

	Wider Actions
	• Radiotherapy short and long-term workforce requirements under review. (Short-term = September 2021, Long-term = 12-18 month programme). • Further demand modelling sessions scheduled during September 2021. Aim is to maximise the service's ability to anticipate and to react to changes in demand for radiotherapy. (September 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 (September-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 (September 2021). • Development of escalation process including clinical prioritisation (September 2021).

Patients Receiving Palliative Radiotherapy Within 14-Days	
Target: 98%	**SLT Lead: Radiotherapy Services Manager**
Trend	Current Performance



The number of patients scheduled to begin palliative radiotherapy treatment in July 2021 (105) was above the monthly average observed in 2020-21 (99), but was fewer than the number scheduled to begin treatment in July 2020 (116).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (July 2021)
Palliative	113	99	105
	Patients Scheduled to Begin Treatment (July 2019)	Patients Scheduled to Begin Treatment (July 2020)	
	118	116	

105 patients referred for radiotherapy treatment with palliative intent were scheduled to begin treatment in July. Of this total, 19 patients did not begin treatment within the 14 day target constituting an overall performance rate of **82%.**
The 19 patients who did not begin treatment within 14 days, commenced their treatment as follows:

Treatment Intent	≤ 20 days	≤ 25 days	≤ 30 days
Palliative (14-day target)	14	3	2

Summary of delays: timeliness of 3D plan (15), change of intent (3), change in plan (1).

Action:

- 3D plan delay reasons to be reviewed with clinical team as they are the major cause of breaches.
- Changes of intent and plans to be reviewed by individual consultant.

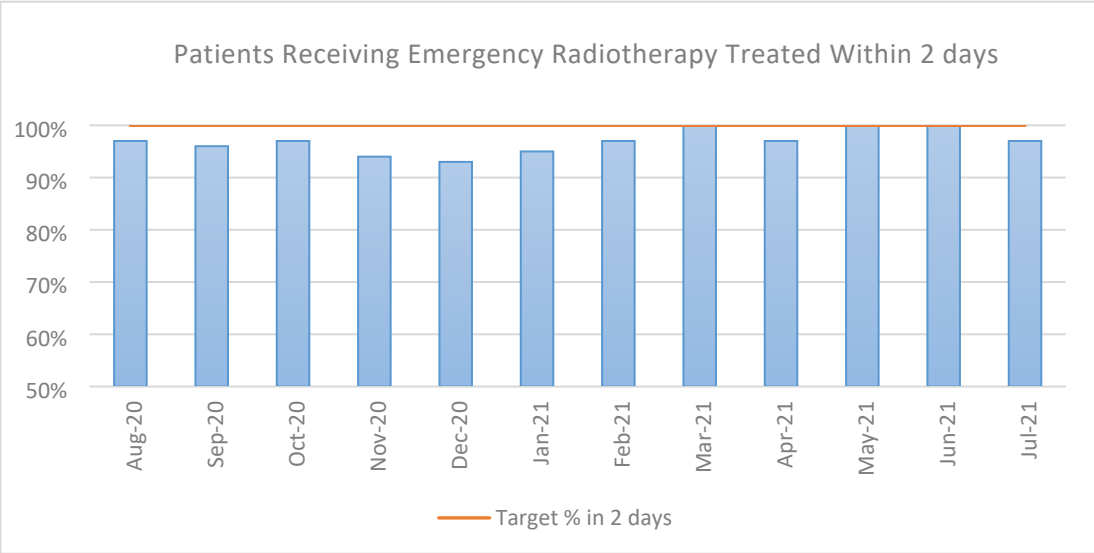
	Wider Actions
	• Radiotherapy short and long-term workforce requirements under review. (Short-term = August 2021, Long-term = 12-18 month programme). • Further demand modelling sessions scheduled during August and September 2021. Aim is to maximise the service's ability to anticipate and to react to changes in demand for radiotherapy. (September 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 (September-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 (September 2021). • Development of escalation process including clinical prioritisation (September 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 July 2021 (32) was higher than the monthly average observed in 2020-21 (29) and was higher than the number scheduled to begin treatment in July 2020 (28).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (July 2021)
Emergency	26	29	32
	Patients Scheduled to Begin Treatment (July 2019)	Patients Scheduled to Begin Treatment (July 2020)	
	15	28	

Current Performance

32 patients referred for emergency radiotherapy treatment were scheduled to begin treatment in July 2021. 31 patients began radiotherapy treatment within 2 days of referral. 1 patient did not begin treatment within the stipulated target. This was due to a change of treatment intent and the patient began treatment within 3 days of the original referral.

Treatment Intent	3 days
Emergency (within 2 days)	1

Radiotherapy – Operational Context

Latest Performance Consolidated

Measure		Target	VCC Jul-21	SBUHB Jun-21	BCUHB Jun-21
Radical (28-day target)		98%	**97%**	**70%**	**92%**
Scheduled (21-day target)	COSC	80%	**35%**	**31%**	**53%**
Palliative (14-day target)		98%	**82%**	**87%**	**91%**
Urgent (7-day target)	COSC	80%	**54%**	**45%**	**41%**
Emergency (within 2-days)		100%	**97%**	**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 and also SBUHB on the 21 day target.

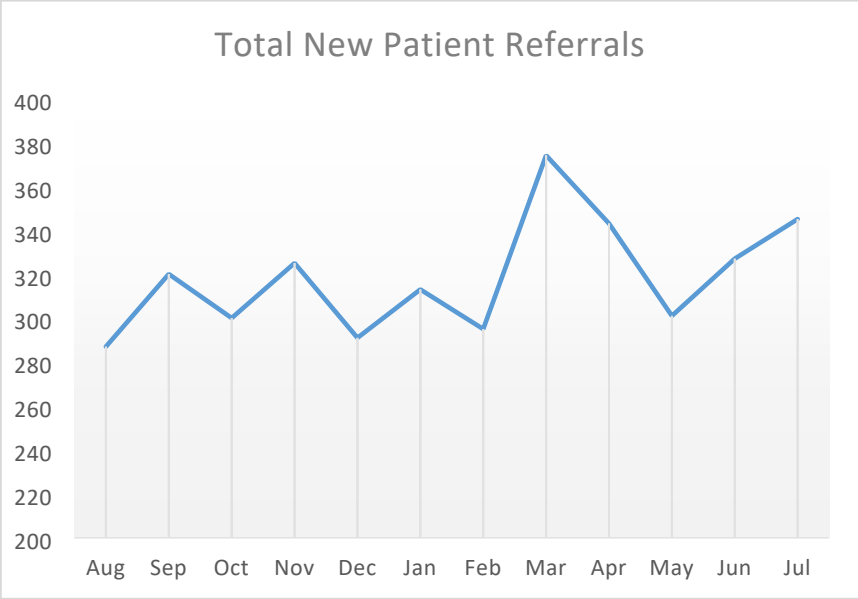
Clinical Oncology Sub-Committee (COSC) Time to Radiotherapy Targets

- 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.
- We will be highlighting the scope of this challenge and the potential financial support required through our IMTP submission for 2022-2025.

The table below describes the allocation of individual patient referrals in terms of the new COSC definitions for July 2021:

Scheduled (21 day target)	Urgent (7 day target)	Emergency (within 1 day)
153	76	27

Referral Trends - Overall



Monthly Average (2019-20)	Monthly Average (2020-21)	Total New Patient Referrals (July 2021)
357	315	345

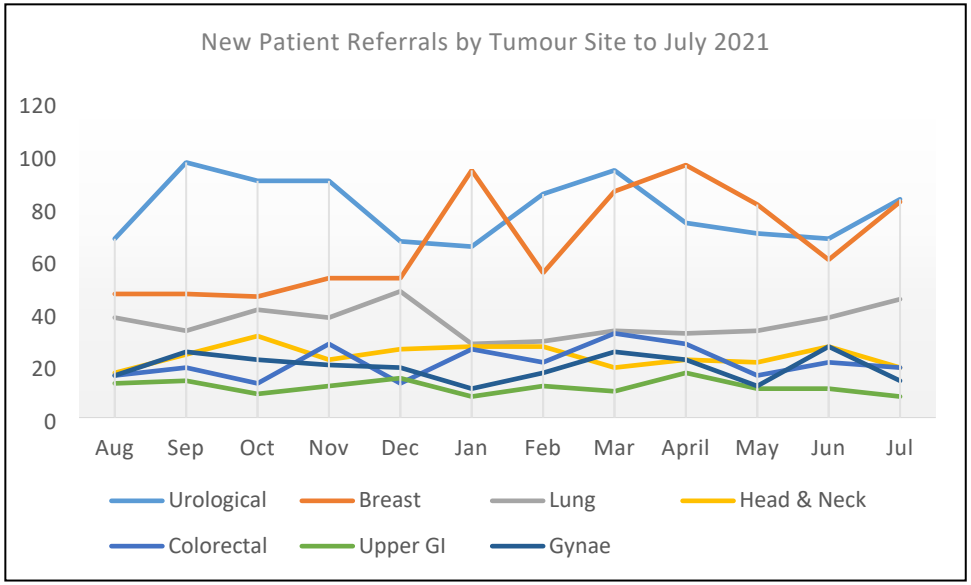
The total number of referrals received in July 2021 was higher than the average number received in any given month in 2020/21 (315). Both figures are lower than the average number received per month in 2019-20 (357). This is reflective of the suppressed demand observed since the advent of the COVID-19 pandemic.

The 345 referrals received in July 2021 represents an increase relative to the 323 received in the previous month. The 374 referrals received in March 2021 represents the largest number received in any given month since March 2020 (386) observed immediately prior to the imposition of the first nation–wide lockdown.

The next greatest number of referrals were received in July 2020 (361). This was driven by an elevated number of referrals for the treatment of prostate cancers. A significant number of these patients had previously had radiotherapy treatment deferred (subject to risk assessment and ongoing clinical management) during the earliest stages of the pandemic.

Radiotherapy – Operational Context

Referral Trends - Tumour Site

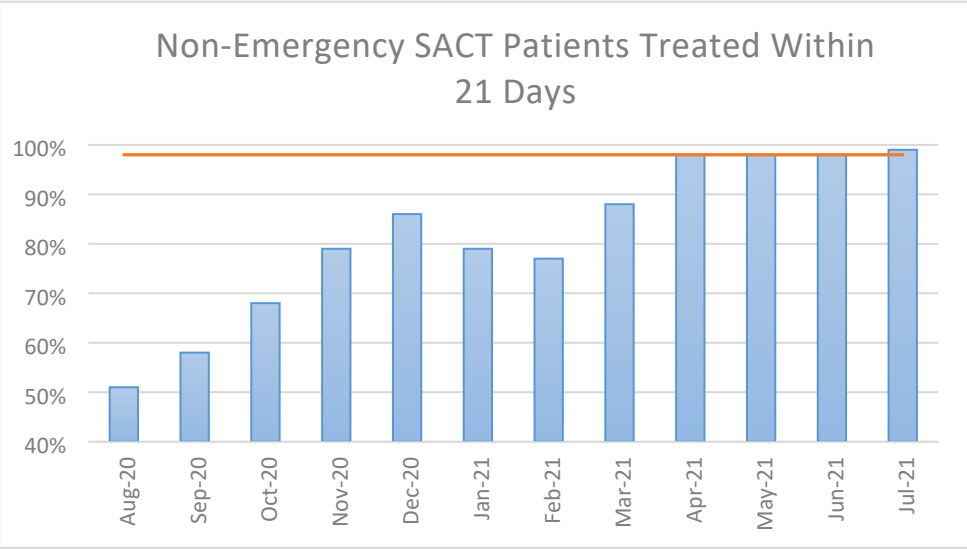


Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (July 2021)
Breast	**88**	**60**	**-32%**	82
Urology	**82**	**82**	**0%**	83
Lung	**47**	**38**	**-19%**	45
Colorectal	**20**	**22**	**+10%**	19
Head and Neck	**23**	**23**	**0%**	19
Gynaecological	**18**	**18**	**0%**	14
Upper Gastrointestinal	**16**	**13**	**- 19%**	8
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**82%**	**81%**		78%

The graph and table show referrals for 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	Trend



The number of patients scheduled to begin non-emergency SACT treatment in July 2021 (383) was above the monthly average observed in 2020-21 (298) and exceeded the number scheduled to begin treatment in July 2020 (279).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (July 2021)
Non - emergency	328	298	383
	Patients Scheduled to Begin Treatment (July 2019)	Patients Scheduled to Begin Treatment (July 2020)	
		279	

383 patients were referred for non-emergency SACT treatment were scheduled to begin treatment in July. Of this total, 1 patient did not begin treatment within the 21 day target, due to capacity challenges, constituting an overall performance rate of 99%. This represents the best performance in this area for 12 months.

The 1 patient who did not begin treatment within 21 days, commenced their treatment as follows:

Treatment Intent	22 - 28 days
Non-emergency (21-day target)	1 (treated on day 22)

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.

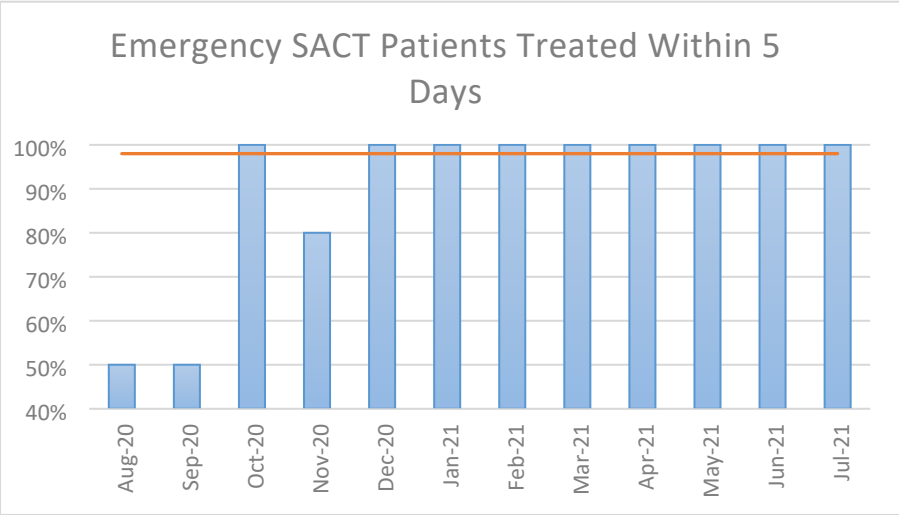
Delivery of plan focused on reopening Neville Hall SACT delivery capacity (Delayed from May 2021. Anticipated delivery in November 2021 due to facility and logistical issues at Neville Hall).

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 July 2021 (10) was above the monthly average observed in 2020-21 (4).

Intent	Monthly Average (2019-20)	Monthly Average (2020-21)	Patients Scheduled to Begin Treatment (July 2021)
Emergency	4	4	10
	Patients Scheduled to Begin Treatment (July 2019)	Patients Scheduled to Begin Treatment (July 2020)	
		9	

Trend

10 patients referred for emergency SACT treatment were scheduled to begin treatment in July 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

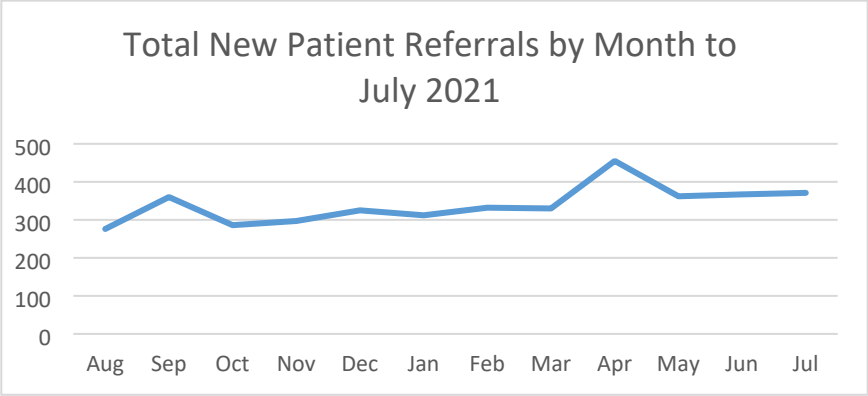
Current Performance Consolidated

Measure	Target	July-21
Non-emergency (21-day target)	98%	**99%**
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 (July 2021)
325	301	371

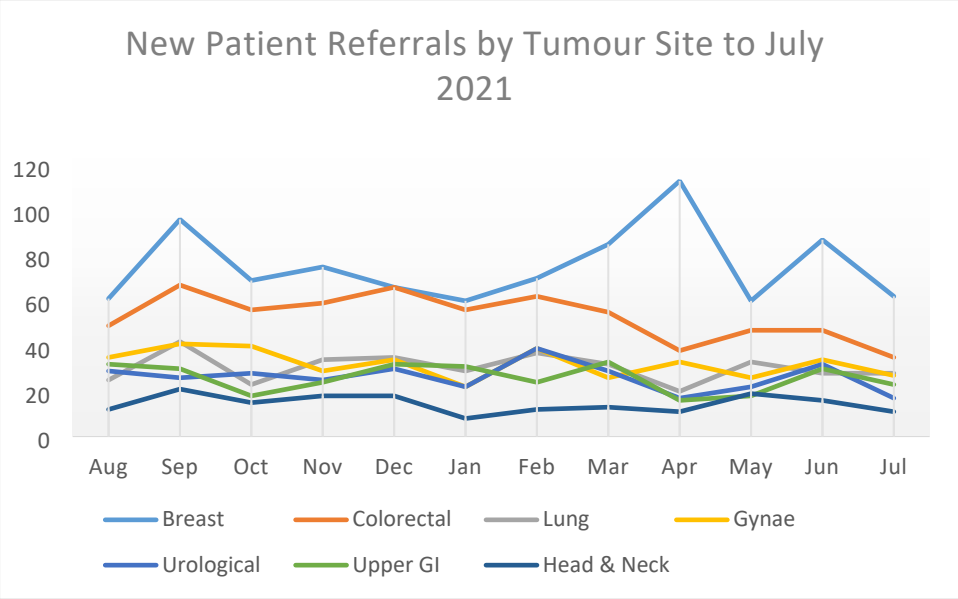
The total number of referrals received in July 2021 (371) was above the average number received in any given month during 2020-21 (301). The number of referrals received in July also exceeds the average number received per month in 2019-20.

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

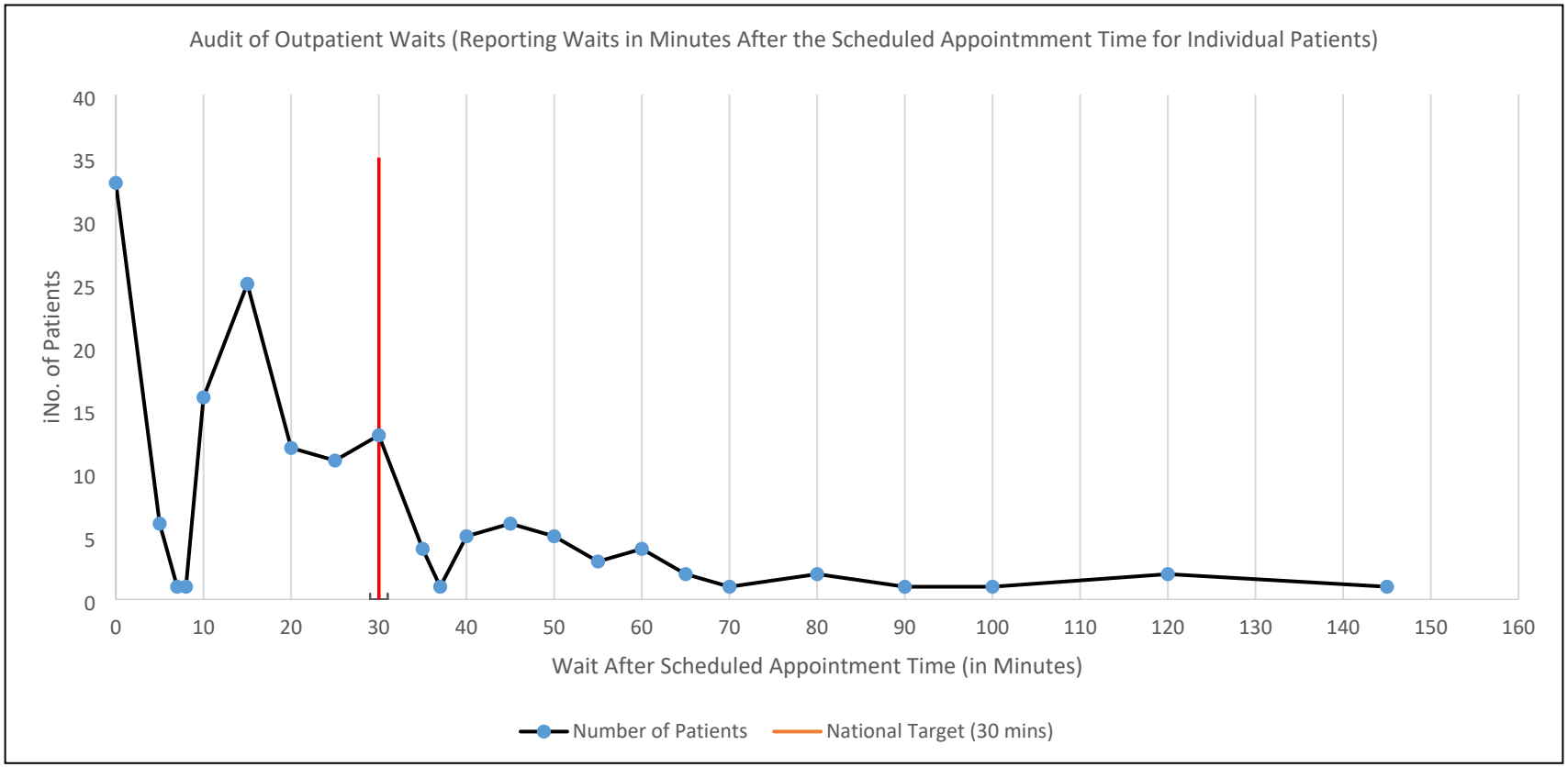
Referral Trends - Tumour Site



Site	Monthly Average (2019-20)	Monthly Average (2020-21)	2020-21 Average Relative to 2019-20 Average	New Patient Referrals (July 2021)
Breast	**92**	**76**	**-17%**	62
Colorectal	**54**	**55**	**+2%**	35
Lung	**33**	**32**	**-3%**	28
Gynaecological	**31**	**31**	**0**	27
Urological	**36**	**26**	**-28%**	17
Upper Gastrointestinal	**18**	**26**	**+44%**	23
Head and Neck	**16**	**14**	**-12%**	11
Top 7 Tumour Sites by Number of Referrals as Percentage of Total Referrals	**86%**	**87%**		55%

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
157	33 (21%)	15 minutes	24 minutes	119 (76%)	145 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

A dedicated Phlebotomy Clinic has been set up on the Patient Administration System (CaNISC) to efficiently manage patient throughput aligned with clinic appointments. At the time of arrival in to the Outpatient Department, the patient is recorded as 'arrived' for all booked appointments scheduled, ie/eg phlebotomy and clinic appointment. The phlebotomy appointment is scheduled a minimum of 30 minutes prior to the clinic appointment to ensure results are available in readiness for the clinical consultation, this will inevitably increase the perceived wait recorded. The 'departure' time is entered when the patient returns to the Outpatient reception prior to leaving the department.

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. The ratio of face-to-face to virtual appointments remains at approximately 50:50. Longest patient wait (145 minutes) was a complex patient pathway requiring appointment time with Clinical Nurse Specialist, non-medical prescriber and Consultant.	• Plan to repatriate the element of phlebotomy activity to local health boards (September 2021). • Continue discussions with Health Boards and plans to repatriate Outpatient Department clinics (September 2021). • Capital funding to be used to scope departmental needs and design requirements was approved by Executive Management Board in July 2021. Consultant to be commissioned to undertake work and to develop options (September 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

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Dietetics	100%	95%	98%	96%	97%	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

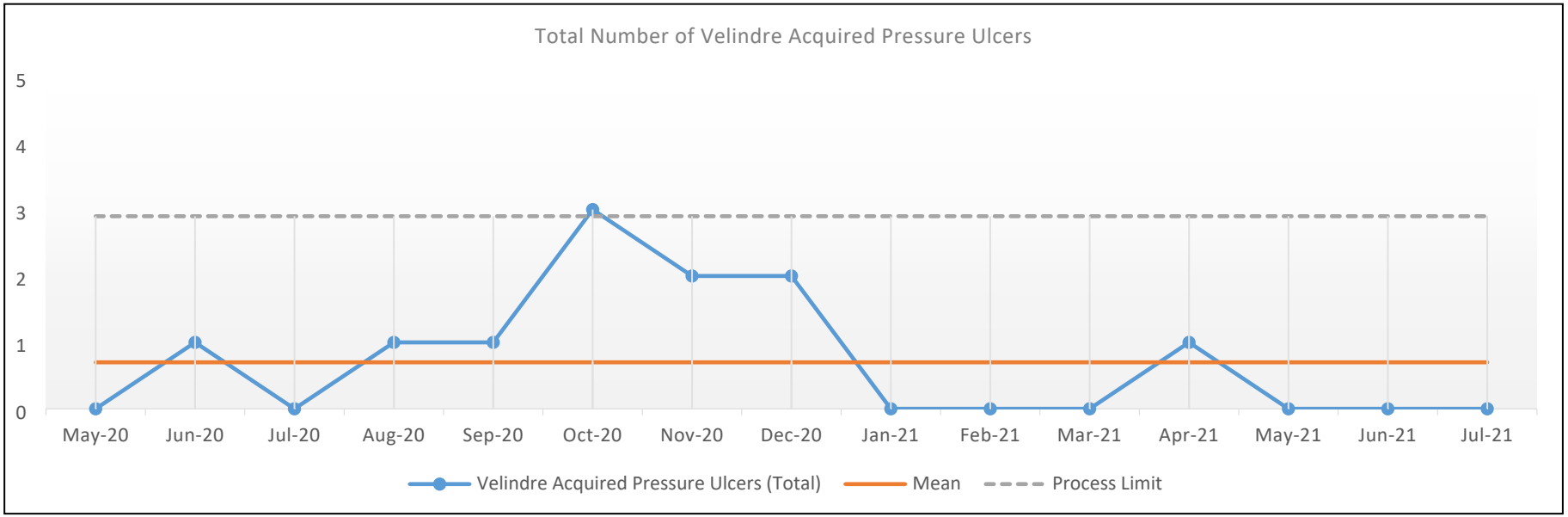
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Dietetics	100%	95%	98%	96%	97%	100%	100%	100%	100%	100%	84%	94%
Physiotherapy	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks

	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Dietetics	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Physiotherapy	88%	67%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%
OT	100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%
SLT	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%	100%

Trend	Action
3 dietetic patients were not seen within the 2 week urgent outpatient referral target. This was due to staff sickness. All patients were seen within the third week. No patient experienced any reported harm as a result of the delay. 1 patient requiring speech and language support was not seen within the 6 week routine outpatient target. This was due to an administrative error.	• A band 7 dietitian is to be recruited to provide cover more a member of staff currently on maternity leave. This will ensure greater capacity (position to be advertised in August 2021). • The patient was contacted as soon as the error became apparent. The patient had had regular contact with the wider Multi-Disciplinary Team throughout the period and is being monitored during radiotherapy treatment as per standard protocols (August 2021). The working practices and processes have been reviewed to ensure that the likelihood of future administrative errors are reduced.

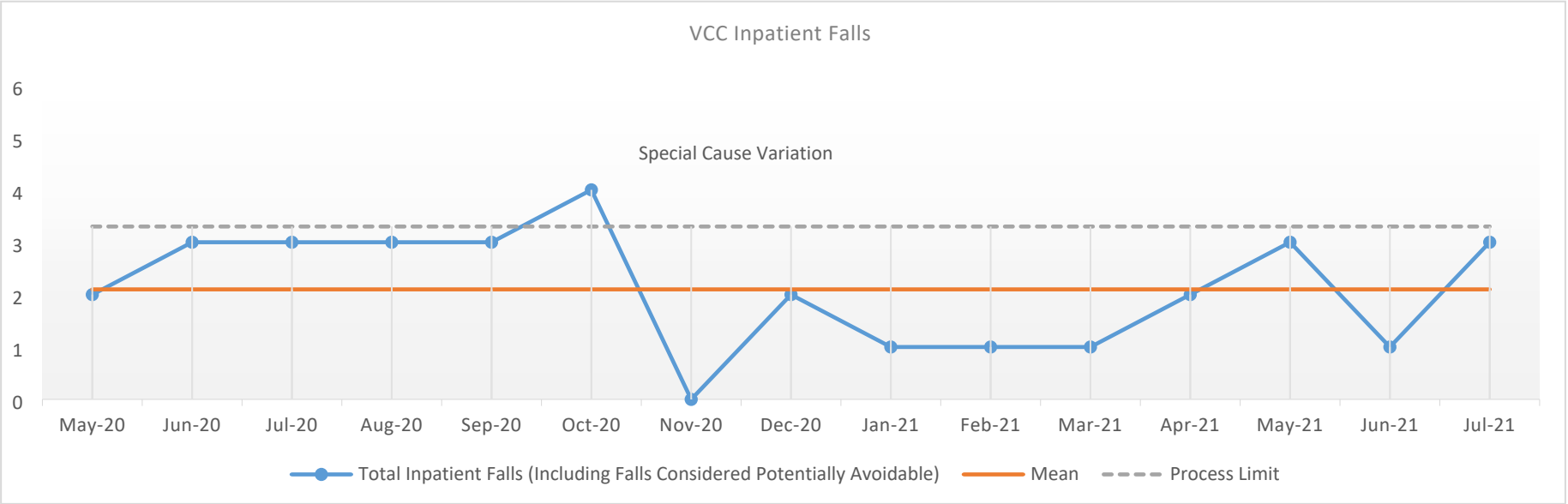
Velindre Acquired Pressure Ulcers	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	May-20	Jun-20	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
Velindre Acquired Pressure Ulcers (Total)	0	1	0	1	1	3	2	2	0	0	0	1	0	0	0
Potentially Avoidable Velindre Acquired Pressure Ulcers	0	1	0	0	0	0	0	1	0	0	0	1	0	0	0

Trend	Action
There were no Velindre acquired pressure ulcers reported in July 2021. No Velindre acquired ulcers were reported to Welsh Government as a Serious Incident (SI).	• We continue to implement best practice in pressure ulcer management to eliminate as far as possible the potential for pressure ulcers to occur.

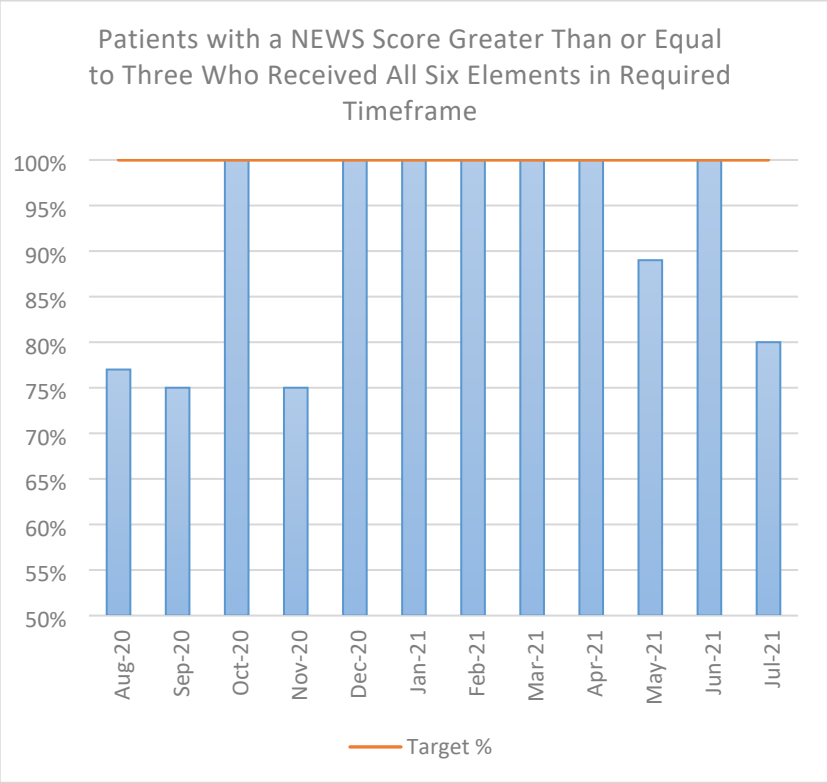
Velindre Inpatient Falls	
Target: 0	**SLT Lead: Head of Nursing**
Current Performance	



	May-20	Jun-20	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
Total Inpatient Falls	2	3	3	3	3	4	0	2	1	1	1	2	3	1	3
Potentially Avoidable Inpatient Falls	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0

Trend	Action
During July 2021 there were 3 falls reported on first floor ward, affecting 3 patients: Each was deemed unavoidable following investigation. In two instances, patients had attempted to mobilise unaided contrary to their care plans which were put in place following falls risk assessments on admission. In the third case, on discovery, the patient could not recall the fall. All appropriate measures had been put in place and a nurse call bell was at hand. A patient handling assessment had determined that the patient was mobile, but only with assistance and the use of a frame. In each instance, a full investigation was undertaken by the VCC Falls Scrutiny Panel. Following review, each fall was deemed unavoidable as it was identified that patients had attempted to mobilise unaided contrary to care plans put in place on admission.	For each patient: • A falls risk assessment was completed on admission, an appropriate care plan developed and put in place. • Post fall, each patient was reviewed by a doctor. • Post fall, each patient was subject to periodic neurological observations the results of which were recorded. The post fall medical review identified that one patient had a small laceration on the head. This patient underwent a CT scan which identified no further injury. No injury or harm was sustained by the other two patients.

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



Five patients met the criteria for sepsis treatment in July 2021. Of these, four patients received all elements of the sepsis bundle within one hour.

The fifth patient received all elements of the bundle within two hours and experienced no harm. The delay was due to the fact that the attending Doctor was required to attend a medical emergency as part of a resuscitation team.

Actions
• In order to avoid a similar future event, the Assessment Unit is examining the possibility of allowing Non-Medical Prescribers to administer the first dose of antibiotics to patients who meet the criteria without the requirement to wait for an individual prescription using a Patient Group Direction (August 2021).

