Public Quality, Safety & Performance Committee

Thu 09 May 2024, 10:00 - 13:00

Velindre University NHS Trust Headquarters, Nantgarw

Agenda

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1. PRESENTATIONS

1.1. Velindre Cancer Service - Patient Story

Provided in person by Dr Helen Hughes, Velindre Cancer Service Patient

Supported by:

Natalie Phillips, IV Access Lead Nurse

Vivienne Cooper, Head of Nursing and

Matthew Walters, Advanced Nurse Practitioner

📄 1.1.0 QSP PORT Slides Final 1.0.pdf (11 pages)

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2. STANDARD BUSINESS

2.1. Apologies

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.2. In Attendance

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.3. Declarations of Interest

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

2.4. Minutes from the meeting of the Public Quality, Safety & Performance Committee held on 14th March 2024

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

📄 2.4.0 DRAFT Minutes - Public Quality Safety and Performance Committee 14th March 2024 (VM).pdf (19 pages)

2.5. Minutes from the Extraordinary Public Joint Audit and Quality, Safety & Performance Committee, held on 21st March 2024

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

📄 2.5.0 Draft Minutes - Public Extraordinary Joint Audit and QSP Committee 21st March 2024 (LF).pdf (5 pages)

2.6. Review of Action Log

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 2.6.0 PUBLIC QSP Action Log Mar-May.pdf (8 pages)

2.7. Matters Arising

To be led by Vicky Morris, Quality, Safety & Performance Committee Chair

There are no matters arising

2.7.1. Change in Allocation of Noddfa Building Wellbeing Centre

To be led by Susan Thomas, Organisational Development and Workforce

Verbal Update

2.7.2. Health and Safety Incidents Trends/Themes

To be led by Jonathan Fear, Interim Assistant Director of Estates, Capital and Environment

Verbal Update

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3. MAIN AGENDA

This section supports the discussion of items for review, scrutiny and assurance.

3.1. Trust Risk Register

To be led by Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 3.1.0 TRR Paper - QSP - May 24.pdf (9 pages)
📄 3.1.0 Copy of RISKS OVER 15 -29.04.2024 (002).pdf (1 pages)
📄 3.1.0 Copy of SAFETY RISKS 12 - 29.04.2024.pdf (1 pages)
📄 3.1.0 INHERENT RISKS FOR 2024 - 29.04.2024.pdf (1 pages)

3.1.1. Trust Assurance Framework

To be led by Lauren Fear, Director of Corporate Governance & Chief of Staff

📄 3.1.1 TAF Paper - QSP- May24.pdf (7 pages)
📄 3.1.1 V50 - TAF DASHBOARD - 19.04.2024.pdf (13 pages)

3.2. Quality, Safety and Performance Reports

3.2.1. Welsh Blood Service Quality & Safety Divisional Report

To be led by Alan Prosser, Director, Welsh Blood Service and Peter Richardson, Head of Quality, Safety & Regulatory Compliance, Deputy Director, WBS

📄 3.2.1 WBS Q+S Report Dec 23 to March 2024 Final.pdf (28 pages)

3.2.2. Performance Management Framework (PMF) Report and Supporting Analysis

To be led by Carl James, Executive Director of Strategic Transformation, Planning & Digital and Sarah Morley, Executive Director of Organisational Development & Workforce

📄 3.2.2 QSP Cttee 9.05.24 MARCH PMF Performance Report FINAL version 005.pdf (68 pages)

3.3. Workforce Supply & Shape and Associated Finance Risks

To be led by Sarah Morley, Executive Director of Workforce & Organisational Development and Matthew Bunce, Executive Director of Finance

- Workforce
- Finance

📄 3.3.0 Supply and Shape Paper QSP May 2024.pdf (11 pages)

3.4. Finance Report for the Period Ended 31st March 2024

To be led by Matthew Bunce, Executive Director of Finance

📄 3.4.0 Month 12 Finance Report Cover Paper QSP 09.05.24.pdf (8 pages)

📄 3.4.0 Appendix 1 -M12 VELINDRE NHS TRUST FINANCIAL POSITION TO MARCH 2024 QSP 9th May 2024.pdf (26 pages)

📄 3.4.0 Appendix 2 - TCS Programme Board Finance Report (March 2024) - Main Report.pdf (16 pages)

3.5. Quarter 4 Quality & Safety Report

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 3.5.0 QSP Q4 2023-24 Quality Safety Highlight Report.pdf (44 pages)

3.6. Private Patient Service Improvement Group Highlight Report and Improvement Plan Update

To be led by Rachel Hennessy, Interim Director, Velindre Cancer Service

📄 3.6.0 Private Patients Report.pdf (3 pages)

3.7. Trust Clinical Audit Plan

To be led by Jacinta Abraham, Executive Medical Director

📄 3.7.0 Cover Report Trust Clinical Audit Plan QSPC.pdf (6 pages)
📄 3.7.0 VUNHST CLINICAL AUDIT PLAN 2024-25 Final V5.pdf (37 pages)

3.8. Trust-wide Policies and Procedures Compliance Report

To be led by Lauren Fear, Director of Corporate Governance & Chief of Staff

Including:
Action plan for the progression of out-of-date policies

📄 3.8.0 Policy Compliance Report QSPC MAY 2024 V1.pdf (14 pages)

BREAK - 10 minutes

4. NHS WALES SHARED SERVICES PARTNERSHIP

4.1. Transforming Access to Medicine (TrAMs) Progress Update

To be led by Gareth Tyrrell, Accountable Pharmacist, NWSSP; Colin Powell, Service Director, TrAMs; and Peter Elliott, Assistant Head, NWSSP Project Management Office

Paper not received

4.2. All-Wales Drug Contracting

To be led by Gareth Tyrrell, Accountable Pharmacist, NWSSP

📄 4.2.0 NWSSP PTS QSP Submission - May.pdf (7 pages)

4.3. Implementation of Duty of Quality Update

To be led by Ruth Alcolado, Medical Director, Corporate Services, NWSSP

📄 4.3.0 QSP Velindre Duty of quality update May 2024.pdf (6 pages)

5. CONSENT ITEMS FOR APPROVAL

The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required.

5.1. Trust Policies for Approval

5.1.1. Fire Safety Policy

To be led by Jonathan Fear, Interim Assistant Director of Estates, Capital and Environment

📄 5.1.1 PP 01 Trust Fire Safety Policy v.5_Sept. 2023 with cover paper_QSP_290424 (SUBMITTED).pdf (17 pages)

5.2. Trust Learning Framework

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 5.2.0 QSP Learning Framework MAY 2024 version.pdf (4 pages)
📄 5.2.0 LEARNING FRAMEWORK.pdf (12 pages)

5.3. Trust Incident Management Framework

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 5.3.0 Incident Management Framework.pdf (4 pages)
📄 5.3.0 Incident Management FRAMEWORK.pdf (26 pages)

5.4. Trust Updated Inquest Guidance and Protocol

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 5.4.0 QSP Updated Inquest Guidance MAY 2024 version.pdf (4 pages)
📄 5.4.0 Inquest Guidance.pdf (32 pages)

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6. CONSENT ITEMS FOR ENDORSEMENT

There are currently no items for endorsement.

6.1. Quality & Safety Framework Refresh

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience

📄 6.1.0 QSP Quality Safety Framework Report.pdf (4 pages)

6.2. Three-Yearly Assurance Report on Compliance with the Nurse Staffing Levels (Wales) Act (2016)

To be led by Anna Harries, Head of Nursing, Professional Standards & Digital

📄 6.2.0 3 Yearly Report 2021-2024-NSA forQSP9.5.24.pdf (17 pages)

6.3. Quality, Safety & Performance Committee Chair's Urgent Action Report

To be led by Liane Webber, Business Support Officer

📄 6.3.0 QSP Chairs Urgent Action Report March-May 2024.pdf (4 pages)

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7. CONSENT ITEMS FOR NOTING

7.1. Medicines Management Group (including Medical Gases & CDs) Assurance Report

To be led by Jacinta Abraham, Executive Medical Director

📄 7.1.0 MMG Assurance Report April 2024 QSPC.pdf (15 pages)

7.2. Radiation Protection & Medical Exposures Strategic Group Highlight Report

To be led by Jacinta Abraham, Executive Medical Director

📄 7.2.0 RPMESC Highlight Report Final QSPC.pdf (4 pages)

7.3. Standards for Competency Assurance of Non-Medical Prescribers in Wales March 2024

To be led by Jacinta Abraham, Executive Medical Director

📄 7.3.0 Standards for Competency Assurance of Non-Medical Prescribers in Wales March 2024 QSPC.pdf (6 pages)
📄 7.3.0 Appendix 1 Standards for Competency Assurance_English.pdf (12 pages)

7.4. Pharmacy Review

To be led by Jacinta Abraham, Executive Medical Director

📄 7.4.0 Pharmacy Report QSPC 09.05.24 v 3.pdf (7 pages)
📄 7.4.0 Appendix 1 Velindre University Hospital NHS Trust Pharmacy review Final September 2023.pdf (23 pages)
📄 7.4.0 Appendix 2 Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales - Welsh Government Response_pdf_(E).pdf (33 pages)

7.5. Infected Blood Inquiry Update

To be led by Alan Prosser, Director, Welsh Blood Service

📄 7.5.0 IBI Update QSP 9th May 2024 Final.pdf (6 pages)

7.6. Education Strategy Audit Report

To be led by Sarah Morley, Executive Director of Organisational Development & Workforce

📄 7.6.0 QSP Education Strategy Audit Paper 9.5.24.pdf (6 pages)
📄 7.6.0 Appendix 1 - Education Strategy Actions 9.5.24.pdf (3 pages)

7.7. Strategic Equality Plan (SEP) Action Plan

To be led by Claire Budgen, Head of Organisational Development

📄 7.7.0 Strategic Equality Plan 2024-28 QSP 9.5.24.pdf (6 pages)
📄 7.7.0 Appendix 1 Strategic Equality Plan 2024- 2028.pdf (5 pages)
📄 7.7.0 Appendix 2 SEP Action Plan 2024-25.pdf (2 pages)

7.8. Integrated Medium Term Plan (IMTP) Quarter 4 Progress Report

To be led by Carl James, Executive Director of Strategic Transformation, Planning & Digital

📄 7.8.0 QSP Cttee 9.05.24 IMTP 2023.24 Quarter 4 Update version 019.pdf (48 pages)

7.9. Integrated Medium Term Plan (IMTP) Accountability Conditions (Q4) Yearend Report

To be led by Carl James, Executive Director of Strategic Transformation, Planning & Digital

📄 7.9.0 QSP Cttee 9.05.24 Accountability Conditions Progress version 004.pdf (5 pages)
📄 7.9.0 Appendix 1 EMB Run 2023-10-02 VELINDRE- Judith Paget - IMTP Accountability Letter 2023.24.pdf (3 pages)
📄 7.9.0 Appendix 2 IMTP Accountability Letter 2.10.23 Quarterly Monitoring as at Q4 version 019.pdf (9 pages)

7.10. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Reports 25th January 2024 and 18th April 2024

To be led by Stephen Harries, Vice Chair and Chair of the TCS Programme Scrutiny Sub Committee

📄 7.10.0a QSP Highlight Report Public 25.01.2024-LF.pdf (2 pages)
📄 7.10.0b QSP Highlight Report Public 18.04.2024- LF.pdf (3 pages)

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8. INTEGRATED GOVERNANCE

The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks.

8.1. May 2024 Analysis of Triangulated Meeting Themes

- Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee?
- Were papers concise and relevant, containing the appropriate level of detail?
- Was open and productive debate achieved within a supportive environment?
- Was it possible to identify cross-cutting themes to support effective triangulation?
- Was sufficient assurance provided to Committee members in relation to each item of business received?

8.2. Committee Effectiveness Survey Report – Reflective Feedback from March 2024 Committee

To be led by Liane Webber, Business Support Officer

9. HIGHLIGHT REPORT TO TRUST BOARD

Members to identify items to include in the Highlight Report to Trust Board:

- For Escalation/Alert
- For Assurance
- For Advising
- For Information

10. ANY OTHER BUSINESS

Prior approval by the Chair required.

11. DATE AND TIME OF THE NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 9th July 2024 from 10:00-13:00.

12. CLOSE

The Quality, Safety & Performance Committee 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).

13. PRIVATE/PART B SESSION

The following item(s) will be discussed at the Private/Part B Session of the Quality, Safety & Performance Committee

- Infected Blood Inquiry
- Private Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report

Patient Story: Dr. Helen Hughes

Current Intravenous (IV) Access Service Provision at VCC

- The current IV Access service at VCC is nurse led. The team comprises of 3 Band 7 specialist nurses.