Healthcare Acquired Infections (HAIs)	
Target: 0	**SLT Lead: Clinical Director**

Current Performance

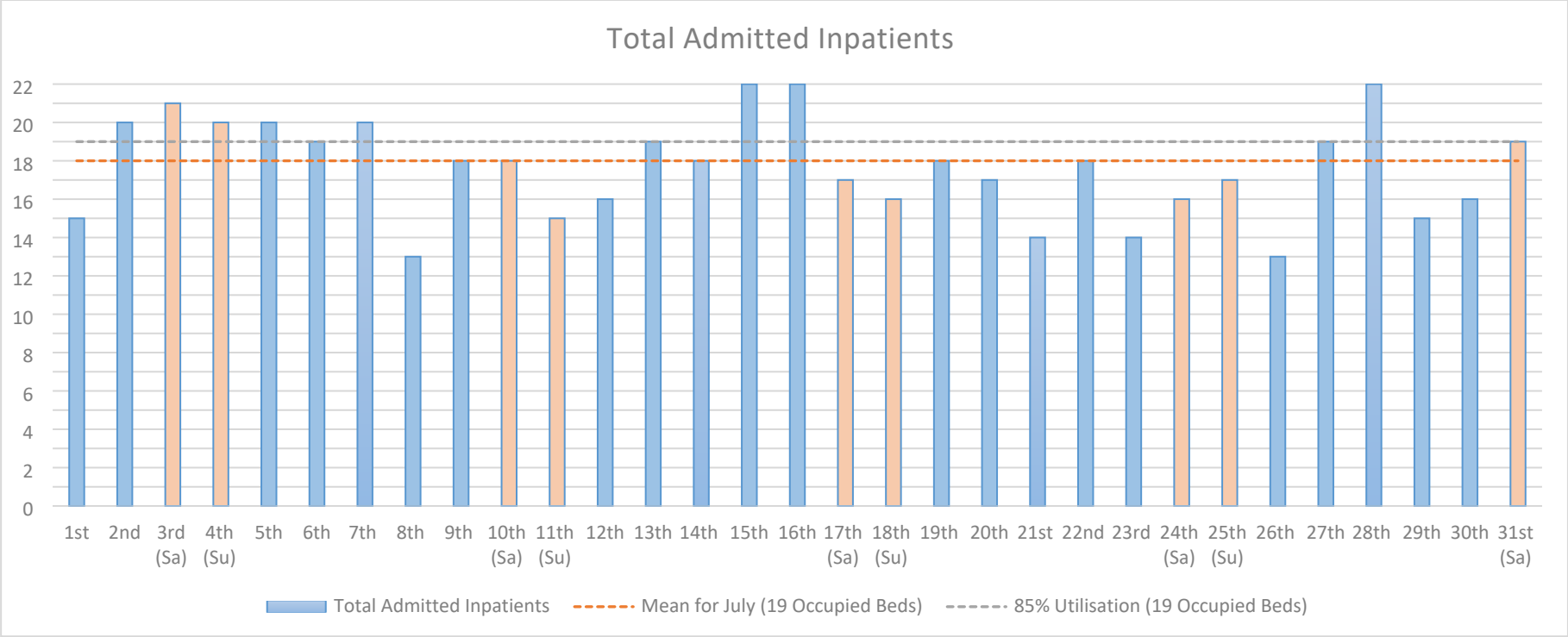
	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
C.diff	0	0	0	0	0	1	0	0	0	0	0	1
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0
E.coli	0	0	0	0	0	0	0	0	0	0	0	0
Klebsiella	0	0	0	0	0	0	0	0	0	0	0	0
Pseudomonas Aeruginosa	0	0	0	0	0	0	0	0	0	0	0	0

Trend	Action
One instance of a *C.diff* infection was reported in July 2021.	• A full root cause analysis has been undertaken. A full multi-disciplinary team panel, involving the consultant microbiologist, will consider the report and identify learning during early September 2021.

Inpatients – Operational Context

Bed Occupancy

VCC currently operates a total of 22 inpatient beds (including 2 isolation cubicles). An occupation rate of 85% would require 19 of the 22 beds to be occupied.



** Bed utilisation rate calculated assuming use of all 22 inpatient beds.

Mean Daily No. of Admitted Patients (Jul-21)	Av. Daily Bed Utilisation Rate (Jul-21)	Minimum No. of Patients Admitted (Jul-21)	Minimum Daily Bed Utilisation Rate (Jul-21)	Maximum No. of Patients Admitted (Jul-21)	Maximum Daily Bed Utilisation Rate (Jul-21)
18	82%	13	59%	22	100% (3 instances)
Mean Daily No. of Admitted Patients (Jun-21)	Av. Daily Bed Utilisation Rate (Jun-21)	Minimum No. of Patients Admitted (Jun-21)	Minimum Daily Bed Utilisation Rate (Jun-21)	Maximum No. of Patients Admitted (Jun-21)	Maximum Daily Bed Utilisation Rate (Jun-21)
19	86%	14	64%	22	100% (3 instances)

TRUST BOARD

FINANCE REPORT FOR THE PERIOD ENDED 31ST JULY 2021 (M4)

DATE OF MEETING	30/09/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Matthew Bunce – Deputy Director of Finance
PRESENTED BY	Matthew Bunce – Deputy Director of Finance
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance & Informatics

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board Quality, Safety & Performance Committee	6/9/21 14/9/21	Noted 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 July 2021.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

KPI Target	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	3	6	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	267	1,271	9,156
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.2%	94.8%	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 July is an underspend of **£6k**, 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 expecting to receive 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. 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.

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs are fully reimbursed by WG, all planned additional income is received and the savings targets achieved.

2.3 PSPP Performance

PSSP performance for the whole Trust is currently 95.82% against a target of 95%, however the performance against the Core Trust excluding NWSSP is falling just short of the target at 94.8%. There is currently a backlog of invoices which have not been processed for payment within the 30 day target due to the OCR scanner in accounts payable being broken which is affecting performance. The Finance team are currently working with NWSSP colleagues to gain an understanding of the impact, with a view to urgently rectify the issue and improve performance to meet the target.

2.4 Covid Expenditure

Covid-19 Revenue Spend/ Funding		
	YTD Actual £000	Plan 2021/22 £000
Mass Covid Vaccination	151	365
Cleaning Standards	261	581
PPE	91	339
Covid Recovery	237	3,479
Other Covid Related Spend Cost Reduction	347	1,231
BFWD Savings Loss	289	700
Total Covid Spend /Funding Requirement 2021/22	**1,376**	**6,695**
Funding Received		3,419
Funding Confirmed		1,266

Balance of Funding Requirement		**2,010**

The overall gross funding requirement related to Covid is £6,695k which includes £5,695k of directly associated expenditure, and £700k in relation to the non-achievement of savings carried forward from 2020/21.

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 £635k.

In addition to the recurrent and emergency reserve, the Executive team have agreed to make available £1.545m of non-recurrent funding for investment during 2021/22 from the release of accountancy gains.

2.6 Financial Risks

The Trust is in dialogue with WG about the balance of the Covid funding requirement to match the anticipated spend and anticipates receiving clarification of the remaining £2,010k during September.

At this stage the Trust is currently planning to fully achieve the savings target during 2021-22. £200k of the target remains amber as it relates to post Covid savings such as reduction of travel expenses and office printing & stationary costs from the potential new working arrangements. The expectation is that this should turn green as the year progresses, once the operating model of future working arrangements is agreed.

There is a revenue forecast overspend of £56k in the TCS Programme which relates to a £21.5k pay overspend on the service change team project (net of programme management pay underspend) and £34.5k overspend on non-pay in nVCC project (£26k) and PMO (£8.5k).

It has been agreed to provide non recurrent funding support for the non pay revenue costs of the nVCC project (as this was previously provided by WG). However there remains a financial risk to the outturn position for the remainder of the Programme as options for mitigating the cost pressures have not been found to date, however the TCS Finance Team continue to explore ways to address the shortfall.

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.

Other Major Schemes in development that will be considered during 2021/22 in conjunction with WG include, Integrated Radiotherapy Solution (IRS), WBS HQ, VCC Ventilation & Infrastructure/ Outpatients.

b) Discretionary Programme

The Trust Discretionary Programme was approved at EMB on the 2nd August.

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 July 2021 is an underspend of £6k with a year-end forecast break-even position in accordance with the approved IMTP

4. RECOMMENDATION

4.1 The Board is asked to **NOTE** 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.

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 JULY 2021/22

TRUST BOARD
MEETING
30/09/2021

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.

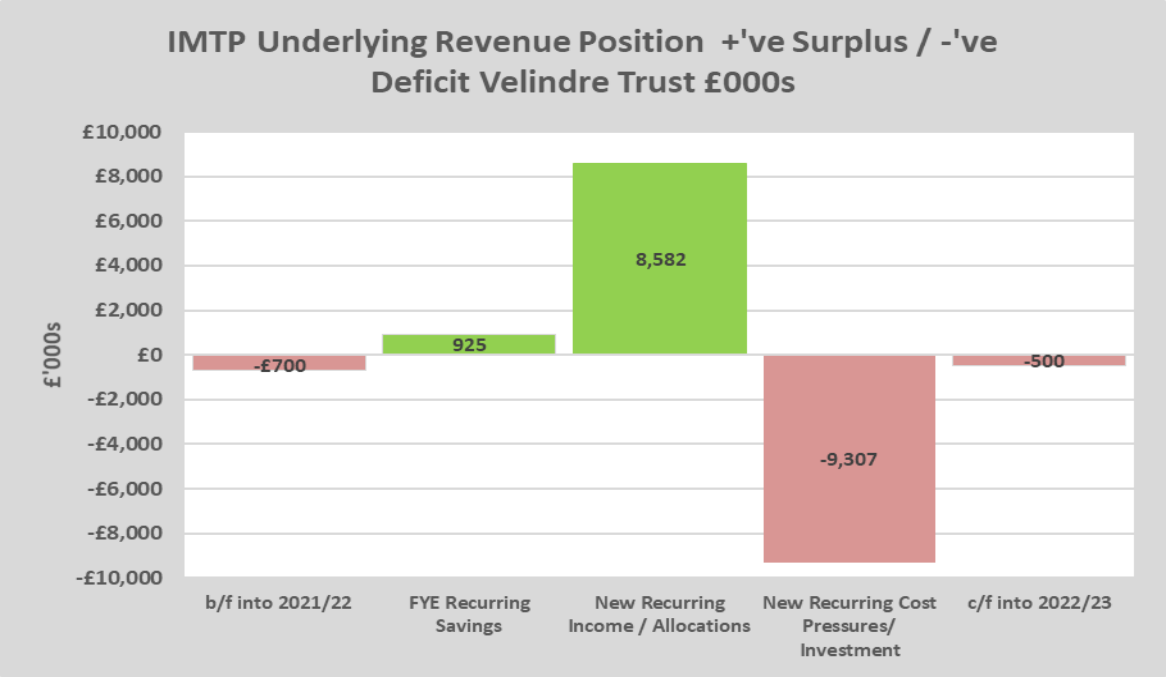
2. Background / Context

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 in a position 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.
- **In order 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

KPI Target	Unit	Current Month £000	Year to date £000	Year End Forecast £000
Revenue (To ensure net operating costs do not exceed income)	Variance	3	6	0
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	267	1,271	9,156
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	93.2%	94.8%	95.0%

Performance against Planned Savings Target

Efficiency Savings	Variance	0	0	0

Revenue

The Trust has reported a **£3k** in-month underspend position for July'21, with a cumulative position of **£6k** underspent, and an outturn forecast of **Breakeven**.

Capital

The approved Capital Expenditure Limit (CEL) as at July 2021 is **£9,156k** for 2021-22. This represents all Wales Capital funding of **£7,245k**, Discretionary funding of **£1,911k.**

PSPP (Excluding Hosted Organisations)

During July '21 the Trust (core) achieved a compliance level of **93.21%** (June'21: 93.5%) of Non-NHS supplier invoices paid within the 30 day target, which gives a cumulative compliance figure of **94.8%** to the end of July compared to the target of 95%. There is currently a backlog of invoices which have not been processed for payment within the 30 day target due to the OCR scanner in accounts payable being broken which is affecting performance. The Trust is urgently working with NWSSP colleagues to resolve the issue.

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. .

4. Revenue Position

Cumulative			
£5,681 Underspent			
Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)
Income	(52,385)	(52,062)	(323)
Pay	23,104	22,775	329
Non Pay	29,281	29,281	0
Total	0	(6)	6

Forecast		
Breakeven		
Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
(159,759)	(159,523)	(236)
70,529	70,187	342
89,230	89,336	(106)
0	0	0

The overall position against the profiled revenue budget to the end of July is an underspend of **£6k**, with an underachievement against income offset by an underspend within Pay. This is further analysed in the tables below:

The Trust is reporting a year end forecast breakeven position; however, this assumes that all additional Covid-19 costs are fully reimbursed by WG, all planned additional income is received, and the savings targets is achieved.

4.1 Income Analysis

	Cumulative			Year End Forecast		
	£(323)k Underachievement			£(236)k underachievement		
Income Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Core Income - HB / WHSSC	23,427	23,427	0	72,253	72,253	0
NICE/ High Cost Drugs	14,994	14,994	0	45,584	45,584	0
WBS Wholesale Blood Products	5,155	5,157	2	13,167	13,175	8
WBS WTAIL	1,101	878	(223)	3,258	2,787	(471)
WBS Blood Components	145	35	(110)	435	395	(40)
Home Care Drugs	214	363	149	661	973	312
Private Patient	591	620	29	1,831	1,861	30
VCC Over Activity	511	511	0	1,534	1,534	0
Radiation Protection	229	249	20	819	868	49
Staff Recharges	793	666	(127)	2,166	2,106	(60)
One Wales Palliative and EOL Care	365	365	0	1,094	1,094	0

	Cumulative			Year End Forecast		
	£(323)k Underachievement			£(236)k underachievement		
Income Type	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Velindre Charity	797	761	(36)	2,467	2,421	(46)
Other Charity	324	299	(25)	949	901	(48)
RD&I*	956	946	(10)	3,104	3,132	28
HTW	548	548	0	1,645	1,645	0
Other Operating Income	775	783	8	2,097	2,099	2
COVID Income	1,460	1,460	0	6,695	6,695	0
Total	**52,385**	**52,062**	(323)	**159,759**	**159,523**	(236)

*RD&I full year budget includes £1,341k of Velindre Charity income.

The Trust has reported a cumulative year to date underachievement of **£(323)k** on Income, and is currently forecasting an outturn underachievement position of circa **£(236)k.**

- Welsh Transplantation and Immunogenetics Laboratory (WTAIL), and WBS Blood Components is underachieving due to reduced activity as a result of Covid. The combined forecast deficit of circa £(511)k is expected to be fully replenished via WG Covid funding.
- Home Care Drugs overachievement is due to the increased volume of homecare service Oral drugs provided in relation to SACT, which is above the baseline budget and is now expected to provide a significant surplus during the year.
- Private Patient's continues to overachieve and relates to higher than planned drug recharges to Insurance companies.
- Staff recharges and Velindre & Other Charity income are expected to underachieve due to vacancies not being recharged to the Charity and other organisations to recover the costs, which will be offset by an underspend in pay.
- At this stage the Trust is expecting to receive £6,695k of income from WG in relation to Covid. £3,419k received to date, which has been deferred in the year to date position to match Covid spend later in the year.

4.2 Pay Analysis by Staff Group

	Cumulative			Year End Forecast		
	£330k Underspend			£342k Underspend		
PAY GROUP	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
ADD PROF SCIENTIFIC AND TECHNICAL	849	802	47	2,502	2,359	143
ADDITIONAL CLINICAL SERVICES	2,369	2,164	205	6,638	6,525	113
ADMINISTRATIVE & CLERICAL	7,271	7,017	254	21,191	20,605	586

	Cumulative			Year End Forecast		
	£330k Underspend			£342k Underspend		
PAY GROUP	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
ALLIED HEALTH PROFESSIONALS	1,931	2,015	(84)	5,947	6,021	(74)
ESTATES AND ANCILLIARY	893	850	43	2,098	2,109	(11)
HEALTHCARE SCIENTISTS	2,833	2,645	188	8,313	7,915	398
MEDICAL AND DENTAL	4,030	4,173	(143)	11,903	12,163	(260)
NURSING	3,442	3,084	358	9,923	9,466	457
STUDENTS	(150)	0	(150)	65	73	(8)
SAVINGS & VACANCY FACTOR TARGET	(364)	24	(388)	(1,954)	(952)	(1,002)
COVID (Forecast Pay Spend)	0	0	0	3,903	3,903	0
Total	**23,104**	**22,774**	330	**70,529**	**70,187**	342

The Trust has reported a cumulative year to date underspend of **£330k** on Pay and is forecasting a year end outturn underspend of circa **£342k.**

Included within the staff group expenditure values within the above table is total agency spend for July of £42k (June £121k), giving a cumulative year to date spend of **£516k** and a forecast outturn spend of circa **£1,223k.** Of these totals the year to date spend on agency directly relating to Covid is £226k and forecast spend is circa £629k.

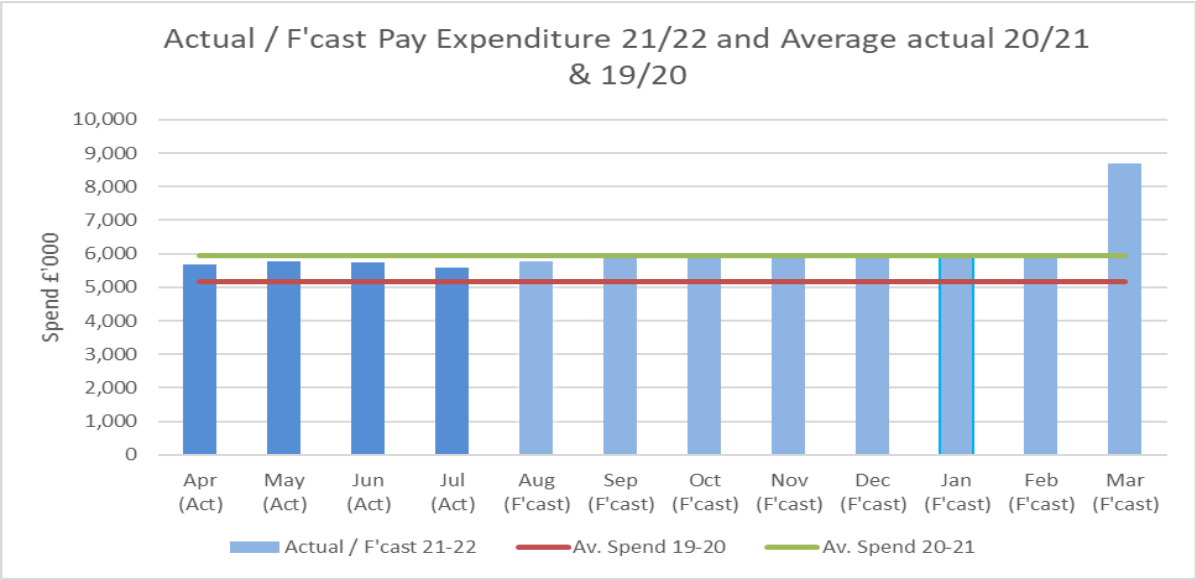
- Allied Health Professionals are experiencing an overspend of £(84)k which is due to the use of agency in both Radiotherapy and Medical Physics. VCC is aiming to recruit on a permanent basis against some of these posts, which is expected to create a saving going forward from the premium cost for agency.
- Medical & Dental costs have increased due to rotation of junior doctors and an increase in consultant sessions for short term resilience.
- Each Division of the Trust will hold a savings and vacancy factor target which will be delivered in year via establishment control. The forecast variance will be achieved through various underspends across numerous staff group, as illustrated in the table above.
- The year to date spend on Covid related Pay costs is £928k and is spread across the various staff groups. The remaining pay costs for the period up until the end of March is £2,975k giving a total expected pay spend on Covid of circa £3,903k.

Pay Spend Trends (Run Rate)

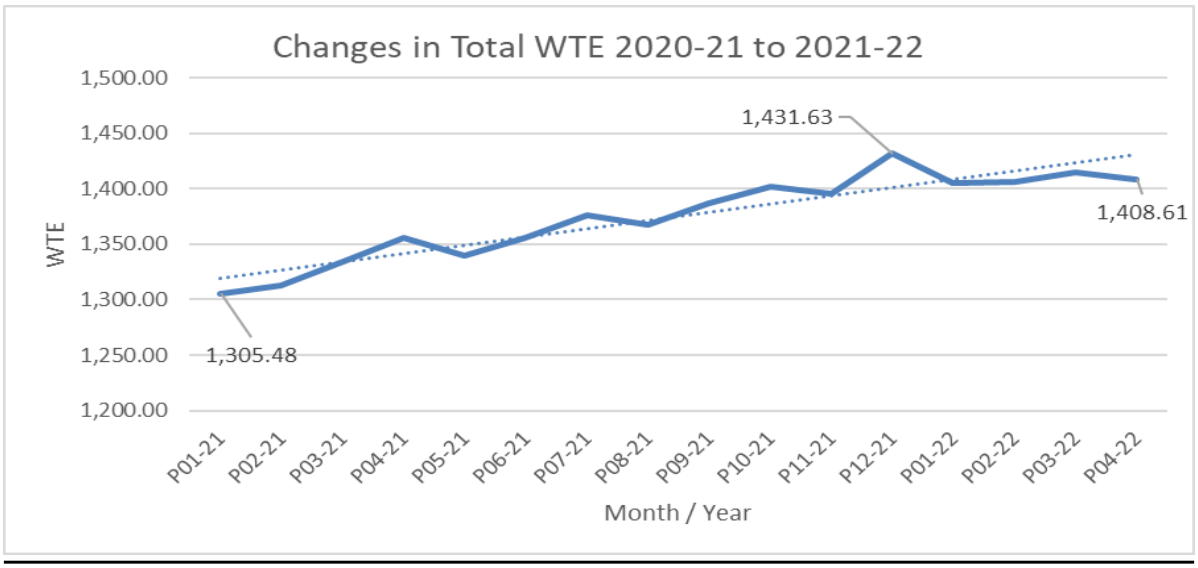
The pay spend for 2020/21 was 14.82% above av. pay in 2019-20. 3% can be accounted for by the pay award, 1.14% can be accounted for by an increase in use of agency, 2.3% relates to the NHS Bonus Payment with the remaining being the additional staff recruited over the course of 2020/21 (c. 126 wte), and the expected pay costs associated with Covid.

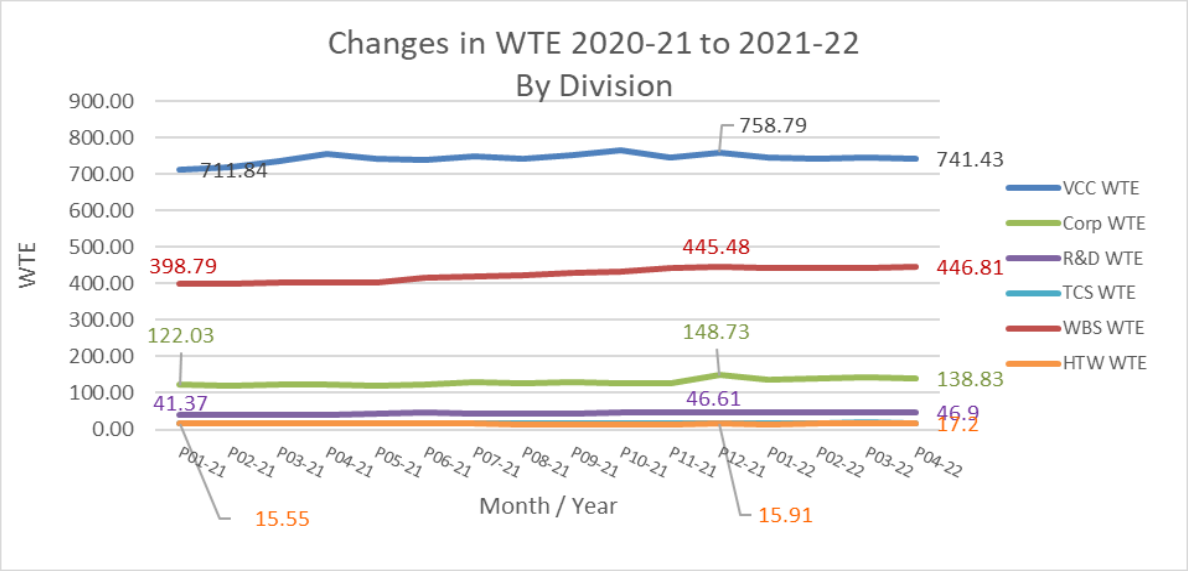
The pay award for 2021/22 has been confirmed at 3% following an announcement from WG. The expectation is that staff will receive the pay award during September and backpay arrears from April 2021 will be received in October. The pay award is not currently included within the figures, with the divisions currently working up the impact of the decision. Excluding the Pay award spend

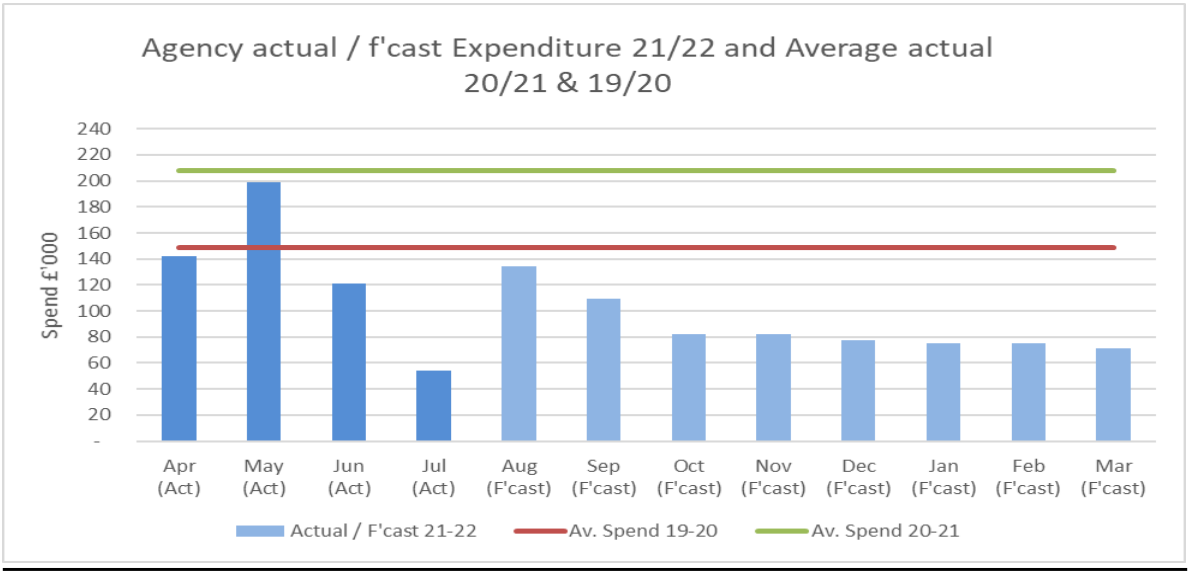
is still expected to increase with the recruitment of additional posts to meet 'surge' capacity in both VCC and WBS in response to Covid recovery, whilst agency costs are expected to reduce over the course of the year as posts are recruited into permanently.



*March costs included the increase in NHS pension (6.3%), which is paid every year in month 12 and funded by WG.







*The increase in May costs has been reviewed and corrected in July following a full review of agency invoices received against orders raised in VCC.

4.3 Non Pay Analysis

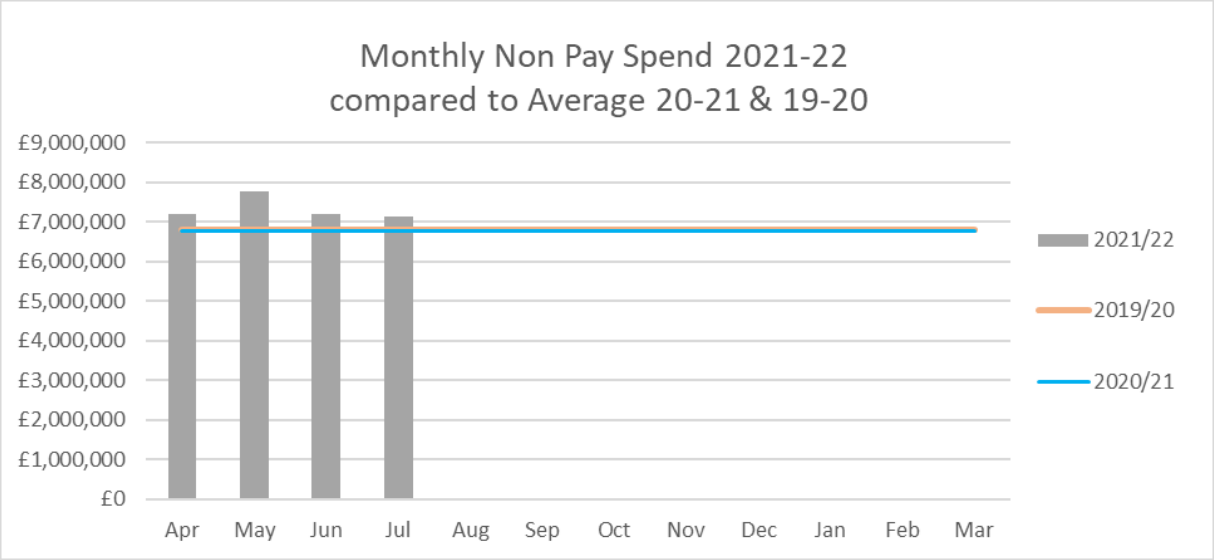
	Cumulative £1k Overspend			Year End Forecast £106k Overspend		
NON PAY CATEGORY	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
NICE & High Cost Drugs	14,792	14,792	0	45,584	45,584	0
Blood Wholesaling	5,179	5,215	(36)	13,241	13,277	(36)
Depreciation	2,139	2,139	0	6,416	6,416	0
Clinical Services & Supplies	1,734	1,744	(10)	5,260	5,161	99
Facilities Management	347	357	(10)	865	999	(134)

	Cumulative			Year End Forecast		
	£1k Overspend			£106k Overspend		
NON PAY CATEGORY	YTD Budget (£'000)	YTD Actual (£'000)	YTD Variance (£'000)	Full Year Budget (£'000)	Full Year Forecast (£'000)	Forecast Variance (£'000)
Maintenance & Repairs	988	984	4	2,963	3,105	(142)
General Drugs	924	810	114	2,008	1,853	155
Utilities/ Rent /Rates	776	776	0	2,283	2,320	(37)
General Services & Supplies	506	565	(59)	1,388	1,383	5
Blood Components	760	662	98	2,140	1,890	250
Transport	342	317	25	1,062	1,014	48
Printing / Stationary / Postage	265	162	103	775	519	256
Computer Maintenance & Supplies	336	310	26	957	937	20
Travel & Subsistence	172	134	38	587	539	48
Equipment & Consumables	89	99	(10)	239	253	(14)
Education & Development	108	96	12	311	293	18
NHS SLA	(131)	(127)	(4)	(177)	(221)	44
Audit Fees	127	126	1	306	303	3
Telecoms	154	129	25	306	304	2
One Wales End of Life Care	(16)	(16)	0	(47)	(47)	0
General Reserves / Savings Target	(310)	8	(318)	671	1,362	(691)
COVID (Forecast Non-Pay Spend)	0	0	0	2,092	2,092	0
Total	**29,281**	**29,282**	(1)	**89,230**	**89,336**	(106)

The Trust has reported a cumulative year to date position of **£(1)k** overspent on Non-Pay and is forecasting an outturn overspend of **£(106)k**.

- General drugs & Blood Components are underspending due to reduced activity related to Covid.
- Facilities Management, along with Maintenance & Repairs are under review in WBS following increased compliance requirements against new contracts which is pushing the outturn into a forecast overspend position.
- Transport, Travel & subsistence and Education are all underspending due to reduced activity and office working in the Trust largely related to Covid.
- Printing / Stationary & Postage is underspending due to a reduction in office based activity and paper based communications given the increased homeworking.
- Telecoms associated costs have increased due to the establishment of virtual hubs in response to Covid but spend is forecast to remain within budget.
- General Reserves / Savings Target is currently reporting an underachievement of £(318)k to date as a result of Cost improvement Plan (CIP) targets held centrally within divisions. These CIP's are being achieved through the underspends in several areas of non-pay as illustrated in the table above. The Trust reserves and investment funding is held in month 12 and will be released into the position to match spend as it occurs.
- The year to date spend on Covid related Non Pay expenditure is £667k and is spread across various Non Pay categories. The remaining non pay costs for the period up until the end of March is £1,425k, giving a total expected non-pay spend on Covid of circa £2,092k.

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 £55k (7.6%) 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
Mass Covid Vaccination	151	365
Cleaning Standards	261	581
PPE	91	339
Covid Recovery	237	3,479
Other Covid Related Spend Cost Reduction	347	1,231
BFWD Savings Loss	289	700
Total Covid Spend /Funding Requirement 2021/22	**1,376**	**6,695**
Funding Received		3,419
Funding Confirmed		1,266
Balance of Funding Requirement		**2,010**

The Trust has currently received funding from WG to the sum of £3,419k, £2,500k towards Covid recovery, and £919k to cover the first six months of Covid response. The Trust has also received confirmation of a further £1,266k funding from WG. This leaves a current funding gap of £2,010k which the Trust anticipates WG will fully fund, against the total forecasted spend of £6,695k.

Covid Recovery

The spend and funding requirement to deliver Covid Recovery / 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).

Vaccinations

The Trust is expecting to spend circa £365k on the Covid Vaccination programme during 2021/22. The £365k revenue spend requirement for 2021/22 largely relates to the WBS storage and distribution for NHS Wales (£312k), with the balance of funding relating to the 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).

The Trust is currently planning for the booster programme, with WG recognising that a request for funding will be presented by the Trust once we have confirmation of how the booster programme model will be delivered.

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 Divisional share of the overall Trust savings target has been allocated to VCC £413k (38%), WBS £368k (33%), and Corporate £119k (11%), with £200k (18%) being set at Trust level for combined vacancy factor above the baseline target set by each Division. This has recently been distributed and included within the divisional savings plans.

Within the identified savings, £900k of the schemes are now RAG rated as green, with £200k relating to post Covid savings currently classified as amber.

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.

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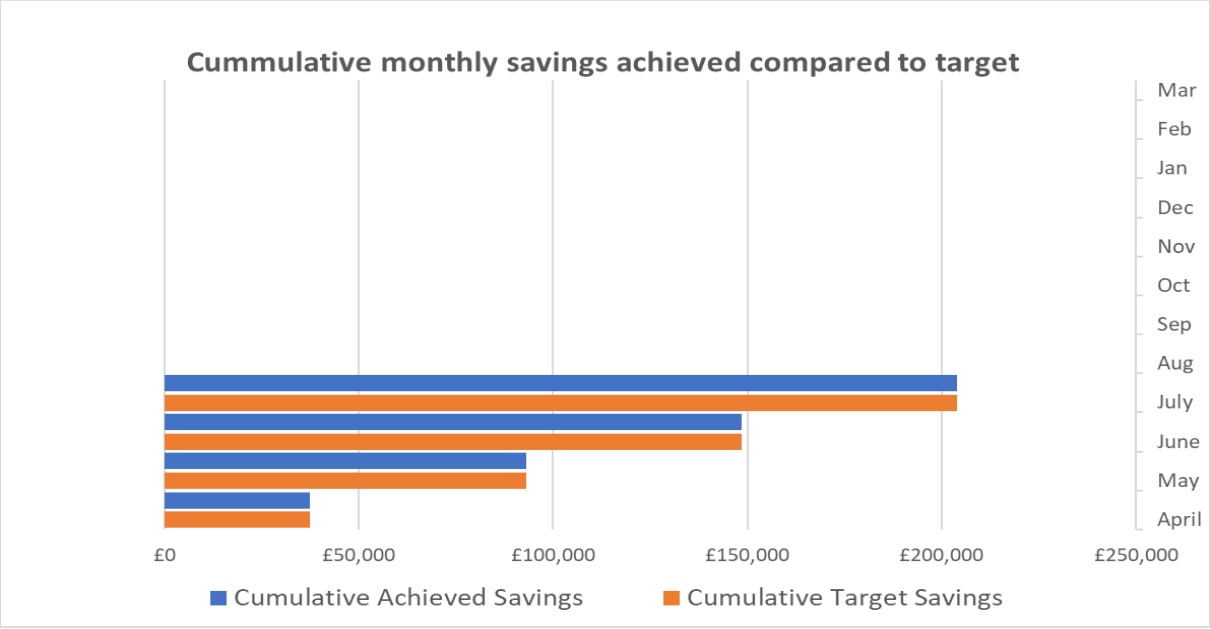
ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	Full Year Actual £000	Variance Full Year £000
VCC TOTAL SAVINGS	413	17	17	0	413	0
			100%		100%	
WBS TOTAL SAVINGS	368	100	100	0	368	0
			100%		100%	
CORPORATE TOTAL SAVINGS	119	33	33	0	119	0
			100%		100%	
TRUST TOTAL SAVINGS IDENTIFIED	900	150	150	0	900	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS	200	54	54	0	200	0
TRUST TOTAL SAVINGS	1,100	204	204	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	0	0	0	150	0
Premium of Agency Staffing	Green	100	0	0	0	100	0
Post Covid Savings (VCC)	Amber	113	0	0	0	113	0
Blood Supply Chain 2020	Green	75	25	25	0	75	0
Blood Supply Chain 2020	Green	25	8	8	0	25	0
Stock Management	Green	200	67	67	0	200	0
Post Covid Savings (WBS)	Amber	68	0	0	0	68	0
Establishment Control	Green	100	33	33	0	100	0
Post Covid Savings (Corporate)	Amber	19	0	0		19	0
Total Saving Schemes		**850**	133	133	0	850	0
Income Generation							
Maximinsing Income Opportunities	Green	50	17	17	0	50	0
Total Income Generation		**50**	17	17	0	50	0
TRUST ADDITIONAL NON-RECURRENT SAVINGS - VACANY FACTOR		200	54	54	0	200	0
TRUST TOTAL SAVINGS		1,100	204	204	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	635

In addition to the recurrent and emergency reserve, the Board has agreed to make available a further £1,545k of non-recurrent funding for investment during 2021/22 generated from the release of accountancy gains. The current spend to July '21 against the £1.5m is £187k with the remaining balance committed, albeit with some slippage anticipated which will be offered up for re-investment if this transpires.