- The team have expertise with insertion of IV access devices including:
  - Venepuncture and Intravenous cannulation
  - Peripherally Inserted Central Catheter (PICC) lines

- Additionally, the team manage IV access complications such as:
  - Difficult Venepuncture and Intravenous cannulation procedures
  - Peripherally Inserted Central Catheter (PICC) lines-infection, blocked or malpositioned lines
  - Totally Implanted Venous Access Port (TIVAP) /PORT- infection or blocked PORTs
  - Advanced IV access complication management e.g. extravasation.

- The team deliver education and training to all clinical staff at VCC. Additionally, the team support clinical staff from surrounding health boards with training as required.

- The team support all clinical areas throughout the cancer centre.

IV Access Devices Available at VCC

◆ Within VCC the IV access team offer a PICC line insertion as the main access device for treatment.

◆ A PICC line is offered to patients for the following reasons:

    ◆ Patients that have difficult peripheral venous access

    ◆ Patients that require an ambulatory pump to receive chemotherapy treatment

    ◆ Dependent on the SACT agent being administered – some agents can cause pain and damage to veins when administered peripherally.

◆ PICC insertion activity has increased by approximately 30-40% during the last financial year.

◆ For some patients a PORT is a preferable IV access option for those that require long-term IV therapy, and this will be addressed below.

VCC PICC Insertion Data

PICC Insertion Data			
	2023/24	2022/23	2021/22
April	70	38	47
May	74	61	46
June	81	53	49
July	84	43	42
August	87	65	46
September	74	67	51
October	73	70	55
November	68	61	61
December	61	65	52
January	81	58	57
February	79	58	57
March	80	83	57
TOTAL	912	722	620

PICC insertion activity has increased by approximately 30-40% during the last financial year.

PICC line versus PORT insertion

◆ The benefits of a PICC line insertion are valued by patients. However, some of these patients would have greatly benefitted from a PORT.

PICC

PORT

PICC CATHETER POSITIONING
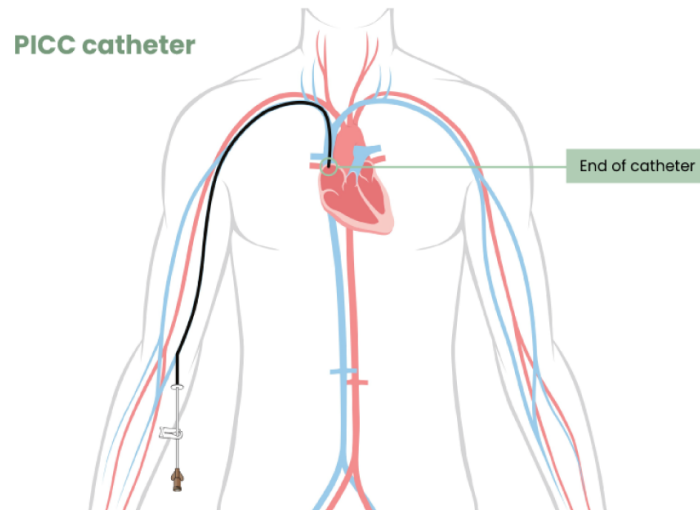
TOTALLY IMPLANTED VASCULAR ACCESS DEVICE
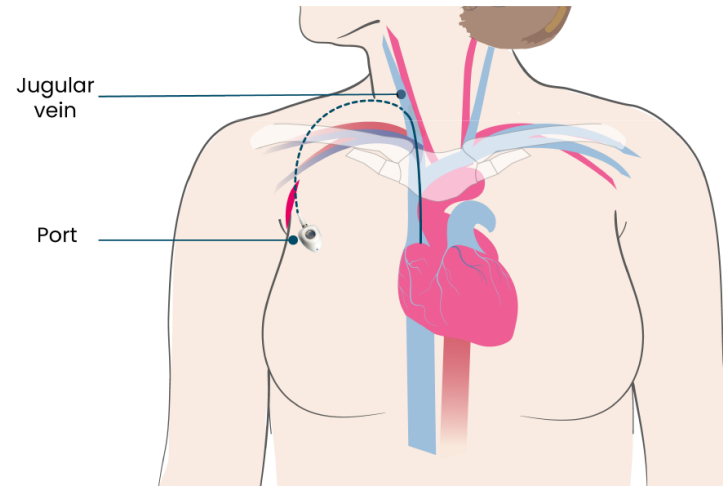
What is a PICC line

◆ Long catheter inserted into a vein in the middle or upper arm.

◆ There are 1 or 2 lumens available to obtain blood samples and administer treatment i.e. SACT, TPN or long-term antibiotics.

◆ The external part of the line is secured to the arm with a dressing.

◆ Patients require a waterproof sleeve for showering.

◆ Patients are restricted from having a bath or swimming due to the risk of the dressing becoming wet and potential introduction of infection.

◆ Additionally, patients are unable to maintain sports that involve high or over arm exercises such as golf or tennis.

The line is threaded through the vein until the end is near your heart

The heart

Line comes out here
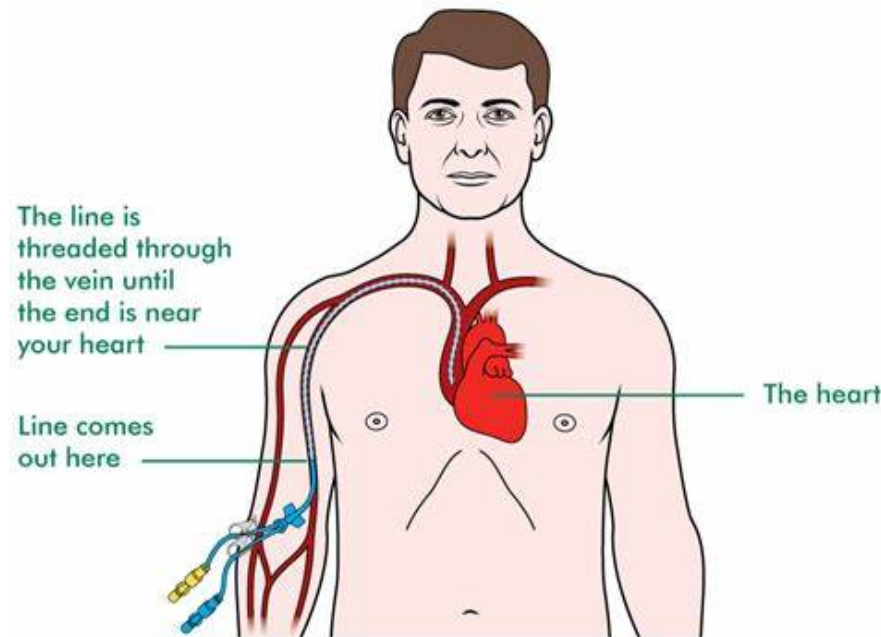
What is a PORT

◆ A PORT is a Totally Implanted Venous Access PORT (TIVAP). It is a device used to administer medium to long term intravenous therapy and is buried under the skin during implantation.

◆ A PORT consists of a stainless steel or plastic portal chamber which encases a silicone septum within it (as seen below). Attached to the chamber is a silicone or polyurethane catheter.

The port is implanted subcutaneously and then sutured into place. Placement sites include the upper chest, the arm or abdomen. It is usual to place the port over a bony prominence to provide a solid base for access purposes. The catheter is then fed into the vein with the tip resting within the superior vena cava or occasionally in the inferior vena cava.

Central Venous Internal Line: Port

Vein
Skin
Port under skin
Heart
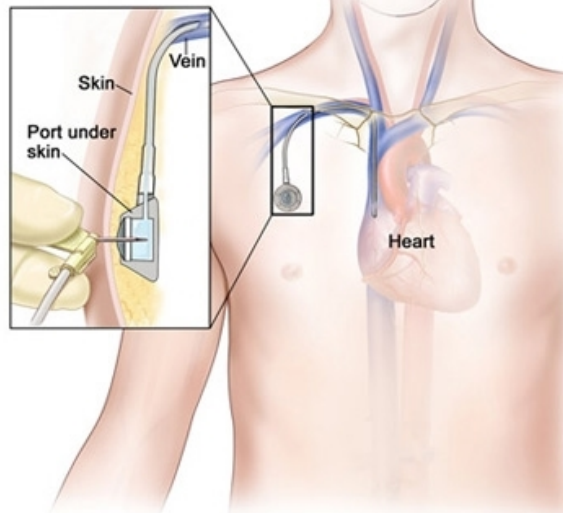
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PICC Vs PORT

PICC

- PICC insertion available at VCC.

- Quick turnaround as its nurse led and the PICC line can be placed in line with treatment.

- Must have weekly dressing change and be flushed once a week.

- The patient is not able to get their arm wet and therefore are provided with a waterproof sleeve for showering.

- No heavy lifting or swinging motions (i.e. not able to play golf).

- Has to be removed if patient is going on holiday for longer than 7 days.

- Has to be removed if patient is on a treatment break.

- External device so can get caught leading to malposition of the line and increase risk of infection.

- Has an impact on patients' quality of life.

PORT

- No dressing required. Flushed every 6-8 weeks.

- No restrictions on lifestyle e.g. swimming,

- Does not get removed for holidays longer than 7 days.

- Does not need to be removed for treatment break.

- Implanted device no risk of dislodging the device.

- Lower risk of infection.

- Enables the patient to maintain the same quality of life pre-treatment.

- PORT placement is currently performed at the patients DGH (only available currently within Cwm Taf and ABUHB).

- Currently there is no standard to advise on the duration of time a patient should wait for a PORT insertion.

Current Process for Velindre Patients that require a PORT Service

◆ Patients that are deemed eligible for a PORT are currently referred to their DGH via the IV Access Team.

◆ There is currently a PORT insertion service available to patients that reside within the Aneurin Bevan and Cwm Taf Morgannwg health boards. The service is streamlined service we have no delays in getting the PORT placed and the Radiologists are very helpful when we need their advice.

◆ Unfortunately, Cardiff and Vale are not accepting PORT referrals from Velindre at present. We are currently working on an interim SLA with St Joseph's.

Next Steps……

◆ In England a PORT insertion is offered to all patients as an option to support long term treatment e.g. SACT for Oncology and Haematology patients.

◆ As a matter of urgency, develop an interim SLA with St Joseph's private hospital to ensure that Cardiff and Vale patients receive an equitable service within South East Wales.

◆ Consider PORT insertion options to future proof the service for all patients within South East Wales:

- ◆ Consider developing an SLA with Aneurin Bevan UHB to place PORTs for the Cardiff and Vale patients.
- ◆ Develop a PORT service or alternative within VCC for Cardiff and Vale patients.

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: 14th March 2024
Time: 10:00 – 13:00
Location: Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Jacinta Abraham	Executive Medical Director	JA
Matthew Bunce	Executive Director of Finance	MB
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Alan Prosser	Director of Welsh Blood Service	AP
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
Susan Thomas	Deputy Director of Workforce and Organisational	ST
Tina Jenkins	Interim Deputy Director Nursing, Quality & Patient Experience	TJ
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Tamarha Jones	Gynae Clinical Nurse Specialist	TaJ
Vivienne Cooper	Head of Nursing, VCS	VC
Phillip Hodson	Deputy Director of Planning & Performance	PH
Katrina Febry	Audit Lead, Audit Wales	KF
Emma Rees	Deputy Head of Internal Audit, NWSSP	ER
Gareth Tyrrell	Accountable Pharmacist, NWSSP	GT

APOLOGIES:		
Steve Ham	Chief Executive Officer	
Carl James	Executive Director of Strategic Transformation, Planning & Digital	CJ
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Emma Stephens	Head of Corporate Governance	ES
Amy English	Regional Director, Llais Cymru	AE

1.0.0	**PRESENTATIONS**	
1.1.0	**Velindre Cancer Service – Patient Story** Led by Tamarha Jones, Gynae Clinical Nurse Specialist The Committee heard a powerful story of Ceri, a current Velindre Cancer Service patient who was diagnosed with stage 4 cervical cancer and is currently receiving SACT treatment. Ceri's story highlighted a number of key issues within the Service as a result of ongoing SACT capacity challenges, including continued poor communication, limited notice with regards to appointment times and difficulty in contacting the booking team despite repeated attempts and requests for call back. The significant impact and psychological distress to the patient and their family as a result of these issues was clear and evident. The story also highlighted several areas of good practice, including: • Strong support provided by the medical and CNS team, • Good complimentary therapies and supportive care input, • Clear documentation regarding patient history and interaction with treatment helpline, • Excellent documentation on Welsh Clinical Portal, • Good support from Treatment Helpline and clinical team. DM acknowledged the ongoing efforts to increase SACT nursing capacity and queried whether these issues would have occurred had there been sufficient nurses in place. VC advised that there are sufficient nurses within SACT to deliver the service, but due to a national Pharmacy capacity issue this area is extremely problematic. Providing further context from an operational perspective, RH advised that the situation is being monitored on a weekly basis and work is underway to improve the communication of appointment times to patients. Efforts to maximise the capacity within Pharmacy are ongoing and service delivery methods are under review.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** Apologies were noted as above.	
2.2.0	**In Attendance** Additional attendees were noted as above.	