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 number of risks which are being managed and closely monitored. The table below summarises the key financial risks & opportunities highlighted to Welsh Government.

Non-Delivery of Savings (Medium)
£200k of the £1,100k target remains in amber as it relates to post Covid savings such as reduction of travel expenses and office printing & stationary costs from the potential new working arrangements. The expectation is that this should turn green as the year progresses but will be depended on what the operating model of the future working arrangements looks like. This is currently being developed through the Trust's agile project working group.

Covid (Low)
.
The Trust has currently received funding from WG to the sum of £3,419k, £2,500k towards Covid recovery, and £919k to cover the first six months of Covid response. The Trust has also received confirmation of a further £1,266k funding from WG. This leaves a current funding gap of £2,010k which the Trust anticipates WG will fully fund, against the total forecasted spend of £6,695k.

TCS Programme (Medium)
There is a revenue forecast overspend of £56k and capital forecast overspend of 32k.

The revenue forecast overspend of £56k relates to a £29.5k pay overspend on the service change team project (offset by £8k programme management pay underspend) and £34.5k overspend on non-pay in nVCC project (£26k) and PMO (£8.5k). The forecast overspend of £26k for the nVCC project will be funded from an allocation of non recurrent reserves.

The capital forecast overspend of £32k relates to non-pay overspends of £33.5k for legal costs above budget for the IRS project (previously shared with the Board and TCS Scrutiny Committee) and £11.5k of staff costs above budget for the enabling works and nVCC projects, offset by forecast pay underspend of £13k mainly relating to Project Leadership.

These remain a financial risk to the outturn position for the Programme as options for mitigating the cost pressures have not been found to date, however the TCS Finance Team continue to explore ways to address the shortfall.

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 @ M4 £000s	Full Year Actual Spend £000s	Year End Variance £000s
All Wales Capital Programme						
VCC - Transforming Cancer Services	3,711	710	0	3,001	3,711	0
VCC Radiotherapy Procurement Solution	993	29	0	619	993	0
IT - WPAS (CANISC replacement phase 2)	312	374	0	283	312	0
Fire Safety	1,100	85	0	1,015	1,100	0
National Programmes - Decarbonisation	109	0	0	109	109	0
National Programmes - Imaging	1,020	0	0	1,020	1,020	0
Total All Wales Capital Programme	7,245	1,198	0	6,047	7,245	0
Discretionary Capital	1,911	73	158	1,680	1,911	0
Sub Total	9,156	1,271	158	7,728	9,156	0
Charitable Funded Capital Scheme	45	0	0	45	45	0
TOTAL	**9,201**	**1,271**	**158**	**7,773**	**9,201**	**0**

The approved 2021/22 Capital Expenditure Limit (CEL) as at July 2021 was £9,156k (excl Charity). This includes All Wales Capital funding of £7,245k, 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 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	50	750		
2	WBS HQ	22,000	PBD approved by WG OBC under development	150	850	11,000	10,000
3	Ventilation	2,490	BJC to be submitted	400	2,090		
4	IRS	38,429	OBC & PBC approved by WG, FBC under development	500	9,422	7,048	21,459

Performance to date

The actual cumulative expenditure to July 2021 on the All Wales Capital Programme schemes was £1,198k, this is broken down between spend on the TCS Programme £710k, Integrated Radiotherapy Procurement Solution £29k, IT WPAS £374k and Fire Safety £85k.

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 £73k with a further £158k committed.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position.

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 agreed with WG that DHCW (formerly NWIS) will continue to be reported within the Velindre SoFP until the 30th September at which date all assets and liabilities will have formally transferred other to DHCW.

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 largely relates to NWSSP WRP £1,132,862 which has remained the same as at March 2021, pending the first Health Board returns due at the end of July ’21, which will be reflected in the August ‘21 report.

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 is intending to unwind the contingency stock during 2021-22 to 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 in order 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.

	Opening Balance Beginning of Apr 20	Closing Balance End of Jul-21	Movement from 1st April Jul-21	Forecast Closing Balance End of Mar 21
Non-Current Assets	**£'000**	**£'000**	**£'000**	**£'000**
Property, plant and equipment	136,558	137,891	1,333	137,891
Intangible assets	20,821	20,822	1	20,822
Trade and other receivables	817,142	816,496	(646)	816,496
Other financial assets	0	0	0	0
Non-Current Assets sub total	**974,521**	**975,209**	**688**	**975,209**
Current Assets				
Inventories	95,564	102,338	6,774	102,338
Trade and other receivables	548,836	503,040	(45,796)	520,008
Other financial assets	0	0	0	0
Cash and cash equivalents	43,263	35,488	(7,775)	18,518
Non-current assets classified as held for sale	0	0	0	0
Current Assets sub total	**687,663**	**640,866**	**(46,797)**	**640,864**
TOTAL ASSETS	**1,662,184**	**1,616,075**	**(46,109)**	**1,616,073**
Current Liabilities				
Trade and other payables	(353,136)	(307,512)	45,624	(307,512)
Borrowings	(8)	0	8	0
Other financial liabilities	0	0	0	0
Provisions	(316,959)	(316,777)	182	(316,777)
Current Liabilities sub total	**(670,103)**	**(624,289)**	**45,814**	**(624,289)**
NET ASSETS LESS CURRENT LIABILITIES	**992,081**	**991,786**	**(295)**	**991,784**
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**	**166,004**	**6**	**166,002**
FINANCED BY:				
Taxpayers' Equity				
General Fund	0	0	0	0
Revaluation reserve	27,978	27,978	0	27,978
PDC	122,468	122,469	1	122,469
Retained earnings	15,552	15,557	5	15,555
Other reserve	0	0	0	0
Total Taxpayers' Equity	**165,998**	**166,004**	**6**	**166,002**

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.

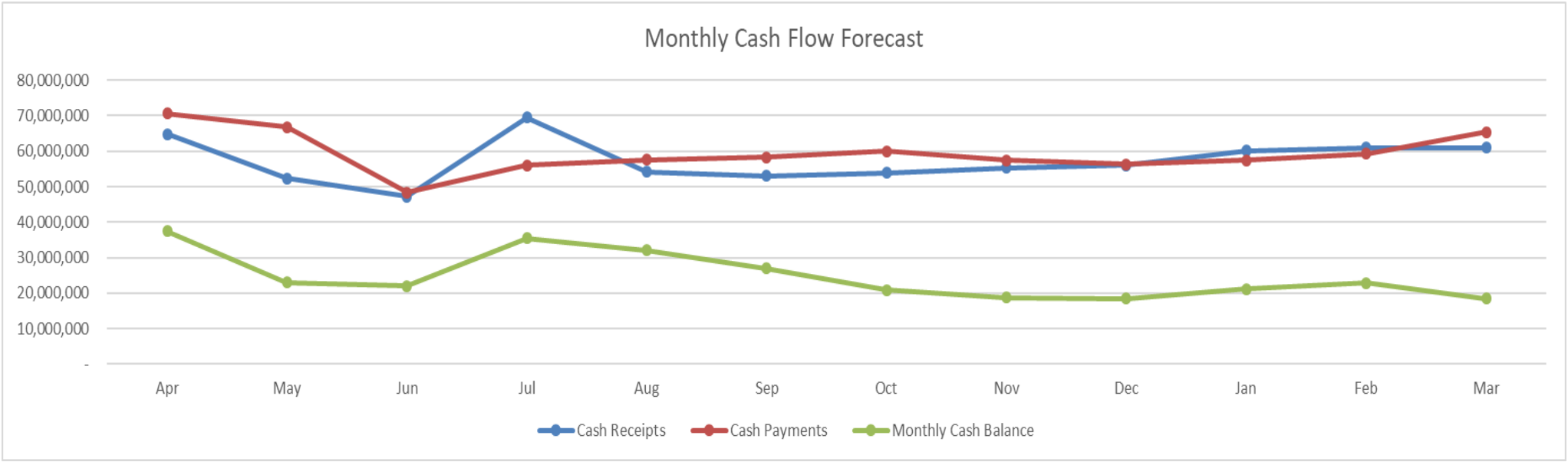
As part of the Brexit emergency planning an additional £5m of stock had been purchased by NWSSP and an additional £2m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability as a result of Brexit.

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 with the expectation that it is now repaid during 2021/22. 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 currently reviewing the timing of the All Wales Brexit stock run down.

Due to the high levels of purchases relating to Covid within NWSSP, the cash levels over the past year 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	30,145	31,200	30,003	32,915	31,985	33,433	34,007	33,252	367,530
2	WG Income	33,807	26,132	11,582	30,431	22,070	19,800	21,890	20,300	22,003	24,800	24,980	22,595	280,389
3	Short Term Loans													0
4	PDC												3,020	3,020
5	Interest Receivable													0
6	Sale of Assets													0
7	Other	7,643	3,682	4,973	5,006	2,025	2,100	2,025	2,100	2,025	1,950	1,950	2,175	37,654
8	TOTAL RECEIPTS	**64,797**	**52,306**	**47,227**	**69,515**	**54,240**	**53,100**	**53,918**	**55,315**	**56,013**	**60,183**	**60,937**	**61,042**	**688,593**
	PAYMENTS													
9	Salaries and Wages	15,189	22,734	22,015	20,181	22,964	23,461	24,086	24,896	27,605	27,653	27,672	31,343	289,799
10	Non pay items	52,989	43,749	25,742	35,377	34,450	34,300	28,423	31,800	28,300	29,480	29,800	31,253	405,663
11	Short Term Loan Repayment							7,000						7,000
12	PDC Repayment													0
14	Capital Payment	2,375	277	540	453	221	480	450	780	400	300	1,800	2,800	10,876
15	Other items													0
16	TOTAL PAYMENTS	**70,552**	**66,760**	**48,297**	**56,011**	**57,635**	**58,241**	**59,959**	**57,476**	**56,305**	**57,433**	**59,272**	**65,396**	**713,338**
17	Net cash inflow/outflow	(5,755)	(14,454)	(1,070)	13,504	(3,395)	(5,141)	(6,041)	(2,161)	(292)	2,750	1,665	(4,355)	
18	Balance b/f	43,263	37,508	23,054	21,984	35,488	32,093	26,951	20,911	18,749	18,457	21,208	22,873	
19	Balance c/f	37,508	23,054	21,984	35,488	32,093	26,951	20,911	18,749	18,457	21,208	22,873	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	11,877	11,881	(4)	35,228	35,228	0
RD&I	(14)	(14)	0	(474)	(474)	0
WBS	6,794	6,797	(3)	21,068	21,068	0
Sub-Total Divisions	**18,657**	**18,664**	**(7)**	**55,822**	**55,822**	**0**
Corporate Services Directorates	2,346	2,336	10	6,819	6,819	(0)
Delegated Budget Position	**21,003**	**21,001**	**3**	**62,641**	**62,641**	**0**
TCS	179	176	3	536	536	0
Health Technology Wales	(22)	(22)	0	0	0	0
Non recurrent measures to achieve financial breakeven general reserves	0	0	0	0	0	0
Trust Position	**21,160**	**21,155**	**6**	**63,177**	**63,177**	**0**

VCC

Velindre Cancer Centre (VCC)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Full Year Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**19,790**	**19,824**	**35**	**62,271**	**62,522**	**251**
Expenditure						
Staff	13,203	12,958	246	41,776	41,481	**295**
Non Staff	18,463	18,748	(284)	55,723	56,269	**(546)**
Sub Total	**31,667**	**31,705**	**(39)**	**97,499**	**97,750**	**(251)**
Total	**11,877**	**11,881**	**(4)**	**35,228**	**35,228**	**0**

VCC Key Issues:

The reported financial position for the Velindre Cancer Centre as at the end of July 2021 was a small overspend of **£(4)k**, and an expected outturn position of **breakeven**.

Income at Month 4 represents an overachievement of **£35k**. 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 Radiation protection SLA, and HSST income within Physics Management is offsetting the divisional savings target.

Staff was **£246k** underspent as at Month 4. A high level of vacancies, sickness and maternity predominantly in Nurse Management, Inpatients, Pharmacy and Radiotherapy which is above the divisional vacancy factor target is helping to offset the cost of agency (£344k to end of July), and also the additional costs for Junior Doctors due to recent rotation and additional consultant sessions for short term resilience.

Non Staff Expenditure at Month 4 was **£(284)k** overspent. There are underspends on general drugs, Nuclear Medicine warranty savings, 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 the VCC management savings target £(306)k.

WBS

Welsh Blood Service (WBS)

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected £000
Income	**7,197**	**6,874**	**(323)**	**19,419**	**18,930**	**(490)**
Expenditure						
Staff	5,730	5,661	68	17,197	17,185	**11**
Non Staff	8,262	8,010	252	23,290	22,811	**479**
Sub Total	**13,991**	**13,671**	**320**	**40,487**	**39,997**	**490**
Total	**6,794**	**6,797**	**(3)**	**21,068**	**21,067**	**0**

WBS Key Issues:

The reported financial position for the Welsh Blood Service at the end of July 2021 was a **£(3)k** overspend with an outturn forecast position of **breakeven** expected.

Income underachievement to date is **£(323)k**, where activity is lower than planned on Plasma Sales, and Bone Marrow due to freezer breakdown and Covid suppressed activity. Any income loss directly impacted by Covid is expected to be recovered via WG funding.

Staff reported a year to date underspend of **£68k** to July, which is above the division's vacancy factor target. Vacancies remain high with on average circa 44 vacancies being held although recruitment is being fast tracked.

WBS will also be appointing a 4th collection team in response to NHS Wales surge capacity and meeting blood demand, with recruitment of the whole team expected to take place during August. These costs are expected to be met by WG.

Non Staff underspend of **£252k** 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

Corporate Services

	YTD Budget £000	YTD Actual £000	YTD Variance £000		Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**467**	**442**	**(25)**		**1,017**	**992**	**(25)**
Expenditure							
Staff	2,672	2,650	22		7,478	7,412	**66**
Non Staff	141	128	13		357	399	**(41)**
Sub Total	**2,813**	**2,778**	**35**		**7,836**	**7,811**	**25**
Total	**2,346**	**2,336**	**10**		**6,819**	**6,819**	**0**

Corporate Key Issues:

The reported financial position for the Corporate Services division at the end of July 2021 was an underspend of **£10k**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

Income underachievement is due to the Charity Director vacancy and not recharging the costs to the Charity, which is offset by an underspend against the post in staff.

Staff is reflecting a small underspend of **£22k** as at the end of July due to the carrying of vacancies.

The forecast Non pay overspend circa **£(41k)** is due to the divisional savings target which is expected to be met in year via staff vacancies but remains a risk. In addition, several departments have little or no non pay budget to allow for unforeseen spend.

RD&I

RD&I

	YTD Budget £000	YTD Actual £000	YTD Variance £000		Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**956**	**946**	**(10)**		**3,154**	**3,182**	**28**
Expenditure							
Staff	870	866	3		2,458	2,491	**(33)**
Non Staff	72	66	6		222	217	**5**
Sub Total	**942**	**932**	**10**		**2,680**	**2,708**	**(28)**
Total	**(14)**	**(14)**	**0**		**(474)**	**(474)**	**0**

RD&I Key Issues

The reported financial position for the RD&I Division at the end of July 2021 was **breakeven** with a current forecast outturn position of **breakeven**.

Currently no issues to flag.

TCS – (Revenue)

Hosted Other - TCS

	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	166	176	(10)	499	499	**0**
Non Staff	12	0	12	37	37	**0**
Sub Total	**179**	**176**	**3**	**536**	**536**	**0**
Total	**179**	**176**	**3**	**536**	**536**	**0**

TCS Key Issues

The reported financial position for the TCS Programme at the end of July 2021 wa**s a £3k** underspend with a forecasted outturn position of **breakeven, on the assumption that the forecast cost pressure of £56k can be mitigated.**

HTW

Hosted Other - HTW

	YTD Budget £000	YTD Actual £000	YTD Variance £000	Annual Budget £000	Full Year Forecast £000	Year End Projected Variance £000
Income	**548**	**548**	**0**	**1,645**	**1,645**	**0**
Expenditure						
Staff	464	463	0	1,425	1,425	**0**
Non Staff	63	63	0	220	220	**0**
Sub Total	**527**	**526**	**0**	**1,645**	**1,645**	**0**
Total	**(22)**	**(22)**	**0**	**0**	**(0)**	**0**

HTW Key Issues

The reported financial position for Health Technology Wales at the end of July 2021 was **breakeven,** with a forecasted outturn position of **breakeven.**

HTW is fully funded by WG**.**

TCS PROGRAMME DELIVERY BOARD

TCS PROGRAMME FINANCIAL REPORT FOR 2021-22 JULY 2021

DATE OF MEETING	-

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Mark Ash, Assistant Director of Finance - TCS Programme
PRESENTED BY	Mark Ash, Assistant Director of Finance - TCS Programme
EXECUTIVE SPONSOR APPROVED	Mark Osland, Executive Director of Finance

REPORT PURPOSE	ENDORSE FOR BOARD APPROVAL

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

ACRONYMS	
TCS	Transforming Cancer Services
Trust	Velindre University NHS Trust
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 04.

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 WG have awarded the Enabling Works Project £0.376m of funding in 2021-22. £0.250m has been provided to date, with the remaining £0.126m to be provided on approval of the Enabling Full Business Case.

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	**£ nil**	**£0.240m** £0.240m
Project 1 – Enabling Works for nVCC Capital funding from WG was provided on 24 March 2021 There is currently no revenue funding for Projects 1	**£0.376m** £0.376m	**£ nil**
Project 2 – New Velindre Cancer Centre Capital funding from WG was provided on 24 March 2021 There is currently no revenue funding for Projects 2	**£3.460m** £3.460m	**£ nil**
Project 3a – Radiotherapy Procurement Solution Final 9 months of a 28 month project, running from 1st July 2019 to 31st December 2021, with a funding allocation of £0.312m for 2021-22 from an overall funding allocation of £1.110m	**£0.312m** £0.312m	**£ 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**
Project 6 – Service Delivery, Transformation and Transition No capital funding requirement at present 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 Funding transferred from Velindre Cancer Centre toward the costs for the Project Manager post	**£ nil**	**£0.296m** £0.180m £0.061m £0.055m
Project 7 – VCC Decommissioning No funding requested or provided for this project to date	**£ nil**	**£ nil**

Description	Funding	
	Capital	Revenue
Total funding provided to date	£4.148m	£0.536m
	£4.684m	

4. FINANCIAL SUMMARY AS AT 31ST JULY 2021

4.1 The summary financial position for the TCS Programme for the year 2021-22 is outlined below:

TCS Programme Budget & Spend 2021-22

CAPITAL	Current Month			Financial Year		
	Budget to Jul-21	Spend to Jul-21	Variance to Jul-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Project Leadership	78,667	56,007	22,659	236,000	213,409	22,591
Project 1 - Enabling Works	54,000	63,684	-9,684	208,000	216,441	-8,441
Project 2 - New Velindre Cancer Centre	196,489	194,137	2,352	1,061,000	1,060,620	380
Project 3a - Radiotherapy Procurement Solution	124,032	125,413	-1,381	178,398	179,995	-1,597
Capital Pay Total	**453,187**	**439,241**	**13,946**	**1,683,398**	**1,670,464**	**12,934**
NON-PAY						
nVCC Project Delivery	10,530	10,520	10	78,500	78,459	41
Project 1 - Enabling Works	62,500	73,259	-10,759	167,500	178,259	-10,759
Project 2 - New Velindre Cancer Centre	166,330	162,818	3,512	2,084,500	2,085,184	-684
Project 3a - Radiotherapy Procurement Solution	65,928	73,188	-7,260	133,602	167,009	-33,407
Capital Non-Pay Total	**305,287**	**319,784**	**-14,497**	**2,464,102**	**2,508,911**	**-44,809**
CAPITAL TOTAL	**758,474**	**759,024**	**-550**	**4,147,500**	**4,179,375**	**-31,875**

REVENUE	Current Month			Financial Year		
	Budget to Jul-21	Spend to Jul-21	Variance to Jul-21	Annual Budget	Annual Forecast	Annual Variance
	£	£	£	£	£	£
PAY						
Programme Management Office	80,799	77,418	3,381	240,000	231,879	8,121
Project 6 - Service Change Team	98,667	110,078	-11,411	296,000	325,424	-29,424
Revenue Pay total	**179,466**	**187,496**	**-8,030**	**536,000**	**557,303**	**-21,303**
NON-PAY						
nVCC Project Delivery	0	7,220	-7,220	0	26,000	-26,000
Programme Management Office	0	0	0	0	8,100	-8,100
Project 6 - Service Change Team	0	89	-89	0	266	-266
Revenue Non-Pay Total	**0**	**7,309**	**-7,309**	**0**	**34,366**	**-34,366**
REVENUE TOTAL	**179,466**	**194,804**	**-15,339**	**536,000**	**591,670**	**-55,670**

5. FINANCIAL POSITION FOR TCS PROGRAMME AND ASSOCIATED PROJECTS AS AT 31ST JULY 2021

CAPITAL SPEND

Projects 1 and 2 Pay Costs

5.1 ***WG Funded Staffing -*** An in-year spend of **£0.314m** for posts funded by WG reflects the current 'interim' posts against a budget of **£0.329m**. The underspend is due to a delay in recruitment of staff into the two Projects. A recruitment drive has now taken place and new staff will take up post during July and August 2021. There is a forecast spend of **£1.490m** for the year against a budget of **£1,505m**. The pay costs have been analysed by each element of the Project(s).

Projects 1 and 2 Non-Pay Costs

5.2 ***nVCC Project Delivery -*** There is an in year capital budget and spend of **£11k** for project support and running costs for Projects 1 and 2. This is made up of office costs and document portal fees. There is a forecast spend this financial year of **£78k** against a revised budget of **£79k**.

5.3 ***Enabling Works -*** There is an in-year spend of **£0.137m** against a budget of **£0.117m.** The overspend of £0.020m is due to a temporary increase in staff costs. There is a forecast spend for the year of **£0.395m** against a budget of **£0.376m**.

Work package	Spend to 30th June 2021
Pay	£0.064m
Third Party Undertakings	£nil
Technical Advisers	£0.063m
Works	£0.007m
Legal Advice	£0.004m
Enabling Works Reserves	£nil

5.4 ***nVCC -*** There is an in-year capital spend of **£0.413m**, against a budget of **£0.411m**. The forecast spend for the years is **£3.359m** against a budget of **£3.382m**. The in-year underspend is due to temporary reduced staff costs and a delay in staff recruitment.

Work package	Spend to 30th June 2021
Pay (including Project Leadership)	£0.250m
Competitive Dialogue – PQQ & Dialogue	£0.166m
Legal Advice	£nil
nVCC Reserves	-£0.004m

Project 3a – Integrated Radiotherapy Procurement Solution

5.5 There is a total in-year spend of **£0.199m** (£0.125m pay, £0.073m non-pay) for the IRS Project against a budget of **£0.190m**. The overspend of £9k is due to increased legal costs. The Project is currently forecasting a spend of **£0.347m** against a budget of **£0.312m**. There is an increase in forecast due to further legal fees of £50k required to progress to the Final Tender phase of the Project. The Project will seek further funding to cover these fees, which would mitigate the risk of overspend for the year 2021-22.

REVENUE SPEND

Programme Management Office

5.6 The PMO spend to date is **£0.077m** against a budget of **£0.081m**, made up of pay costs. The budget and current forecast outturn for the financial year 2021-22 is **£0.240m**.

Projects 1 and 2 Delivery Costs

5.7 There is a revenue project delivery cost for the nVCC and Enabling Works Projects of **£7k** with an expected spend for the year of **£26k**. This spend is made up of rates and other running costs. There is currently no revenue budget allocated for these costs by WG and consequently it has been agreed to allocate an element of the Trust Non recurrent revenue reserves

Project 6 – Service Delivery, Transformation and Transition (Service Change)

5.8 Service Change spend to date is **£0.110m** against a budget of **£0.097m**. This spend is made up of pay costs. The Project is currently forecasting a spend of **£0.326m** for the year against a budget of **£0.296m**. The forecast overspend of £0.030m is due to increased pay costs and remains a financial risk to the outturn position for the Project.

6. Financial Risks & Issues

6.1 The overspend currently forecast for the IRS Project is planned to be mitigate by further funding. The forecast overspend for the Service Change Project remains a risk to the outturn position for the Programme.

7. CONSIDERATIONS FOR BOARD

7.1 An extract of this report is reported in the Trust Boards 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 TCS Programme Board are asked to **ENDORSE** the financial position for the TCS Programme and Associated Projects for 2021-22 as at 31st July 2021.

TRUST BOARD

TRUST RISK REGISTER

DATE OF MEETING	30/09/2021

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 NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	06/09/21	Noted
Quality Safety and Performance Committee	16/09/21	Noted

ACRONYMS:	
Velindre Cancer Centre	VCC
Welsh Blood Services	WBS
Transforming Cancer Services	TCS
Trust Risk Register	TRR

1. SITUATION/BACKGROUND

The purpose of this report is to present Trust Board the organisational risks, which meet the Trust Board's risk appetite for reporting, as recorded in Datix, and to highlight the management actions being taken to manage or mitigate these risks.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Risk Register is received and reviewed at Executive Management Board, Trust Board, and other Committees. Trust Board are asked to note risks and satisfy themselves with regard to the adequacy of management actions, and the control measures being implemented. The Board are requested to scrutinise decisions taken with regard to risk ratings and risk escalations and in so doing, acknowledge the following work underway:

- Implementation of the board approved risk process, risk appetite and risk framework;
- The change of systems – version 12 to version 14 of Datix;
- User set up and access to the new system;
- Training and support packages for staff.

2.1 Trust Risk Register

The Trust Risk Register submitted meets the following agreed risk appetite Board escalation levels. Of the nine risk categories, all fall within reporting to Trust Board at score 12, except for "Partnerships" which is set at 15.

Risk Appetite Levels	**Escalation level to Trust Board if risk at level** **Score below – according to the 5x5 matrix**
0 – Avoid	9
1 – Minimal	12
2 – Cautious	12
3 – Open	12
4 – Seek	15
5 – Mature	15

In addition, the Board agreed it would like to have escalated all risks with a current impact of 5 regardless of risk rating.

In comparing this approach to other NHS organisations – most focus on 15/16 and above rated risks in their Board reports although a number also give visibility to 12s.

There are two risk registers included one recorded in version 12 of the Datix system and one in version 14. Data was extracted for the TRR on 2nd September. Work has been undertaken and prioritised to transfer risks >=12 and impact of 5 into version 14, and to manage and closure of all other risks in version 12. The transfer of risks has been completed for Corporate Services, Transforming Cancer Services and Velindre Cancer Centre, included in this submission of the Trust Risk Register, version 14. The closure of risks in Vs 12 will be monitored on a regular basis with the expectation that Vs 12 can continue to be used for storage purposes. Discussions are currently being held with the Once for Wales team, and a final decision is awaited.

The Welsh Blood Service (WBS) are currently completing their change control process and it is expected that completion of this work will take place in the coming weeks following which, all including WBS will utilise version 14 of the Datix system.

2.2 Summary of Risks in the Trust Risk Register

A summary is provided of risks escalated to Trust Board via the Trust Risk Register which includes risks by division/directorate, risks by rating and further detail and breakdown of risks with ratings 16 and 20. There are no risks with a rating of 25. Graphs are included extracting data from both Vs 12 and Vs 14 therefore, some data is represented separately due to the nature of the data extracted from different versions of the system.

2.2.1 Our Journey in Risk Reporting

The core foundations of our Trust approach to risk are:

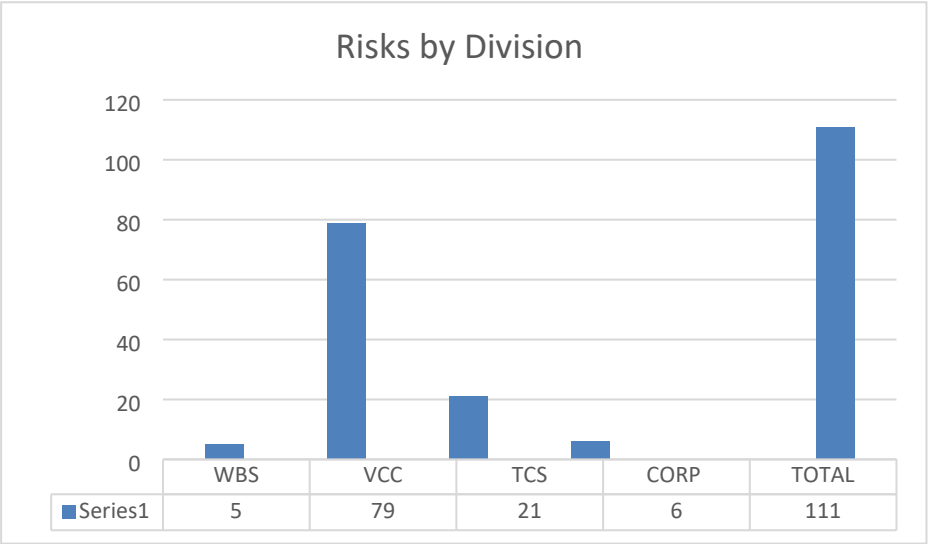
- Access to all staff to input a risk - with then appropriate control and quality mechanisms;
- Focus on the practical management of risk – with system to support this with clear approach to risk ownership, tracking of actions and review cycles;
- Reporting direct from the core system through management and governance structures – to support the continued development of quality of the data and transparency.

It has been acknowledged by the Committee, Audit Committee and Trust Board that the implementation of the refreshed framework would be a journey in this respect. It was important to start this journey however and to align with the principle of transparent reporting from the core systems.

As a Trust Board there was also an acknowledgment that in setting the risk appetite levels linked to risk scoring, that when the reporting commenced this was likely to require further consideration and possibly reviewing the levels accordingly. This is in parallel with the on-going focus, review and calibration of the way in which risks are currently being scored.

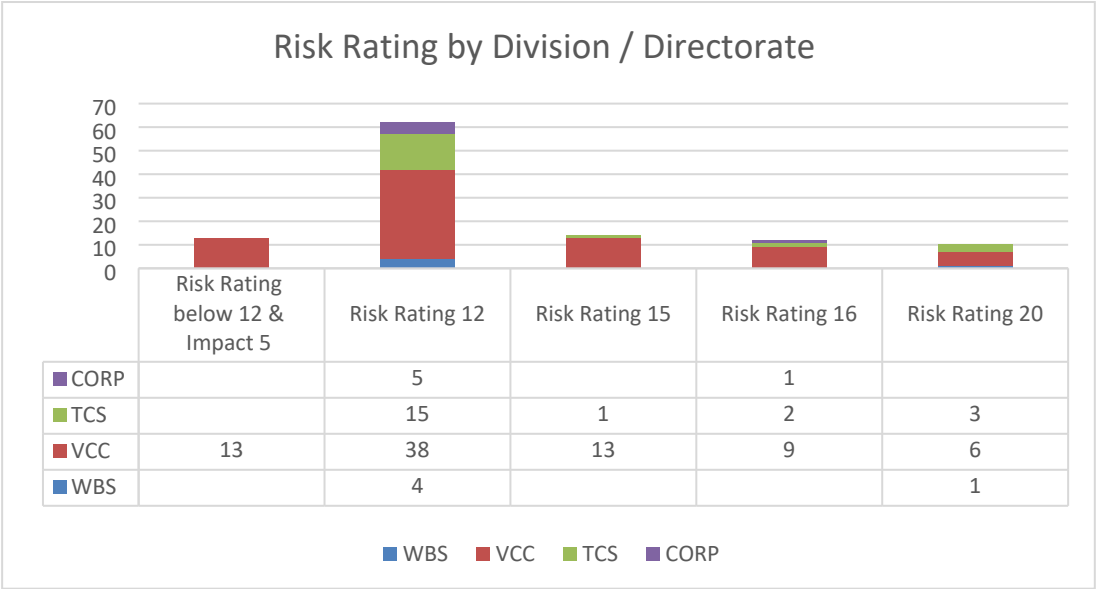
2.2.2 Reporting Overview

There is a total of 111 (versions 12 and 14 combined) open risks included in the current Trust Risk Register (risks >=12 (for eight of the nine categories) and impact 5). A breakdown of the total number of risks recorded by Division is presented in the graph below.



2.2.3 Risks Ratings by Division / Directorate

A representation of risks by current risk rating and Division or Directorate is provided in the graph below. A further breakdown of risks rated 16 and over is presented in the graphs and tables below, 15 for VCC, 5 for TCS, 1 for WBS and 1 for corporate services, as recorded in Datix and included in Trust Risk Register for escalation to Trust Board.



2.2.3.1 Risks in Vs 14 with risk ratings 20 and 16

Risks with ratings 20 and 16 by category is presented in the graphs. In recent weeks, divisions/directorates have prioritised the transfer of risks which is a significant undertaking. Risks are discussed and managed at various levels throughout the organisation on a regular basis. Following the transfer of risks, a validation and authentication process has initiated and is currently progressing, which includes the setting up of permissions in Datix to ensure access is provided to risk owners to monitor, follow up and update risks accurately and timeously.

- ***Risks Rating – 20***

There are 10 risks with a current risk rating of 20 recorded. Details can be seen in the chart and table below. A further breakdown is provided table below for each of the risks with a current risk rating of 20.

Risk Category	Risk reference Number	Initial Risk Rating	Current Risk Rating	Target Risk Rating	Brief description / additional information
Performance and Service Sustainability	2252	20	20	10	Large number of development projects in Radiotherapy – prioritisation of projects being done
	2207	20	20	10	eIRMER Radiotherapy Workflow Solution
	2193	20	20	2	Medical Physics Expert cover for Molecular Radiotherapy (Nuclear Medicine)
	2191	20	20	4	Inability to meet COSC / Single Cancer Pathway targets
	14764	20	20	-	Brexit - Implications of Exiting the EU
Compliance	2399	20	20	10	Risk of Legal challenge being raised by unsuccessful bidder regarding Integrated Radiotherapy Solution
	2194	20	20	5	Private Patient Service Indemnity

	2188	25	20	6	Lack of physical space at VCC to accommodate the current service requirement and related standards
Workforce	2401	16	20	8	Risk of insufficient resources being made available to the – Project 3 Integrated Radiotherapy Solution
	2400	20	20	6	Risk that there is lack of project support – Outreach project

- ***Risks Rating – 16***

  A breakdown of risks with a rating of 16 is represented in the graph. Risk title and brief information about each of these risks is provided in the table below.