2.3.0	**Declarations of Interest** There were no declarations of interest.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 16th January 2024** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from the 16th January 2024 Public Committee.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed in detail and Committee members confirmed that they were assured that all actions identified as closed on the action log had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed and will remain open. The following was noted: *2.6.1 (16/01/2024) - Target dates to be applied against all actions in future Performance Management Report* - PR advised that the narrative for this closed action had been added incorrectly and should instead read *"Target dates for all audit actions now recorded in Divisional Integrated Quality and Safety Hub reports, in preparation for reporting to the Quality, Safety and Performance Committee from May 2024 onwards"*. *3.10.0 (14/09/2023) - Validation of mortality data to be completed* - JA advised that very good progress has been made on this issue. The digital BI angle has now been resolved in terms of automation of data around deaths, particularly for radiotherapy which is now complete. Some challenges remain around the reporting of SACT data which is impacted by the existing requirement to manually enter data in several locations at the time of administrating SACT/dispensing medication which is currently a 3-step process. JA highlighted a disconnect between the systems in which this data is recorded and suggested that this be addressed as a priority. Action date to be amended to 9th May 2024. *3.5.1 (16/11/23) - Confirm that amber risks within the IMTP are sufficiently set out within the TAF* - the Committee noted the update in the action log and the assurance provided that this action will be closed by the stated target date of 31st March 2024. *3.4.2 (16/01/24) - Serious Incident data and in-year targets in the Healthcare Acquired Infection to be added to the Performance Management Report* - the Committee noted the update provided. PH advised that although the performance metrics have now been included in the Performance Management Framework (PMF), limited data will be available at this stage and a fuller picture will be provided in the April PMF report. This action is to remain open with a revised	LW LW

	target date of 9th May 2024 when the April report will be received by the Committee. The Committee **REVIEWED** and **UPDATED** the actions from the January 2024 Committee.	
2.6.0	**Matters Arising** Led by Vicky Morris, Quality, Safety & Performance Committee Chair	
3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
3.1.0	**Committee Functioning 2024-2025**	
3.1.1	**Proposed Future Reporting** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science NW presented the report which outlined a proposal in respect of future quality and safety reporting to the Committee. Given the role of the now well-established Integrated Quality and Safety Group (IQSG), it is proposed that all separate departmental reports will feed into the IQSG and, following full analysis and discussion, a single quality and safety report produced covering all items to be presented to this Committee on a quarterly basis. Individual matters of escalation would be brought to the Committee by exception and in full, allowing for the provision of clearer, more focused data. Whilst supportive of the proposals contained within the paper, DM raised some concern around the lack of clarity of what would constitute an exception and asked that some guidance be provided on this. SH raised additional concern at the possibility of missing gradual trends and sought clarity on the trigger points for escalation. DM also requested that a review date be agreed upon following implementation of the proposal. NW agreed that in addition to the post-Committee reflection after each meeting, a formal six-month review would take place. HJ suggested that, rather than the individual departmental highlight reports being presented to the IQSG, it may be more beneficial for the group to receive the minutes of each meeting to ensure oversight of all matters of discussion. NW was supportive of this suggestion. Moving to the Committee cycle of business, HJ raised concern around the high number of annual reports scheduled to be received at the July Committee. VM and NW to consider how the Committee could have additional time to give all Annual Reports due attention. As a matter of public assurance, DM sought to highlight that although many of the reports included in the cycle of business are *annual* reports, any issue which arises during the year which warrants	**NW** **VM/NW**

attention, governance or assurance can and will be brought to the Committee as and when necessary.

The Committee **APPROVED** the proposal to provide a more integrated quality & safety report and the proposed changes to the 2024/2025 Committee cycle of business to reflect these changes.

3.1.2	**Amendment To Standing Orders - Schedule 3 - Terms Of Reference Review** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The Committee received the revised Quality, Safety and Performance (QSP) Committee Terms of Reference which are subject to review in March annually, in line with the full annual reporting cycle. Referring to the Wider Governance & Accountability Framework diagram, VM noted that there was no clear link between the Integrated Quality & Safety Group (IQSG) and requested that this be amended to clearly reflect the link from the IQSG to this Committee. VM suggested that the Terms of Reference for both the IQSG and QSP Committee be circulated together to all members to ensure full alignment. In terms of quoracy, VM highlighted that under the current Terms of Reference no executive directors are required to be present. It was agreed that this required review and would be discussed at the forthcoming Independent Members Group meeting. Following the discussions and points raised above, the Committee were unable to endorse the amendments to the Committee's Terms of Reference at this stage. The Chair will seek out of Committee approval upon receipt of the revised Terms of Reference document.	**VM**
3.2.0	**Integrated Quality & Safety Group Highlight Report** *Including 2023-24 Quarter 3 Quality and Safety Report (inc. Putting Things Right)* Led by Tina Jenkins, Interim Deputy Director of Nursing, Quality and Patient Experience TJ presented the report which covers the activities and outcomes of the Integrated Quality & Safety Group meetings held in January and February 2024. The following points were highlighted: • Mortality Reviews - the Group had received a reassuring presentation around the development of a process to ensure 30-day mortality from palliative radiotherapy and 90-day mortality from radical or adjuvant radiotherapy reviews are undertaken in line with best practice. Much work is underway to ensure a robust process is in place, with a view to full implementation across the Trust by September 2024. This will remain as a regular agenda item to ensure consistent monitoring of progress.	

- Incident Management and Learning Framework - both documents are progressing well and in line with project timelines.
- Quality Priorities - following Audit Wales feedback proposed Quality Priorities have been identified and are included within the report to seek Committee approval.

VM applauded the progress made in terms of the quality and safety tracker and queried the plan for progression of actions awaiting approval. TJ advised that alignment with the Audit Committee methodology is being considered. VM agreed that this would be helpful governance and would bring consistency in the signing off of actions. TJ to bring Standard Operating Procedure back to the May Committee for eventual inclusion in the cycle of business.

TJ

In terms of the AMaT (clinical audit assurance) system, the Committee were advised that a recent request to provide an update around a national enquiry proved to be a particularly straightforward process as a result of the extensive work undertaken to move the actions across to AMaT.

With reference to the Quality Management System, HJ suggested that in order to further embed the new Trust values throughout the organisation, it would be appropriate to include them in any document that contains the Trust's visions and aims.

With regards to the overdue actions report at appendix 2, SH noted that the table did not contain headings and requested that these be added in future reporting. SH queried the *National Reportable Incident/2023/10* in the table as it would appear that the action was raised in October but is still outstanding. TJ advised that there have been some challenges with regard to final closedown of actions, however in terms of the action in question, the work had in fact been completed although this detail was not currently reflected in the extracted data.

2023-24 Quarter 3 Quality and Safety Report (inc. Putting Things Right)

TJ presented an overall positive report which covered the period 1st October 2023 to 31st December 2023 and gave a comprehensive overview of the key outcomes, trends and themes in respect of Complaints, Redress, Claims, Duty of Candour, Safety Alerts, Infection Prevention & Control and Safeguarding. The following key points were noted:

- Clear, continuing themes remain within complaints around appointments, patient communication and treatment planning,
- Patient and donor satisfaction scores remain high,
- Safeguarding training compliance has increased and a substantial increase in Mental Capacity Act/Deprivation of Liberty Safeguards training has been noted. TJ reported positive

	engagement from the medics with the new Mental Capacity Act lead, whose work is already beginning to demonstrate real benefits and improvements. DM highlighted a recurring issue of donors being turned away from their session due to attending with an infant in a pram and asked that consideration be given as to how the service can facilitate the donation process in instances such as this. PR to look into this further. The Committee: **NOTED** the discussions that took place during the during the Integrated Quality and Safety Groups held during January and February 2024. **APPROVED** the proposed 2024/25 Quality Priorities for inclusion in the IMTP. **DISCUSSED** and **APPROVED** the quarter 3 Quality & Safety report and its findings, in particular the continued trends relating to communication and systems issues at Velindre Cancer Service.	**PR**
3.3.0	**Medical Examiner Service Report** Led by Jacinta Abraham, Executive Medical Director The Committee received the report which provided assurance that the Trust is meeting the recommendations of the Medical Examiner's Service and are fully compliant. The Committee **NOTED** the contents of the report.	
3.4.0	**Independent Review of Clinical Pharmacy Services in NHS Hospitals in Wales (30th October)** *Paper withdrawn due to potentially sensitive/identifiable information*	
3.5.0	**Quality, Safety & Performance Reports**	
3.5.1	**Velindre Cancer Service Quality & Safety Divisional Report** *Including CCTV & Email Audit* Led by Rachel Hennessy, Interim Director, Velindre Cancer Service The Quality and Safety report covering the period October to December 2023 was presented to the Committee and the following key points were noted: - Continued 100% compliance with Putting Things Right regulations related to concerns and complaints - improvements seen in terms of incidents closed within 30 days. - A process for the management of the outcomes of serious incidents has been agreed. Once formally accepted each department will be required to develop an action plan which will be monitored through the divisional Quality and Safety Management Groups (QSMG) and to this Committee as appropriate.	

	• The Clinical Audit team have joined the Quality and Safety team, this will improve triangulation between clinical audit, quality and safety, and service improvement. • A more robust risk management process has been agreed through the division. • 30/90-day mortality data reporting continues to present a challenge in terms of data quality. • A successful joint pilot has been implemented with Aneurin Bevan University Health Board (ABUHB) for direct referral from the VCC Treatment helpline in to the ABUHB Same-Day Emergency Care unit. • Outpatient and Medical Records Management Group have drafted an improvement plan to address key themes previously highlighted to this committee, progress of which will be monitored through the QSMG. • CCTV - All actions in relation to this issue are now closed, except for the one remaining action to re-audit following completion. • Email audit - recommendations have been shared with EMB and a working group will be set up to take these forward. The Committee **APPROVED** the content of this report.	
3.5.2	**Trust Performance Management Framework Report and Supporting Analysis for January 2023/24** *Including SACT Gold Command paper [addendum]* Led by Rachel Hennessy, Interim Director, Velindre Cancer Centre, Alan Prosser, Director, Welsh Blood Service, Sarah Morley, Executive Director of Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance The Committee received the report which provided an overview of Trust-wide performance against key national performance targets and best practice standards through to the end of January 2024. With regards to the **Velindre Cancer Service** RH highlighted the following key points: • Radiotherapy - a slight decline in performance was noted, this is understood to be linked in part to the Bank Holidays over the Christmas period. A return to the pre-Christmas position by February is anticipated. Planning to compensate for the forthcoming Spring Bank Holidays and impact arising from the Linac replacement are underway. • Falls - a relatively high number of eight falls were recorded, however there were no incidents of patient harm and all were found to be unavoidable. TJ reported on discussions with the Quality and Safety Manager at the Cancer Centre who had been involved in the work of the Falls Scrutiny Panel and had advised that, as a result of the excellent quality and massively improved documentation, several key areas of learning have been derived	

and the ward manager is developing some relevant patient information/advice to be placed at the bedside.

In terms of Systemic Anti-Cancer Therapy (SACT), RH gave a brief overview of the current challenges, notably those in respect of pharmacy capacity and the significant increase in service demand. Business continuity has been put in place, weekly meetings are held with the operational and executive teams and a number of related actions have been undertaken, in particular:

- Funding received from end-of-year monies to reconfigure capacity space within Pharmacy which, once recruited into, will provide additional storage space and infrastructure to facilitate buying in additional SACT pharmaceuticals.
- Procurement contract to extend the Medicines at Home service with Lloyds Pharmacy beyond the current two days per week is in its final stages.
- Working with the wider service team to provide divisional-wide solutions in order to optimise pharmacy capacity.

SH queried the percentage growth in demand figures which did not appear to correlate between the two documents presented. RH explained that in the 23/24 financial year there was an anticipated increase in referrals of 8% which was based on 8% over and above outturn as at 31st March the previous year. This year an increase of 12% is anticipated, based on outturn at 31st March 2023. Following a detailed explanation of the forecasts for the Integrated Medium-Term Plan, SH raised concern of the projected cumulative impact on services. PH highlighted that although the figures are high, similar demand forecasts are being observed nationally.

VM requested that the Committee receive a SACT update report at each meeting to demonstrate the impact of the various actions put in place.