Risk Category	Risk reference Number / Theme	Initial Risk Rating	Current Risk Rating	Target Risk Rating	Brief description / additional information
Safety	*2393*	16	16	9	Infection control - There is a risk that staff could contract COVID-19 in their working environment
	2197	16	16	9	Breach of current Welsh Government Social Distancing
Performance & Service Sustainability	*2326*	16	16	9	Capacity within VCC to support the implementation of the Digital Health & Care Record against other service delivery requirements.
	2212	25	16	16	The threat to systems and processes against Cyber Security
	2213	20	16	4	Resilience of VCC phone system due to dependency on legacy / end of life infrastructure
	2200	16	16	4	Availability of sufficient radiotherapy capacity within available financial resource

	2199	25	16	9	Medical Device Management Database Software at VCC - No Medical Device Management Software System currently
	2196	16	16	4	Radiotherapy Department - COVID Isolation impact of staff isolation as a result of coming in to contact with a COVID positive person
	2190	*20*	*16*	*10*	*BI Support for reporting Lack of high-quality data informing in real time key activity*
	2402	*16*	*16*	*9*	*Risk of time-consuming infrastructure work - delays due to infrastructure work –TCS Outreach project*
Quality	*2403*	*12*	*16*	*9*	*Risk that enabling works construction exceeds timescale - enabling works construction, including bridges, exceeds 15 months, leading to delays to VCC construction and potential financial loss*
Financial	*2198*	*16*	*16*	*6*	*Contract/SLAs lacking - VCC has numerous contracts and Service Level Agreements for services delivered by NHS organisations and external companies - robust governance structures needed for better management of contracts*

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below) The high-risk areas considered to have an impact on quality and safety are identified in the Trust Risk Register
RELATED HEALTHCARE STANDARD	Safe Care The related healthcare standard will vary for each risk identified on the Trust Risk Register.
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes The high-risk areas considered to have an impact on equality are identified in the Trust Risk Register – none identified in this Risk Register.
LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) The high-risk areas may have legal implications and will be identified on the Trust Risk Register
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below) Financial risk will vary for each individual risks reported on the Trust Risk Register

4. RECOMMENDATION

- The Trust Board is asked to **NOTE** the Trust Risk Register (Version 12 and Version 14), the actions status of individual risks and next steps.
- To **NOTE** that a project plan is in place to manage the transition from Vs 12 to Vs 14 of Datix.

Risk Type	ID	Division	Approval status	Opened	Closed date	Title	Risk (in brief)	RR - Current Controls	Rating (initial)	Rating (current)	Rating (Target)
Workforce	2398	Corporate Services	New risk	17/10/2018		Welsh Language Standards	The Trust will need to comply with the Standards to ensure a fully bilingual service for patients and users.	Action has been taken and is ongoing in relation to compliance and the Welsh language standards. A new Governance structure has been put in place, consisting of three divisional groups and a Trust wide group. The Trust wide group will feed information into the Executive Board directly. • We have focussed on staff training and are providing two courses at Entry and Foundation level in order to support the language development skills of staff • The Trust recruitment process has been strengthened to ensure job evaluation processess now include a thorough evaluation of Welsh langauage skills requirements not only for the specific post but for the needs of the team and area of expertese • Divisional working groups have been increasing Staff awareness by using promotional information as part of daily staff communication • Patient and donor information has been audited and translation needs identified. Radiotherapy now have fully bilingual patient information letters	20	12	4
Safety	2397	Corporate Services	Accepted	18/05/2018		Infection Prevention & Control Service including staff attendance	1. Reduced capacity in the Infection Prevention and Control Team (IPCT) will reduce service provision within Velindre NHS Trust as operational workload will be prioritized. 2. Reduction in microbiology consultant ward rounds due to decreased capacity within the Public Heath Wales laboratories (PHW). Core service continues but educational opportunities will be missed and robust antimicrobial review may not occur. 3. Multi-disciplinary approach to root cause analysis investigation will not occur due to reduced medical input driven by a reduction in the number of doctors within VCC. This will compromise the quality of the clinical review as medical expertise will be absent and opportunities for learning to inform practice will be missed. 4. There has been persistently poor medical attendance at core IPC meetings such as RCA review, AMT / sepsis leading to reduced engagement. This will hinder required service improvement in clinical audit.	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
Performance and Service Sustainability	2396	Corporate Services	Accepted	20/04/2017		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

Safety	2395	Corporate Services	Accepted	26/05/2020		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 compartmentation issues) as part of Capital Refurbishment schemes.	15	12	9
Performance and Service Sustainability	2394	Corporate Services	Accepted	21/04/2016		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
Safety	2393	Corporate Services	Accepted	19/06/2020		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	16	16	9

Compliance	2343 Velindre Cancer Centre	Accepted	20/12/2010	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
Safety	2342 Velindre Cancer Centre	Accepted	22/10/2013	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
Safety	2341 Velindre Cancer Centre	Accepted	02/12/2006	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
Compliance	2340 Velindre Cancer Centre	Accepted	22/10/2013	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

Safety	2339 Velindre Cancer Centre	Accepted	07/04/2007	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
Safety	2338 Velindre Cancer Centre	Accepted	03/11/2005	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 training. Hot works permit to works are in use on site. PPE is available for all members of Estates (this includes CAT B disposable suits and over boots, FP3 masks, safety shoes, and gloves).	15	5	5
Safety	2336 Velindre Cancer Centre	Accepted	08/06/2009	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 illuminated. Medical staff available on site should a medical emergency occur. Maintenance staff will assess the need to use a safety	15	5	5

Safety	2335 Velindre Cancer Centre	Accepted	17/03/2014	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. Safe DDA compliant designated pedestrian access with tactile paving highlights safe routes to the Main entrance from the main	15	5	6
Safety	2333 Velindre Cancer Centre	Accepted	07/08/2021	Checking the balance of controlled drugs - First Floor Ward	Abuse or misuse of unauthorised access to controlled drugs. Controlled drugs are medicines which have the potential to be abused. Therefore there are strict regulations regarding prescribing, usage, storage and recording of controlled drugs. A risk assessment is needed to aid decision making on how often the cupboards are to be checked by the registered nurse.	1. Schedule 2 controlled drugs are signed in and out of a dedicated drug cupboard within keeping with regulations. 2. Witnessed signing out and witnessed administration by 2 registered nurse or 1x registered nurse and 1x year 2 student. 3. Total balance checked each shift by 2 registered nurses (twice every 24 hours) 4. Senior nurse holds the keys to the controlled drug cupboard 5. Pharmacy double check the balance every 6-12 weeks.	10	5	5
Safety	2262 Velindre Cancer Centre	Accepted	16/08/2018	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

Safety	2261	Velindre Cancer Centre	Accepted	10/12/2015		Lack of electronic prescribing at Teenage Cancer Trust	There is a potential safety risk to Teenagers and Young Adults who are under the care of VCC and TCT and therefore can be admitted to either facility. Currently VCC and TCT have two different systems, VCC operate an e-prescribing system whilst TCT still use paper prescriptions.	Experienced medical and nursing staff - familiar with both processes. TCT staff have access to CANISC but any changes to dose etc. would be via chemocare. The actual dose prescribed will be transferred to Canisc in the next version of chemocare. Pharmacy staff clinically check script(only if access to medical records/prior treatment). Inpatients will receive visit from pharmacist/med recs/clerking but this is not always the case for outpatients so its probably a highter risk for outpatients. Business case is being developed for an all Wales National e-Prescribing solution (single solution). VCC to provide input and implement procured solution. Timescales to be confirmed. 31.08.20 - Working group has been established between VCC Pharmacy, UHW Pharmacy and wider UHW TCT reps since Feb 2020. An interim work around solution has been developed to enable TCT access to VCC ChemoCare and thus for the prescribing of regimens to occur	16	10	4
Compliance	2260	Velindre Cancer Centre	Accepted	02/09/2011		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. Contractors are given tool box talks before being allowed to work on site which includes information on Asbestos and known locations. Prior to any destructive	15	10	5
Safety	2259	Velindre Cancer Centre	Accepted	01/11/2012		Contamination & harm to all on site & reputation loss in event of fire, flood & security incidents impacting radiation sources.	Fire- Training, prevention and evacuation. No smoking or use of E-Cigarettes site, patient induction. Detection – L1. Compartmentation. Means of escape designated assembly point. Straight warning - housekeeping. Fire RA.	Fire:- Training, prevention and evacuation. No smoking site, patient induction. Detection – L1. Compartmentation. Means of escape designated assembly point. Straight warning - housekeeping. Flooding:- Blockages – accurate drainage drawings, colour coded drain covers, contractors tool box talks. Safe systems of work Geiger-counter. Conformity to current building Regs. Estates staff provide Planned Preventative Maintenance and Reactive Maintenance and call out cover. (Hot drains x 3). Staff health monitored local procedure. Security:-Radioactive hazard signage on doors. CRB checks on staff, Security doors to Source rooms strengthened to provide additional protection top the rooms. Front desk is manned or the entry doors are locked. Security guards carry out daily checks. Limited CCTV and PIR in place.	12	10	8

Performance and Service Sustainability	2391	Velindre Cancer Centre	Accepted	17/05/2021		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 sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been	Chief Pharmacist and MaH technician have sufficient baseline knowledge of service to enable short to medium term continuation of the CURRENT service provision Medication Safety and Governance Pharmacist reviews all incidents inputted via Datix with review medication safety group, reports to MMG Engagement with Wales Homecare Medicines Committee (manage high level relationship between NHS Wales and homecare providers) and direct with providers who provide standard KPIs details	16	12	4
Safety	2389	Velindre Cancer Centre	Accepted	28/05/2021		The management of patients with altered airways and respiratory needs across VCC	The VUNHST Patient Safety Task Force was established on the 28th September 2020. It was a time limited intervention for a 2 month period, and completed on the 27th November 2020. The objective was to investigate and review the patient safety concerns which had been raised (internally and externally to the organisation) regarding certain elements of the current Velindre Cancer Centre clinical model. The Task Force identified a risk in relation to patients with altered airways resulting from head and neck cancers and associated treatment receiving care at VCC and agreed the following action; Undertake a formal risk assessment re the appropriateness of H&N, SVCO & Tracheostomy patients with altered airways or the potential to have airway compromise on the in-patient ward, and re-review admissions criteria on the basis of the risk assessment There is a risk that patients with altered airways may not receive care from the MDT	•Group 1 patients •1 x SLT works Mon/Tues and Thursday and able to see these patients with good skill level •Advice available from PSU nursing team Mon-Fri in basic competency levels - needs scoping as there is potential for enhancing straining and assessment through this service. •Ward Nursing staff – some basic skills – training needs analysis needs to be completed •H&N CNS and consultant radiographer – skills need scoping but these work Mon-Fri, what are the opportunities for cover across the 7 days? •Training being sourced by nurse education lead •Group 2 & 3 patients •Recent survey of competencies of VCC physios (available on request) with an action plan for roll out to the other disciplines •Establish competencies and work out how best to complete/maintain them •Link with Pall Care to determine a clearer pathway for when suction is required	12	12	6
Safety	2388	Velindre Cancer Centre	Accepted	18/06/2021		OPD Environment - Temperature of the Outpatients department	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.	Doors and windows left open where possible to increase ventilation. Wall mounted fans in the waiting are and fans in some clinic consultation rooms, although use is limited due to COVID-19 restrictions. IPC team have advised that fans should not be used in a clinical area. Staff provide cold drinks to patients in the department throughout the day	12	12	8

Performance and Service Sustainability	2329	Velindre Cancer Centre	Accepted	09/06/2021		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	12	16
Performance and Service Sustainability	2328	Velindre Cancer Centre	Accepted	09/06/2021		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	12	16
Performance and Service Sustainability	2325	Velindre Cancer Centre	Accepted	09/06/2021		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
Performance and Service Sustainability	2324	Velindre Cancer Centre	Accepted	09/06/2021		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.	12	12	8

Performance and Service Sustainability	2290	Velindre Cancer Centre	Accepted	07/11/2019		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
Performance and Service Sustainability	2258	Velindre Cancer Centre	Accepted	17/05/2021		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 sustainability because lack of service resilience may result in the service prematurely ceasing either because of governance issues which could have been	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
Workforce	2257	Velindre Cancer Centre	Accepted	28/05/2021		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

Performance and Service Sustainability	2256	Velindre Cancer Centre	Accepted	26/03/2020		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 3 - Recognition that a solution to identify patients whom have not been referred for treatment to VCC due to COVID-10 has not	16	12	12
Financial Sustainability	2255	Velindre Cancer Centre	Accepted	24/02/2021		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
Performance and Service Sustainability	2254	Velindre Cancer Centre	Accepted	16/06/2020		Lack of mechanical ventilation at the VCC site (including in-patient 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 • Further mitigations are being assessed, including use of theatre scrub uniforms for nursing staff and washable cooling blankets and mattresses for patients.	12	12	4

Performance and Service Sustainability	2253	Velindre Cancer Centre	Accepted	27/10/2020		Catastrophic Loss of CANISC System	In the event of a catastrophic CANISC system failure, Velindre Cancer Centre would have no electronic patient record and radiotherapy workflow management systems. In this scenario patient care would be seriously compromised, for inpatient admissions and /or outpatient appointments. Electronic access of patient medical histories would not be available or limited to a point in time to guide care decisions. This would lead to the unavailability of clinical information to support decision making. As well as loss of patient administration activities tasks including the booking and processing of outpatient and inpatient activity, clinic lists etc.	CANISC Case Note Summary to provide historic record Chemocare (existing patients) Welsh Clinical Portal (WCP) for viewing all results, documents and Canisc CaseNote Summary. WCP is linked to Master Patient Index (MPI) to access patient demographic information Backload of all VCC radiology reports into Welsh Results Reporting Service (WRRS) - complete Paper Radiotherapy Workflow (IRMER) Manual Registration - new patients on Chemocare Manual Registration - new patients on Aria and Mosaiq Availability of Clinical correspondence created at VCC in Document Management System (DMS) from April 2019 that feeds into Welsh Clinical Record Service (WCRS) Procurement of single radiotherapy vendor to include workflow WPAS Implementation Project underway CANISC Replacement Programme underway Access to paper record that holds inpatient documentation, charts etc	15	12	6
Compliance	2251	Velindre Cancer Centre	Accepted	18/03/2016		XVI imaging termination faults resulting in repeat acquisitions	When using XVI CBCT (Elekta only), faults are occurring intermittently during the image acquisition. This is resulting in repeat image acquisitions needed which increases the overall dose the patient is receiving from imaging. It is also worth noting that these scans usually terminate part-way into the scan. If a full additional scan is acquired the patient will receive a maximum of 2 - 20 mGy additional dose, which is <0.1% of a typical treatment dose. CBCT imaging is essential to verify correct patient position during treatment, ensuring the radiotherapy treatment targets the tumour and spares Organs at Risk and critical structures. This is a known issue nationally and Public Health England and HIW are aware.	1. If a patient is having a routine offline XVI CBCT and the unit faults during acquisition attempts should be made to clear the fault and carry on. If the radiographers cannot clear the fault themselves the engineers should be contacted for advice. One further attempt at a full scan is permitted. If this fails then the CBCT should be repeated on the next fraction on an alternate unit. A Datix should be completed for all failed scans that cannot be continued from the point of failure. Scans that can be continued should still be recorded in the machine log. 2. For online scans the same as above applies but if a second scan fails then the patient should be moved to an alternate machine prior to treatment. 3. When a patient receives a total of 2 extra partial scans due to faults, then a superintendent must be informed, and the patient must be moved by the radiographers on-set to another LA for the remaining imaging fractions. 4. All partial scans to be recorded on the imaging form. 5. Radiotherapyl Physics and the treatment superintendents must be informed if the	15	12	9
Financial Sustainability	2249	Velindre Cancer Centre	Accepted	27/02/2020		Use of 'Soft' Monies for Workforce	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

Safety	2248	Velindre Cancer Centre	Accepted	29/10/2020		Social Distancing Risk - Nursing Departments (FFW, CIU,)	Social Distancing – Nursing 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. Analysis and then clear signage of occupancy levels in appropriate areas if	8	12	12
Workforce	2246	Velindre Cancer Centre	Accepted	01/02/2021		Single Handed - Patient Experience	There is one member of the Patient Experience Team at VCC. There is limited or no cover for many aspects of the role therefore the service is paused, stopped or curtailed during periods of absence. Some support and cross cover previously provided by Communications contractor. This has changed as a result of centralised approach to communications/increased requirement due to new VCC etc.	Work paused in January 2021 as agreed by Gold Incident Command	12	12	9
Performance and Service Sustainability	2245	Velindre Cancer Centre	Accepted	12/04/2019		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 treatment should ideally not be prolonged for more than 2 days). Regular update of staff from management	15	12	3
Workforce	2244	Velindre Cancer Centre	Accepted	14/09/2020		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

	2243	Velindre Cancer Centre	Accepted	30/06/2021		SACT staff turnover	SACT day case is at risk of not being able to deliver SACT at the current level due to Staff turnover	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
Performance and Service Sustainability	2240	Velindre Cancer Centre	Accepted	05/12/2019		Potential overcrowding in the outpatients department	Potential overcrowding of outpatient department It has been recognised that on certain days of the week, increased demand is adversely affecting the outpatient department, seeing high volumes of patient numbers within the clinical environment. It is considered that there is the potential for overcrowding through site specific clinics with high demand.	UPDATE June 21 - Continue to progress capital plans to relocate the phlebotomy dept. to reduce numbers of patients in the OPD and also improve the OPD environment. Plans for RT to undertake their own bloods are also being progressed, this will help to reduce footfall in the OPD. Ongoing monitoring of numbers of patients attending VCC for F2F appointments and blood tests. Try to reduce overbooking of clinics where possible thereby reducing overall numbers of patients and relatives in the OPD. Staff to be reminded of the correct process for booking blood tests for patients. Patients to be encouraged to have bloods taken locally where possible to reduce demand on phlebotomy service, which is being exacerbated by the high number of 'walk-ins' and patient turning up without appointments. Further work also to be done to reduce the numbers of patients having 'on the day' bloods. Continue to adhere to guidance on visitors.	16	12	12
Safety	2239	Velindre Cancer Centre	Accepted	06/06/2012		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 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. This work is now linked with the new	12	12	9
Performance and Service Sustainability	2236	Velindre Cancer Centre	Accepted	08/04/2019		Outpatient accommodation and environment	Outpatient Accommodation and environment Due to the increased activity, shortage of medical staff etc. VCC are centralising outpatient activity to reduce the risks. This has led to the current accommodation being fully utilised with the exception of Friday afternoons. This is causing poor patient and staff experience. This risk has been identified separate from the main accommodation risk entry to ensure the Committees are aware of the specific problem.	UPDATE June 21 - Plans to relocate phlebotomy department and treatment room are being progressed, along with plans to re-model the OPD and improve the environment. Small working group established to progress this work. Project support from PMO is likely to be needed for this capital project. External canopy in use as additional waiting area. Virtual clinic hub has been established for the running of virtual clinics and to release rooms in the main OPD.	20	12	12

Compliance	2235	Velindre Cancer Centre	Accepted	16/02/2014		Operational Support for the management of health and safety within VCC	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 imbalance between the corporate responsibilities of the role and operational support being provided. H&S is currently included in all job descriptions, with managers having additional	1.Trust Quality & Safety department providing interim 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 Manager advising as needed.	16	12	3
Compliance	2234	Velindre Cancer Centre	Accepted	01/07/2020		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 communicated to the staff. Staff awareness should be improved with regards to chemicals COSHH across VCC.	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
Workforce	2229	Velindre Cancer Centre	Accepted	12/03/2019		Lack of Dedicated Communication Resource at Velindre Cancer Centre	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	Short term contractor support engaged to produce weekly staff newsletter. Patient Experience Manager, Director of Operations and Fundraising Team use social media channels as part of their roles. EMB aware of current structure and gaps been highlighted in numerous assessments. Corporate resource recruited. In current COVID19 incident support provided via Head of Fundraising which has been extremely successful and allowed daily consistent communications. 18.6.20 - meeting arranged with Director, Trust Head of Comm's to discuss options Resource increased within corporate communications and TCS teams. Increased level of support provided to VCC for social media management and incident management during COVID	12	12	4

Compliance	2227	Velindre Cancer Centre	Accepted	22/05/2020		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
Safety	2225	Velindre Cancer Centre	Accepted	14/09/2020		Extreme Hypofractionation - increased pressure on Pre-treatment Pathway	Extreme hypofractionation may alter type of capacity limiters – moving the pressure to pre-treatment. Timelines for key stages within the pathway are currently not identified, lack of guidance within these pathways and adherence to time frames will result in increased pressures on all deliverables within the pathway subsequently increasing the risk of breaches as the number of required plans increase. Extreme hypofractionation may alter type of capacity limiters – moving the pressure to pre-treatment. Timelines for key stages within the pathway are currently not identified, lack of guidance within these pathways and adherence to time frames will result in increased pressures on all deliverables within the pathway subsequently increasing the risk of breaches as the number of required plans increase	Document to present to SSTs to clarify process, responsibility and impact of delayed outlining Review of pre-treatment pathway to improve working practices required. RSG to agree the minimum planning timescales in the proposal Recovery Phase Physics Pathway	15	12	4
Performance and Service Sustainability	2224	Velindre Cancer Centre	Accepted	07/11/2019		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
Performance and Service Sustainability	2223	Velindre Cancer Centre	Accepted	21/07/2020		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. Agreement from ABUHB to re-start outreach clinics in Nevill Hall, 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

Performance and Service Sustainability	2222	Velindre Cancer Centre	Accepted	07/11/2017		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. Aria and Mosaiq not reliant on Canisc – Radiotherapy treatment can continue in the event of a Canisc outage. ChemoCare decoupled from Canisc and held	16	12	12
Performance and Service Sustainability	2211	Velindre Cancer Centre	Accepted	09/10/2020		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	20	12	6
Performance and Service Sustainability	2206	Velindre Cancer Centre	Accepted	09/10/2020		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

Performance and Service Sustainability	2204	Velindre Cancer Centre	Accepted	07/12/2020		BDC contract and DH&CR Programme implementation window	Implementation Window - Given the timeframe of the BDC contract end date and the amount of work that is required to ensure the successful implementation of WPAS and the critical functionality. The window for training falls during the summer months posing a risk to be able to the adequately train over 750 staff in the timeframe. Difficult to train all staff and for departments to release staff when they are operating with reduce numbers due to leave. Also a lack of availability of staff for training during the current COVID-19 pandemic	The programme of work will be managed through tight controls and detailed project plans. Any risks or issues will be closely monitored and escalated through governance structure to SMT and EMB. Early engagement and clarity around timescales and roles will be put in place by each work stream project manager. Produce Training materials and consider train the trainer approach.	16	12	9
Performance and Service Sustainability	2221	Velindre Cancer Centre	Accepted	24/02/2021		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 completing and the eIRMER development. This could affect the implementation timescales. DHCW confirmed that they can replicate the	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	12	9
Performance and Service Sustainability	2189	Velindre Cancer Centre	Accepted	15/04/2020		Covid - SCT - VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic	VCC Futures: Clinical plan for SACT Services through the COVID 19 pandemic As a stand-alone cancer centre, VCC has a vital role to play in ensuring continuation of essential cancer services throughout the pandemic and effective and rapid recovery of services afterwards. This will be essential to prevent worsening cancer outcomes from occurring as 'collateral damage' from the pandemic. VCC will be a 'cancer treatment hub' for the population of South-East Wales during the COVID-19 pandemic. Systemic Anti-Cancer therapy (SACT) is a highly effective cancer treatment, which can be given to cure cancer as primary treatment (with or without radiotherapy), to reduce the risk of relapse (after surgery) and to palliate symptoms and reduce complications. It is imperative that this service continues as comprehensively as possible throughout the pandemic and beyond. Clinical/Medical oncologists, pharmacists and nurses with SACT competencies are highly specialist NHS staff who will continue to utilise their skills throughout the pandemic to treat cancer patients.	Document providing strategic oversight of core documents produced by the Velindre Cancer Centre (VCC) SACT Strategic Group (SSG) and national bodies during Covid-19 and beginning to explore future adaptation to these as the risk from the pandemic changes, as well as a perspective on the recovery phase as the pandemic wanes - submitted to Silver Command 24.04.20 (Velindre Futures plan for SACT through COVID-19_Final Version 1.1 April 27 2020.docx) It is assumed that this evolution will happen over approximately six to nine months (March to December 2020), although the timings may vary. It is also accepted that there will be peaks and troughs in demand over this period so we need a system that will be agile. The aim is for VCC to be able to deliver a centralised, high quality, specialised SACT service, adapting quickly to the needs of cancer patients / services in SE Wales whilst minimising patient harm.	20	12	12

Performance and Service Sustainability	2215	Velindre Cancer Centre	Accepted	16/03/2017		Windows XP	The Windows XP Operating System went End of Life April 2014, there are still a number of VCC machines running XP. There are a number of significant vulnerabilities with Windows XP at present which will continue to grow in the future, these vulnerabilities range from corrupting systems to unauthorised access. There are also compatibility issues with applications when running older versions of windows. There are additional vulnerabilities with web browsing as Windows XP is limited to Internet Explorer 9 which also went End of Life Jan 2016 - this also has significant security vulnerabilities.	National Firewalls in place, anti-virus. Direct internet access denied to XP machines. Most XP machines have been decommissioned; some remain that are related to legacy services. Physics department are seeking upgrades to XP machines from suppliers, Nuclear Medicine are seeking an alternative to dose calculation and patient letters. Support is being provided to both departments by IT.	20	12	0
Performance and Service Sustainability	2296	Velindre Cancer Centre	Accepted	11/01/2021		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. This has impacted directly on the capacity of the Head of Information to assist in the development and testing of the data migration extract and provided	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
Performance and Service Sustainability	2220	Velindre Cancer Centre	Accepted	07/11/2018		Treatment Planning System End of Life	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.	Most physics developments are on hold to redirect resource to the commissioning of RayStation. Commissioning plan is in place.	15	15	1

Performance and Service Sustainability	2219	Velindre Cancer Centre	Accepted	19/03/2021		Robustness of local IT support to database underpinning the Radiation Protection Service role	There is a risk that the individual currently system managing the Microsoft Access database that underpins the Radiation Protection Service business of supplying personal radiation dosimetry materials will either retire or leave the organisation. This risk builds to a certainty as time passes. At present, the system is running with a single point of failure in that no other members of staff are able fully to discharge the function of managing the database in its entirety.	Admin & clerical staff are able to undertake a limited range of functions within the database, but not to the extent of undertaking system management and maintenance of the database. One member of the clinical technologist team has limited ability to manage and maintain the database. A piece of work is currently progressing to document all of the processes involved with operation of the database. This will enable other members of staff to operate the database. Colleagues at WBS are currently re-writing the database using standard programming techniques and with full documentation, which will enable other staff to act as system manager. At present, WBS are unable to commit to a delivery date due to other calls upon their time. The ultimate control measure is that scientific staff of the Radiation Protection Service would need to be reassigned to the task of database management until an IT	6	15	6
Safety	2218	Velindre Cancer Centre	Accepted	23/10/2015		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. - Security staff in situ to monitor the above. - Some staff currently using Whitchurch Hospital car park. - Staff regularly reminded of inconvenience to local residents of parking on highways. - A number of patients use Welsh	20	15	3
Workforce	2217	Velindre Cancer Centre	Accepted	14/09/2020		Medical Capacity for RT Planning in Job Plans	Medical time for RT Planning within job plans is not consistent. Any time allocated may not be protected and there are risks associates with outlining delays which delays the patients treatment within RT.	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

Safety	2216	Velindre Cancer Centre	Accepted	13/04/2021		Overhead Strip Lighting with Therapies Office	The Therapies department hosts 4 professions; Dietetics, Physiotherapy, Occupational Therapy and Speech and language Therapy. There are currently 29 Therapists who share one large office with an additional 3 complementary Therapists. Throughout the department there is strip lighting in situ and during a recent return to work interview and subsequent occupational health appointment and stress risk assessment, it has been highlighted that a member of staff within the Occupational Therapy department (Individual 1) is struggling with the lighting which can impact on a chronic health condition (migraines). The impact of the lighting is such that it can impact on the likelihood of a migraine being triggered which can result in the individual's health and well-being. She describes the impact being that the light appears to be flickering in her peripheral vision which results in dizziness, pain and difficulties with attention and concentration. This has also been highlighted by another member of the Occupational Therapy team (Individual 2) who also reports that the	1. The individual (1) has been provided with a specific desk within the office environment that has the most minimal impact on her migraines. This can be difficult to manage however with the office space available within the Therapies department when considering the current restrictions needed to maintain social distancing guidelines. 2. Roller blinds have been installed into the Occupational Therapy space within the office area of the desk for individual (1), however the overhead strip lighting can still impact on the vision and migraines for the individual. 3. Individual 2 has reported that when the overhead strip lights are on their maximum, this can impact on the likelihood and severity of a migraine occurring. Seeking alternative seating within the department is again difficult to incorporate due to the limitations of social distancing required with the current restrictions in place due to Coronavirus.	15	15	4
Performance and Service Sustainability	2210	Velindre Cancer Centre	Accepted	08/10/2020		Blaenavon Data Centre Relocation	DHCR001(R) - Risks have been identified in relocating the Cansic system from the Blaenavon Data Centre due to the age of the platform and specifically the legacy nature of the application layer. This would leave a single platform in Newport Data Centre leaving no capacity for fail over. Therefore, if the system was to go down for any reason, there would be no back up, posing a significant risk to patients and service delivery	Accelerated delivery of the DH&CR. NWIS to negotiate a longer period to move from the Blaenavon Data Centre. Reduce reliance across the Service on Canisc by implementing parts of WCP DHCW to test the failover ahead of plan and business continuity in VCC, deliver MVP ASAP.	25	15	15
Performance and Service Sustainability	2208	Velindre Cancer Centre	Accepted	08/12/2020		Operational Risk of Canisc Failing	Canisc is the main system used across Velindre Cancer Centre. It was initially introduced in the late 1990s at VCC and was ahead of its time in providing an electronic patient care record crossing secondary and tertiary care boundaries, supporting multidisciplinary team working, providing chemotherapy and radiotherapy workflow management, collection and also reporting against cancer targets, collection of structured datasets (e.g. national audit) and allowing user definable data queries. Canisc was developed using a combination of Visual Fox Pro and .NET technologies. From 2014, Microsoft declared that they would need formal support for Visual Fox Pro in December 2015. As a result, any future system patches and safety critical enhancements of operating systems, hardware diagnostics tools etc. cannot be safely applied to Canisc. The risks to Canisc can be summarised as follows: - Unsupported and outdated software - Longstanding freeze on developments	Access to other Health Board Information Systems: For certain patients, access is to Welsh Clinical Portal / Clinical Workstations can provide an element of patient record/history to allow some treatment/diagnosis to occur. Access to Radiotherapy/ Radiology / ChemoCare Systems: Able to review images for existing patients Able to prescribe and administered Chemotherapy for existing patients Continue treatment for existing Radiotherapy patients Able to review administration of Molecular Radiotherapy Access to Canisc Casenote Summary in WCP: Enables the Clinicians to access a summary of the patient's casenotes	25	15	12

Performance and Service Sustainability	2187	Velindre Cancer Centre	Accepted	14/09/2020		Radiotherapy Physics Staffing	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. The Engineering Section in particular is identified as an area of risk to the radiotherapy service. Not only are staffing numbers significantly under those recommended by IPEM but the age profile	Staffing SBAR outlining requirements to meet service needs presented to SLT on 03/03/2021.	25	15	6
Workforce	2202	Velindre Cancer Centre	Accepted	23/02/2021		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	15	4
Performance and Service Sustainability	2201	Velindre Cancer Centre	Accepted	23/02/2021		Consultant Delivery in Gynae Tumour Site	There are three Consultants in the Gynae SST. 1 is currently off long term sick due to a bereavement and will return in March on restricted duties (phased return) - this Consultant undertakes Brachy Therapy for Gynae for VCC, the second is at home shielding - working but solely virtually and the third is experiencing symptoms of stress which is symptomatic of a reoccurrence of a mental health condition previously diagnosed.	Facilitate the recruitment of a locum Gynae Oncologist for a period of twelve months (business case not yet approved). A locum has been identified and a business case will now be submitted to scrutiny for approval for the post for 1 year to stabilise the workforce and ensure consistent care for patients. Update: 5/3/2021 Forward planning for March and April now in place – with the return of 1 Consultant on 8th March on phased return and 2nd consultant who is shielding on 1st April 2020. Speciality Doctor Recruited who will start in April and be solely dedicated to Gynaecology. Discussion with SACT Head of Service in terms of additional NMP support for AQ (Gynae) going forward.	12	15	4

Performance and Service Sustainability	2205	Velindre Cancer Centre	Accepted	14/09/2020		CANISC failure	Currently the CANISC electronic IR(ME)R form is the only way for the Oncologist to request a CT simulation scan and subsequent radiotherapy treatment for all patients bar emergencies. It is also the system used to manage the complex radiotherapy pre-treatment workflow and to document and authorise the detailed dose information for a patient plan prior to treatment. This documentation and authorisation is required under the IR(ME)R 2017 regulations. If CANISC is unavailable, there is no "fall-back" method for the above tasks. Business Intelligence (BI) data is also sourced from the electronic IR(ME)R form in CANISC, the loss of which will reduce the ability for BI reporting, forecasting and modelling. CANISC will no longer be available from September 2021, with the long-term IR(ME)R form replacement (part of the IRS) not being fully procured and in-house until around this time. CANISC will no longer be available from	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
Safety	2185	Velindre Cancer Centre	Accepted	14/09/2020		Delination Risk treatment delay (16284)	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 physics planning stages. Action is required to ensure these errors do not propagate to treatment.	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
Performance and Service Sustainability	2190	Velindre Cancer Centre	Accepted	14/09/2020		BI Support for reporting	BI Support for reporting There is a 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.	Large amount of BI is occurring, with better understanding of RT BI and complexity of internal RT processes	20	16	10
Performance and Service Sustainability	2196	Velindre Cancer Centre	Accepted	14/09/2020		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.	16	16	4

Safety	2197	Velindre Cancer Centre	Accepted	05/05/2020		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 1. Process constantly reviewed against guidance. 2. Analysis and then clear signage of occupancy levels in other areas if applicable	16	16	9
Financial Sustainability	2198	Velindre Cancer Centre	Accepted	29/12/2017		Lack of process/clarity/varied level of monitoring for contract/SLA's for services delivered by wider NHS and external companies	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
Performance and Service Sustainability	2199	Velindre Cancer Centre	Accepted	18/11/2015		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 audit. VCC gave approval to purchase a medical devices database at the start of August. Per Trust procedure, this is now being fully worked up into a business case, including	25	16	9