SM gave a brief overview of the **Workforce and Wellbeing** performance data, highlighting in particular the following key points:

- A downward trend in sickness absence is evident,
- Compliance with statutory and mandatory training maintained,
- PADR compliance maintained - although this has dipped slightly, a full review of the PADR process is included in the work programme for 2024/25

SM advised that work is underway to further develop the Key Performance Indicators (KPIs) around equality, diversity and inclusion in advance of the first cut of the Workforce Race Equality Standard in April.

HJ highlighted that although the narrative states that statutory and mandatory training compliance is consistently on target, the Trust Assurance Report indicates that health and safety is not currently on

target. SM agreed that there are some titles which are falling below their own individual target, these are being managed by the specific reference groups associated with them with actions plans developed to increase compliance in these areas. HJ suggested that areas falling below compliance be highlighted in the report.

With regards to the overall positive **Welsh Blood Service** data, AP highlighted the following key points:

- The blue alert issued in December 2023 was lifted on 25th January 2024 and the service has managed to sustain this position over what has been a difficult period. A Task & Finish Group has been established to examine workforce related pressures in the collection clinic model.
- Particularly encouraging wastage figures and encouraging figures for stem cell collection which are beginning to return to pre-COVID conditions.

Although not contained within the report, AP advised that, following a detailed discussion at the January Committee in relation to bone marrow swab drives, the service is beginning to see particularly encouraging figures, significantly outperforming the target figure that has previously remained largely unchanged. Most notably AP highlighted that 40% of the volunteer recruitment are from black, Asian and other minority ethnic groups. VM acknowledged the extremely positive progress and asked that the Committee's thanks be extended to the team for their achievements in this area.

VM also commended recent WBS communications, noting in particular a recently encountered, targeted social media post which gave details of an upcoming local blood donation session.

The Committee:
- **NOTED** and **DISCUSSED** the January 2024 Performance Management Framework
- **NOTED** the targeted work being undertake through business continuity arrangements in respect of the delivery of SACT
- **NOTED** the establishment of SACT Gold Command and the key deliberations that have taken place.

| 3.6.0 | **Workforce Supply and Shape & Associated Finance Risks**
 Led by Susan Thomas, Deputy Director of Organisational Development & Workforce and
 Matthew Bunce, Executive Director of Finance

 ST presented the report which provided an overview of the key workforce issues in delivering the correct supply and shape of the workforce. These were:

 - Recruitment and retention,
 - Ensuring a work environment that supports staff wellbeing,
 - Developing effective service and workforce planning. | |

The paper also addressed the emerging risk of the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness, and detailed the strategic interventions and operational plans put in place to mitigate this risk, along with resulting improvement performance trajectories for 23/24 due to actions successfully implemented.

VM applauded the work undertaken to progress the format of the report following previous Committee feedback, noting the clearer and more effective triangulation of issues as a result of the improvements made.

As a matter of accuracy MB highlighted the following errors:

- **Vacancies** section on page 9 of the report should read *"As at January 2024, the current staff in post is 1560 WTE"*
- **Pay Budget 2023/24** section on page 13 should read *"The full year pay budget as at end of January 2024 is £85.276m based on 1,639 WTE."*

With regards to the above and other paper amendments, DM suggested that the updated paper be added to the Admincontrol system to ensure that when papers are needed to be accessed at a later date, the revised, correct version can be obtained. | **LW**

VM queried the graph which depicted a 4% reduction in vacancy rates, noting that there did not appear to be a corresponding reduction in agency spend. MB explained that as this represents true vacancies as opposed to sickness absence, where agency staff are often engaged, a correlation in figures would not necessarily be expected, although there was indeed some correlation between agency spend and reduction in sickness absences.

The Committee noted an overall positive improvement performance trend as a result of the actions and workforce and service interventions undertaken.

DM highlighted the actions towards creating a positive working environment and raised an issue in relation to the Noddfa building at the VCS site which had been leased in order to provide a 'sanctuary' as part of the Trust's staff wellbeing initiative, but has gradually been repurposed for meeting rooms, etc. ST agreed to look into this. | **ST**

The Committee **NOTED** the workforce supply and shape updates and associated financial impacts as outlined within the contents of the report.

| 3.7.0 | **Finance Report for the Period Ended 31st January 2024**
Led by Matthew Bunce, Executive Director of Finance |

MB presented the report which provided an overall positive review of the financial position and performance for the period to the end of January 2024. The following points were highlighted:

- Key financial targets/KPIs - revenue, capital and public sector performance are all forecast to be delivered. The Committee noted that although the capital figures are shown in the table as red, a Welsh Government letter received since the report was published confirms the availability of the funding to cover the project costs within the new Velindre Cancer Centre.
- Long Term Agreement (LTA) income & COVID recovery/planned care capacity - the latest trajectory, based on the December forecast, indicates that income will cover the cost of the Welsh Government-funded investment made in additional capacity during the COVID period.
- All-Wales financial pressures - following receipt of a letter from the Health Minister regarding the current NHS Wales financial pressures, the Trust has identified a number of cost savings proposals to support the all-Wales position. In addition to this, an offer has been made to pass across an underspend in relation to the Trust's emergency reserve, on a non-recurrent basis.

DM wished to thank the Finance team and all of those who have worked hard to contribute to the performance figures and this was echoed by the Committee. MB wished to also thank the divisional directors and their teams as the large budget holders for their efforts and support.

The Committee **NOTED** the contents of the January 2024 financial report and in particular the expectation that the Trust will deliver against its 3 statutory Financial Targets at year end.

| 3.8.0 | **Integrated Medium Term Plan 2023-2024** | |
| 3.8.1 | **Trust Integrated Medium Term Plan - Progress Against Quarterly Actions for 2023 / 2024 (Quarter 3)** Led by Philip Hodson, Deputy Director of Planning & Performance | |

The Committee received an overall positive report which covered the period October to December 2023 and provided an update on progress against the actions included within the Integrated Medium Term Plan (IMTP) for 2023/24.

The report demonstrated good progress against the majority of actions, with Welsh Blood Service reporting delivery against all 15 actions and Velindre Cancer Service reporting delivery against 20 of the 22 actions. The two remaining actions are:

- Implementation of the national Transforming Access to Medicines (TrAMS) Model across the service

	• Implementation of the approved Full Business case for the development of the new Velindre Cancer Centre (nVCC) by 2025/26 (December 2025). Referring to the blank sections towards the end of the report, PH explained that these are included as a signal of intent for future reporting - as we move forward into the new financial year, reporting against some of the other key support functions, such as digital, estates and workforce, will be included. The Committee **NOTED** the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 3 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide initiatives.	
3.8.2	**Integrated Medium Term Plan - Accountability Conditions** Led by Philip Hodson, Deputy Director of Planning & Performance PH presented the report which provided a progress update against the accountability conditions set by the NHS Wales Chief Executive and as laid out in their letter of 2nd October 2023. PH confirmed that all four of the accountability conditions are anticipated to be discharged accordingly, with actions plans in place where appropriate. The Committee **NOTED** the progress update against the Welsh Government accountability conditions in Appendix 1 and 2.	
3.9.0	**Trust Estates Assurance Group Highlight Report** Led by Jonathan Fear, Interim Assistant Director of Estates JF presented an overall positive the report which provided a summary of the key issues considered, and actions taken, by the Trust Estates Assurance Group during quarter 3 (2023/24). The following points were noted: • Compliance standards above benchmark targets in some areas across the Trust. Although some improvements have been seen in health and safety, this remains below benchmark in some areas. Bespoke training has been arranged in these areas where possible, to improve this standard. • A new Violence and Aggression Module C, added in February 2024 is currently at 20.4% competency. This is now being progressed as a priority, although it was noted that this module has only recently become available. • Work is ongoing in relation to the risk of RAAC within blood collection venues. HJ reiterated a previous request, that when alert/escalate issues are being brought to the attention of the Committee, that they are accompanied by a SMART action plan. HJ to discuss further with JF outside of the meeting.	**JF/HJ**

	VM noted the ten health and safety incidents within the Performance Management Framework and queried whether there were any trends/themes, or if they were single incidents across the Trust. JF to look into this further and report back to the next meeting. The Committee **DISCUSSED** and **REVIEWED** the contents of the report and the actions which are being taken.	**JF**
3.10.0	**Trust Risk Register** *Paper not received* **3.10.1** **Trust Assurance Framework** *Paper not received*	
3.11.0	**Policy Management Review and Compliance Status: October 2023 to February 2024** The Committee acknowledged receipt of the paper. VM highlighted that whilst there is a positive tone in terms of increased compliance, 51 policies remain out of date. All department leads are requested to return to the May Committee with a clear plan regarding all out-of-date policies, with timescales to be applied. SM advised that although a significant number of the out-of-date policies are in relation to Organisational Development and Workforce, the team has been heavily impacted by the work associated with the recent industrial action. However, the planning phase is in progress with priority given on a risk basis. The Committee • **NOTED** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. • Await the plans for progress of the remaining out-of-date policies, to be brought to the May Committee.	**LF**
3.12.0	**Education Strategy Audit** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the Education Strategy Audit which, although largely positive, did highlight the need for a robust implementation plan to sit under the strategy. The other two recommendations were around evaluating and measuring success, a theme which triangulates with other audits received at this Committee. In terms of timelines, SM assured the Committee that work is already well underway in relation to the development of the robust implementation plan and it is expected that this will be brought through the governance process in April.	

	The Committee **NOTED** the plan to implement the recommendations of the Audit.	
4.0.0	**NHS WALES SHARED SERVICE PARTNERSHIP**	
4.1.0	**Transforming Access to Medicine / Clinical Pharmacy Technical Services Update** Led by Gareth Tyrrell, Accountable Pharmacist, NWSSP GT presented the report to the Committee highlighting the following key points: • A programme of work is currently underway on an ad-hoc basis between Velindre Cancer Service (VCS) and NHS Wales Shared Services Partnership (NWSSP) to support the capacity issues as discussed throughout this meeting. • Medicines Unit are working with Welsh Government to implement the national influenza programme. NWSSP will, under Welsh Government direction, purchase, store and then distribute the influenza vaccine on a national basis. • Work undertaken with health boards across Wales to discontinue an infusion product due to the introduction of a subcutaneous injection which will improve capacity locally as patients will attend for a 15-minute injection rather than a longer infusion. In addition, GT advised the Committee that the Medicines Value Unit within NWSSP, which sits within the pharmacy division, is currently undertaking a national piece of work around all-Wales drug contracting which, in addition to developing an all-Wales pricing structure, will put in place an all-Wales Service Level Agreement which will improve the resilience of commercial suppliers and ensure that local services, such as VCS do not experience short-notice cancellations and delays in the delivery of medicines as currently experienced across Wales. More detailed information will be brought to the next meeting. VM raised concern regarding progress in relation to Transforming Access to Medicines (TrAMs) and requested a specific TrAMs report be brought to the next meeting. GT to provide further information in terms of key issues and progress made to the May Committee, with colleague support as appropriate. The Committee **NOTED** the report.	**GT** **GT**
4.2.0	**Implementation of Duty of Quality Update** Led by Ruth Alcolado, Medical Director, Corporate Services, NWSSP *Paper deferred to May Committee*	
5.0.0	**CONSENT ITEMS FOR APPROVAL** (The consent part of the agenda considers routine Committee business as a single agenda item. Members may ask for items to be moved to the main agenda if a fuller discussion is required).	

5.1.0	**Trust Policies and Procedures for Approval**	
5.1.1	**Infection, Prevention and Control Policy Register** Led by Hayley Harrison Jeffreys, Head of Infection Prevention and Control • IPC 00 – Framework Policy for Infection Prevention and Control • IPC 11 – Transport of Specimens Policy VM highlighted that the policy presented to this Committee currently has a review date of December 2024 and suggested that this should be amended to March 2025 given the date of its submission to this Committee. The Committee **APPROVED** the revised policies listed above.	
5.1.2	**Planning, Performance and Estates Policies** Led by Carl James, Executive Director of Strategic Transformation, Planning & Digital • PP10: Medical Gas Piped Systems Policy • PP11: High Voltage Electricity Supply Systems using a Contractor as the Authorised Person • PP12: High Voltage Electrical Supply System Operational Policy • PP13: Electrical Low Voltage Policy • PP14: Ventilation Policy It was highlighted that there were a number of small typographical errors within the documents, these will be amended prior to formal publication of the policies. With regards to PP10, VM noted that this currently is not a Trust-wide policy and requested that although specific to VCS and managed by the division, should be Trust-wide in order to ensure effective policy management. JF to raise this with the chair of the Medical Gases group. With regards to the substantial gap between the policies being reviewed by the relevant groups and subsequent presentation to Executive Management Board, JF explained that this was as a result of delays with the EqIA process, which has now been completed for all of the policies submitted to this Committee. The Committee **APPROVED** the revised policies listed above.	**JF**
6.0.0	**CONSENT ITEMS FOR ENDORSEMENT**	
	There were no items for endorsement.	
7.0.0	**CONSENT ITEMS FOR NOTING**	

7.1.0	**Professional Nursing Forum Update** Led by Tina Jenkins, Interim Deputy Director, Nursing, Quality & Patient Experience The Committee **NOTED** the Professional Nursing update for the period December 2023 and February 2024.	
7.2.0	**Research, Development & Innovation Sub Committee Highlight Report** Led by Jacinta Abraham, Executive Medical Director The Committee **NOTED** the key deliberations and highlights from the Public Meeting of the Research, Development & Innovation Sub-Committee held on the 06/02/2024.	
7.3.0	**15-Step Visits Update Report** The Committee received the report which provided an update on progress against recommendations and identified actions following a programme of 15-step visits undertaken across both divisions to date. In relation to the narrative within the report, SH queried the process for maintenance of the You Said We Did board at Velindre Cancer Service Outpatients department and other locations, as it appeared that the VCS board had not been updated for some time. TJ advised that although a clear mechanism is in place for this, the information supplied would be reviewed in order for updates to be more apparent. VM requested that a forward programme for future 15-step visits be brought to the next Committee to ensure work in this area is continuing at pace. The Committee **NOTED** the contents of the report and the assurance it provides regarding the activities undertaken to address recommendations identified following 15-step visits.	**LF**
7.4.0	**Bi-annual Value-Based Healthcare Programme Update** Led by Matthew Bunce, Executive Director of Finance The Committee **NOTED** the continued development of the Value Based Healthcare Programme including: • Positive impact of the Pre-op anaemia programme and proposal to extend scope to cover Anaemia for more clinical areas • Achievements of the Value Intelligence Centre to date and objectives for 2024/2025 • The development of a Velindre Food Mission with Welsh Government support.	
7.5.0	**Highlight Report from the Chair of the TCS Programme Scrutiny Sub-Committee** Led by Stephen Harries, Vice Chair & Chair of the Transforming Cancer Services Programme Scrutiny Sub Committee	

	Paper not received	
8.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks).	
8.1.0	**March 2024 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members Due to the executive focus on essential matters related to the new Velindre Cancer Centre Final Business Case, the Risk Register and Trust Assurance Framework were not submitted for discussion at this Committee, this therefore presented a gap in effective triangulation. However, the following key themes were identified: • Increasing demand and pharmacy capacity continue to present significant challenges within SACT (Systemic Anti-Cancer Therapy) • Issues around patient experience in terms of booking and general communication • Ongoing challenges related to manual workarounds.	
8.2.0	**March 2024 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members • Was sufficient time allocated to enable focused discussion for the items of business received at today's Committee? • Were papers concise and relevant, containing the appropriate level of detail? • Was open and productive debate achieved within a supportive environment? • Was it possible to identify cross-cutting themes to support effective triangulation? • Was sufficient assurance provided to Committee members in relation to each item of business received?	
9.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	Members to identify items to include in the Highlight Report to the Trust Board: • For Escalation • For Assurance • For Advising	

	• For Information	
10.0.0	**ANY OTHER BUSINESS**	
	Prior approval by the Chair required.	
11.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on the: **9th May 2024 from 10:00-13:00**	
CLOSE		
The Committee 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 OF THE PUBLIC EXTRAORDINARY JOINT AUDIT COMMITTEE
AND QUALITY, SAFETY & PERFORMANCE COMMITTEE
VELINDRE UNIVERSITY NHS TRUST HQ / TEAMS
THURSDAY 21 MARCH 2024 AT 9:00AM**

PRESENT:	
Vicky Morris	Chair and Independent Member
Gareth Jones	Independent Member
Hilary Jones	Independent Member
ATTENDEES:	
Matthew Bunce	Executive Director of Finance
Lauren Fear	Director of Corporate Governance & Chief of Staff
Steve Ham	Chief Executive Officer
Carl James	Director of Strategic Transformation, Planning & Digital
Carl Taylor	Chief Digital Officer
Peter Richardson	Head of Quality & Safety, Deputy Director - Quality Assurance
Fay Sparrow	Freedom of Information and Compliance Officer
Simon Cookson	Director of Audit & Assurance (NWSSP - Audit and Assurance Services)
Steve Wyndham	Audit Wales
Jacinta Abraham	Executive Medical Director (Joined approximately 9:15AM)
Emma Rees	Deputy Head of Internal Audit (NWSSP - Audit and Assurance Services) (Joined approximately 9:15AM)
Liane Webber	Business Support Manager

		Action
1.0.0	**STANDARD BUSINESS** Led by Vicky Morris, Chair	
	Introduction Led by Vicky Morris, Chair	
1.1.0	**Apologies** Led by Vicky Morris, Chair Apologies were received from: • Donna Mead, Chair and Independent Member • Nicola Williams, Director of Nursing, AHP's & Medical Scientists • Sarah Morley, Executive Director of Organisational Development & Workforce • Alan Prosser, Director of Welsh Blood Service • Katrina Febry, Audit Wales • David Osborne, Head of Finance Business Partnering	
1.2.0	**In Attendance** Led by Vicky Morris, Chair Vicky Morris welcomed attendees from Audit Wales and Internal Audit Services.	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Chair No declarations of interest were declared.	
1.4.0	**Draft Minutes from the Public Part A Extraordinary Audit Committee meeting held on 12 January 2024** Led by Vicky Morris, Chair The Committee decided this item would not be taken on the meeting agenda and would be deferred to the July 2024 Audit Committee.	

2.0.0	**INTERNAL ASSURANCE AND RISK MANAGEMENT MONITORING**	
2.1.0	**Trust Risk Register** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear took the Committee through the Trust Risk Register Report. Lauren Fear gave apologies that Rachel Hennessy, Director of Velindre Cancer Services, could not attend the meeting to answer any specific questions on any Velindre Cancer Service risk but clarified that any questions could be taken away from the meeting if required. Lauren Fear thanked Peter Richardson for attending in relation to any Welsh Blood Service risks. Vicky Morris raised a question in relation to *risk 2515* as there had been discussion in Quality, Safety & Performance Committee regarding the fact there is only being only one member of staff in terms of Brachytherapy, and that this is a fragile service. Lauren Fear confirmed this has not been accepted and explained there is a need to go back around this action to clarify why the Head of Service has signed this off. ****ACTION: Gareth Jones highlighted *risk 2187* has reduced 15-12 based on the progress of recruiting additional posts. Gareth Jones felt more narrative was needed to inform whether the post holders' employment has commenced or if they have been employed but not yet commenced employment. Lauren Fear agreed to investigate this and update the action.**	
		LF
	Lauren Fear continued to take the Committee through the report, stating that six new risks were opened during this period. *Risks 3337 3293 3277* had limited rationales for the scores so Executive Management Board have been asked to review for further rationale to be provided at the 02 April 2024 meeting, and will confirm to both Audit Committee and Quality, Safety and Performance Committee following. Vicky Morris in relation to *risk 3337* understood the risk and concurred with the score of 16, noting this is going to be reviewed, but highlighted that *risk 3230* is scored at a 12 and is a similar issue. Lauren Fear assured this has been confirmed with Rachel Hennessy that Velindre Cancer Services specifically think this is a different risk. ****ACTION: Vicky Morris requested that when the Risk Register is reviewed on the 02 April 2024 at Executive Management Board, could the meeting also look at how some of the risks could be combined and how the material total of the risk applies to the organisation and patients in terms of the root cause.**	
		LF
	Lauren Fear informed the Committee that *risk 3193 and 3197* have been signed off by the Senior Leadership Team in Welsh Blood Service and supported by Executive Management Board. Peter Richardson gave the Committee feedback on the risks, which reflect whether funding will be received and the risk if this does not get the funding. Peter Richardson gave assurance that the Welsh Blood Service are working on securing the finance for the programme. Gareth Jones questioned *risk 3338* and the wording *'as a result of lack of pharmacy capacity'* and asked for clarity on if this is because of people, supplies or space. Gareth Jones stressed the need to understand the risk. Carl James responded that in Pharmacy there is lack of capacity in relation to the number of people and there is active recruitment happening currently. The second part to this is the current Pharmacy department are in the Cancer Centre and the Discretionary Capital Programme is aware that £40-50K is needed to increase the storage area from bringing insourcing drugs, so the physical capacity is being resolved with the Discretionary Capital Programme and then numbers of people is also a challenge, and this is also happening across South East Wales. ****ACTION: Hilary Jones raised the point that reviewing the new risks in the Risk Register and the current controls, some are very short and don't give much assurance that the risks are being managed effectively. For example, *risk 3197* does not give details of when funding will be received and how the current system will be managed. Peter Richardson agreed to add**	
		PR

	more detail on what doing to secure funding and assured agreement has been made to extend the existing contract to November 2027. ****ACTION: Carl Taylor agreed to share the plan with the Audit Committee and Quality, Safety and Performance Committee, for the BECS Procurement, and informed the Committee that in terms of timescales, are intending to go out to market in May 2024 for the BECS system.** ****ACTION: Gareth Jones specified that the additional information in the columns is quite hard to follow and requested it be made more user friendly. Lauren Fear agreed to work on the format.** Lauren Fear continued to take the Committee through the report stating that four risks remained consistent in scoring over the reporting period: *risks 3001, 3230, 2465 and 3227*. Lauren Fear took the Committees through the '*Key Matters Summary of actions taken / In Plan from Recent Governance Cycle*' which summarised the development actions that have been taken over the last two cycles. Vicky Morris underlined the need of good timing and making sure the formal Committees have a conclusion of all the organisational wide debate. The Committees discussed the timing of risk review through the Divisional Senior Leadership Teams, Executive Management Board to Committees. There was an acknowledgement that there should be a balance between ensuring that most up to date information can be shared, alongside being able to demonstrate closure of matters raised through the process. It was agreed that this would be explored offline to ensure there was agreement on what the optimum process and timings were. ****ACTION: Lauren Fear to map out a couple of options in terms of timings and what that would mean for the age if the Risk Register profile coming through. Lauren Fear will then share this with members of the Committee to agree a process.** Gareth Jones pointed out that if these were high-level risks, an oral update would be expected at the Committees from Executives. The AUDIT Committee and Quality, Safety and Performance Committee: • **NOTED** the risks of 15 and above as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper. • **NOTED** the on-going developments of the Trust's risk framework.	CT LF LF
2.2.0	**Trust Assurance Framework** Led by Lauren Fear, Director of Corporate Governance & Chief of Staff Lauren Fear took the Committees through the Trust Assurance Framework report and informed the Committee that the refreshed set of strategic risk were approved in January 2024 Trust Board and are now in the normal cycle going forward in terms of managing and updating the risks. In relation to the table on the cover paper '*Matter raised through recent governance cycle*' item '*1 - Populate refreshed TAF on Power BI template*' Vicky Morris asked for confirmation on when this timeframe would be confirmed. Lauren Fear responded that it needs to get resource into do it so just the timing of that. Vicky Morris felt it would be helpful to know the timeframe at the next Committees. Lauren Fear assured the Committee that the Trust Assurance Framework was discussed via email where the overall Trust Assurance Framework was circulated by exception. Vicky Morris highlighted that some of the sections were not being kept up to giving examples - *TAF 01* - The action plan in *section 5* has only got one date and it was questioned how scrutiny could be provided to keep this on track. The action reference is blank and the last two actions have not been updated.	ACTION HERE FOR LOG

	Vicky Morris commended the section on digital data as this was well populated and all of the gaps and assurances were really clear and the Committee would expect this for all of the Trust Assurance Framework sections. Vicky Morris highlighted that the Workforce section, particularly *TAF 03*, states there are no risks in Workforce which does not fit with the discussions in Quality, Safety and Performance Committee and there are risks within the Risk Register. Carl James responded that some of the risks by nature are more in the Trusts control and easier to respond to, but noted the need to think about how precise can be with some updates versus others. Vicky Morris advised that this would involve looking at the strategic objective that this is aimed to be delivered and what are the risks against that, which will help to be more specific. This piece of work will be done outside of Committee. ****ACTION: TAF 01 - The Risk Lead is to be changed from Cath O'Brien to Steve Ham.** Gareth Jones stressed that Independent Members want to see the risk scores reducing over time and one of the challenges back to the Executive Team has been that the scores haven't necessarily been reducing. Although Gareth Jones pointed out that in this version of the Trust Assurance Framework of the scores except one have reduced but questioned is the Executive team looking through the Trust Assurance Framework as the current risk or is this a realistic assessment of what these risks are. Vicky Morris informed the Committee that another organisation she is aware of, ensures that any new controls that are being effective, and any new assurances that are established, are written in a different italic text to show what's different and how has it mitigated the risk and felt that as Independent Members there is a need to see what's different from the last version. ****ACTION: Lauren Fear will check if risk scores have changes and reduced over time and will follow up with Gareth.** Steve Ham confirmed they are looked at as the likelihood of impact and the Trust is in the best place where they are currently. The AUDIT Committee and Quality, Safety and Performance Committee **DISCUSSED** and **NOTED** the Trust Assurance Framework The AUDIT Committee and Quality, Safety and Performance Committee **NOTED** there are further considerations to take back into the routine cycle of the Audit and Quality, Safety and Performance Committees.	<mark>LF</mark> <mark>LF</mark>
3.0.0	**CONSENT AGENDA** Led by Vicky Morris, Chair	
3.1.0	**Endorse for Approval**	
3.1.1	**Audit Committee Terms of Reference** Led by Matthew Bunce, Executive Director of Finance The Committees agreed to postpone this agenda item and refer these back to the Audit Committee in July 2024 meeting.	
3.1.2	**All Wales Flexible Working Policy** Led by Sue Thomas, Deputy Director of Organisational Development & Workforce The Committees agreed this agenda item should go through Quality Safety and Performance Committee routinely and be placed on the May 2024 Quality, Safety and Performance meeting agenda.	