Performance and Service Sustainability	2200	Velindre Cancer Centre	Accepted	01/05/2011		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).	Ongoing monitoring of capacity and demand Ongoing monitoring of breaches of waiting times targets Reports and business cases have been prepared Radiotherapy strategy Discussion underway regarding future radiotherapy configuration through the TCS programme Extended working hours are in place on the treatment machines and in many other areas of the service Agency radiographers in place to support additional hours Updated 23/5/19 (PJ) Ongoing monitoring of capacity, demand breaches and waiting times targets. Extended working hours are in place on the treatment machines and in many other areas of service. Agency Radiographers are in place to support additional hours. Changes made to radiotherapy booking processes, and staff flexibility used to	16	16	4
Performance and Service Sustainability	2212	Velindre Cancer Centre	Accepted	06/11/2017		Cyber Security	There is an organisational risk of cyber security attack that if realised could affect the confidentiality, integrity or availability of Velindre Cancer Centre's systems, services or data. This could result in financial loss, organisation reputational damage, data loss, service loss and severely affect patient treatment and care. Common threats associated with cyber security are listed below (not exhaustive): Malicious code infection Unauthorised access Network attack Network intrusion Software vulnerability exploit Social engineering	The following controls are in place to mitigate cyber security threats: Antivirus Software updates Firmware Updates Port control Web detection Backups Vulnerability assessment tools Secure disposal A new Strategic Delivery Plan has been developed to address and manage our ongoing threats against Cyber Security	25	16	16
Performance and Service Sustainability	2213	Velindre Cancer Centre	Accepted	09/07/2018		Phone System External Phone Lines	The phone system on place at VCC currently relies on an internal PBX, gateway and an ISDN30 line. Internal calls are routed entirely through the PBX system and external calls through the PBX then the gateway and then traverse the ISDN30 to the outside recipient which is then reversed for external calls being made in inside the organisation. The PBX gateway is a legacy service that is end of life and the components used for the service are out of warranty. The ISDN30 is a legacy service that is end of life and the components used for the service are out date. The support options within the UK are minimal, which increases service recovery time following an incident dramatically. The PBX gateway is a single point of failure in that it only has one interface to manage and route calls. No resilience options are available as a result. The ISDN30 is a single point of failure in that	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. Recent telephony infrastructure upgrade to ensure improved performance and resilience. Supplier engagement underway re: move to modern resilient / supported platform	20	16	4

Performance and Service Sustainability	2326	Velindre Cancer Centre	Accepted	24/05/2021		Outpatient Workstream – Clinic Capacity over DH&CR Go-live	DHCR030(R) - There is a risk that the Service will be unable to significantly reduce the capacity of clinics over the Digital Health & Care Record Go-Live period. 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.	Service managers and teams to be available on site. Training champions/super users to support on site during the Go-Live period.	16	16	9
Compliance	2194	Velindre Cancer Centre	Accepted	02/03/2021		Private Patient Service - Indemnity	For those patients wishing to opt out of the NHS system and pay (self-funding or private healthcare insurance) for their treatment and care following a cancer diagnosis can do so via the patient referral pathway to the Velindre Cancer Centre Private Patient Service. Unlike the NHS, the Private Patient Service may not covered by the Welsh Risk Pool. If the appropriate level of indemnity insurance is not in place the main risks can be summarised as:- 1. Breach of the All Wales Policy on Indemnity and Insurance 2. Private work conducted at Velindre Cancer Centre, and the NHS Practitioners (excluding Consultants) providing a service to private patients in the course of their NHS duties may not be covered by the Welsh Risk Pool. 3. The Trust may have conducted Private Patient activity without the correct level of indemnity insurance in place. 4. The Private Patient Service may need to stop for a period of time.	Every Consultant or healthcare professional who undertakes private activity (outside of their NHS duties) is required to procure personal indemnification. This is checked prior to the Trust permitting the individual to practice under the auspices of the Trust Private Patient service. Clarification being sought from the Welsh Risk Pool to advise whether Velindre NHS University Trust is indemnified for the purposes of delivering a Private Patient Service at the Velindre Cancer Centre site. The Trust's Finance Business Partner is also benchmarking with other services.	20	20	5
Performance and Service Sustainability	2191	Velindre Cancer Centre	Accepted	14/09/2020		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
Performance and Service Sustainability	2193	Velindre Cancer Centre	Accepted	05/02/2021		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. MPE cover within Nuclear Medicine for MRT has been extremely stretched for a number of years.	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	20	2

Performance and Service Sustainability	2207	Velindre Cancer Centre	Accepted	07/12/2020		eIRMER RT Workflow Solution	DHCR009(R) - eIRMER supports radiotherapy workflow within Canisc. eIRMER will be replaced by a Radiotherapy system when new contract is awarded. Potential for there to be a time difference of a number of months when VCC comes off Canisc and Radiotherapy system ready to be implemented and replace eIRMER functionality. Not having an eIRMER solution and having to revert to paper for a planned period of time would have a detrimental effect on the number of patients radiotherapy colleagues could see and treat.	SBAR written. Option to develop an interim solution being considered and option to pull forward awarding contract in line with timescales being considered. Paper option to be considered for business continuity.	20	20	10
Performance and Service Sustainability	2252	Velindre Cancer Centre	Accepted	14/09/2020		Large number of development projects in Radiotherapy	Large number of development projects 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 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	20	20	10
Compliance	2188	Velindre Cancer Centre	Accepted	18/04/2018		Risk associated with lack of accommodation affecting service delivery	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%	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 become available in early 2021. 9. Non-critical staff relocated from VCC site or WFH under COVID principles. 10. Capital bids placed and timelines produced. 11. Business case submitted to WG for Fire Improvement work. 12. Business case being produced for ventilation improvements in clinical areas. 13. Trust has entered into formal lease agreement with for additional accommodation (Bobath). This has provided	25	20	6
Performance and Service Sustainability	2387	Transforming Cancer Services	New risk	08/07/2020		Lack of TCS programme wide communications plan	A communications plan is needed to ensure: Objectives of the project not communicated properly and the wider model not clear.	There is currently a programme master plan. TCS works closely with the Comms team. Task team working on putting together a comms plan.	12	12	6
Workforce	2401	Transforming Cancer Services	New risk	26/02/2021		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

Performance and Service Sustainability	2407	Transforming Cancer Services	New risk	17/01/2020		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
Performance and Service Sustainability	2402	Transforming Cancer Services	New risk	10/05/2021		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
Performance and Service Sustainability	2414	Transforming Cancer Services	New risk	10/12/2020		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
Quality	2409	Transforming Cancer Services	New risk	05/10/2020		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 13) Benefits Realisation Plan to be reviewed by PMO team	12	12	4
Quality	2416	Transforming Cancer Services	New risk	30/06/2020		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

Quality	2403	Transforming Cancer Services	New risk	08/06/2020		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
Performance and Service Sustainability	2423	Transforming Cancer Services	New risk	08/09/2021		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
Performance and Service Sustainability	2408	Transforming Cancer Services	New risk	22/04/2021		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
Performance and Service Sustainability	2412	Transforming Cancer Services	New risk	05/07/2021		Risk that Judicial Review is approved for consideration	There is a risk that the judicial review request lodged by a member of the public against Welsh Government's decision to approve the nVCC OBC is approved for further consideration, which may lead to delays to or stoppage of the competitive dialogue procurement process.	Note: Mitigating actions are primarily led by Welsh Government. Actions that can be taken by Velindre as an Interested Party are: 1. Provide any available evidence to assist WG in refuting points made within the Judicial Review request (e.g. lack of stakeholder consultation, etc.)Complete 2. Remain in regular contact with WG and provide any assistance required. Ongoing	12	12	8
Quality	2415	Transforming Cancer Services	New risk	17/12/2019		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
Quality	2405	Transforming Cancer Services	New risk	30/06/2020		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

Performance and Service Sustainability	2413	Transforming Cancer Services	New risk	29/06/2020		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
Reputational	2418	Transforming Cancer Services	New risk	05/10/2020		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) 7) Dialouge beteen exisiting cancer forums e.g. cancer leads in SE Wales HBs - ongoing through CCLG 8) Monthly meeting with WG Head of	16	12	4
Workforce	2400	Transforming Cancer Services	New risk	30/06/2020		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
Reputational	2417	Transforming Cancer Services	New risk	08/07/2020		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
Partnerships	2411	Transforming Cancer Services	New risk	04/11/2020		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) TCS may not be delivering the agreed VF scope & clinical outputs Disengagement of stakeholders	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

Workforce	2410	Transforming Cancer Services	New risk	05/10/2020		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

ID	Division	Approval status	RA Date	Closed date	Description	Controls in place	Title	Initial Risk Rating	Current Risk Rating
13819	Welsh Blood Service	Final approval	21/02/2018		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.	Blood Supply Chain 2020 Initiative - Impact on Staff	20	12
14508	Welsh Blood Service	Final approval	09/07/2018		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	Management of Work Place Related Stress	16	12
14862	Welsh Blood Service	Final approval	23/10/2018		"Future litigation - Excess payment from Velindre Trust for each claim (£25000 per claim). This is not an immediate risk, although should be considered in the future (These costs had previously been WG funded) "	Welsh Risk Pool	Infected Blood Inquiry	20	12

15373	Welsh Blood Service	Final approval	27/06/2019		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).	Risks associated with MAK-System introduction of new interfacing policy for devices connected to ePROGESA	12	12
14764	Welsh Blood Service	Final approval	09/10/2018		Increased expenditure	Public Contract Regulations Budgeting and financial controls	Brexit - Implications of Exiting the EU - No Deal Situation	20	20

TRUST BOARD

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	30 September 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable

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

REPORT PURPOSE	FOR DISCUSSION / REVIEW

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	20/09/2021	Endorsed for Board Approval

1. SITUATION

The purpose of this paper is to provide the Trust Board with an update on the development of the Trust Assurance Framework (TAF), and set out next steps in terms of its further development, articulation and operationalisation within the Trust.

2. BACKGROUND

The Trust Assurance Framework sets out the high level principal risks that may threaten the achievement of the organisation's strategic objectives and intent.

There is not expected to be significant movement in the articulation of these risks in the short-term, instead these would be reviewed and evolved in line with the organisation's strategic development cycles or in response to significant external changes.

The focus of the management of the framework is twofold:

I. Setting out the key controls, identifying any gaps in controls and taking action to address these;

II. Setting out the sources of assurance, from first, second and third line of defence sources, and then tracking the insight that each of these sources of assurance is demonstrating against each of the risks. In addition, identifying any gaps in assurance and taking action to address these. To clarify on these terms:

- **First line of defence** – are sources of assurance from the functions that own and manage the risk
- **Second line of defence** – are sources from the functions that oversee the day-to-day operations – e.g. Quality & Safety, Corporate / Clinical Governance
- **Third line of defence** – are sources from functions that provide independent assurance – e.g. Internal /External Audit, Regulators, Audit Wales

Each of the risks has an Executive owner, who will be responsible for co-ordinating the actions required to improve the effectiveness of the key controls and assurance on an on-going basis. The Head of Corporate Governance will then work with each of the Executive owners to update the Trust Assurance Framework on a bi-monthly basis for reporting at Audit Committee, Strategic Development Committee and Trust Board.

The Trust approved the new Risk Management and Trust Assurance Frameworks at the tail end of 2020. Work on populating the Trust Assurance Framework (TAF) is now being progressed by the Executive team, following re-prioritisation during Covid-19 wave 2. It was agreed that full reporting to the Trust Board on the Trust Assurance Framework (TAF) would commence from September 2021 onwards.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The strategic risks set out in the table below have been previously agreed by the Trust Board, following initial shaping by the Strategic Development Committee.

	Risk Theme / Title	Draft Risk Description	Owners
01	Demand and Capacity	Failure to adequately model demand and capacity and service plan effectively, results in failure to deliver sufficient capacity leading to deterioration in service quality, performance or financial control.	COB
02	Partnership Working / Stakeholder Engagement	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.	CJ

	Risk Theme / Title	Draft Risk Description	Owners
03	Workforce Planning	Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.	SM
04	Organisational Culture	The risk of not effectively building a joined up organisation. This is fundamental to the future success for the organisation.	SM
05	Organisational change / 'strategic execution risk'	Risk that aggregate levels of organisational change underway across the Trust creates uncertainty and complexity, leading to a disruption to business as usual (BAU) operations; an adverse impact on our people/culture; deterioration or an unacceptable variation in patient/donor outcomes; and/or a failure to deliver on our strategic objectives and goals.	CJ
06	Quality & Safety Risk – Holistic Service	Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes amd datasets including ability to en-mas learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides.	NW
07	Digital transformation - failure to embrace new technology	Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.	CJ
08	Investment	There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical practices and thus ensure appropriate funding mechanisms are in place and agreed.	MO
09	Future Direction of Travel	Opportunity risk of the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.	CJ
10	Governance	There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.	LF

Appendix A is the agreed template by Trust Board for the Trust Assurance Framework. Each of the agreed strategic risks have been reviewed and completed by the Executive owners as a first iteration. In working through the detail, the Executive Owners have reframed and refined the articulation of the strategic risks for **Demand and Capacity** and **Quality and Safety** (highlighted in red in the table above for ease of reference) to more accurately reflect the scope of each of these strategic risks and the developments in framework approach in recent months for Quality & Safety. As such, the full articulation of the **Demand and Capacity** strategic risk will be received

at the November Trust Board and is not included within this first iteration of the populated Trust Assurance Framework. In addition, it is anticipated that the articulation of the controls and assurance mechanisms described for Quality & Safety will be further enhanced in the interim period between the September and November Trust Board. The **Organisational Change / Strategic Execution** risk is also in the early stages of development to reflect the emerging Trust wide strategy for 2032 and as such will be incorporated into the November iteration.

It should also be noted that the **Organisational Culture** strategic risk is being worked up further. There are many facets of work that the Trust has underway or in development that will ultimately effect the culture of the organisation and the way in which it works as a whole to effectively deliver services and achieve its ambitions. Key to development of the Trust Assurance Framework for this strategic risk and to reflect the complexity of that work will be the approval and adoption of the Trust People Strategy and its three themes of a Healthy and Engaged Workforce, a Skilled and Developed Workforce and a Planned and Sustained Workforce. This will be completed by the end of this calendar year and will have underneath it a work programme that will align to support and develop the culture of the organisation.

The whole further developed set of strategic risks will then be brought again through Strategic Development Committee, Audit Committee and Trust Board on the 25 November 2021.

Appendix B 'Trust Risk Assurance Framework document' approved by the Trust Board previously, has been updated to encompass the feedback received through the initial stages of operationalisation and is also included with this report for reference. However, a full refresh and review will form part of the planned annual revision cycle.

4. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	ALL
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.
	Related to Quality legislation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

5. RECOMMENDATION

The Trust Board is asked to:

I. **NOTE** the progress to date, and **DISCUSS / REVIEW** the first iteration of the Trust Assurance Framework included at ***Appendix A***.

II. **NOTE** next steps in the development pathway to support full operationalisation of the Trust Assurance Framework.

Risk ID:	**TAF 01**	Failure to establish and maintain effective relationships with internal and external stakeholders, and/or align our operational actions or strategic approach with system partners, resulting in confusion, duplication or omissions; threatening collaborative working initiatives; and/or an inability to deliver required change to achieve our medium to long term objectives.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations
Executive Lead:	**Director of Strategic Transformation, Planning and Digital**	

RISK SCORE (see definitions in Appendix C)								
Inherent Risk			**Residual Risk**			**Target Risk**		
Likelihood	**Impact**		**Likelihood**	**Impact**		**Likelihood**	**Impact**	
4	4	***16***	3	4	***12***	2	4	***8***

Overall Level of Control Effectiveness: Rating & RAG	**Overall Trend in Assurance Rating:** Rating & RAG

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Although each of these mechanisms and controls are reported through various mechanisms – a specific action plan against these controls will be developed and reported through governance to support this strategic risk	CJ		November 2021
1.2	Consideration of second and third line opportunities for further assurance to be incorporated into action plan as per action 1.1	CJ		November 2021

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
1.1	System structures – core cancer services commissioning arrangements;		X			PE	Commissioning contracting reporting	*IA*				
1.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	*IA*				
1.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	*IA*				
2.1	Blood - core blood services commissioning arrangements;		X			PE	Commissioning contracting reporting	*IA*			Regulatory scope re MHRA tbc	
2.2	with effectively delivering ways of working/ work programmes;			X		PE	Supply and demand reporting	*IA*				
2.3	and data and measures to clearly track progress against objectives.				X	PE	Linked through performance framework insight	*IA*				
3.1	South Wales Collaborative Cancer Leadership Group system model;		X			PE	Agreed to model for next phase	*IA*				
3.2	with effectively delivering ways of working/ work programmes;			X		PE	Collectively agreed to and documented work programme	*IA*				
3.3	and data and measures to clearly track progress against objectives.				X	NE	With respective measures reported	*IA*				
4.1	Partnership Board arrangements with partner Health Boards model;		X			PE	Agreed to model for each organisation	*IA*				
4.2	with effectively delivering ways of working/ work			X		NE	Collectively agreed to and documented	*NA*				

	programmes;							work programme				
4.3	and data and measures to clearly track progress against objectives.				X	NE		With respective measures reported	*NA*			

Risk ID:	**TAF 02**	**Workforce Planning** Risk of not having the right staff in right place at right time with right capability, as a result of not having appropriate and effective workforce plan owned in the right place, resulting in deterioration of operational performance, decline in the safety/quality of service provision, threatening financial sustainability and/or impacting our transformation ambitions.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** A leading provider of clinical services that always meet, and routinely exceed, expectations

Executive Lead:		**RISK SCORE (see definitions in Appendix C)**								
		Inherent Risk			**Residual Risk**			**Target Risk**		
		Likelihood	**Impact**		**Likelihood**	**Impact**		**Likelihood**	**Impact**	
		3	3	***9***	3	3	***9***	2	3	***6***

Overall Level of Control Effectiveness: Rating & RAG	**Overall Trend in Assurance Rating:** Rating & RAG

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Paper to Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	SM/ST		December Strategic Development Committee
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	SM/ST		December Strategic Development Committee

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Draft Trust People Strategy clearly noting the strategic intent of Workforce Planning – 'Planned and Sustained workforce'	SM	x			PE	Tracking key outcomes and benefits map – aligned to Trust People Strategy	*Yet to be measured*	Internal Audit Reports	*None to report for previous period*	To be completed as per compliance/ reg tracker update	
C2	Workforce Planning Methodology approved by Executive Management Board	ST	x			PE	Staff Feedback	*Yes to be measured*	Trust Board reporting against Trust People Strategy	*As above*	As above	
C3	Workforce Planning – Skills Development – Training and Development Package in Place	ST	x			PE	Performance reports via divisional and committee structures					
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	ST	x			PE						
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	ST	x			PE						
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	ST	x			PE						
C6	Widening access Programme in train to support development of new skills and roles	ST	x			PE						
C7	Workforce analysis available via ESR and Business Intelligence support	ST	x			PE						
C8	Agile Workforce Programme established to assess implications for planning a	SM/ST			x	PE						

	workforce following COVID and leaning lessons – will include Technology Impact assessments											

Risk ID:	**TAF 03**	**Quality & Safety Risk – Holistic Service** Trust does not currently have cohesive and fully integrated Quality & Safety mechanisms, systems, processes amd datasets including ability to en-mas learn from patient feedback i.e. patient / donor feedback / outcomes / complaints / claims, incidents and ability to gain insight from robust traingulated datasets and to systematically demostrate the learning, improvement and that preventative action has taken place to prevent future donor / patient harm. This could result in Trust not meeting its national and legislative responsibilities (Quality & Engagement Bill (2020)) and a reduction in public/patient/donor, external agency, regulator and commissioner confidence in the quality of care the Trust provides
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** 1 – Outstanding for quality, safety and experience
Executive Lead:	**Nicola Williams, Executive Director Nursing, AHP & Health Science**	

RISK SCORE (see definitions in Appendix C)								
Inherent Risk			**Residual Risk**			**Target Risk**		
Likelihood	**Impact**		**Likelihood**	**Impact**		**Likelihood**	**Impact**	
5	5	***25***	3	5	***15***	2	5	***10***

Overall Level of Control Effectiveness: Rating & RAG

Overall Trend in Assurance Rating: Rating & RAG

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Trust Quality & Safety Framework to be finalized and implementation plan developed.	NW	Trust wide consultation on the Quality & Safety Framework completed. Executive engagement session held. Final version being drafted.	December 2021
1.2	Corporate & Divisional Quality Hubs to be established	NW; PW & AP	• Constitution of Corporate Quality & Safety Hub agreed & resourcing determined- awaiting confirmation of funding – aligned with restructuring of corporate Quality & Safety Team • WBS Quality Hub requirements determined – minor changes required from existing arrangements • VCC Quality Hub high level requirements determined - additional / realignment of resources maybe required. Detail needs to be worked through	March 2022 March 2022

1.3	Trust Quality & Safety Framework implementation plan to be completed in line with agreed timescales	Exec Team & Div Drts	Will be developed once Framework finalized	
1.4	Instigate a Quality & Safety monthly operational meeting where cross cutting outcome review & triangulation takes place	NW		March 2022
1.5	Ensure the Action & learning sections within the Once for Wales Datix System are robustly implemented & audited	NW		March 2022
1.6	Implement a robust compassionate leadership programme	SM		
1.7	Ensure all responsible officers receive Investigation Training	NW/ COB		June 2022
1.8	Implement National Duty of Candour guidelines / requirements	JA		April 2023
1.9	Implement National Duty of Quality guidelines / requirements	NW		April 2023
1.10	Explicitly define the required Quality, Safety & Governance assurance mechanisms for Hosted Organisations	LF		Zq1` January 2022
1.11	Complete Risk Register Review, transmission onto Datix v. 14 (O4W when available) & ensure regular reviews at all levels in line with Quality & Safety outcomes	LF		March 2022

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Control name	Initials	X in appropriate box			See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG
C1	Once for Wales Datix System implemented	NW			x	PE	Staff Feedback		Internal Audit Reviews		Audit Wales Reviews	
C2	CIVICA pt/donor feedback system system being implemented	NW			X	NE	Patient / Donor Feedback		Quality, Safety & Performance Committee		HIW Inspect	
C3	Trust wide Divisional to Board level Quality & Safety meeting structure in place	Execs	x	x	x	PE	15 step challenge		Peer Reviews		MHRA	
							EMB				Prof bodies	
C4	Quality & Safety Teams in place corporately & in each Division	NW /AP /PW	X	X	X	NE	Divisional Q&S Groups				DU	
							PMF					
C5	PMF in place & under review to include experience & outcomes	CJ			X	NE	Perfect Ward audits					
							Clinical Audit					
C6	Trust Risk Register in place	LF	X	X	X	NE	Mortality Reviews					
C7	Regular Staff Feedback sought	SM			X	PE						
C8	Staff Q&S training & Education	NW	X			NE						

Risk ID:	**TAF 07**	**Digital transformation - failure to embrace new technology** Risk that the Trust fails to sufficiently consider, exploit and adopt new and existing technologies (i.e., assess the benefits, feasibility and challenges of implementing new technology; implement digital transformation at scale and pace; consider the requirement to upskill/reskill existing employees and/or we underestimate the impact of existing and new technology and the willingness of patients to embrace it/ their increasing expectation that their care be supported by it) compromising our ability to keep pace and be seen as a Centre of Excellence.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** A leading provider of clinical services that always meet, and routinely exceed,expectations

Executive Lead:	**Director of Strategic Transformation, Planning and Digital**	**RISK SCORE**								
		Inherent Risk			**Residual Risk**			**Target Risk**		
		Likelihood	**Impact**	**12**	**Likelihood**	**Impact**	**12**	**Likelihood**	**Impact**	**6**
		3	4		3	4		2	3	

Overall Level of Control Effectiveness: Partially Effective

Overall Trend in Assurance Rating: Inconclusive assurance

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Chief Digital Officer to bring a paper to next Strategic Development Committee with further detail on the plans to develop each of the key controls to an “effective” level	StMo		December Strategic Development Committee
1.2	Development of 3rd Line of defence assurance to be completed in line with the development of the compliance and regulatory tracker	StMo	.	December Strategic Development Committee

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Digital Strategy	CJ	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	*Yet to be measured*	SIRO Reports	*None to report for previous period*	To be completed as per compliance/ reg tracker update	
C2	Active work on-going to leverage existing and deliver on new technologies – e.g. LIMs, IRS, Becs	StMo		X		E	Trust digital governance reporting	*Yet to be measured*	Internal Audit Reports	*None to report for previous period*		
C3	Training & Education packages to develop internal capabilities – including for exec and Board	SaMo	X			PE	Staff feedback	*Yet to be measured*	Trust Board reporting against Trust Digital Strategy	*Yet to be measured*		
C4	Training & Education packages for donors, patients	StMo	X			PE	Patient and donor feedback	*Yet to be measured*	Feedback and progress of working with Universities	PA		
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	CJ	X			PE						
C6	Specifically development of digital resources capacity and capability	StMo	X									
C7	Digital inclusion – in wider community	StMo	X			PE						
C8	Opportunities for digital career paths	StMo	X			PE						
C9	Prioritisation and change framework to manage service requests	StMo		X		PE						
C10	Levels of unsupported applications/ legacy systems	StMo			X	PE						
C11	Trust digital governance	CJ		X		PE						
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	StMo			X	PE						

Risk ID:	**TAF 08**	**Trust Financial Investment Risk** There is a risk that the contracting arrangements between Velindre and its Commissioners do not adequately acknowledge future service developments and changes in clinical & scientific practices and thus ensure appropriate funding mechanisms are in place and agreed.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** Goal 5: A sustainable organisation which contributes to a better world for future generations across the globe

Executive Lead:	**Director of Finance**	**RISK SCORE (see definitions in Appendix C)**								
		Inherent Risk			**Residual Risk**			**Target Risk**		
		Likelihood	**Impact**		**Likelihood**	**Impact**		**Likelihood**	**Impact**	
		3	4	***12***	4	4	***16***	3	3	***9***

Overall Level of Control Effectiveness: Rating & RAG

Overall Trend in Assurance Rating: Rating & RAG

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
1.1	Support the embedding of investment framework within Velindre Cancer Centre	DO	Process continues to be embedded, terms of reference and process established. Communications throughout Division and “live” operation to follow.	Nov-21
1.2	Review of contracting model for impact of COVID related measures	DO	Areas of concern identified, discussions to inform are underway with Services. Board to be advised of present volatility and Commissioners engaged.	Oct-21
1.3	Establish Trust Investment Prioritisation Framework	MB	Initial proposals prepared, Executive discussions to shape and take forward	Dec-21

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Financial Strategy	MB	X			PE	Tracking forecast delivery against financial strategy via Performance Committees and Trust Board	PA	Monthly Performance Review with Executives	PA	Monthly Performance Reporting to Senior Management Teams	PA
C2	Active engagement with Commissioners and Welsh Government to ensure inclusion of Velindre requirements within their Financial Planning	MB		X		PE	Inclusion in Health Board IMTP Financial Plans	*IA*	Monthly Commissioner Meetings held to confirm financial planning requirements	IA		
C3	Active engagement with Trust & Divisions to ensure investment does not exceed available funding	DO	X			PE	Monthly Financial Performance Review Reported to Execs and Senior Management Teams	*PA*	Quarterly Directorate financial reviews established across both Divisions	PA		
C4	Continuous review of contracting currencies and direct WHSCC funding to ensure reflective of efficient cost of delivery	DO		X		PE	Frequent formal Reviews to be established, combined with routine contract reporting	*IA*				
C5	Benchmarking with appropriate services to ensure value	MB			X	PE						
C6	Routine contracting reporting and discussion with Commissioners to review activity and early identify income volatilities	DO			X		Monthly Financial Performance Review Reported to Commissioners with Monthly Meetings	*PA*				
C7	Establish Investment Prioritisation Framework at a Trust and Divisional level to ensure no investment creep and strategic priority alignment	MB	X			PE						

Risk ID:	**TAF 09**	Risk that the Trust's ability to develop new services and failure to take up and create opportunities to apply expertise and capabilities elsewhere in the healthcare system.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** Goal 2: An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed, expectations

Executive Lead:	**Director of Strategic Transformation, Planning and Digital**	**RISK SCORE (see definitions in Appendix C)**								
		Inherent Risk			**Residual Risk**			**Target Risk**		
		Likelihood	**Impact**	***16***	**Likelihood**	**Impact**	**12**	**Likelihood**	**Impact**	**8**
		4	4		3	4		2	4	

Overall Level of Control Effectiveness: Rating & RAG	**Overall Trend in Assurance Rating:** Rating & RAG
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
•	•

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1	Develop full suite of strategic documents to provide clarity om future	CJ		
1.2	Board decision on strategic areas of focus/to pursue	Board		
1.3	Discussion with partner(s) to determine whether opportunity viable	Director(s)		
1.4	Identify capability required and funding solution/source	Director(s)		

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Development of a Trust strategy and other related strategies (R, D& I; digital etc) which articulate strategic areas of priority					PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy					
C2	Trust Clinical and Scientific Strategy	IJA/NW	X			PE	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy	See definitions in Appendix C & RAG				
C3	Development of a Clinical and Scientific Board to lead clinical direction of travel					PE						
C4	Development of improved local, regional and national clinical commissioning arrangements					PE						
C5	Agreement of system leadership roles for primary services: i. Blood Services ii. Cancer Services					PE						
C6	Change in strategic workforce plan to recognize/address any new leadership/clinical/management skills related to strategic growth					PE						
C7	Refresh of Investment and Funding Strategy??					PE						
C8	Development of commercial strategy					PE						
C9	Attraction of additional commercial and business skills					PE						

Risk ID:	**TAF 10**	**Governance** There is a risk that the organisation's governance arrangements do not provide appropriate mechanisms for the Board to sufficiently fulfil its role and the organisation to then be effectively empowered to deliver on the shaping strategy, culture and providing assurance, particularly through a quality and safety lens.
Last Review: **Next Review:**	**September 2021** **November 2021**	**Most Relevant Strategic Goal:** 1 – Outstanding for quality, safety and experience
Executive Lead:	**Director of Corporate Governance & Chief of Staff**	

RISK SCORE								
Inherent Risk			**Residual Risk**			**Target Risk**		
Likelihood	**Impact**		**Likelihood**	**Impact**		**Likelihood**	**Impact**	
4	4	**16**	3	4	**12**	2	4	**8**

Overall Level of Control Effectiveness:

Overall Trend in Assurance Rating: Inconclusive assurance

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

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	**Owner**	**Progress Update**	**Due Date**
C4	**Board Development Programme:** • Development of a more structured needs based approach to inform a longer terms plan for the Board Development Programme. • Ongoing input from the Independent Members via the repurposed Integrated Governance Group		• Supported by the development priorities identified through an externally facilitated programme of Board development underway. • Terms of Reference and supporting refreshed standard agenda has been reviewed and is to be agreed by Independent Member by.	December 2021 October 2021

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Annual Assessment of Board Effectiveness	**ES**			**X**	**E**	• Annual Board Effectiveness Survey • Annual Self-Assessment against the Corporate Governance in Central Governance Departments: **Code of Good Practice 2017**	**P**	• Audit Committee • Trust Board	**P**	• Internal Audit Reports • Audit Wales Structured Assessment Programme / Reports • Joint Escalation & Intervention Arrangements	**P**
C2	Board Committee Effectiveness Arrangements	**LF**	**X**			**TBC**	• Internal Annual Review	**TBC**	• Audit Committee • Trust Board	**TBC**	• Internal Audit of Board Committee Effectiveness • Audit Wakes Structured Assessment • Audit Wales Review of Quality Governance Arrangements	**TBC**
C3	Health & Care Standards Self-Assessment Arrangements: Standard 1.0 - Governance, Leadership and Accountability	**LF**			**X**	**E**	• Divisional Management Arrangements for overseeing effective implementation and monitoring	**P**	• The Trust has an established framework through which self-assessment are undertaken and action taken to implement improvements and changes required – reported on a quarterly basis to EMB Run, Quality, Safety & Performance Committee and Board as required	**P**	• Annual Internal Audit Report against the Health & Care Standards for Wales (20/21 assessment provided Substantial Assurance) • Audit Wales review outcomes of report as part of Annual Report - Accountability Report	**P**
C4	Board Development Programme	**LF**	**X**			**PE**	• Programme established	**PE**	• Independent Member oversight via	**PE**		

										repurposed 'Integrated Governance Group'			
C5	All-Wales Self-Assessment of Quality Governance Arrangements	**LF**		**X**		**E**	• Action plan developed in response to self-assessment exercise. All actions complete /on track to complete by end of this financial year.	**E**	• Monitoring and oversight via EMB and Quality, Safety & Performance Committee	**E**	• Audit Wales review of Quality Governance Arrangements	TBC

Control effectiveness

Definitions

Control effectiveness

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

Assurance Rating

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA

Risk Score:

IMPACT Matrix

	Impact, Consequence score (severity levels) and examples				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/ minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis

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

				Purchasers failing to pay on time	results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood – MATRIX

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

Risk Rating Matrix- Impact X Likelihood

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

Trust Assurance Framework (TAF)

Executive Sponsor: Lauren Fear, Director of Corporate Governance & Chief of Staff

Document Author: Lauren Fear, Director of Corporate Governance & Chief of Staff

Approved by: Trust Board

Approval Date: 30 September 2020

Review Date: November 2021

Version: 1.1 – Updated August 2021

Version 1.1 Note – the changes compared to the Board approved version September 2020 are:

1. *Section 3.2 – Strategic objective section – updated in line with current drafting – will be finalised in line with agreement of final version of mission, vision and goals*
2. *Section 3.6 – Definitions of control effectiveness – when work completed to populate the TAF, guidance around consistent definitions was required*

Table of contents

1. Introduction

1.1 Background

All Health Boards and Trusts are required to create and maintain a Board Assurance Framework (BAF). In doing so, the VUNHST Board must be able to assure itself that the Trust is operating effectively and meeting its strategic objectives. It does this through its internal governance structures, management controls and by providing assurance that its controls are operating effectively, and objectives are being met.

There are several ways in which the effectiveness of internal controls will be assessed and through which assurance will be provided to the public such as the Annual Governance Statement and the internal audit function providing an opinion as to whether the Board has identified its objectives, risks, controls and sources of assurance and accurately assessed the value of assurance obtained.

1.2 BAF Definition

To ensure consistent language and understanding, the following external definitions for 'BAF' are used:

Source	Definition
The Audit Committee Handbook	"the key source of evidence that links strategic objectives to risk and assurance, and the main tool that the Board should use in discharging its overall responsibility for internal control".
The Institute of Chartered Secretaries and Administrators	"a structured approach for ensuring that boards get the right information which is accurate and relevant at the right time and with the level of assurance attributed to each source of data. It pulls together all data pertaining to organisations strategic goals and the risks it faces".

It was agreed to name this document and process Trust Assurance Framework (TAF) to firstly reflect the fact that the process should be of value for the whole Trust and secondly to reflect the ambition of this framework to, in time, effectively link with both the Quality & Safety and Performance frameworks.

1.3 Purpose of TAF

The TAF enables the Board to identify and understand principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks, and where improvements are needed suitable action plans are in place and being delivered; and to provide an assessment of the risk to achieving the related objective.