4.0.0	**ANY OTHER BUSINESS**	
	Prior Agreement by the Chair Required	
	The Committee agreed the process for the minute's approval following this joint meeting. The minutes will go through Quality Safety and Performance May 2024 meeting and Audit Committee July 2024 meeting for approval. ****ACTION: Vicky Morris and Gareth Jones discussed that July 2024 was too long from March 2024 for the next Audit Committee to be held. The Committee recognised this is due to the July 2024 Audit Committee being an extended meeting with the accounts incorporated, to enable only four meetings to run through the year. Vicky Morris, Gareth Jones, and Matthew Bunce will take a view of this outside of Committee to look at the Cycle of Business for Audit Committee next year in respect of this.**	MB
5.0.0	**DATE AND TIME OF NEXT MEETING**	
	Quality, Safety & Performance Committee: Thursday 09 May 2024 at 10:00AM Audit Committee: Wednesday 10 July 2024 at 10:00AM	
6.0.0	**CLOSE**	
	The meeting CLOSED at 9:55am.	

QUALITY, SAFETY & PERFORMANCE COMMITTEE - PART A

ACTION LOG

Minute ref	Action	Action Owner	Progress to Date	Target Date	Status (Open/Closed)
**Actions agreed at the 13th July 2023 Committee**				
9.1.0	Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future annual reports	Emma Stephens (Head of Corporate Governance) / Lauren Fear (Director of Corporate Governance & Chief of Staff)	**Update 30/04/2024:** A Trust Committee Annual Report Template has been developed that will be adopted for the 2023-2024 board committee annual reporting. For other annual reports, there is a corporate branded template in development with an external agency to ensure a more consistent approach to the reporting. All report owners have now been contacted to update on progress. The final template will be shared with all report owners by 17th May.	~~31/03/24~~ 17/05/24	OPEN
**Actions agreed at the 14th September 2023 Committee**				
3.10.0	Validation of mortality data to be completed	Dr Jacinta Abraham (Exec. Medical Director)	**Update 30/04/24:** The Mortality data validation exercise has now been completed, and the previously identified BI data integrity issues are now fully resolved. Updated Annual Mortality data will be presented in the QSP Annual Report July 2024	09/05/24	CLOSED
**Actions agreed at the 16th November 2023 Committee**				
3.5.1	Confirm that amber risks within the IMTP are sufficiently set out within the TAF	Carl James (Exec. Director of Strategic Transformation, Planning & Digital)	**02/05/24:** No further update received. **Update 09/01/24:** The Trust is currently updating its IMTP. As part of this process all risks will be re-assessed to ensure that they are aligned and included within the TAF. WG confirmed the IMTP submission date is 29/03/2024.	31/03/24	OPEN

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Actions agreed at the 16ᵗʰ January 2024 Committee					
2.6.2a	Freedom of Information Act report: • Tables to be clearly linked to supporting narrative • Exemption numbers for the Trust to be benchmarked against that of other organisations • Omission of data regarding timescale and completion of breached FOI responses to be addressed	Lauren Fear (Director of Corporate Governance & Chief of Staff)	**Update 30/04/2024:** Addressed in FOI report on May meeting agenda	09/05/24	CLOSED
2.6.2b	Detail of each of the FOI exemption sections be added to the Trust website to enable cross-referencing, with a link included in the report to signpost to this detail	Lauren Fear (Director of Corporate Governance & Chief of Staff)	**Update 30/04/2024:** Exemptions information included on FOI Intranet pages	09/05/24	CLOSED
3.1.0a	Risk 3230 to be reviewed and updated.	Lauren Fear (Director of Corporate Governance & Chief of Staff)	The risk was reviewed and updated as part of the March Committee governance reporting cycle.	14/03/24	CLOSED
3.1.0b	Actions in Risk Register paper to be reviewed and updated to align with main report	Lauren Fear (Director of Corporate Governance & Chief of Staff)	All actions will be reviewed and updated and reflected in future reporting.	14/03/24	CLOSED

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3.4.2	Serious Incident data and in-year targets in the Healthcare Acquired Infection to be added to the Performance Management Report	Carl James (Exec. Director of Strategic Transformation, Planning & Digital)	**Update 22/04/2024:** National Reportable Incidents, Duty of Candour and Never Events are now included within the Velindre University NHS Trust Performance Management Framework. Annual targets for Health Care Acquired Infections will be included using data from April 2024 data. These will be reported to the QSP in July 2024.	~~09/05/24~~ 09/07/24	OPEN
7.2.0	Committee members to offer suggestions in respect of how the Committee's cycle of business could be revised to ensure that future meetings could be even more productive and afford sufficient time to critical or emerging matters.	All		14/03/24	CLOSED
Actions agreed at the 14th March 2024 Committee					
3.1.1a	Provide guidance on trigger points for matters of escalation identified at Integrated Quality and Safety Group	Nicola Williams (Executive Director of Nursing, AHPs & Health Science)	Proposed trigger guidance produced and circulated to committee members 2nd May 2024	09/05/24	CLOSED
3.1.1b	Review arrangements for receipt of annual reports scheduled for July Committee	Nicola Williams (Executive Director of Nursing, AHPs & Health Science)/ Vicky Morris (Independent Member)	15/04/2024 - Additional Committee arranged for the 9th July 2024 to ensure sufficient time to give all annual reports sufficient scrutiny and facilitate effective triangulation.	09/05/24	CLOSED
3.1.2	Review Committee quoracy at Independent Members Group meeting	Vicky Morris (Independent Member)	VM discussed at IM meeting with CEO/ Lauren and IMs	09/05/24	CLOSED

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3.2.0a	The Standard Operating Procedure for Quality & Safety Tracker to be brought to the Committee	Tina Jenkins (Head of Quality & Assurance)	SOP circulated to Committee members by email following approval at EMB 29/04/24	09/05/24	CLOSED
3.2.0b	Options for how WBS could facilitate donation when donor presents with an infant/child to be considered	Peter Richardson (Head of Quality, Safety & Regulatory Compliance, Deputy Director, WBS)	The Collections team have confirmed that donors presenting with a child are managed on an individual basis depending on the age/needs of the child and the suitability of the venue to support their safe care. This is considered as part of the individual venue risk assessment. The decision rests with the nurse in charge. The only sessions where children are excluded by default are mobile donation vehicles which have been assessed as not suitable for children.	09/05/24	CLOSED
3.6.0a	Establish version control method to ensure Committee papers requiring revision are uploaded to Admincontrol	Liane Webber (Business Support Officer)	Discussed with Business Support team. Request will be added to Chair's Brief for highlighting to attendees at the beginning of each meeting.	09/05/24	CLOSED

3.6.0b	Review Noddfa building usage	Susan Thomas (Deputy Director of Organisational Development & Workforce)	**Update 16/04/24:** Weekly working group to get the staff space finished. Opening planned for June, final plans to go to VCS SLT next week There will be a launch week and a planned programme of events/ opportunities for staff to engage with the space and the rooms will be described for their intended use to ensure that staff know about the potential for the space. Item on agenda for discussion at May meeting.	09/05/24	CLOSED
3.9.0a	Discuss Estates SMART action plan for alert/escalate issues	Jonathan Fear (Interim Assistant Director of Estates, Capital and Environment)) / Hilary Jones (Independent Member)	SMART action plans are now being developed for alert escalate actions list in future reports.	09/05/24	CLOSED
3.9.0b	Identify trends/themes in respect of the ten health and safety incidents reported in the Performance Management Framework	Jonathan Fear (Interim Assistant Director of Estates, Capital and Environment)	**Update 30/04/24:** New Head of Health & Safety now in post and currently looking at all data to create the pareto analysis for the annual report to be presented in July EMB.	~~09/05/24~~ 09/07/24	OPEN
3.11.0	Provide the Committee with clear plan, with timescales for reviewing and providing for assurance all out-of-date policies	Lauren Fear (Director of Corporate Governance & Chief of Staff)	**Update 30/04/2024:** Forecast dates for all 30 Trust Policies and any insight on the 10 All Wales Policies to be provided by Exec Leads for June Executive Management Board paper and will be shared with the Committee prior to the next meeting	~~09/05/24~~ 07/06/24	OPEN
4.1.0a	Provide detailed report in respect of all-Wales drug contracting to the Committee	Gareth Tyrrell (Accountable Pharmacist, NWSSP)	Report presented at May Committee - agenda item 4.2.0	09/05/24	CLOSED

4.1.0b	Provide TrAMs progress/key issues report to the Committee	Gareth Tyrrell (Accountable Pharmacist, NWSSP)	**30/04/24:** No update received.	09/05/24	OPEN
5.1.2	PP10 (Medical Gas Piped Systems Policy) to be Trust-wide in order to ensure effective policy management	Jonathan Fear (Interim Assistant Director of Estates, Capital and Environment)	**Update 30/04/2024:** Medical Cylinders Policy discussed with Chief Pharmacist and discussion will be raised at Medical Gas Committee on Cylinder Policy being implemented as Trust-wide.	09/05/24	OPEN
7.3.0	Provide to the Committee forward programme for future 15-step visits	Lauren Fear (Director of Corporate Governance & Chief of Staff)	**Update 30/04/2024:** Full 2024-25 schedule under development and will be discussed with Executive Management Board in Executive Management Board in June and also with Independent Member colleagues following that. Propose to included in next Committee meeting agenda	~~09/05/24~~ 11/07/24	OPEN
Actions agreed at the 21st March Extraordinary Joint QSP/Audit Committee					
2.1.0a	Trust Risk Register Gareth Jones highlighted risk 2187 has reduced 15-12 based on the progress of recruiting additional posts. Gareth Jones felt more narrative was needed to inform whether the post holders' employment has commenced or if they have been employed but not yet commenced employment. Lauren Fear agreed to investigate this and update the action.	Lauren Fear (Director of Corporate Governance & Chief of Staff)			OPEN

Action Log - version 02.05.2024

	Trust Risk Register Executive Management Board, to look at how some of the risks could be combined and how the material total of the risk applies to the organisation and patients in terms of the root cause.	Lauren Fear (Director of Corporate Governance & Chief of Staff)			OPEN
2.1.0b					
2.1.0d	Trust Risk Register Hilary Jones raised the point that reviewing the new risks in the Risk Register and the current controls, some are very short and don't give much assurance that the risks are being managed effectively. For example, risk 3197 does not give details of when funding will be received and how the current system will be managed. Peter Richardson agreed to add more detail on what doing to secure funding and assured agreement has been made to extend the existing contract to November 2027.	Peter Richardson, Head of Quality, Safety & Regulatory Compliance, Deputy Director of WBS			OPEN
2.1.0e	Trust Risk Register Carl Taylor agreed to share the plan with the Audit Committee and Quality, Safety and Performance Committee, for the BECS Procurement, and informed the Committee that in terms of timescales, are intending to go out to market in May 2024 for the BECS system.	Carl Taylor, Chief Digital Officer	BECS procurement timescales circulated to the Committee by email 08/05/24.		CLOSED

2.1.0f	Trust Risk Register Gareth Jones specified that the additional information in the columns is quite hard to follow and requested it be made more user friendly. Lauren Fear agreed to work on the format.	Lauren Fear (Director of Corporate Governance & Chief of Staff)			OPEN
2.1.0g	Trust Risk Register Lauren Fear to map out a couple of options in terms of timings and what that would mean for the age if the Risk Register profile coming through. Lauren Fear will then share this with members of the Committee to agree a process.	Lauren Fear (Director of Corporate Governance & Chief of Staff)			OPEN
2.2.0a	Trust Assurance Framework TAF 01 - The Risk Lead is to be changed from Cath O'Brien to Steve Ham.	Lauren Fear (Director of Corporate Governance & Chief of Staff)	Amendment made.		CLOSED
2.2.0b	Trust Assurance Framework Lauren Fear will check if risk scores have changed and reduced over time and will follow up with Gareth.	Lauren Fear (Director of Corporate Governance & Chief of Staff)			OPEN

QUALITY, SAFETY & PERFORMANCE COMMITTEE

TRUST RISK REGISTER

DATE OF MEETING	9TH MAY 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to: • Share the current extract of risk registers to allow the Committee to have effective oversight and assurance of the way in which risks are currently being managed across the Trust. • Note the on-going development activity and status of these actions.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **NOTE** the risks of 15 and above as well as

1

risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in this paper.
- **NOTE** the on-going developments of the Trust's risk framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
Executive Management Board	29TH APRIL
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board discussed the Trust Risk Register and endorsed for submission to the Quality, Safety and Performance Committee.	

Please complete this section if you have indicated that the report purpose is for ASSURANCE.

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0

ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR	2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.

APPENDICES	
1	Current risk register data.

1.   SITUATION

The report is to inform the Committee of the status of risks reportable to Trust Board, in line with the renewed risk appetite levels.   In addition, the report will update on progress against the Risk Framework.

2.   BACKGROUND

The risks currently held on Datix, and above the Trust Board approved Risk Appetite level of reporting, are to be considered.

3. ASSESSMENT

3.1 Trust Risk Register

There are a total of 15 risks to report in line with the Trust's risk appetite during this reporting period. This includes 11 risks with a current score over 15 and 4 risks with a current score of 12, reported in the 'Safety' domain. The information is pulled from Datix 14.

Changes since January reporting:
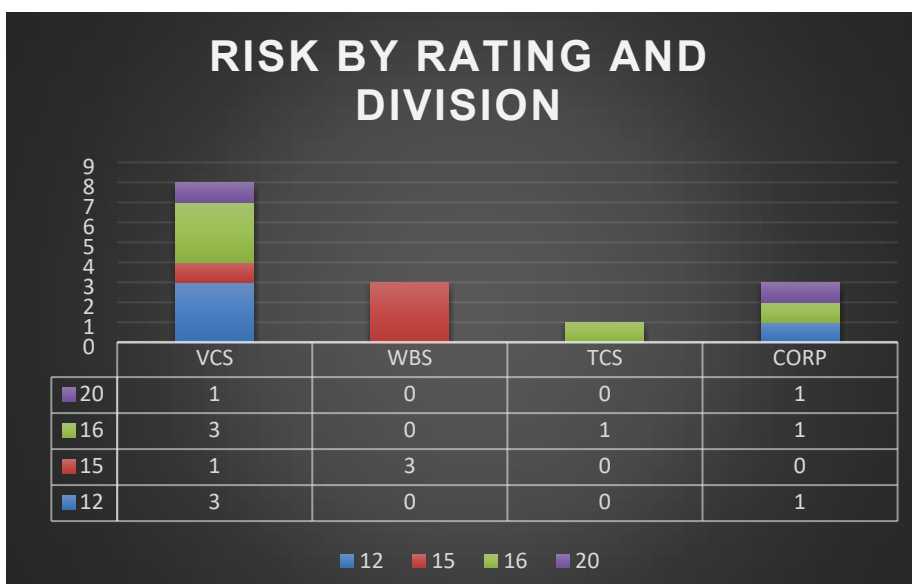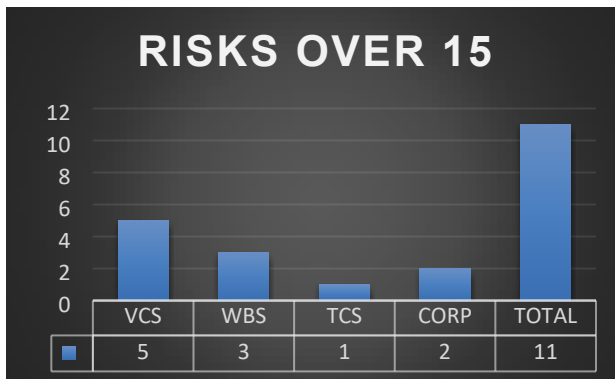
3.2 New Risks Opened in Period

- **3094** - There is a risk that we will not meet IRR17 regulatory compliance as a result of insufficient activity or resources to deliver the relevant risk assessments and subsequent actions leading to reputational risk and potential risk of inappropriate radiation to patients and staff (Score 20)

- **3095** - There is a risk that HSE will issue a non-compliance order or enforcement notice on VCC as a result of lack of compliance with IRR17 regulations and risk assessments leading to reputational damage and potential radiation risk. (Score 16)

- **3247** - There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times. (score 16)

- **2200** - There is a risk to the performance of the radiotherapy service as a result of insufficient capacity within the current linear accelerator fleet, leading to the radiotherapy service being unable to meet the current and anticipated demand. (Score 15)

3.3 All other risks have remained at consistent scoring for the period.

3.4 As a new addition, all risks which have a residual score of more than risk appetite levels and new for April are included in separate appendices – there are 5 risks.

This is to provide visibility for assurance purposes that the quality of the control framework is in line with the residual scoring.

3.5 As a further addition, the spilt of risks is shown below:

RISKS OVER 15

	VCS	WBS	TCS	CORP	TOTAL
■	5	3	1	2	11

SAFETY RISK RATING 12

	VCS	WBS	TCS	CORP	TOTAL
Series1	3	0	0	1	4

RISK BY RATING AND DIVISION

	VCS	WBS	TCS	CORP
20	1	0	0	1
16	3	0	1	1
15	1	3	0	0
12	3	0	0	1

■12 ■15 ■16 ■20

4. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle or Matters raised by Trust Risk Group

4.1 All Wales Datix module

Work is progressing and the Trust will need to make a decision on next steps over the summer. This is being coordinated at an All-Wales level.

4.2 Other development and improvement work tracker is below. The matters that were agreed as closed in the March Trust Board have been removed from the table.

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe/ Update	Status to report in January reporting cycle
8	Review of risk domains – particular concern with respect to Clinical safety being clearly part of Quality domain on Datix	Review of Policy by Trust Risk Team, including this. Data pull for Quality and Safety domains during December – (to report on in January) – to review categorisation	May (for Trust Board approval) May reporting cycle	Deep dive work underway for July cycle reporting.
9	When risks first loaded onto Datix, inherent risks reported above risk appetite levels – for assurance on effectiveness of controls	To action for March reporting cycle	May reporting cycle	Propose to close – implemented in this report
10	Risk report to track overall number of risks at different scores in Datix	To action for March reporting cycle	May reporting cycle	Propose to close – implemented in this report

11	Risk Register format	The format of the attached risk register has become difficult to read given the level of detail	May reporting cycle	Requires further input from IMs – to address by time of Trust Board in May
12	Timing of the cycle of risk review	Review timing of the cycle of risk review and oversight between the Divisional Senior Leadership Teams, Executive Management Board, Committees and Trust Board.	May reporting cycle	Requires further input from IMs – to address by time of Trust Board in May
13	Management of risk reviews in timely way	Review all risk review dates in a structured way through management and governance	July reporting cycle	To then discuss with Independent Members offline

5. IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical ☐ services that always meet, and routinely exceed expectations . A beacon for research, development and innovation in our stated ☐ areas of priority . An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. . A sustainable organisation that plays its part in creating a better ☐ future for people across the globe	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Cantered	☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	Not required	
	There are no socio economic impacts linked directly to the current risks in paper.	
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	Choose an item.	
	There are no direct well-being goal implications or impact in the current risks in this paper.	
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.	
EQUALITY IMPACT ASSESSMENT	No - Include further detail below	
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.	

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risk register is detailed in Appendix 1 and throughout the paper.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Actions plans for individual risk require further work.
BY WHEN?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1

Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of 7 Levels

RAG rating	ACTIONS	OUTCOMES	RAG rating	SUMMARY STATEMENTS OF 7 LEVELS
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.	7	Improvements sustained over time - BAU
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.	6	Outcomes realised in full
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.	5	Majority of actions implemented; outcomes not realised as intended
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.	4	Increased extent of impact from actions
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.	3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.	2	Symptomatic issues being addressed
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.	1	Actions for symptomatic issues, no defined outcomes
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.	0	Enthusiasm, no robust plan