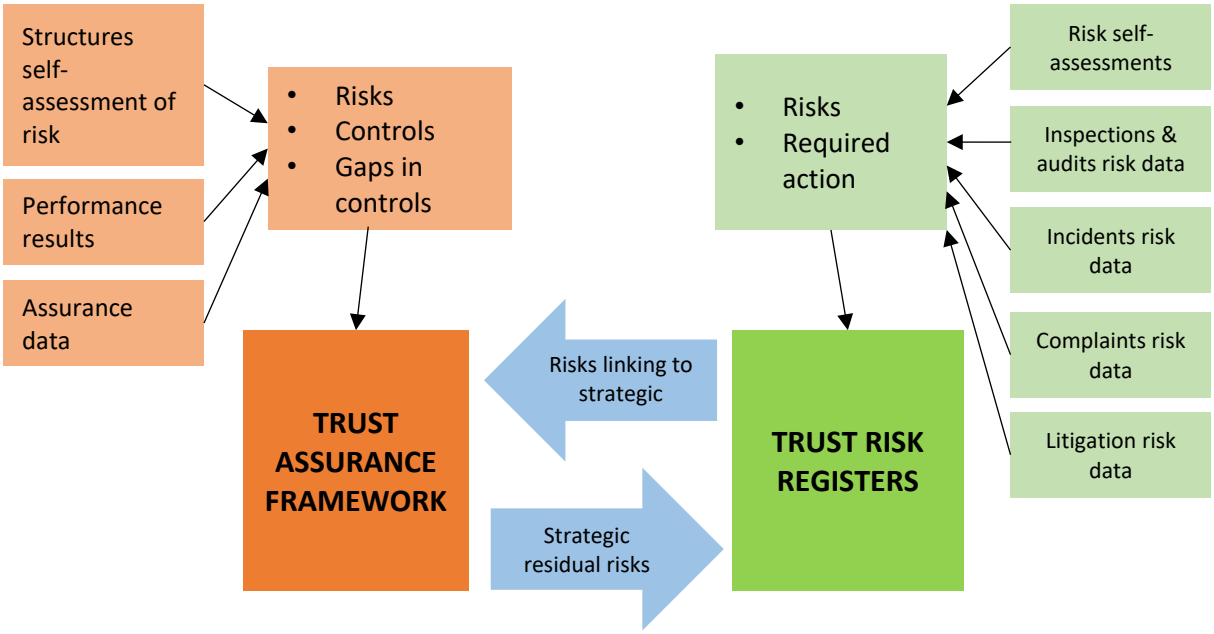
The TAF is used by the Trust to:

a) To provide assurance to the Board that risks with the potential to impact on strategic objectives/vision, mission and purpose are being managed appropriately.
b) As a key document to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.
c) As a systematic method to identify and understand the principal risks to achieving its strategic objectives, receive assurance that suitable controls are in place to manage these risks and where improvements are needed.
d) Provide an assessment of the risk to achieving the objectives based on the strength of controls and assurances in place.

e) A method to provide aggregated board reporting, ensuring prioritised action plans are in place and are being delivered.

The TAF is the key source of information that links VUNHST's strategic objectives to risk and assurance, as demonstrated in figure 1 below:

Figure 1: Information flows between the risk register & the assurance framework



1.4 Benefits of the TAF

An effective assurance framework:

a) Provides timely and reliable information on the effectiveness of the management of major strategic risks and significant control issues.
b) Facilitates escalation of risk and control issues requiring visibility and attention by senior management, by providing a cohesive and comprehensive view of assurance across the risk environment.
c) Provides an opportunity to identify gaps in assurance needs that are vital to the Trust, and to plug them in a timely, efficient and effective manner.
d) Can be used to raise organisational understanding of its risk profile and strengthen accountability and clarity of ownership of controls and assurance thereon, avoiding duplication or overlap.
e) Provides critical supporting evidence for the production of the Annual Governance Statement.
f) Facilitates better use of assurance skills and resources.

1.5 Barriers to an effective assurance framework

The goal is to ensure that the TAF is not seen as an add on, stand alone or tick box exercise but forms an integral part of the agendas and work of each committee and sub-committee. If developed and used correctly, it is a tool for formulating and driving the agenda and ensuring that risk is managed accordingly. Potential barriers to keep in view when implementing and then operating are:

a) Absence of clear, measurable, time limited strategic objectives and forward trajectories of performance against which risk can be identified and mitigated.
b) Failure to provide adequate focus on the effectiveness of the controls and the strength of the assurance.
c) Some risks held on the TAF are intangible, we know they exist, we have no tangible controls, but they have a potential for major impact on our organisation.
d) No clear understanding of the purpose and benefit of a robust TAF.
e) Infrequent review and TAF not seen as a live document i.e., risk owners / handlers only reviewing their risks when an update is due at Board.
f) Lack of accountability/ownership i.e., little challenge or questions from the Boards not seeing themselves as owning it - more as another paper that comes their way for information.
g) Over reliance on internal assurance, without an independent element of scrutiny.

2. Governance and Assurance

2.1 Good governance requirements

An efficient and effective assurance framework is a fundamental component of good governance and provides a tool for the Board to identify and ensure that there is sufficient, continuous and reliable assurance, organisational stewardship and the management of the major risks to the Trust's success.

Additionally, the Chief Executive Officer must sign an Annual Governance Statement, as part of the organisations statutory accounts and annual report, which reinforces the need for the Board to be able to demonstrate that it has been properly informed about the organisational risk profile.

In order to be confident that the Trust's systems of internal control are robust, the Board needs to be able to provide evidence that it has identified its objectives and managed the principal risks to achieving them. The TAF will helps the Board to undertake this duty.

2.2 Levels of Assurance / "Three Lines of Defence"

As outlined in the Risk Management Framework, the Trust applies the 'Three Lines of Defence' model to assure ourselves and those we are accountable to that we are managing our organisation well. Assurance information is provided as standard across the lines of defence as displayed below.

First Line of Defence (functions that own and manage risk)	**Second Line of Defence** (functions that oversee or specialise in risk management)	**Third Line of Defence** (functions that provide independent assurance)
Self-Assurance: • Risk and control management as part of day-to-day business management • Staff training and compliance with policy guidance • Teams take responsibility for their own risk identification and mitigation	**Internal oversight** / specialist control teams, such as: • Quality & Safety • IT • Governance (Corporate / Clinical)	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as: • External Audit • Regulators & Commissioners • Wales Audit Office reviews • Stakeholder reviews • Scrutiny from public, Parliament, and the media
Examples of assurance: • *Management Controls / Internal Control Measures* • *Local management information / departmental management reporting* • *Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)* • *Operational planning / Business Plans - Delivery Plans and Action Plans* • *Governance statements / self-certification* • *Local procedures* • *Exceptions reporting* • *Targets, Standards and KPIs* • *Incident Reporting* • *Staff Training Programmes*	Examples of assurance: • *Board, Committee and Management Structures which receive evidence from the 1st Line of Defence that risks are being managed effectively* • *Finance reports* • *KPI's and management information* • *Quality, Safety and Risk reports* • *Training records and statistics* • *Performance reports* • *BAF, VUNHS risk register* • *Policies and Procedures including Risk Management Policy* • *Compliance against Policies*	Examples of assurance: • *Recent internal audit reviews and levels of assurance* • *External Audit coverage* • *Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews* • *Patient Feedback / Patient experience feedback* • *Staff surveys / feedback* • *Comparative data, statistics, benchmarking*

3. Compiling the TAF

3.1 Process for compiling the TAF

The structured mapping of assurances is one of the fundamental steps in building an assurance framework. Understanding the sources of assurance and their scope means focus can be applied most effectively on the riskier areas.

The process for gaining assurance is fundamentally about taking all of the relevant evidence together and arriving at informed conclusions. The most objective assurances are derived from independent reviewers; these are supplemented by internal sources such as clinical audit, internal management representations, performance management and self-assessment reports.

Trust's 5 stage process for building the TAF is depicted in figure 2 below.

Figure 2: TAF development process

The key components of each of the 5 stages the assurance process are explained below;

Strategic Objectives - The first step in designing the assurance process is for the Board to identify its strategic objectives, e.g. clinical, financial, workforce, commercial and other objectives, focusing on those which are crucial to the achievement of its aims and values.

Strategic Risks - These are risks which threaten the achievement of the Trust's objectives. Strategic risks should be identified through Board meetings, workshops and/or seminars where the strategic objectives that these risks relate to are identified and debated. As part of the identification of strategic risks the level and type of risk the Trust is prepared to accept, or its appetite, should also be reviewed.

Key Controls - These are the management systems and processes the Trust has in place to manage its strategic risks. Controls will be scrutinized internally and externally e.g. by independent reviewers, which includes internal auditors, HIW and Audit Wales in conjunction with clinicians and other specialists where necessary. Key controls have been mapped to the principal / strategic risks. When assessments are made about the adequacy of key controls, consideration will be given not only to the design of the control itself but also their effectiveness in light of the governance and risk management framework within which they will operate.

Assurance on Controls - The Board must then gain assurance about the effectiveness of the controls in place to manage the principal risks. They not only need to ensure that controls are in place and effective, but to make use of the work of external reviewers and ensure that the control framework is proportionate to the associated risk. A gap in assurance is deemed to exist where it has not been possible to gain evidence that controls are effective. Any gaps in either controls or assurance will be identified in the TAF, along with agreed actions to be implemented, action owners and timescales for implementation. During the course of its business members of the Board should continually ask questions to assess the strength of the internal controls and assurances being presented.

Board Reports and Actions - The TAF provides a framework for identifying which of the Trust's objectives are at risk because of inadequacies in controls or where the Trust has insufficient assurance about those controls. At the same time, it provides structured assurances about risks which are being managed effectively and objectives that are on track to be delivered. This allows the Board to determine where to make best use of its resources and address the issues identified in the delivery of strategic objectives.

3.2 Strategic Objectives

The TAF serves to inform the Board of the principal risks threatening the achievement of strategic objectives and describes how the Trust is provided with assurances on the delivery of its:

[Draft wording currently undergoing engagement – to be updated when final version agreed]

- **Mission** To Improve Lives
- **Vision** Excellent Care, Inspirational Learning, Healthier People
- **Five Strategic Goals for 2032**:
  - → Goal 1: Outstanding for quality, safety and experience
  - → Goal 2: A leading provider of clinical services that always meet, and routinely exceed, expectations
  - → Goal 3: A beacon for research, development and innovation in our stated priority areas
  - → Goal 4: An established 'University' Trust which provides highly valued knowledge and learning for all
  - → Goal 5: A sustainable organisation which contributes to a better world for future generations across the globe

3.3 Content of the Trust Assurance Framework

The TAF template is provided in Appendix A and B. Each risk identified in the TAF will have the following minimum data set:

- A sequential reference number (Risk ID)
- A description of the risk
- Link to strategic objective
- Inherent risk rating
- Current/residual risk rating
- Target risk rating
- Last and next review dates
- Executive Lead / Responsible Executive Director
- Key Control(s)
- Control effectiveness
- Gap in Control
- Actions required to bridge gaps in control / assurance
- Trend / a way of demonstrating trajectory / the history of the risk rating throughout the reporting period
- Source / Form of Assurance (internal and/or external evidence to show that effective controls are in place)
- Gaps in assurance
- Assurance Rating / level of assurance (as per ratings below)

3.4 Assurance Ratings

Executive Leads must provide an assessment of the level of assurance for each risk on the TAF. The following key is used by committees when assigning assurance ratings:

- **Positive assurance**: the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- **Inconclusive assurance**: the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
- **Negative assurance**: the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity

3.5 Risk Quantification Matrix

To score the risks identified VUNHST will use its Risk Quantification Matrix – see Appendix C.

3.6 Control Effectiveness Rating

Executive Leads must provide an assessment of the level of assurance for each risk on the TAF. The following key is used by committees when assigning control effectiveness ratings:

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

4. Operationalising the TAF

4.1 Summary / scrutiny and challenge of the TAF, including frequency

The TAF aligns strategic risks, key controls, risk appetite, and assurance with strategic objectives. It sets out strategic objectives, identifies risks in relation to each strategic objective and maps out both the key controls that should be in place to manage those objectives and the sources of assurance (evidence) that these controls are operating effectively. Gaps are identified where key controls are insufficient to mitigate the risk of non-delivery of objectives. This enables the Board to develop and monitor action plans intended to close the gap and improve outcomes.

The TAF supports the Annual Accountability Report, which includes the Annual Governance Statement. The TAF should drive the Board agenda and be a standing agenda item at Board, monthly.

The Board reviews a monitored, dynamic TAF. It is therefore important to note that the TAF must remain a live assurance tool. The Executive Team and Scrutiny Committees have responsibility to discuss the TAF and any amendments, to ensure there is appropriate scrutiny and challenge of principal risks prior to the TAF being submitted to the Board for approval. This will include:

- Reviewing updates to the existing principal risks since it was last approved by the Board.
- Consider de-escalation of any principal risks to operational risk registers and make this recommendation to the Board.
- Agree the submission of any new principal risks to the Board for approval.

The Trust's Committees will oversee scrutiny and assurance on behalf of the Board for strategic risks captured on the TAF which are delegated to them for review. Committees will review their sections of the TAF on a monthly basis and draw to the attention of the Board any issues or concerns or the need for action plans.

4.2 Risk reporting and escalation routes

Full guidance on risk reporting and escalation can be found in the VUNHST Risk Management Framework (RMF) and Risk Management Process documents. In summary:

- → The Head of Corporate Governance will compile a Trust Assurance Framework (TAF) for the Board, consisting of the top strategic risks to VUNHST's objectives and any other risks the Board have requested sight of regardless of score. For example, the TAF is cross-referenced with the Trust Risk Register to ensure that any material operational risks that meet the escalation criteria below are included as appropriate to ensure completeness of coverage.
- → Risks scored >=15, and any risks where the impact is scored as 5 regardless of likelihood will require confirmed review by the relevant Executive Committee and confirmed review by the Board. It should be escalated according to the RMF and considered for inclusion on the TRR and BAF, monthly.
- → Risks outside Board-specified tolerance ranges: As outlined in the Risk Appetite Strategy, the Trust Board has developed indicative tolerance ranges against 9 principal risk categories (or risk domains). Any risks outside these ranges will require confirmed review by the relevant Executive Committee and considered for inclusion within the TAF.

5. Appendix A: TAF Summary

Risk ID	Principal Risk Description	Related Strategic Goal	Executive Risk Lead	Residual Risk Score (& Movt from previous)	Target Score	Control Effectiveness (& Movt from previous)	Assurance Rating (& Movt from previous)	Next Review Date

6. Appendix B: TAF Dashboard

Risk ID:	**TAF XX**										
Last Review: **Next Review:**	**Month Year** **Month Year**	**Most Relevant Strategic Goal:** (see section 3.2)									
Executive Lead:		**RISK SCORE (see definitions in Appendix C)**									
		Inherent Risk			**Residual Risk**			**Target Risk**			
		Likelihood	**Impact**	***Score & RAG***	**Likelihood**	**Impact**	***Score & RAG***	**Likelihood**	**Impact**	***Score & RAG***	

Overall Level of Control Effectiveness: Rating & RAG	**Overall Trend in Assurance Rating:** Rating & RAG
GAPS IN CONTROLS	**GAPS IN ASSURANCE**
•	•

ACTION PLAN FOR ADDRESSING GAPS IDENTIFIED ABOVE

	Action Plan	Owner	Progress Update	Due Date
1.1				
1.2				

	KEY CONTROLS						SOURCES OF ASSURANCE					
	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Control name	Initials	X in appropriate box			See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG	Assurance source	See definitions in Appendix C & RAG

7. Appendix C: Definitions

Control effectiveness

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

Assurance Rating

Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	P
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA

Risk Score:

IMPACT Matrix

	Impact, Consequence score (severity levels) and examples				
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Quality/complaints/ audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

			implications if findings are not acted on		
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report

Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business Objectives/ Projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5-10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance Including Claims	Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood – MATRIX

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

Risk Rating Matrix- Impact X Likelihood

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

TRUST BOARD

HIGHLIGHT REPORT FROM THE CHAIR OF THE STRATEGIC DEVELOPMENT COMMITTEE

DATE OF MEETING	30 September 2021
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
PREPARED BY	Kay Barrow, Corporate Governance Manager
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 12 August 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	**Discretionary Capital Programme 2021- 2022:** The Committee noted the Trust's approach to the prioritisation of capital investment and the Executive Management Board's approval of the Discretionary Capital Programme for 2021-2022. **Performance Management Framework Development:** The Committee noted the update on the progress being made on the phased approach to the development of the Trust's Performance Management Framework. **Developing our Future Strategic Direction 2022 – 2032:** The Committee received a presentation on the work being progressed to refresh the Trust's strategic plans and setting a clear direction of travel for the period 2022-2032. This included focused discussion on the Trust's mission and vision; goals; and a set of strategies and plans to deliver them. **Wellbeing and Future Generations Act:** The Committee received a presentation which provided an overview of the progress against the key components of the Act linked to the Trust's goals and objectives. **Velindre@UHW Programme:** The Committee received a presentation which provided an overview of the structure of the Velindre@UHW Programme, the progress being made for each of the component projects and the key risks were noted. An update on the progress against the Nuffield recommendations was noted by the Committee.
ASSURE	**Acute Oncology Service (AOS) Business Case Update:** The Committee considered the final AOS business case for South East Wales, which had been developed in partnership with Health Boards, and the proposed governance arrangements.

	The Committee noted the governance arrangements and endorsed the business case for submission to the Trust Board for approval.
INFORM	There were no items identified to Inform the Trust Board.
APPENDICES	None.

TRUST BOARD

Communications and Engagement Update

DATE OF MEETING	30st September 2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable – Public Report

PREPARED BY	NON GWILYM, ASSISTANT DIRECTOR OF COMMUNICATIONS AND ENGAGEMENT
PRESENTED BY	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE AND CHIEF OF STAFF
EXECUTIVE SPONSOR APPROVED	LAUREN FEAR, DIRECTOR CORPORATE GOVERNANCE AND 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**
TCS Programme Delivery Board	21/9/21	Noted

ACRONYMS	
	None

1. BACKGROUND

This paper provides the Board with an update on programme communications and engagement since August 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. ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

Over the reporting period we focused our efforts on:

- Responding to correspondence from a wide range of stakeholders including via the FOI process;
- Preparing communications to support the start of competitive dialogue.
    - A comprehensive communications pack was developed for a wide range of stakeholders
    - Liaison with key stakeholders including Welsh Government, local representatives and those participating in competitive dialogue.
- Planning communications and engagement activity for potential work on site;
- Planning communications and engagement activity to support the publication of the results of the Digital Conversation working with Down to Earth;
- Preparing for publicising the winners of the Velindre Minecraft Competition in October;
- Planning meetings to consider the role Fundraising could play in supporting key aspects of the project;
- Media activity regarding:
    - the publication of a letter written by the Wales Cancer Research Centre External Advisory Board in November 2020;
    - responding to queries about the timing of the court's consideration of the legal challenge application;
    - ITV Wales Y Byd yn ei Le programme questions;
- Radiotherapy Satellite Centre service change engagement infographic finalised. Press release in draft;
- Preparing the third Velindre Matters e-newsletter;
- Preparing the first Velindre Matters printed e-newsletter;
- Preparing for future meetings with local residents affected by flooding.

Next Steps

For the next month, our priorities will be as follows:

- Reviewing the timelines and communications and engagement requirements in support of competitive dialogue.
- Implementing any communications and engagement needs in support of potential works on site;

- Establish communication channel with Enabling Works contractor to map and coordinate communications and engagement requirements;
- Ongoing information sharing with MS / MP, as well as wider political stakeholders;
- Provide appropriate ongoing communications and engagement counsel regarding communications for new cancer centre site;
- Continue to maintain media briefings and information sharing with key outlets;
- Deliver three weekly content plan on Velindre Matters social media channels;
- Plan for first Velindre Matters podcast;
- Supporting the patient engagement framework and related activities linking with the project needs.
- Deliver second round of local residents meetings.

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

The Trust Board is asked to **NOTE** the paper.

TRUST BOARD

QUARTERLY ACTION PLAN 2021/22 – PROGRESS UPDATE

DATE OF MEETING	30/9/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Peter Gorin, Head of Corporate Strategic Planning and Performance
PRESENTED BY	Carl James, Director of Strategic Transformation, Planning, Performance & Estates
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 Quality Safety and Performance Committee	6th September 2021 16th September 2021	NOTED NOTED

ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee

VCC SMT	Velindre Cancer Centre Senior Management Team
WBS SMT	Welsh Blood Service Senior Management Team
EMB	Executive Management Board
RAG	Red Amber Green – quarterly action progress rating

1. SITUATION/BACKGROUND

1.1 The Quarterly Action Plan for this financial year was developed as part of the Annual (IMTP) Plan for 2021/22 which was approved by the Trust Board on 28th June 2021. The action plan monitors progress against the Trust's operational planning intentions by quarter for the current year and progress reports presented to each QSP Committee.

1.2 Due to COVID-19 operational pressures, a number of 2020/21 actions were paused. These actions have been carried forward, amended as appropriate, to this year's Quarterly Action Plan.

1.3 The quarterly actions for the Welsh Blood Service (WBS), Velindre Cancer Centre (VCC) and Corporate Enabling Functions, have been scrutinized by the Executive Management Board (EMB) on 6th September and noted by the Quality Safety and Performance Committee on 16th September 2021

1.4 The purpose of this paper is to provide assurance to the Trust Board on progress being made against our quarterly actions for 2021/22.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 The EMB receives regular progress reports, highlighting the detailed actions, timescales and leads responsible for delivering our WBS, VCC and Corporate plans for 2021/22. The actions this year have a particular focus on preparing for, and delivering recovery from, the effects of the continuing pandemic.

2.2 The VCC, WBS and Corporate actions are reviewed in detail by WBS and VCC SMTs and progress 'RAG rated' (red amber green).The majority of 2021/22 Quarter 1 Actions are making satisfactory progress as shown by the table below:

VUNHST Annual Plan 2021/22 Quarter 1 actions	Green Actions	Amber Actions	Red Actions
	Completed or satisfactory progress	Issues identified and being resolved	Challenges causing problems
Welsh Blood Service	4 Q1 actions	None	1 Q1 action (ref: B17)
Velindre Cancer Centre	20 Q1 actions	2 Q1 actions (ref:V05 & V08)	None
Corporate functions	21 Q1 actions	None	None

In addition, our 2021/22 actions have been categorized under the 'four COVID harms' identified by Welsh Government, namely: harm from Covid itself; harm from an overwhelmed health and social care system; harm from reduction in non-Covid activity and harm from wider societal actions/lockdowns.

Overall progress updates are given in the following paragraphs with reference being made to any Q1 actions facing challenges to progress.

2.3 **Velindre Cancer Centre**

COVID-19 continues to have a significant impact on physical site capacity, workforce availability and infection control and prevention measures at VCC, and is particularly challenging for SACT and Radiotherapy services. However, outreach services are starting to be 'repatriated' to Local Health Boards (**Q1 Action V05 above**) which will relieve some of the pressure. The staff Well Being Unit at Park Road is making progress (**Q1 Action V08 above**) with detailed requirements provided to estates team, with outline costs identified during August 2021.

The attached action plans include a range of measures to mitigate the above impacts as far as possible, to support our 'COVID recovery' strategy to meet a 20% anticipated increase in activity in the second half of 2021/22. Key to our response will be the successful recruitment of skilled Radiotherapy and SACT staff in a highly competitive marketplace.

The Welsh Government has to date provided total funding to the Trust of £3.4m i.e. £2.5m towards Covid Recovery and £919k to cover the first six months for Covid Response. The trust has also received confirmation of a further £1.2m funding. This funding is to allow us to maximize our SACT, Radiotherapy and Outpatients capacity plus outsourcing further SACT and Radiotherapy activity to private sector providers. The remaining financial consequences of our COVID response and recovery strategies contained within our Annual (IMTP) Plan for 2021/22 (£2m) is being considered by Welsh Government as part of the second tranche of £140m waiting list recovery funding.

2.4 **Welsh Blood Service**

Similarly for WBS, the pandemic continues to provide significant challenges, with venue restrictions and social distancing at blood collection sites. However, WBS plans in place will ensure the distribution of blood and blood products to Local Health Boards (LHB), with ongoing monitoring of availability of stocks and contingency plans to address any shortages.

The Plasma Derived Medicine Fractionation Project is awaiting guidance from Welsh Government (Q1 Action B17 above) on moving forward formally with this programme of work. The WBS SMT have improved temporary appointments for a small scoping team for the plasma project whilst a mandate for funding is awaited.

Recruitment of a 4th blood collection team to meet the anticipated surge in blood and blood products from LHBs, is making good progress, with the new team to be established in the autumn of this year. The financial impact of this additional team (£600k), has been included in our Annual (IMTP) Plan 2021/22, and is also being considered by Welsh Government.

2.5 **Corporate Enabling Functions**

Workforce and Organisational Development continue to ensure risk assessments are being carried out keep our staff safe within their work and home environment, and staff's wellbeing supported via a raft of wellbeing offers and ongoing monitoring of workforce availability.

Workforce is also supporting the VCC and WBS recruitment campaigns referred to in paragraphs 2.3 and 2.4, promoting working in VUNHST.

2.6 Digital resources during 2021/22 have been focused on the delivery of core services, including the new Digital Service Desk, and the continued support for key strategic projects, in particular the Digital Health & Care Project (i.e. replacement of the CANISC system) is a major focus.

2.7 Finance colleagues are engaging in contract discussions with LHB commissioners for 2021/22 and are liaising with Welsh Government over the further COVID response and recovery funding which remains unconfirmed.

3. IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	All plans are subject to the Trust quality assurance framework and the processes established during the Covid 19 outbreak.
RELATED HEALTHCARE STANDARD	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below: • Staff and Resources • Safe Care • Timely Care • Effective Care • Staying Healthy
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Financial impact of all service changes are being monitored and reviewed with finance colleagues for onward engagement with Welsh Government on Covid related costs.

4. RECOMMENDATION

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

Disability Equality in Velindre University NHS Trust

Carl James

Director of Transformation, Planning and Digital

Executive Team Disability Ambassador

The Story

1. The issue/key drivers
2. A bit about me and what we are doing
3. Some personal reflections and thoughts on the future

1. Issue and Key Policy Drivers

- Disability (discrimination) directly impacts people who need to use services and people who wish to work for them and currently work within them

Key drivers (law and policy)

- Disability Discrimination Act
- Equality and Diversity Legislation
- Trusts' Strategic Equality Objectives and action plan 2020-2024
- Annual Equality Monitoring Report
- All Wales Standards for Accessible Communication and Information for People with Sensory Loss
- Welsh Government report 'Locked Out' Liberating disabled people's lives and rights in Wales beyond Covid-19

2. A bit about me and what we are doing

My experience

- 25 years in public service
- Responsible for strategy, planning, estates, digital etc over my career
- Roles all involved central principle of securing:
  - Equity
  - Diversity

- Involved in various organisations in planning and/or delivery of disability discrimination act audits etc and putting in place facilities and arrangements to provide equality

What did I know and what did I do ?

- Thought I had a reasonable understanding of:

  - the term disability
  - the legislation
  - the areas of work that we needed to do in Velindre/public services generally

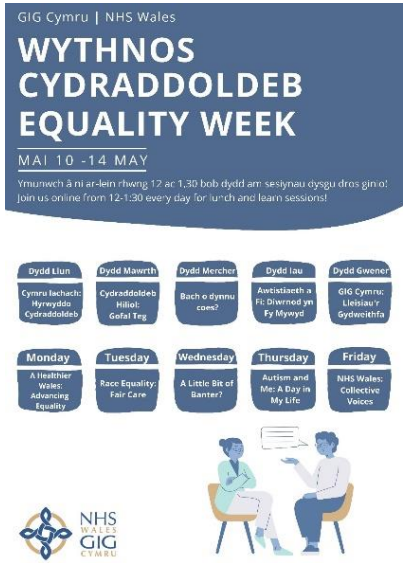
What is the Trust doing ?

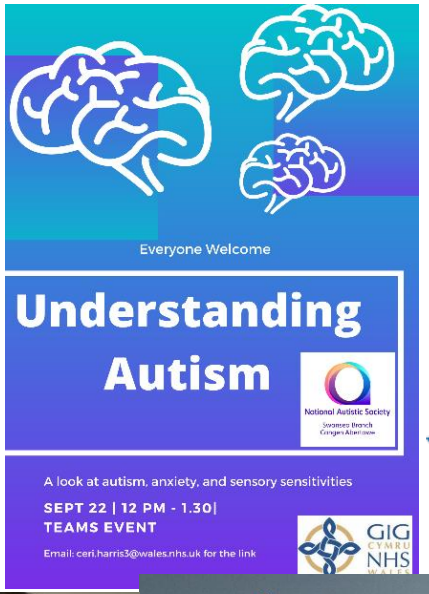
A huge amount including…….

- Design services around need
- Implementing the various legal requirements and policies (Disability Discrimination Act; Equality and Diversity Legislation)
- Education and learning
- Hard wiring e.g. business decision-making; measurement framework

Providing space, time and connecting people

The Disability Equality Profile @VUNHST is active





sight cymru

It Makes Sense
SENSORY LOSS AWARENESS MONTH

Gwneud Synnwyr
MIS YMWYBYDDIAETH COLLED SYNHWRAIDD

GIG CYMRU NHS WALES

Disability Wales
Anabledd Cymru

BDA
BRITISH DEAF ASSOCIATION

disability confident EMPLOYER

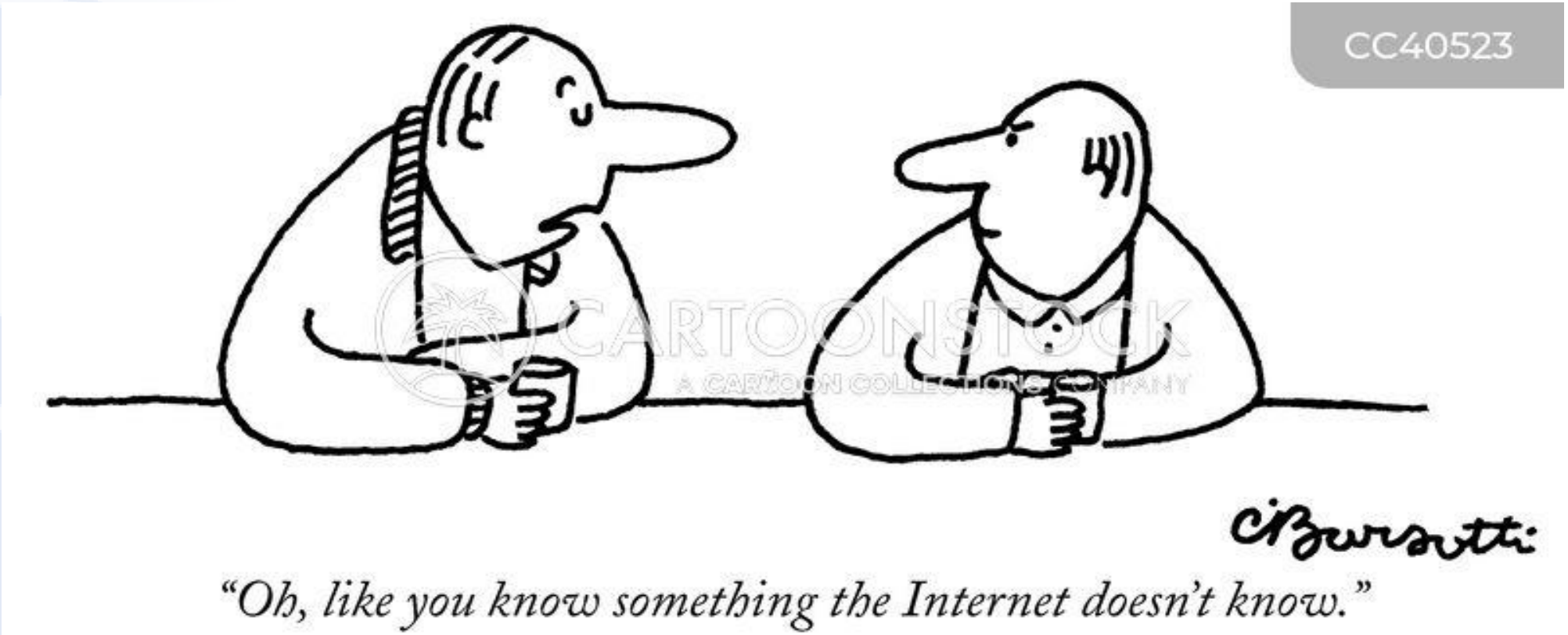
hyderus o ran anabledd YMRODDEDIG

Staff Network

Enable@Velindre

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

3. First reflections as the Trusts Ambassador




Being
disabled
in Britain
A journey
less equal

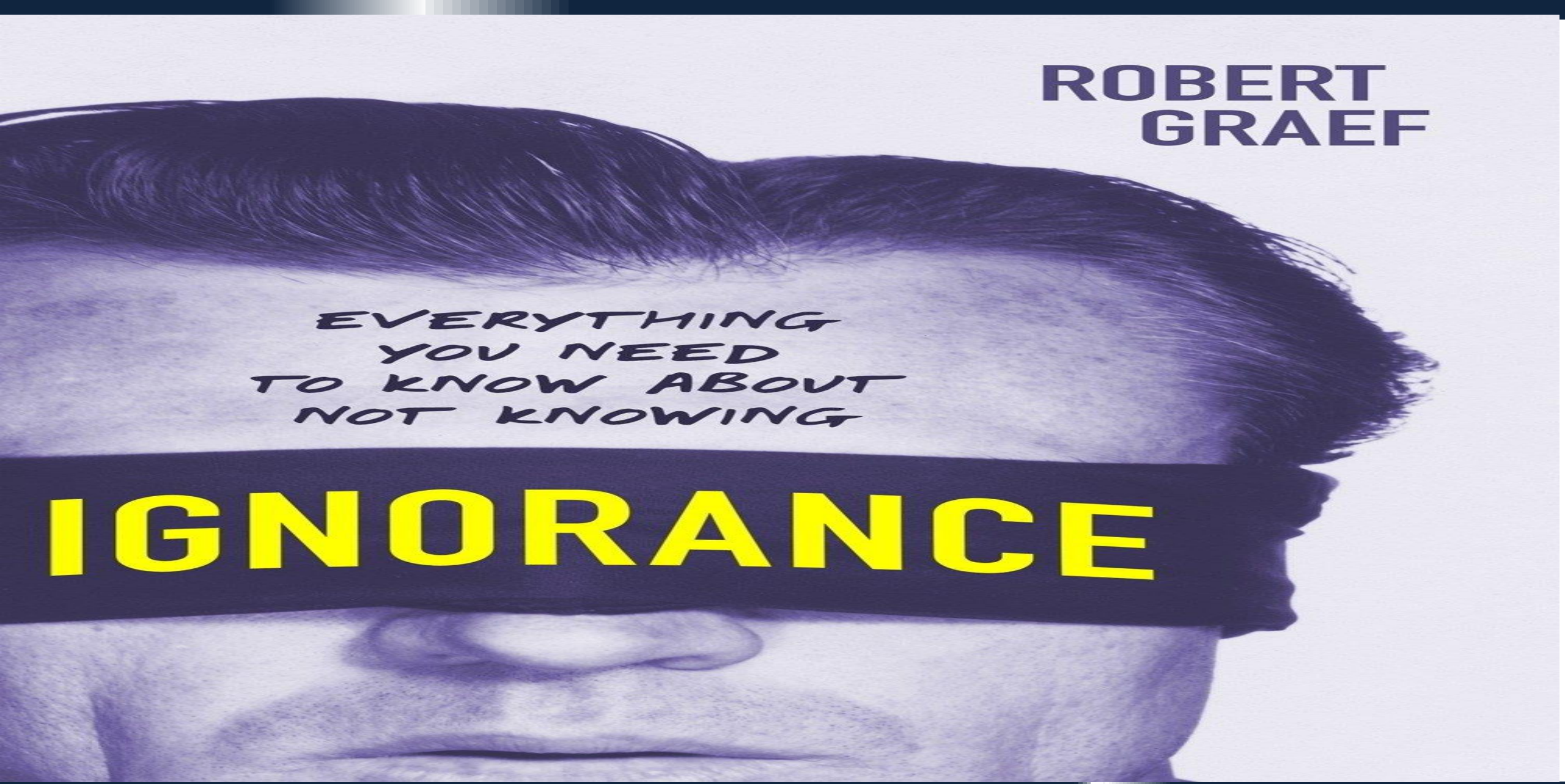
Call for urgent action to prevent learning disability deaths BBC News

Published 12 June 2021

People with learning disabilities are still dying 25 years earlier than the rest of the population, a report has said.

The Learning Disabilities Mortality Review (LeDeR) calls for urgent action to prevent more avoidable deaths.

A quarter of learning disability deaths were caused by Covid in 2020, compared to 13% of other deaths.
NHS England said improving the health of people with a learning disability was a priority.


ROBERT
GRAEF
EVERYTHING
YOU NEED
TO KNOW ABOUT
NOT KNOWING
IGNORANCE

First reflections as the Trusts Ambassador

Personally

- Knowledge: need to continue learning
- Getting it right is easier than getting it wrong
- Embedding into our DNA
- Conversations: more of them and more meaningful

What does it mean for the Trust and wider public services ?

- The above
- Walk in someone else's shoes
- The little things matter ….. A lot

Reflections from Executive Management Board

- How do we assure ourselves that we are meeting our responsibilities to people with a disability
- We should identify comparator organisations exhibiting best practice so we know what good looks like
- We need to hold the mirror up to ourselves and identify our potential to develop
- We need to embed this work in our patient engagement framework
- Identify how we best publicise what the Ambassadors doing

What does this role mean for the Trust?

- **Getting out and about**: more conversations with the right people
- **Leadership and accountability**: Visible involvement of diversity in leadership and zero tolerance of discrimination
- **Workforce**: Promote staff engagement including the staff networks. Giving staff a voice to help achieve the inclusive environment.
- **Data and intelligence**: Accurate and timely intelligence which we then used to make a difference
- **Access and enrichment:** doing the right things and doing them well (communication needs, physical access, working with people to meet individual needs
- **Health Inequalities**: The Pandemic has exposed the gap, we now need to rise to the challenge it poses.


If you want to go fast
go alone.
If you want to go far
go together.
African proverb

TRUST BOARD

GENDER PAY GAP REPORT

DATE OF MEETING	30/09/21

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Ceri-Ann Lawless, Head of Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Director of Organisational Development & Workforce

REPORT PURPOSE	FOR APPROVAL

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board Quality, Safety & Performance Committee	06/09/2021 16/09/2021	Endorsed for Board Approval Endorsed for Board Approval

ACRONYMS	

1. SITUATION/BACKGROUND

1.1 Gender Pay Gap reporting to Welsh Government, and publication of the report findings, is an annual requirement of the Trust and all public bodies in Wales. Due to the COVID-19 pandemic of 2020, this requirement was suspended by Welsh Government and a report for 2020/21 requested for October 2021. The Velindre University NHS Trust report attached contains data from both 2019/20 and 2020/21, demonstrating the Trust's commitment to transparency around pay, to identifying the causes of the pay gap and to finding solutions to address this gap.

1.2 It should be noted that gender pay gap analysis differs from that of equal pay issues, which deals with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value.

1.3 The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. The pay gap is expressed as a percentage of male employee's earnings e.g. a female employee earns % age less than male employees.

2. ASSESSMENT

2.1 The attached report provides the detail of the Trust's Gender Pay Gap reporting and analysis and outlines actions and priorities to address the key findings.

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	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Not required

LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Trust Report to be uploaded on WG Portal by 5th October 2021
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.

4. RECOMMENDATION

4.1 The Trust Board is asked to approve the Gender Pay Gap Report for submission to Welsh Government, which includes publication of the data and findings.

VELINDRE UNIVERSITY NHS TRUST

GENDER PAY GAP

AND

EQUALITY MONITORING REPORT

As at

31st March 2019 & 31st March 2020

CONTENTS

1. Introduction

Velindre University NHS Trust aims to ensure that people are treated fairly and equally at work. Our focus ensures that staff have the same access and opportunities to reward, recognition and career development.

The Trust believes that it is important to analyse its pay data, to gain an understanding of any gaps, what this means for our workforce and as appropriate, to use this information and data to develop an action plan that will respond to any identified gender pay gaps.

In March 2020, the UK went into lockdown due to the COVID-19 pandemic. Following this and because of the growing impact of the pandemic on organisations, the Equality and Human Rights Commission (EHRC) suspended entirely the requirement for organisations to report on their gender pay gap data for 2019. Despite the above, this report provides the data for both the 2019 and 2020 reporting periods, which demonstrates the Trust's commitment to transparency around pay, to identifying the causes of the pay gap and then to finding solutions to address this gap.

2. What is the Gender Pay Gap?

It should be noted that gender pay gap analysis differs from that of equal pay issues, which deal with the pay differences between male and female employees who carry out the same jobs, or similar jobs, or work of equal value. It is unlawful to pay employees unequally because of their gender.

The gender pay gap shows the difference between the average (mean or median) earnings of male and female employees. The pay gap is expressed as a percentage of male employee's earnings e.g. a female employee earns % age less than male employees. When gender pay reporting is used to its full potential, it provides a valuable tool to assist an organisation to assess levels of equality in the workplace, male and female participation and how effectively talent is being maximised.

Where gender pay gap analysis identifies a particularly high gender pay gap, this can be an indication that there may be a number of issues which the organisation which may need to deal with as a matter of priority. The individual gender pay calculations may help the organisation to identify what those issues are.

3. Who Counts as an Employee for Gender Pay Gap Reporting?

In respect of gender pay gap reporting, only 'full pay relevant employees' should be included. A 'full pay relevant employee' is any employee employed by the Trust on the snapshot data of 31st March 2019 and / or 31st March 2020 and who is paid their usual, full basic pay during the relevant pay period (1st April 2018 – 31st March 2019 and / or 1st April 2019 – 31st March 2020). If employees are being paid less

than their usual basic pay, or are in receipt of 'no pay' during the relevant pay period as a result of being on leave, then they are not a 'full pay relevant employee.' It does not matter whether the leave is taken during the relevant pay period, what matters is whether the pay is reduced during the relevant pay period, due to leave. If an employee is paid less than their usual basic pay during the relevant period for reasons other than leave, they will still count as a 'full pay relevant employee.'

For the purposes of the gender pay report, the Trust has used the Equality Act 2010 definition to determine who counts as an employee. The following are therefore counted as employees for the purpose of the report;

- Employees with a contract of employment with the Trust;
- Workers or agency workers who are contracted by the Trust to undertake work, or provide a particular service. It should be noted that whilst they are included, they are counted by the agency providing them to the Trust; or
- Self-employed workers who personally perform work on the Trust's behalf.

4. Gender Pay Gap Reporting Requirements

This report will set the scene in terms of considering the national picture, specifically in relation to:

- The most common sector of employment within the UK, by gender;
- Employment by Occupation, including gender and contracted hours (i.e. full and part time).

It will also provide an overview of the Trust (including Trust Board and Trust Board salaries), as well as the following rich, local data, which will contribute to and inform Gender Pay Gap Action Plans (based on snapshot data as at 31st March 2019 and 31st March 2020):

- The gender composition of the Trust's workforce by Corporate, Division & Hosted organisations;
- A summary of the Trust's overall Gender Pay Gap data by Workforce Gender and Contract Status (i.e. full-time and part-time);
- Analysis on the following six basic calculations:
    - The mean gender pay gap;
    - The median gender pay gap;
    - The mean bonus gender pay gap;
    - The median bonus gender pay gap;
    - The proportion of males and females receiving a bonus payment; and
    - The proportion of males and females in each quartile band.

- Gender information in respect of incremental credit applications, which can have an impact on the pay progression of newly appointed Trust employees.

5. Methodology and Data Collection

All information used to support the analyses listed above, as well as to calculate the six statutory calculations, has been generated from the Electronic Staff Record (ESR) system, using standard 'Business Intelligence' (BI) reports. Information relating to incremental credit applications has been drawn from various Trust and Hosted Organisations' Incremental Credit Spreadsheets.

6. What is a Significant Gender Pay Gap Difference?

The Equality Act 2010 (Specific Duties and Public Authorities Regulations, 2017) confirms that a percentage pay difference of ≥5% should be treated as a significant gap. Where a gap of this percentage exists within the Trust, and/or Hosted Organisations, actions plans will be developed to reduce the gap over a specified planned period of time.

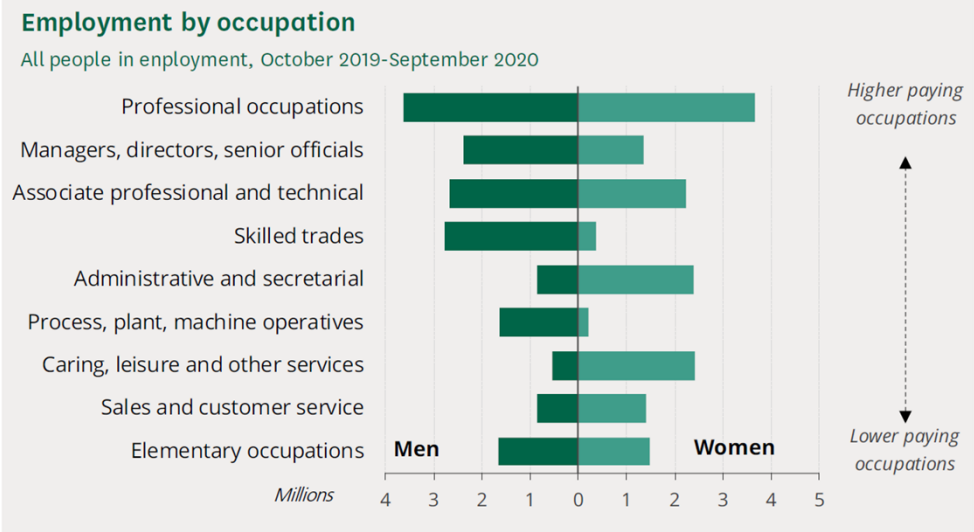
7. Common Sector of the Employment of Female Workers in the UK

The most common sector of employment for women in the UK, according to a paper produced by the Government (Women and the Economy, March 2021) is health and social care. This sector accounts for 20% of all jobs held by women in the UK as at September 2020. This research also confirmed that 78% of jobs in the health and social care sector are held by women.

7.1 Employment by Occupation

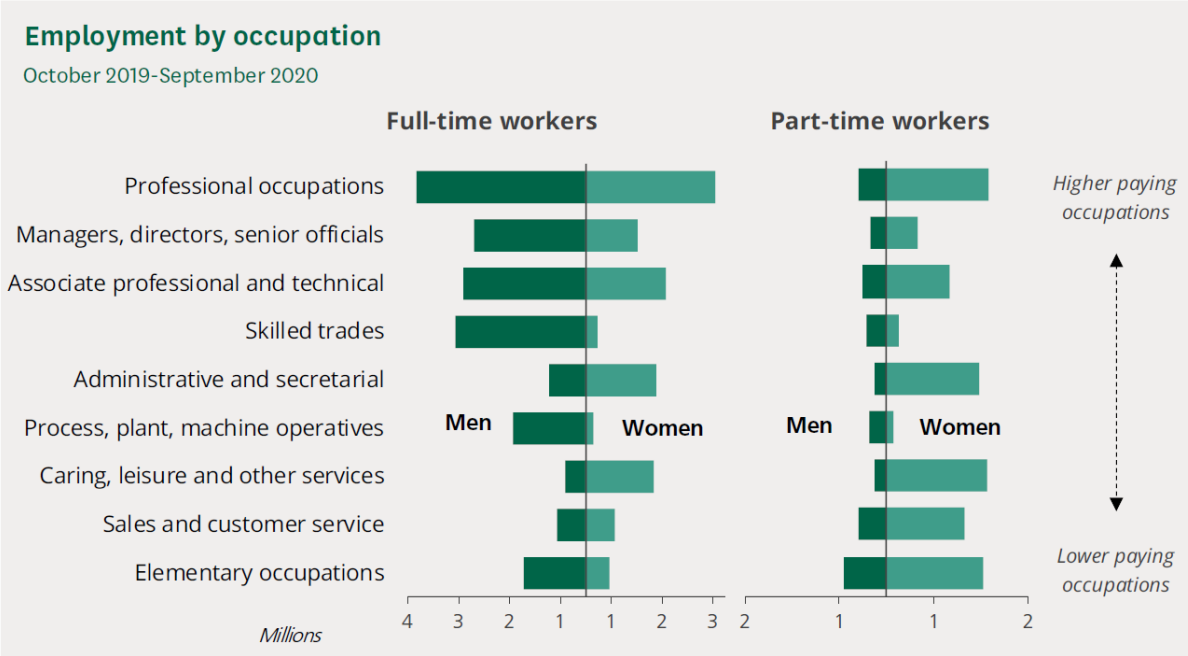
In 2020, 24% of women worked in high-skilled professional occupations (e.g. engineers, doctors and nurses, teachers, accountants and lawyers), compared to around 21% of men. Around half of women in professional occupations in 2020 were employed as nurses, teachers, or other educational professionals. However, a higher share of men than women were working as managers, directors or senior officials, with 14% of men in these roles, compared to 9% of women. Men were also more likely than women to be working in skilled trades; as process, plant or machine operatives and in associate professional and technical occupations. Women were more likely than men to be working in administrative and secretarial occupations; caring, leisure and other service occupations; and in sales and customer-service occupations.

Source: Women and the Economy, March 2021



Note: Occupations ranked based on median hourly pay (excluding overtime) for employees at April 2020.
Source: ONS, Employment by status and occupation, and *Annual Survey of Hours and Earnings* via NOMIS

Across these occupational groups, women are more likely to work part-time than men. For both men and women, the share of workers who are part-time is highest in the lowest-paid occupations:



Source: Women and the Economy, March 2021

8. Overview of Velindre University NHS Trust Organisation

8.1 Velindre University NHS Trust

Velindre University NHS Trust provides specialist services to the people of Wales. The operational delivery of services is managed through Velindre Cancer Centre and the Welsh Blood Service.

8.2 Trust Board

The Board is accountable for Governance, Risk Management and Internal Control for those services directly managed and those managed via hosting arrangements. As Accountable Officer and Chief Executive of the Board, the Chief Executive has responsibility for maintaining appropriate governance structures and procedures, as well as a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding the public funds and this organisation's assets for which the Chief Executive is personally responsible. These are carried out in accordance with the responsibilities assigned by the Accounting Officer of NHS Wales.

The Trust, via its statutory instrument, is required to have five Executive Board members. Three of these are female, making up 60% of the Board's membership.

8.2.1 Trust Board Salaries

The salaries of the Executive Board members are determined by the Welsh Government's Job Evaluation for Senior Posts (JESP) scheme. JESP is an analytical job evaluation methodology that has been designed specifically for evaluating roles in the Senior Civil Service with the JESP evaluation factors being:

- Managing people
- Accountability
- Judgement
- Influencing
- Professional competence
- The range of responsibilities and accountabilities of the Executive Director
- The differing size of NHS Wales health organisations

NHS Wales has a 14 point Executive Salary Scale ranging from £93,839 - £220,7966, which are mapped against the above aforementioned factors.

Executive Board member pay is transparent and publicly available via the Trust's Annual Report. There is pay parity for male and female board members, as determined by the JESP process.

8.3 Velindre University NHS Trust Corporate Functions

The Trust has Corporate Functions, which provide the following strategic and operational services to the Trust's divisions; Chief Executive's Office, Finance, Workforce and Organisational Development, Clinical Governance and Risk, Planning and Performance, Estates, Communications, Research Development and Innovation and Transforming Cancer Services.

Table 1a below shows the breakdown of corporate staff by gender, as at 31st March 2019. 69% of the workforce is female, which is consistent with the gender make up of employees who traditionally work within corporate services.

Table 1a

Gender	Head Count	FTE	% of HC
Female	114	101.67	69%
Male	51	50.8	31%
Grand Total	**165**	**152.47**	100%

The above position did not change significantly as at 31st March 2020, as can be seen in ***Table 1b*** below:

Gender	Head Count	FTE	% of HC
Female	134	121.22	68%
Male	62	58.392	32%
Grand Total	**196**	**179.61**	100%

8.4 Velindre Cancer Centre

Specialist cancer services for South East Wales are delivered by Velindre University NHS Trust using a hub and spoke model. The hub of our specialist cancer service is Velindre Cancer Centre. This is a specialist treatment, teaching, research and development centre for non-surgical oncology. Velindre Cancer Centre treats patients with chemotherapy, Systemic Anti-Cancer Treatments (SACTs), radiotherapy and related treatments, together with caring for patients with specialist palliative care needs.

Table 2a overleaf shows the breakdown of VCC staff by gender, as at 31st March 2019. Almost 80% of this workforce is female, which is consistent with the gender make up of employees who traditionally work in health care related services and roles.

Table 2a

Gender	Head Count	FTE	% of HC
Female	603	509.29	79%
Male	159	152.45	21%
Grand Total	**762**	**661.74**	100%

While the Headcount and FTW of both females and males increased as at 30th March 2020, this did not change the % age, in terms of headcount by gender, as evidenced in ***Table 2b*** below:

Gender	Head Count	FTE	% of HC
Female	645	547.32	79%
Male	167	157.27	21%
Grand Total	**812**	**704.6**	100%

8.5 Welsh Blood Service

The Welsh Blood Service plays a fundamental role in the delivery of healthcare in Wales. It works to ensure that the donor's gift of blood is transformed into safe and effective blood components, which enables NHS Wales to improve quality of life and save the lives of many thousands of people in Wales every year.

Table 3a below shows the breakdown of WBS staff by gender, as at 31st March 2019. Just over 70% of the workforce is female, which is consistent with the gender make up of employees who traditionally work in blood collection / scientific processing services.

Table 3a

Gender	Head Count	FTE	% of HC
Female	324	273.31	71%
Male	135	125.65	29%
Grand Total	**459**	**398.96**	100%

While the Headcount and FTW of both females and males changed as at 30th March 2020, this did not change the %age, in terms of headcount by gender, as evidenced in ***Table 3b*** overleaf:

Table 3b

Gender	Head Count	FTE	% of HC
Female	326	277.12	71%
Male	132	122.11	29%
Grand Total	**458**	**399.23**	100%

8.6 Velindre University NHS Trust Hosted Organisations

The Trust hosts organisations on behalf of other bodies. A host organisation is one that provides a statutory framework that furnishes facilities and resources for a function/organisation on behalf of a third party. Accountability for the operational delivery and associated performance and risks resulting from the activity of the hosted function/organisation rests with the third party.

Organisations hosted by Velindre University NHS Trust include:

8.6.1 NHS Wales Shared Services Partnership (NWSSP)

NHS Wales Shared Services Partnership (NWSSP) is a dedicated organisation that supports the statutory bodies of NHS Wales through the provision of a comprehensive range of customer focused support functions and services.

Table 4a below shows the breakdown of NWSSP staff by gender, as at 31st March 2019. Almost 60% of the workforce is female, which is consistent with the gender make up of employees who traditionally work in support services and functions.

Table 4a

Gender	Head Count	FTE	% of HC
Female	1224	1099.8	57%
Male	921	890.5	43%
Grand Total	**2145**	**1990.3**	100%

The above position did not change significantly as at 31st March 2020, as can be seen in ***Table 4b*** overleaf:

Table 4b

Gender	Head Count	FTE	% of HC
Female	1287	1150.7	56%
Male	1008	972.36	44%
Grand Total	**2295**	**2123.1**	100%

8.6.2 NHS Wales Informatics Services (NWIS)

NHS Wales Informatics Service (NWIS) operates under the direction of the Deputy Director, Digital Health and Care of the Welsh Government and is responsible for both the strategic development of Information Communications Technology (ICT) and the delivery of operational ICT services and information management across NHS Wales. NWIS has a national remit to support NHS Wales to make better use of scarce skills and resources, and facilitate a consistent approach to health informatics and the implementation of common national systems. The Director of NWIS is accountable to the Deputy Director, Digital Health and Care of the Welsh Government.

Table 5a below shows the breakdown of NWIS staff by gender, as at 31st March 2019. Just over 60% of the workforce is male, which is consistent with the gender make up of employees who traditionally work in IT related services and roles.

Table 5a

Gender	Head Count	FTE	% of HC
Female	257	243.61	38%
Male	418	413.78	62%
Grand Total	**675**	**657.4**	100%

The above position did not change significantly as at 31st March 2020, as can be seen in ***Table 5b*** below:

Table 5b

Gender	Head Count	FTE	% of HC
Female	291	276.02	39%
Male	451	447.1	61%
Grand Total	**742**	**723.11**	100%

8.6.3 Health Technology Wales (HTW)

Health Technology Wales (HTW) became a host organisation of Velindre University NHS Trust in November 2017 and is funded by Welsh Government under the 'Efficiency through Technology Programme'. HTW was established to facilitate the timely adoption of clinically and cost effective health technologies in Wales, working with, but independently of NHS Wales. HTW's remit covers all health technologies that are not medicines. This could be medical devices, surgical procedures, tele-monitoring, psychological therapies, rehabilitation or any health intervention that isn't a medicine.

Table 6a below shows the breakdown of HTW staff by gender, as at 31st March 2019. 75% of the workforce is female. The gender breakdown is not consistent with the gender make up of employees who traditionally work in research / technology related roles and services.

Table 6a (includes 2 Cancer Research Wales staff)

Gender	Head Count	FTE	% of HC
Female	12	9.2	75%
Male	4	4	25%
Grand Total	**16**	**13.2**	100%

The above position did not change significantly as at 31st March 2020, as can be seen in ***Table 6b*** below:

Table 6b

Gender	Head Count	FTE	% of HC
Female	16	13.28	76%
Male	5	5	24%
Grand Total	**21**	**18.28**	100%

9. Summary of Velindre University NHS Trust Gender Pay Gap Data

The following section of the report provides a summary of the high level Gender Pay Gap Data for Velindre University NHS Trust, as at the 31st March 2019 and 31st March 2020.

9.1 Workforce Gender Breakdown

As at the 31st March 2019, Velindre University NHS Trust employed a total of 4222 employees (***Table 7a** below*). 60% of the workforce were female and 40% were male. In this financial year, there was a 1% age point decrease in the number of females employed by the Trust when compared with 31st March 2018 data.

Table 7a

Gender	Head Count	FTE	% of HC
Female	2534	2236.847	60%
Male	1688	1637.178	40%
Grand Total	**4222**	**3874.025**	100%

As at 31st March 2020, the Trust employed a total of 4524 employees (***Table 7b*** below). Although there was no % age point difference in relation to the gender composition of the workforce from the position in March 2019, the head count and FTE numbers had increased for both genders.

Table 7b

Gender	Head Count	FTE	% of HC
Female	2699	2385.67	60%
Male	1825	1762.231	40%
Grand Total	**4524**	**4147.901**	100%

Across the NHS as a whole, the NHS Confederation Research data found that 77% of the workforce were female, compared with 23% who were male. The Velindre University NHS Trust's gender breakdown does not reflect that of other NHS organisations, as its gender breakdown is effected by NWIS that employs a predominantly male workforce.

It should be noted however that almost a quarter (22%) of the female workforce are contracted to work on a part-time basis; this has not changed over the last 2 reporting years (see ***Tables 8a & 8b*** overleaf). However, as a percentage of the overall female workforce, this equates to 37% of Trust female employees being employed on a part-

time contract, receiving a pro-rata value of the annual gross salary. This data should be noted as it will affect all high level gender pay gap data.

Table 8a

As at 31st March 2019

Contract Status	Number Female	% Female	Number Male	% Male
Full Time	1603	38%	1547	37%
Part Time	931	22%	141	3%
Total	2534	60%	1688	40%
Total M&F	**4222**			

Table 8b

As at 31st March 2020

Contract Status	Number Female	% Female	Number Male	% Male
Full Time	1704	38%	1650	36%
Part Time	995	22%	175	4%
Total	2699	60%	1825	40%
Total M&F	**4524**			

9.2 Mean Hourly Rate Gender Pay Gap

The analysis in the table below (which represents the position as at 31st March 2019), shows that a mean gender pay gap of £0.83, or a % age point difference of 4.86% existed between male and female employees within Velindre University NHS Trust. It should be noted that this percentage is not deemed to be significant, as it is less than 5%.

Mean Hourly Rate at 31st March 2019	Female	Male	Actual Pay Difference	% Point Difference
	£16.2904	£17.1217	£0.8314	4.86%

Mean Hourly Rate at 31st March 2020	Female	Male	Actual Pay Difference	% Point Difference
	£17.0101	£17.6973	£0.6872	3.88%

As at 31st March 2020, this picture slightly improves in that a mean gender pay gap of £0.69, or a % age point difference of 3.88% existed between all Velindre University NHS Trust male and female employees.

Similarly to the 2019 position, as the percentage figure as at 31st March 2020 is less than 5%, it is not deemed to be significant and therefore the Trust is not required to put in place an action plan to reduce this gap over time.

9.3. Median Hourly Rate Gender Pay Gap

The analysis below shows that as at 31st March 2019, a median gender pay gap of £0.56, or a % age point difference of 3.87% existed between all Velindre University NHS Trust male and female employees. As at 31st March 2020, a median gender pay gap of £0.90, or a % age point difference of 5.82% existed between all Trust male and female employees.

Median Hourly Rate 31st March 2019	Female	Male	Actual Pay Difference	% Point Difference
	£13.7890	£14.3449	£0.5559	3.87%

Median Hourly Rate 31st March 2020	Female	Male	Actual Pay Difference	% Point Difference
	£14.5024	£15.3994	£0.8970	5.82%

Given the above and as the median gender pay gap, in terms of hourly rate, is deemed to be statistically significant, the Trust will need to identify why this is the case and in response to the findings, develop an action plan and present this to Trust Board, as appropriate, for approval. **Please see Appendix A for the Trust's overarching action plan.**

9.4 Proportion of Male and Female Employees Receiving a Bonus Payment

The hosted organisation, NWSSP operates a bonus payment scheme for its employees. It is confirmed that no other Velindre University NHS Trust Division or Hosted Organisation operate a bonus payment scheme.

The NWSSP prescription processing bonus is paid to all prescription processing employees, against an incremental table related to daily office average keying rate and quality assurance i.e. number of items keyed linked to quality assurance. The payment of this bonus has no direct or indirect relationship with the gender of the employee.

The prescription processing work is allocated equally to all employees, irrespective of gender. It should be noted that the prescription processing department employs more female than male employees on a 2:1 ratio.

The current workforce data shows that the team comprises 32 part time female employees, compared to 1 male, however the proportion of males is higher when working on a full time basis, the team have 22 full time males and 13 full time females.

In respect of the skills and abilities required to undertake the processing data input work, there is no difference in complexity or physicality. Every employee's role is generic i.e. it is a paperless process which requires the employee to input prescription data using a computer based work station.

The payable bonus rate itself is pro-rata'd against contracted hours. This system reflects the volume of work undertaken and uses the same principal as salary payment/hours etc.

There is a larger proportion of part time female than male employees employed in the prescription processing department and therefore there may be differences in the net bonus payment between the genders. When comparing the proportion of male and female employees receiving a bonus against full-time equivalence the gender pay gap is more favourable towards female employees.

It should be noted that the prescription processing bonus scheme has been equality impact assessed. The equality impact assessment did not identify any inequalities which would or could have a real or potential impact on any employees, in respect of protected characteristics.

9.5 Mean Bonus Gender Pay Gap

The mean bonus pay information for NWSSP, as at 31st March 2019 and 31st March 2020, is presented overleaf.

Mean Bonus Pay Part-time Employees

Mean Bonus Pay at 31st March 2019	Female Pro-rata	Male Pro-rata	Actual Pay Difference	% Point Difference
	£2,869.28	£2,862.54	£6.74	0.24%

Mean Bonus Pay at 31st March 2020	Female Pro-rata	Male Pro-rata	Actual Pay Difference	% Point Difference
	£3,221.29	£3,690.63	£469.34	12.72%

This data shows that between 31st March 2019 and 31st March 2020 the mean bonus gender pay gap between part-time male and female employees has widened by 12.48% points, with a current percentage point difference of 12.72%. This percentage figure is deemed to be significant, as determined by the Equality Act 2010 definition. Work will be undertaken to investigate and remedy this (see Appendix A for the Trust's overarching Action Plan)

Mean Bonus Pay Full-time

Mean Bonus Pay at 31st March 2019	Female Full entitlement	Male Full entitlement	Actual Pay Difference	% Point Difference
	£4,429.22	£3,786.65	£642.57	17%

Mean Bonus Pay at 31st March 2020	Female Full entitlement	Male Full entitlement	Actual Pay Difference	% Point Difference
	£5,128.55	£5,195.16	£66.61	1.28%

This data shows that between 31st March 2019 and 31st March 2020, the mean bonus gender pay gap between full-time male and female employees has significantly decreased and the position reversed from that in 2019 (in that in 2020, male full entitlement was greater than female full entitlement).

9.6 Median Bonus Gender Pay Gap

The median bonus pay gap information for NWSSP is presented below:

Median Bonus Pay Part-time Employees

Median Bonus Pay 31st March 2019	Female Pro-rata	Male Pro-rata	Actual Pay Difference	% Point Difference
	£2,983.04	£2,862.54	£120.50	4%

Median Bonus Pay 31st March 2020	Female Pro-rata	Male Pro-rata	Actual Pay Difference	% Point Difference
	£3,311.34	£3,690.63	£379.29	10.28%

This data shows that between 31st March 2019 and 31st March 2020 the bonus gender pay gap between part-time male and female employees has widened by 6.28% points, with a current percentage point difference of 10.28%. This current percentage figure is deemed to be significant, as determined by the Equality Act 2010 definition (see Appendix A for the Trust's overarching Action Plan).

Median Bonus Pay Full-time Employees

Median Bonus Pay at 31st March 2019	Female Full entitlement	Male Full entitlement	Actual Pay Difference	% Point Difference
	£5,460.60	£3,974.34	£1,486.26	37%

Median Bonus Pay at 31st March 2020	Female Full entitlement	Male Full entitlement	Actual Pay Difference	% Point Difference
	£5,616.05	£5,588.97	£27.08	0.48%

This data shows that between 31st March 2019 and 31st March 2020, the median bonus pay gap between full time male and females have significantly reduced. Since

2019, the pay gap has decreased by £1459.18, which represents a percentage point difference of 36.52%.

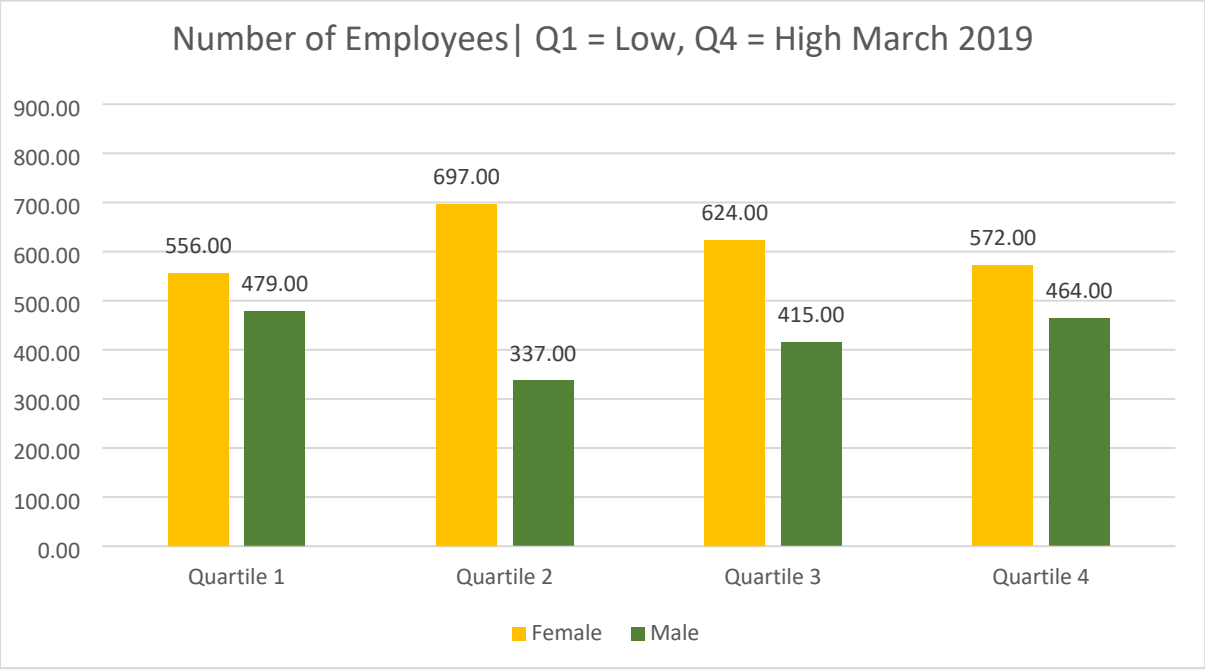
9.7 Proportion of Male and Female Employees in each Quartile Band

The purpose of collecting this data is to assist the Trust to understand where the pay progression of its female and male employee may be stalling, to enable it to take appropriate actions to support career progression, which is intrinsically linked with pay progress.

The data as set out in ***Graph 2*** below shows the distribution of male and female salaries across the Trust's pay hierarchies, as at 31st March 2019. The data confirms that on average, 1036 employees were employed within each of the pay quartiles. This represents a fairly even distribution of employees across the low to high pay quartiles.

As at the 31st March 2019,14% of employees in the highest pay quartile within the Trust are female (a 0.5% point decrease from 2018), compared to 15% in the upper middle quartile (a 1% point decrease from 2018), 17% in the lower middle quartile (no % change from 2018), and 13% in the lowest pay quartile (no % change from 2018). In each of these quartiles the number and percentage of male employees is significantly lower, as to be expected in an organisation which has a 60% female to 40% male workforce ratio.

Graph 2

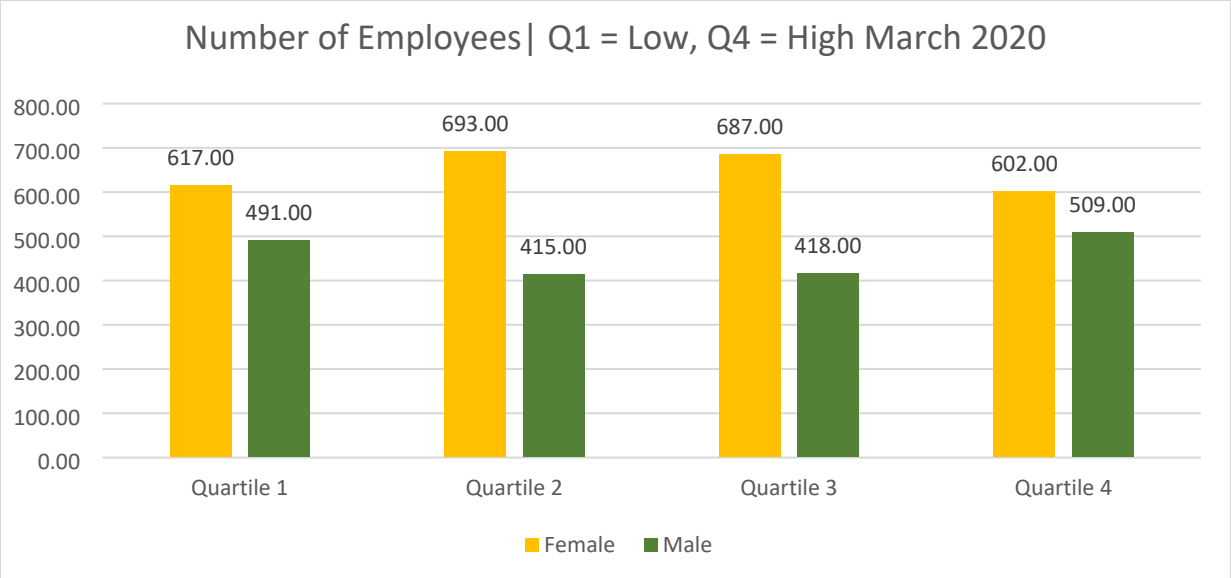


The data, as set out in ***Graph 3 overleaf*** shows the distribution of male and female salaries across the Trust's pay hierarchies, as at 31st March 2020. The data confirms that on average, 1108 employees were employed within each of the pay quartiles. This

represents a fairly even distribution of employees across the low to high pay quartiles.

As at the 31st March 2020, 14% of employees in the highest pay quartile within Velindre University NHS Trust are female (no change from 2019), compared to 15.5% in the upper middle quartile (a 0.5% point increase from 2019), 16% in the lower middle quartile (a 1% point decrease from 2019), and 14% in the lowest pay quartile (a 1% point increase from 2019).

Graph 3



10. Approved and declined Incremental Credit Applications

The Trust has an 'Incremental Credit Procedure' which permits new employees who are either joining or re-joining the NHS to request that their previous reckonable service and or experience is considered when determining their starting salary on the relevant NHS pay scale / band. This policy was developed when the Agenda for Change pay structure was introduced in 2006, to reinforce the principle of fair pay for all employees of the Trust. The aim of the procedure is to ensure that new employees are remunerated in a fair and consistent way (compared with the payment of time served and experienced extant employees) by recognising their previous reckonable NHS service or reckonable equivalent experience, gained in a different sector. The process is evidence based and requires the new starter to provide specific documentary evidence to support their application.

Note - this procedure is not applicable to Very Senior Managers and Executives, as their pay band and point are determined by the Welsh Government.

During the financial year of 1st April 2018-31st March 2019, the Trust received and approved **30** incremental credit applications (compared to 101 in 2017-18) and as a result, the applicants were placed on an incremental pay band point, appropriate to the job evaluated pay band, based on evidence of their previous reckonable service or experience.

In respect of the applications received, 40% of these were submitted by female appointees, which is a lower proportion than expected given that 60% of the Trust's workforce is female.

The following is a summary of the number of applications received by pay band and gender from newly appointed employees, as well as those re-joining, as at 31st March 2019;

- **Band 3** Only one application was received. The application was from a female employee.
- **Band 4** Only one application was received. The application was from a female employee.
- **Band 5** A total of 9 applications were received, 4 from female employees and 5 from male employees;
- **Band 6** A total of 2 applications were received, 1 from a female employee and 1 from a male employee;
- **Band 7** A total of 8 applications were received, 3 from female employees and 5 from male employees;
- **Band 8a** A total of 4 applications were received, all of which were from male employees
- **Band 8b** A total of 2 applications were received, 1 from a female employee and 1 from a male employee;
- **Band 8c** A total of 2 applications were received, both of which were from male employees;
- **Band 8d** Only one application was received. The application was from a female employee.

As shown in ***Appendix B*** there is no evidence, based on the available data that this process results in either newly appointed female, or male employees being treated more favourably, in respect of the approval of incremental credit, which impacts on their starting salary. Across the Agenda for Change pay bands and genders there is an equitable spread in respect of the number of increments awarded regardless of gender.

During the financial year of 1st April 2019 - 31st March 2020, the Trust received and approved **35** incremental credit applications, compared to 30 in 2018/19.

In respect of the applications received, 43% of these were submitted by female appointees, which is an increase on 2019's figures.

The following is a summary of the number of applications received by pay band and gender from newly appointed employees, as well as those re-joining, as at 31st March 2020 **(see Appendix C)**:

- **Band 2** Only one application was received. The application was from a female employee.
- **Band 5** A total of 4 applications were received, 2 from female employees and 2 from male employees;
- **Band 6** A total of 7 applications were received, 3 from female employees and 4 from male employees;
- **Band 7** A total of 8 applications were received, 5 from female employees and 3 from a male employee;
- **Band 8a** A total of 7 applications were received, 1 from a female employee and 6 from male employees;
- **Band 8b** A total of 2 applications were received, both of which were from male employees;
- **Band 8c** A total of 5 applications were received, 2 from female employees and 3 from male employees;
- **Band 8d** Only one application was received. The application was from a female employee.

This high level data analysis has identified that female employees, who make up the majority of Velindre University NHS Trust new recruits, are still applying in fewer numbers for incremental credit, when compared to male new recruits. This could be resulting in a gender pay gap, with a higher proportion of new male recruits being given incremental credit advancement, which will have a positive impact on their annual salary.

Information regarding incremental credit will be made available to all applicants in their induction pack information. New recruits have 3 months from their commencement date to apply for incremental credit (**see Appendix A for the Trust's overarching Action Plan**).

11. Intersectionality

Gender Equality cannot be viewed in isolation, people's lives and identity are shaped by many factors. So within this Gender Pay report it is only right that we look at the Trust workforce in all of its intersectionality. This means that we recognise the way in which structures based on the factors such as sex/gender, race, sexuality, disability, age and faith interact with each other and create potential inequalities, discrimination and barriers.

One single form of discrimination cannot be viewed and understood in isolation from another. It is about recognising the multiple layers of discrimination that exist and the barrier preventing people from being the best they can be and our roles to support and

remove those barriers to have a workforce that is both supported, represented and can thrive.

We also recognise that data can be a challenge when it comes to intersectionality and this can be used a reason to not look at data in this way. But it is only when we look at the details we can then see the wider picture and look at the gaps and barriers that are preventing our workforce from developing and being truly representative of the communities we provide our services too.

The Trust will continue to work with staff to improve its collection and use of demographic data to better develop its analysis of pay and opportunities across the employment journey.

12. Equality Monitoring

Equality matters, to ensure that individuals across all protected characteristics enjoy the same rights, opportunities and outcomes but also drive economic growth and wellbeing.

The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year (deferred to 5th October 2020 for the 2020 reporting period). This year the Trust has provided the wider equality monitoring data within the gender pay report, as to provide a clearer picture of areas that need support to ensure a fully representative workforce.

13. Conclusion – Working to close the Gender Pay Gap within Velindre University NHS Trust

The Trust is committed to addressing workplace barriers to equality, supporting diversity and creating an open and inclusive community and recognises that for this to happen it needs to improve support both inside the organisation as well as working with external partners, communities and individuals.

In addition to addressing the findings and actions listed in the body of this document, we will, going forward, look to undertake the following:

- Identify an Equality Ambassador for Gender in both the Executive Team and Workforce and Organisational Development team.
- Continue to monitor job adverts for inclusive language as well as the number of male and female applicants, including part time workers
- Continue to provide financial support for parents during the Summer and Easter school holidays.
- Include an objective within our Strategic Equality Plan on Fair Pay

- Work with our Staff Diversity Networks on inclusive recruitment and raising awareness
- Work with the National Bodies Strategic Equality Objectives partnership to identify best practice to develop inclusive recruitment and workplaces.
- Continue to raise awareness through speakers, factsheets and staff training

The impact of these actions will not be seen immediately and are unlikely to show a positive impact straight away, but will enable us to move in a positive direction.

Appendix A

Trust Overarching Action Plan

Action No	Findings	Action	Lead	Accountability	Target Date	Monitoring
9.3	**Median Hourly Rate Gender Pay Gap** As at 31st March 2020, a median gender pay gap of £0.90, or a % point difference of 5.82% existed between all Trust male and female employees.	The Trust will: • identify why such a significant gap exists; • develop an action plan, in response to the above findings and present this to Trust Board for approval; • keep Trust Board informed of progress to reduce the median gender pay gap hourly rate; • report back findings in the 31st March 2021 Gender Pay Gap Report. The above will be informed via the Trust's active participation in the Wales Public Bodies Equality Partnership group, and the achievement of one of its specific objectives around Eliminating Pay Gaps. This work will involve: • Sharing and standardising systems for collating and analysing data across bodies,	Trust OD & Equality Manager	Velindre University Trust Executive Director of OD & Workforce	Dec 2021	Trust Senior WOD Leadership Team

Action No	Findings	Action	Lead	Accountability	Target Date	Monitoring
		supporting staff to disclose information • Agree a standard methodology for defining and collating pay gaps, interpreting/ communicating. • Sharing strategies for workforce planning. • Joining together to create workforce development opportunities. • Joint management and leadership training (HR Group). • Sharing practice on work patterns and ways of working.				
9.5	**Mean Bonus Gender Pay Gap (specifically for those who work part time).** **NB** This only relates to the Prescription Processing Department within NWSSP. Between 31st March 2019 and 31st March 2020	The NWSSP People and OD Team, in conjunction with the Prescription Processing Department, will investigate why such a very significant mean and median bonus payment differential has developed between part time, male and female prescription processing employees between 2019/20.	Deputy Director of People & OD, NWSSP	Velindre University Trust Executive Director of OD & Workforce	Dec 2021	Trust Senior WOD Leadership Team

Action No	Findings	Action	Lead	Accountability	Target Date	Monitoring
	the mean bonus gender pay gap between part-time male and female employees has widened by 12.48% points, with a current pay differential of 12.72% points	NWSSP will also: • continue the focus on the Prescription Processing Bonus scheme at the Primary Care Services quarterly reviews; • Working in conjunction with the Primary Care Services team, set up a working group to explore the future of the bonus scheme and its equity and fairness of payment, including the development of a performance framework. • report back findings in the 31st March 2021 Gender Pay Gap Report.				
9.6	**Median Bonus Gender Pay Gap (specifically for those who work part time)** **NB** This only relates to the Prescription Processing Department within NWSSP. Between 31st March 2019 and 31st March 2020, the bonus gender pay gap between part-time male and female employees widened by 6.28% points, with a current pay differential of 10.28% points.					
10	**Approved Incremental Credit Applications**	The Trust will: • Continue to provide	Trust WOD Business Partners &	Velindre University Trust Executive Director of OD & Workforce	Ongoing	Trust Senior WOD Leadership Team

Action No	Findings	Action	Lead	Accountability	Target Date	Monitoring
	Fewer numbers of female employees are applying for incremental credit in comparison to male employees.	information regarding incremental credit to all applicants in their induction pack information. • Advise Managers, as part of recruitment processes, of availability of incremental credit, should employees meet criteria	Operational Team			
13	**Trust overarching actions**	The Trust will: • Identify an Equality Ambassador for Gender in both the Executive Team and Workforce and Organisational Development team. • Continue to monitor job adverts for inclusive language as well as the number of male and female applicants, including part time workers • Continue to provide financial support for parents during Summer and Easter school holidays.	Trust OD & Equality Manager	Velindre University Trust Executive Director of OD & Workforce	Dec 2021	Trust Senior WOD Leadership Team

Action No	Findings	Action	Lead	Accountability	Target Date	Monitoring
		• Include an objective within our Strategic Equality Plan on Fair Pay • Work with our Staff Diversity Networks on inclusive recruitment and raising awareness • Work with the National Bodies Strategic Equality Objectives partnership to identify best practice to develop inclusive recruitment and workplaces. • Continue to raise awareness through speakers, factsheets and staff training				

Appendix B

Velindre University NHS Trust
Incremental Credit Data as at 31/3/19

***Salaries may differ due to pay increase awarded to pay bands in year**

Male / Female	New / Re-joining	Post Band	Point Awarded	Number of Increments	Actual Starting Salary*
Female	New	**3**	11	5	£19,700
Female	New	**4**	4	3	£21,582
Female	Existing NHS	**5**	23	7	£28747
Female	New	**5**	20	4	£25,934
Female	New	**5**	20	4	£25,551
Female	Re-joiner	**5**	20	4	£25,551
Male	New	**5**	19	3	£24,547
Male	New	**5**	23	7	£28,747
Male	New	**5**	18	2	£23,597
Male	New	**5**	18	2	£23,597
Male	New	**5**	20	4	£25,934
Female	New	**6**	26	5	£32,171
Male	New	**6**	26	5	£31,697
Female	New	**7**	29	3	£35,578
Female	New	**7**	30	4	£36,613
Female	New	**7**	32	2	£39,656
Male	New	**7**	32	6	£39,070
Male	New	**7**	32	6	£39,070
Male	Re-joiner	**7**	30	4	£36,613
Male	New	**7**	30	5	£36,613
Male	New	**7**	28	2	£34,403
Male	New	**8a**	35	2	£43,469
Male	New	**8a**	35	4	£43,469
Male	New	**8a**	36	3	£45,827
Male	New	**8a**	35	2	£44,121
Female	Re-joiner	**8b**	41	4	£57,515
Male	Re-joiner	**8b**	40	3	£54,625

Male	Re-joiner	**8c**	45	4	£68,256
Male	New	**8c**	46	5	£69,860
Female	New	**8d**	50	5	£80,606

Appendix C

Velindre University NHS Trust
Incremental Credit Data as at 31/3/2020

***Salaries may differ due to pay increase awarded to pay bands in year**

Male / Female	New / Re-joining	Post Band	Point Awarded	Number of Increments	Actual Starting Salary*
Female	Re-joining	**2**	6	6	£17,983
Female	New	**5-6**	22	7	£28,358
Female	New	**5**	20	5	£26,970
Male	New	**5**	20	5	£26,220
Male	New	**5**	21	5	£27,260
Female	New	**6**	27	6	£34,782
Female	New	**6**	28	7	£34,782
Female	New	**6**	24	3	£32,525
Male	New	**6**	24	3	£32,525
Male	New	**6**	27	7	£33,587
Male	New	**6**	29	8	£37,267
Male	New	**6**	25	5	£32,525
Female	New	**7**	34	8	£43,772
Female	New	**7**	33	8	£41,486
Female	New	**7**	33	8	£41,486
Female	New	**7**	33	7	£41,486
Female	New	**7**	33	7	£41,486
Male	New	**7**	33	7	£41,486
Male	New	**7**	33	7	£41,486
Male	New	**7**	33	8	£41,486
Female	Re-joining	**8a**	38	6	£50,189
Male	New	**8a**	37	5	£48,324
Male	New	**8a**	37	5	£48,324
Male	New	**8a**	38	6	£50,819
Male	New	**8a**	37	5	£48,324
Male	New	**8a**	37	4	£48,324
Male	New	**8a**	37	4	£48,324
Male	New	**8b**	41	4	£58,148
Male	New	**8b**	41	4	£58,148
Female	New	**8c**	46	6	£69,007
Female	New	**8c**	45	4	£69,007

Male	New	**8c**	44	4	£64,670
Male	New	**8c**	45	5	£69,007
Male	Re-joining	**8c**	44	4	£69,007
Female	New	**8d**	50	6	£86,687

Appendix D

VELINDRE UNIVERSITY NHS TRUST

EQUALITY MONITORING REPORT

1st APRIL 2018 – 31st MARCH 2019

1. Introduction

We are pleased to present Velindre University NHS Trusts Equality Monitoring Report for April 2018- March 2019. This report provides the equality monitoring data in line with our duties under the Equality Act 2010.

2. Legal Context

The Public Sector Equality Duty (PSED) requires that all public authorities covered under the specific duties in Wales should produce an annual equality report by 31st March each year. The essential purpose of the specific duties under the Equality Act, in relation to monitoring, is to help authorities to have better due regard to the need to achieve the 3 aims of the general duty, which are to;

- **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Act;
- **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and
- **foster good relations** between people who share a protected characteristic and people who do not share it.

Therefore, as a specific duty itself, the role of annual reporting is to support the Trust in meeting the general duty. It also has a role in setting out achievements and progress towards meeting the other specific duties.

In particular, the annual report supports the Trust to have a better due regard

to the duties by providing an opportunity to;

- Monitor and review progress;
- Monitor and review the effectiveness and appropriateness of arrangements;
- Review objectives and processes in light of new legislation and other new developments;
- Engage with stakeholders around these issues, providing partners and the public with transparency.

3. Equality Data

The tables below provide a breakdown of equality data in several areas, following the format requested by Welsh Government for Open Government License;

- Staff in post by their protected characteristic;
- All staff breakdown by grade;
    - Each grade broken down by sex;
- Working pattern broken down by sex;
- Employment assignment broken down by sex;
- Recruitment applications by their protected characteristics;
- All staff breakdown upon leaving the Trust;
    - Leavers by their protected characteristics.

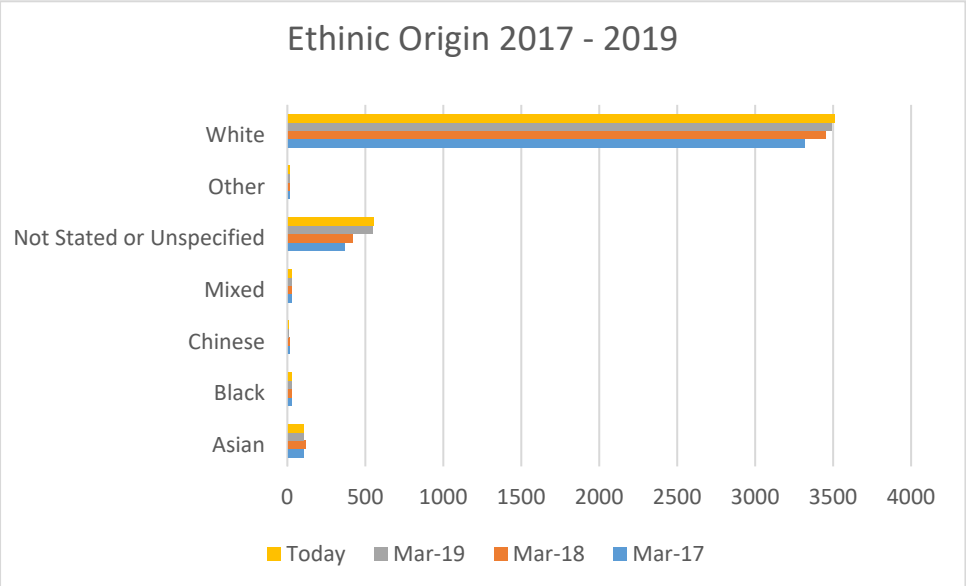
The data demonstrates that in a number of the more sensitive equality areas, many staff have either decided that they would prefer not to declare or the data has not been captured at all. Data capture is an area that has been identified for improvement.

The Trust acknowledges that it must increase employee confidence in how the data will be used, which overtime may see the data gaps close.

Note: Percentages are based on the total Headcount (4231) used for the report, which is based on the headcount on the 31st March 2019.

Interrogation of data.

When we look at progress across one of the protected characteristics of Race, it shows that in some groups there has been a decrease in diverse workforce. As a result workforce diversity as well as intersectional pay gaps is one of the five Strategic Equality Objectives for the 2020-2024 Plan.



Age Profile

Age Band	Headcount	%
<=20 Years	29	0.69
21-25	247	5.84
26-30	610	14.42
31-35	569	13.45
36-40	519	12.27
41-45	477	11.27
46-50	570	13.47
51-55	574	13.57
56-60	393	9.29

61-65	196	4.63
66-70	34	0.80
>=71 Years	13	0.31
Grand Total	**4,231**	**100**

Religious Beliefs

Religious Belief	Headcount	%
Atheism	682	16.12
Buddhism	13	0.31
Christianity	1688	39.90
Hinduism	29	0.69
I do not wish to disclose my religion/belief	619	14.63
Islam	81	1.91
Judaism	1	0.02
Other	301	7.11
Sikhism	5	0.12
Unspecified	812	19.19
Grand Total	**4231**	100

Sexual Orientation

Sexuality	Headcount	%
Bisexual	19	0.45
Gay or Lesbian	46	1.09
Heterosexual or Straight	3057	72.25
Not stated (person asked but declined to provide a response)	328	7.75
Other sexual orientation not listed	1	0.02
Undecided	1	0.02
Unspecified	779	18.41
Grand Total	**4231**	100

Gender Reassignment or Gender Identity

The ESR system currently does not have the data fields to allow for the collection of data on gender reassignment or gender identity.

Disability

Disability	Headcount	%
No	2873	67.90
Not Declared	170	4.02
Prefer Not To Answer	1	0.02
Unspecified	1058	25.01
Yes	129	3.05
Grand Total	**4231.00**	100.00

Ethnic Origin

Ethnic Origin	Headcount	%
Asian	108	2.55
Black	30	0.71
Chinese	12	0.28
Mixed	27	0.64
Not Stated or Unspecified	543	12.83
Other	15	0.35
White	3496	82.63
Grand Total	**4,231**	**100**

Marital Status

Marital Status	Headcount	%
Civil Partnership	40	0.95
Divorced	234	5.53
Legally Separated	26	0.61
Married	2095	49.52
Single	1333	31.51
Unknown	477	11.27
Widowed	26	0.61
Grand Total	**4231.00**	**100.00**

Pregnancy and Maternity

On Maternity	Headcount	%
Yes	95	2.25

No	4136	97.75
Grand Total	**4231**	**100**

Employment Category by Sex

Employment Category	Female	Male	Grand Total
Full Time	1607	1547	3154
Part Time	935	142	1077
Grand Total	**2542**	**1689**	**4231**

Pay Scales by Sex

Pay Scales	Female	Male	Grand Total
Band 1	31	1	32
Band 2	217	322	539
Band 3	409	185	594
Band 4	419	153	572
Band 5	314	213	527
Band 6	342	214	556
Band 7	253	158	411
Band 8 - Range A	94	105	199
Band 8 - Range B	54	58	112
Band 8 - Range C	38	47	85
Band 8 - Range D	10	15	25
Band 9	5	12	17
Medical Consultant	35	21	57
Medical SAS	1	4	5

Medical Trainee	307	167	474
Other	13	14	27
Grand Total	**2542**	**1689**	**4231**

Profession by Sex

Profession	Female	Male	Grand Total
Add Prof Scientific and Technic	41	18	59
Additional Clinical Services	175	60	235
Administrative and Clerical	1532	1022	2554
Allied Health Professionals	106	18	124
Estates and Ancillary	57	303	360
Healthcare Scientists	88	59	147
Medical and Dental	346	194	540
Nursing and Midwifery Registered	197	15	212
Grand Total	**2542**	**1689**	**4231**

Contract Type by Sex

Contract Type	Female	Male	Grand Total
Fixed Term Temp	458	258	716
Honorary	1		1
Locum	1	1	2

Non-Exec Director/Chair	1		1
Permanent	2081	1430	3511
Grand Total	**2542**	**1689**	**4231**

Appendix E

VELINDRE UNIVERSITY NHS TRUST

EQUALITY MONITORING REPORT

1st APRIL 2019 – 31st MARCH 2020

1. Introduction

We are pleased to present Velindre University NHS Trusts Equality Monitoring Report for April 2019- March 2020. This report provides the equality monitoring data in line with our duties under the Equality Act 2010.

2. Equality Data

The tables below provide a breakdown of equality data in several areas, following the format requested by Welsh Government for Open Government License;

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    - Each grade broken down by sex;
- Working pattern broken down by sex;
- Employment assignment broken down by sex;
- Recruitment applications by their protected characteristics;
- All staff breakdown upon leaving the Trust;
    - Leavers by their protected characteristics.

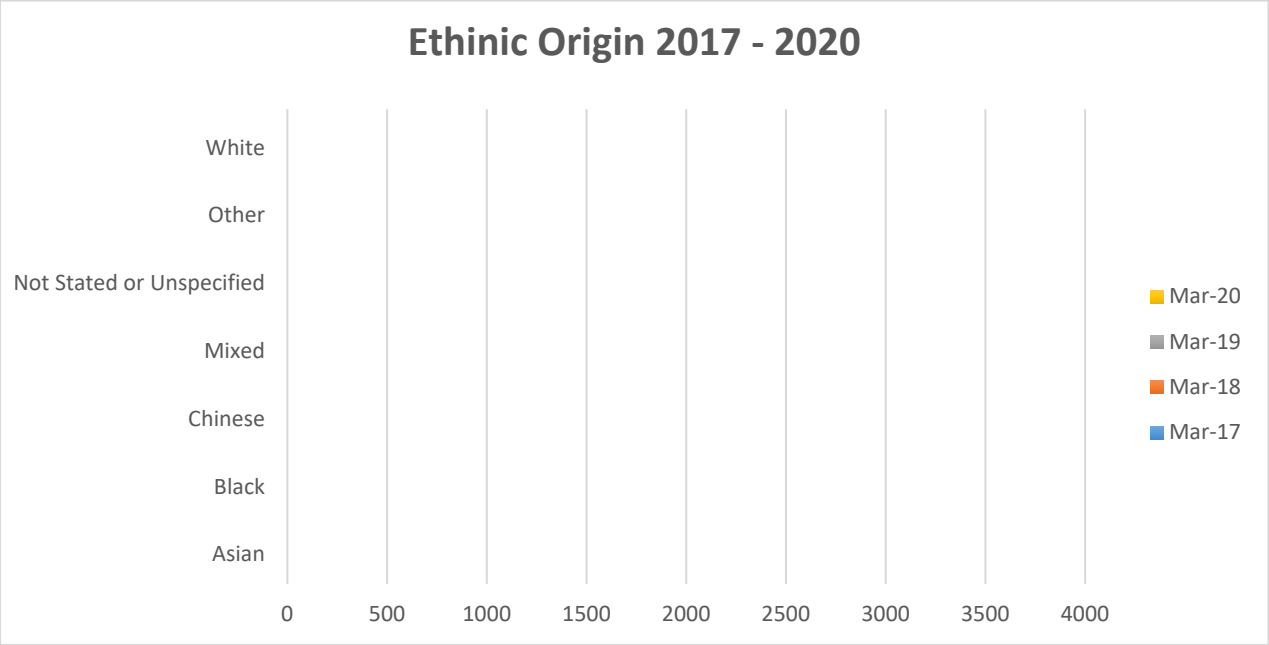
The data demonstrates that in a number of the more sensitive equality areas, many staff have either decided that they would prefer not to declare or the data has not been captured at all. Data capture is an area that has been identified for improvement.

The Trust acknowledges that it must increase employee confidence in how the data will be used, which overtime may see the data gaps close.

Note: Percentages are based on the total Headcount (4590) used for the report, which is based on the headcount on the 31st March 2020.

Interrogation of data.

When we look at progress across one of the protected characteristics of Race, it shows that in some groups there has been a decrease in diverse workforce. As a result workforce diversity as well as intersectional pay gaps is one of the five Strategic Equality Objectives for the 2020-2024 Plan.



Age Profile

Age Band	Headcount	%
<=20 Years	27.00	0.59
21-25	272.00	5.93
26-30	654.00	14.25
31-35	652.00	14.20
36-40	587.00	12.79
41-45	491.00	10.70
46-50	587.00	12.79
51-55	594.00	12.94
56-60	448.00	9.76
61-65	228.00	4.97
66-70	37.00	0.81
>=71 Years	13.00	0.28
Grand Total	**4590.00**	100.00

Religious Belief

Religious Belief	Headcount	%
Atheism	756.00	16.47
Buddhism	13.00	0.28
Christianity	1783.00	38.85
Hinduism	30.00	0.65
I do not wish to disclose my religion/belief	624.00	13.59
Islam	88.00	1.92
Judaism	1.00	0.02
Other	357.00	7.78
Sikhism	5.00	0.11
Unspecified	933	20.33
Grand Total	**4590.00**	100.00

Sexual Orientation

Sexuality	Headcount	%
Bisexual	22.00	0.48
Gay or Lesbian	61.00	1.33
Heterosexual or Straight	3282.00	71.50
provide a response)	315.00	6.86
Other sexual orientation not listed	2.00	0.04
Undecided	3	0.07
Unspecified	905	19.72
Grand Total	**4590.00**	100.00

Gender Reassignment or Gender Identity

The ESR system currently does not have the data fields to allow for the collection of data on gender reassignment or gender identity.

Disability

Disability	Headcount	%
No	3117.00	67.91
Not Declared	144.00	3.14
Prefer Not To Answer	3.00	0.07
Unspecified	1161.00	25.29
Yes	165	3.59
Grand Total	**4590.00**	100.00

Ethnic Origin

Ethnic Origin	Headcount	%
Asian	113.00	2.46
Black	42.00	0.92
Chinese	10.00	0.22
Mixed	42.00	0.92
Not Stated or Unspecified	681.00	14.84
Other	15.00	0.33
White	3687.00	80.33
Grand Total	**4590.00**	100.00

Marital Status

Marital Status	Headcount	%
Civil Partnership	53	1.15
Divorced	259	5.64
Legally Separated	25	0.54
Married	2237	48.74
Single	1435	31.26
Unknown	444	9.67
Widowed	29	0.63
(blank)	108	2.35
Grand Total	**4590.00**	100.00

Pregnancy and Maternity

On Maternity	Headcount	%
Yes	104	2.27
No	4486	97.73
Grand Total	**4590.00**	100.00

Employment Category by Sex

Employment Category	Female	Male	Grand Total
Full Time	1735	1662	3397
Part Time	1015	178	1193
Grand Total	**2750**	**1840**	**4590**

Pay Scales by Sex

Pay Scales	Female	Male	Grand Total
Band 2	237	330	567
Band 3	469	205	674
Band 4	432	176	608
Band 5	334	212	546
Band 6	370	229	599
Band 7	289	176	465
Band 8 - Range A	110	119	229
Band 8 - Range B	66	61	127
Band 8 - Range C	38	55	93
Band 8 - Range D	10	16	26
Band 9	6	12	18

Medical Consultant	37	25	62
Medical SAS	4	3	7
Medical Trainee	330	207	537
Other	18	14	32
Grand Total	**2542**	**1689**	**4231**

Profession by Sex

Profession	Female	Male	Grand Total
Add Prof Scientific and Technic	50	17	67
Additional Clinical Services	190	59	249
Administrative and Clerical	1664	1104	2768
Allied Health Professionals	111	19	130
Estates and Ancillary	68	330	398
Healthcare Scientists	84	59	143
Medical and Dental	375	237	612
Nursing and Midwifery Registered	208	15	223
Grand Total	**2542**	**1689**	**4231**

Contract Type by Sex

Contract Type	Female	Male	Grand Total
Fixed Term Temp	475	304	779
Honorary	5	1	6
Locum	1		1
Non-Exec Director/Chair	1		1
Permanent	2268	1535	3803
Grand Total	**2750**	**1840**	**4590**

TRUST BOARD

CHARITABLE FUNDS COMMITEE HIGHLIGHT REPORT

DATE OF MEETING	14/09/2021

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Alison Hedges, Business Support Officer
PRESENTED BY	Prof. Donna Mead OBE, Chair
EXECUTIVE SPONSOR APPROVED	Mark Osland, 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 14 September 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 14 September 2021:

ALERT / ESCALATE	There were no items for alerting or escalating to the Trust Board.
ADVISE	**FUNDRAISING** The Committee were advised of the continued impact of the COVID 19 pandemic on fundraising activity. At the start of the pandemic Fundraising activities were halted for a significant period, which has been followed by a slow return to activities based in the UK. The Committee noted that we have seen an opportunity in the last couple of weeks of getting to the levels of pre-COVID and that foreign travel for events will be recommencing in 2022. The Committee were advised that there is a significant opportunity for the development of a comprehensive multi-layer fundraising programme targeting the new Velindre Cancer Centre. The Committee noted that the key focus for the coming period will be the development of a 5 year strategy for the Charity which will be completed by the end of December 2021. This will encompass a review of the current funding model in parallel with a fundamental review of the existing systems, processes and procedures. The Committee were advised that to enable the planned changes the Fundraising Team will undertake a comprehensive training and development programme with a number of key strands to support their professional development. The Committee were also advised of plans underway to hold a Fundraising Annual Meeting towards the end of January 2022. This will include 2-4 guest speakers, with a target audience of 150-200 people, made up of Stakeholders and Fundraisers from throughout the year. Final plans for the event will be received at the Committee in November 2021. **FINANCIAL POSITION** • **Income** The Committee noted that the Charity has raised £741,000 during the period which is an overachievement of £240,000 against the planned target. This includes £185,000 in legacies, which has notably helped performance for the period to date.

The Committee were advised that income for the period to date was down by £437,000 when compared with the same period last year, this is due to a one-off donation of £500,000 from the Moondance Foundation received in 2020/21.

- **Forecast Income**

The Committee noted that the Charity is on course to achieve the £1,566,000 forecast income target against the unrestricted general fund which was included in the 2021/22 Financial Delivery Plan, and to have a balance of circa £898,000 at the end of the financial year.

- **Expenditure**

The Committee were advised that for the period 1st April to 31st July 2021 expenditure was lower than planned by £237,000. This underspend is in most cases due to timing issues due to vacancies against projects and the spend is expected to be deferred over future years.

- **Investments**

The Committee noted that the investment portfolio position has increased by £256,000 since the start of the financial year, which represents an increase in valuation of 4.27% during the year.

The Committee were advised that the term for the current Investment Broker for the Charity ends in January 2022. Plans are in hand to tender for investment management and plan is to remain within the existing cost profile for this service.

The Committee received the highlight report from the June 2021 meeting of the Investment Performance Review Sub-Committee. The Committee were advised that the Sub-Committee continues to keep under review the investment policy and in particular the Investment Risk Tolerance Category of **LOW**; this was **ENDORSED** by the Committee. The Committee noted that there are currently no plans to either transfer funds into or withdraw from the Investment Portfolio. In addition, the Committee **APPROVED** the updated Charitable Funds Investment Policy. This is included within the September Trust Board Policies for Approval report, and so is not appended to this highlight report to avoid duplication.

BUSINESS CASES

The Committee **APPROVED** 2 business case requests:

1. Clinical Psychologist for Staff and Teams

2. Sepsis Velindre Charitable Funds Grant 2018_18 No Cost Time Extension

	1. Clinical Psychology Service The Committee agreed that this was a key support service for staff and teams and of particular importance given the recent impact of COVID-19. The Committee noted that further discussion was required on the most appropriate funding source for future arrangements to enable the service to be embedded in the long term. This would need to form part of the planned discussions via the established IMTP commissioning process in the Autumn. Funding was approved until March 2023 to be coterminous with existing funding arrangements in place for the Clinical Psychology Team. **2. Sepsis Velindre Charitable Funds Grant No Cost Time Extension** The Committee agreed the no cost extension of the ADVANCE: Community based point of care white cell count testing, until 30 December 2021.
ASSURE	**BUSINESS CASE & FUNDRAISING EVALUATION REPORTS** The Committee considered 4 Business Case and Fundraising Evaluation Reports, which provide assurance that projects funded by the Charity have delivered or are delivering their expected outputs. This included: 1. Health, Cancer & Screening, Blood and Blood Products Awareness Resource for ESOL Learners in BAME Communities 2. Clinical Psychology Service 3. Library – Knowledge & Information Services 4. Clinical Nurse Specialists (CNS) The Committee highlighted that the overall theme running across all of the Annual Evaluation reports was the need to provide a more outcome focused approach to provide the Committee with assurance of the benefits derived from the funding provided by the Charity. The Committee noted that plans are already underway to address this which will be further reinforced and supported with the introduction of the revised annual report templates. Three of the 4 annual reports were subsequently approved with further details requested in respect of the first report in order to be approved by the Committee. The committee was advised that the on-going funding for library and information services and clinical nurse specialists will be addressed.
INFORM	**Appointment of New Ambassadors** The Committee noted that three new Ambassador nominations had been **APPROVED** by the Committee via Chairs Urgent Action which were subsequently **ENDORSED**. The Chair has written to the each of the nominees inviting them to join the Charity as an Ambassador.

3. RECOMMENDATION

The Trust Board is asked to **NOTE** the contents of this report.