ID	Risk Title - New	Risk Type	Opened	Approval status	Does this risk apply across the entire health board?	Division	Service	Area	Site/Function	Handler	Manager	Is this a Private & Confidential Risk?	Coronavirus/COVID-19	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	RR - Direction of Travel	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Closed date	Due date	Description
3094	There is a risk that we will not meet IRR17 regulatory compliance as a result of insufficient activity or resources to deliver the relevant risk assessments and subsequent actions leading to reputational risk and potential risk of inappropriate radiation to patients and staff	Multiple Risk Domains	27/04/2023	Accepted	Yes	Corporate Services	Whole Service	Health and Safety		Abraham, Jacinta	Hoskins, Jason	No		No	ad hoc activity ongoing in departments	there is a risk that we will not meet IRR17 regulatory compliance and consequently be issued with improvement notice/s by the Health and safety executive as a result of insufficient activity or resources to deliver the relevant risk assessments and subsequent actions leading to reputational risk and potential risk of inappropriate radiation to patients and staff. Not meeting IRR17 (ironizing, radiation regulations) related H&S compliance	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate		Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8		27/07/2023			
3095	There is a risk that HSE will issue a non compliance order or enforcement notice on VCC as a result of lack of compliance with IRR17 regulations and risk assessments leading to reputational damage and potential radiation risk.	Multiple Risk Domains	28/04/2023	Accepted	Yes	Corporate Services	Whole Service	Health and Safety		Abraham, Jacinta	Hoskins, Jason	No	Yes	ad hoc activity to support risk assessment completion and review	There is a risk that HSE will issue a non compliance order or enforcement notice on VCC as a result of lack of compliance with IRR17 regulations and risk assessments leading to reputational damage and potential radiation risk. In addition, there is lack of clarity over the ownership of this regulatory responsibility at Divisional level	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate		Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8		27/07/2023			
3293	There is a risk to Financial Sustainability as a result of a failing to secure sufficient	Financial Sustainability	07/09/2023	Accepted	No	Welsh Blood Service	Whole Service	Affecting Whole Service		Prosser, Alan	Evans, Fran	No	No	Full costs to be confirmed via procurement.	There is a risk to PERFORMANCE & SUSTAINABILITY as a result of a failure to secure sufficient	Probable - Will probably occur/reoccur but will not be a persistent issue.	5 - Critical	20	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Treat - actions agreed to reduce the level of risk which will be		Adequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional	5 - Critical	5	13/05/2024	30/11/2023 review/update; 11/04/2024 review/update; 13/05/2024 Review/update			
3197	There is a risk to Quality as a result of failing to secure sufficient funding for the delivery	Quality	08/05/2023	Accepted	No	Welsh Blood Service	Whole Service	Affecting Whole Service		Prosser, Alan	Evans, Fran	No	No	"Respond to change notifications Collaborate with other UK Services in groups such as The	Ability to maintain compliance to Blood Safety Quality Regulations (BSQR) whilst proceeding with	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Treat - actions agreed to reduce the level of risk which will be		Adequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional	5 - Critical	5	13/05/2024	30/11/2023 review/update; 11/04/2024 review/update; 13/05/2024 Review/update			
3227	There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	Financial Sustainability	16/10/2023	Accepted	No	Transforming Cancer Services	Transforming Cancer Services	Velindre Hospital		Powell, David	Powell, David	Yes	No	1.Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial bootcamp is scheduled for w/c 09/10/23 to try to finalise commercial position on various issues Ongoing 2. See comments against Action 1. Ongoing	changes during the design development process lead to a design which costs more overall, increasing project costs.	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor	8	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Risk Increasing	Probable - Will probably occur/reoccur but will not be a persistent issue.	2 - Minor		31/10/2023		14/12/2023 Increasing Costs	
3247	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	Workforce	08/11/2023	Accepted	No	Velindre Cancer Centre	Medics	Outpatients	Velindre Hospital	Stockdale, Ann Marie	Miller, Jeanette	No	No	Clinic review as part of the preparation process. Audit of consultation room utilisation. Controls and risk mitigation to be developed.	Increased patient demand leading to clinics being overbooked, increasing Consultant and Clinical workload	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Tolerate - the level of risk are tolerable where there are no safe alternatives and any action(s) considered would increase the level of risk		Inadequate	Risk Increasing	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	29/03/2024	27/11/2023 Group Review of Risk for Acceptance and Escalation to SLT; 29/03/2024 Implementation of a virtual consultation hub; 29/03/2024 Conversion of OP office space to Consultation Room; 29/03/2024 Business Case to be developed to create 4 Consultant Rooms; 31/01/2024 Baseline of clinic start/end times; 30/11/2023 Establish Workstream - Demand and Capacity; 31/05/2024 Amendment to Clinic Start/End Times; 28/06/2024 Amendment to clinic templates		
3293	There is a risk to Quality, Performance and Service as a result of any delay in the new Velindre Cancer Centre (nVCC) leading to capacity at the current site not being sufficient to meet the demand, resulting in increased waiting time for radiotherapy, failure to meet All Wales time to radiotherapy metric and reduced patient experience.	Multiple Risk Domains	21/12/2023	Accepted	No	Velindre Cancer Centre	Radiotherapy Services	Radiotherapy	Velindre Hospital	Ikin, Kathy	Payne, Mrs Helen	No	No	Monitoring of capacity and demand. Development of breast escalation process to ensure patients are prioritised as per clinical need. Unlimited extended working hours on treatment machines and other areas of the department in response to demand. Limited extended working hours on treatment machines and other areas of the department in response to demand. Limited to safe staffing, skills mix and age and configuration of the fleet. Agency radiographers in place to support additional hours. Unlimited replacement of new linear accelerators on current site. Policies and procedures on how to manage Radiotherapy scheduling and delays. Development of detailed transition plan to be	Current provisions for Radiotherapy Services at VCC are based on the clinical service model of having 10 clinical linear accelerators, 3 CT simulators, orthovoltage and Brachytherapy across the new Cancer Centre (nVCC) and associated Satellite Radiotherapy Unit (SRU). There is an assumption that the new Velindre Cancer Centre will be operational in 2027. Delays on this project will impact negatively on the Radiotherapy Department at VCC.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Tolerate - the level of risk is tolerated where there are no safe alternatives and any action(s) considered would increase the level of risk		Adequate		Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	21/06/2024			
3337	there is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm	Safety	13/02/2024	Accepted	No	Velindre Cancer Centre	SACT	Chemotherapy Administration (inc Bookings)	Velindre Hospital	Cooper, Mrs Vivienne	Harvey, Stephanie	No	No	daily escalation meetings take place to ensure that patients are identified and managed appropriately	review of booking systems within SACT services has indicated that the booking team are using multiple lists to manage patient, there is a risk that a patients name may be missed due to the need to coordinate these list when booking patient appointments	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate		Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	29/03/2024			
3338	there is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	Safety	13/02/2024	Accepted	No	Velindre Cancer Centre	SACT	Chemotherapy Day Unit (CDU)		Tranter, Bethan	Tranter, Bethan	No	No	daily escalation meetings outsourcing more product to suuport capacity within pharmacy	Demand for SACT delivery (oral and parenteral) has exceeded forecast demand for 2023/2024. There is insufficient Pharmacy capacity at VCC to meet this increased demand at present.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate		Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	04/06/2024			
3350	There is a risk to performance and service sustainability due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	Performance and Service Sustainability	04/03/2024	Accepted	No	Welsh Blood Service	Blood Collection Services	Transport	Any Blood Collection Session Offsite	Davey, Jayne	Francis, Clive	No	No	Daily vehicle checks/Robust defect reporting system Annual service/MOT Resilience vehicles Rotation of vehicles to manage mileage and extend operating life of vehicle Transport office staff available to assist during normal working hours as well as on call cover	A risk assessment was undertaken to determine the risk associated with operating an ageing commercial fleet of vehicles and how this could impact on the ability of the transport function to deliver the required levels of service to both internal and external customers. The risk assessment took into account the impact of specific vehicle failures (minibuses, delivery vans, lorries and support vehicles and the MDC combination) and the overall risk of not replacing the vehicle fleet within the appropriate timeframe.	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Tolerate - the level of risk is tolerated where there are no safe alternatives and any action(s) considered would increase the level of risk		Inadequate	Risk Increasing	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	12/06/2024		12/06/2024 Reiew risk assessment 3350 - review date 12/06/2024	
2200	There is a risk to the performance of the radiotherapy service as a result of insufficient capacity within the current linear accelerator fleet, leading to the radiotherapy service being unable to meet the current and anticipated demand. see Risk assessment attached for full details.	Multiple Risk Domains	01/05/2011	Accepted	No	Velindre Cancer Centre	Radiotherapy Services	Velindre Hospital	Velindre Hospital	Ikin, Kathy	Payne, Mrs Helen	No	No	UPDATED 3/4/2024 - Ongoing monitoring of capacity and demand. - Ongoing monitoring of breaches of waiting times targets. - Extended working hours are in place on the treatment machines and in many other areas of the service. - Machine replacement program initiated, improving the age and capability of the linac fleet but not linac configuration.	There is a risk to Performance and Service as a result of insufficient capacity within the current linear accelerator fleet, leading to the radiotherapy service being unable to meet the current and anticipated demand. The lack of sufficient capacity within the Radiotherapy service has had the following consequences: Compliance risk -·Inability to maintain waiting times compliance. -·Breation of waiting lists. -·Inability to meet RCR clinical guidelines. Patient safety risk -·Patients will wait longer to start treatments resulting in possible poorer clinical outcomes, lack of symptom control and poor patient experience.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Expected - Will occur/reoccur and likely to be frequent.	3 - Moderate	15	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate	Stable/No Movement	Unlikely - Not expected to occur/reoccur but there is some possibility.	3 - Moderate	6	28/06/2024			

ID	Risk Title - New	Risk Type	Opened	Approval status	Does this risk apply across the entire health board?	Division	Service	Area	Site/Function	Handler	Manager	Is this a Private & Confidential Risk?	Coronavirus/COVID-19	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	RR - Direction of Travel	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Closed date	Due date	Description
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	Safety	09/12/2022	Accepted	Yes	Corporate Services	Whole Service	No Further Coding Required		Morley, Sarah	Budgen, Claire	No		People Management Policies and Procedures Infrastructure and resources to support wellbeing Values, behaviours and culture work programmes Leadership development and management training Regular monitoring and analysis of feedback and data This risk is now a standing agenda item at the Healthy and Engaged Steering Group	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery. Work related stress is the adverse reaction people have to excessive pressure or other types of demand placed on them. Due to the wide range of factors that cause stress, within work and outside of work, no single action will address the issue. Moreover, progress towards stress reduction will take time as new ways of working come into effect. Trust sickness absence figures show mental health issues and stress to be the highest cause of absence from work.	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Stable/No Movement	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	31/03/2024		31/03/2024 09/12/2022 21/03/2023 22/12/2023 11/03/2024	Divisions/Departments should have proactive stress risk assessments Formal arrangements not in place for the Healthy and Engaged Steering Group to evaluate wellbeing interventions This risk needs a SMART action plan Systemic factors that impact on levels of workforce stress to be described and associated actions plans and associated Develop management training in managing stress
3230	REFERRAL PROCESS - There is a risk to patient safety, cas a result of variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	Safety	19/10/2023	Accepted	No	Velindre Cancer Centre	Health Records	Medical Records	Velindre Hospital	Stockdale, Ann Marie	Stockdale, Ann Marie	No		Monitoring the receipt of paper and electronic communications specific to new patient referrals to ensure timely actions to be taken.	Multiple methods for the communication of new patient referrals to Velindre Cancer Centre	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented	Monitoring of paper and electronic communication sent to Velindre Cancer Centre to enable the prioritisation and management of patient referrals.	Inadequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	4 - Major	4	31/05/2024		26/10/2023 31/03/2024 31/12/2024 29/09/2023 31/03/2024 29/02/2024 31/10/2024 08/03/2024	An Action Plan needs to be established Short term central management of new patient referrals Electronic Solution (Long Term) Escalation to the Chief Operating Officer and Chief Digital Officer New Patient Waiting List Referral Discussion with Health Board Colleagues Establish Workstream - Referrals and Referral Process Transformation Fund - Planned Care
2187	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	Safety	14/09/2020	Accepted	No	Velindre Cancer Centre	Medical Physics (previously Radiotherapy Physics)	Medical Physics	Velindre Hospital	Windle, Rebecca	Millin, Tony	No		Radiotherapy Physics workforce remains below recommended (IPEM) levels. Additional surge funding has been utilised alongside IRS funding to increase recruitment in the short term. The service head has developed an outline workforce plan, looking at roles and responsibilities and demands on the service, mapping out the essential BAU activity, critical projects and programmes of service development to implement a prioritisation if activity and resource utilisation.	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks. Inadequate staffing may result in: - Patient treatment delay and breaches - Key projects not keeping to time with an impact on radiotherapy capacity e.g. commissioning and implementation of IRS systems, system upgrades of essential	Expected - Will occur/reoccur and likely to be frequent.	5 - Critical	25	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented			Risk Increasing	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	31/05/2024		31/01/2023 31/01/2023 31/03/2023 30/09/2023 31/10/2023 30/11/2023 23/10/2024 23/10/2024	Recruitment Action Plan 0 0 5 year workforce plan Readvertise post that did not recruit Prioritise business critical tasks and ensure detailed project and resource plans are kept up to date Log when IRS implementation put on hold to meet clinical demand
2465	There is a risk to patient safety, caused by the duplication of information, excessive use of	Safety	05/11/2021	Accepted	No	Velindre Cancer Centre	Medics	No Further Coding Required	Velindre Hospital	Hennessy, Rachel	Hennessy, Rachel	No	No	There is a lack of current controls that enable the mitigation of this risk. As a result a formal	There is a risk of severe harm due to the excessive use of email both internally and externally to	Probable - Will probably occur/reoccur but will not be a persistent issue.	4 - Major	16	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be		Inadequate	Stable/No Movement	Unlikely - Not expected to occur/reoccur but there is some possibility.	2 - Minor	4	28/06/2024		30/06/2023 30/06/2023 09/10/2023	0 0 0

ID	Risk Title - New	Risk Type	Opened	Approval status	Does this risk apply across the entire health board?	Division	Service	Area	Site/Function	Handler	Manager	Is this a Private & Confidential Risk?	Coronavirus/COVID-19	RR - Current Controls	Risk (in brief)	Likelihood (initial)	Impact (initial)	Rating (initial)	Likelihood (current)	Impact (current)	Rating (current)	Risk Decision	Controls in place	Adequacy of Controls	RR - Direction of Travel	Likelihood (Target)	Impact (Target)	Rating (Target)	Review date	Closed date	Due date	Description
3326	There is a risk to staffs health as a result of Repetitive strain injury leading to potential claims and staff sickness.	Safety	06/02/2024	Accepted	Yes	Corporate Services	Whole Service	No Further Coding Required		Hoskins, Jason	Pell, Ceri	No	No	ESR online mandatory training (no renewal) Face to face assessments picked up by the H&S Advisors and Compliance Manager. (informal arrangement) Revision of the Trust DSE policy May 2023 to include home self assessments SLA with Cardiff & Vale Occupational Health for ill health referral (does not include DSE assessment provision)	It is not yet known if the Covid-19 pandemic and working from home arrangements, including hybrid working and ad hoc hot desk arrangements will result in personal injury claims, given that repetitive strain injuries can take a while to develop. There is therefore a requirement to ensure that health and safety requirements have sufficiently been met to comply with health and safety legislation and ensure that there is adequate provision for safe systems of work to prevent staff from sustaining injury that could otherwise have been prevented. To comply with regulation our policy states: •Suitably trained DSE Assessors are available to provide advice on DSE assessments and to refer to health and safety teams or Occupational Health where the issues are beyond their capacity.	Probable - Will probably occur/reoccur but will not be a persistent issue.	3 - Moderate	12	Possible - May occur/reoccur at some time / occasionally.	3 - Moderate	9	Treat - actions agreed to reduce the level of risk which will be implemented		Inadequate	Stable/No Movement	Possible - May occur/reoccur at some time / occasionally.	2 - Minor	6	30/03/2024			
3346	There is a risk that the continuation of safe patient care and financial income may be	Safety	26/02/2024	Accepted	No	Velindre Cancer Centre	Health Records	Medical Records	Velindre Hospital	Stockdale, Ann Marie	Bell, Mrs Tracy	No		1. Appointments not processed on WPAS reviewed and processed.	Outpatient Oncology Notes (OON) have not been created/created correctly or	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Unlikely - Not expected to occur/reoccur but there is some possibility.	4 - Major	8	Treat - actions agreed to reduce the level of risk which will be	1. Staff training and awareness on the accurate processing of patient activity.	Adequate	Stable/No Movement	Unlikely - Not expected to occur/reoccur but there is some possibility.	3 - Moderate		28/06/2024		28/06/2024	Implementation of Medical Secretarial Service Model
3367	There is a risk to PERFORMANCE, SERVICE SUSTAINABILITY and SAFETY as a result of the termination of the current contract for Chemocare in October 2024, leading to a failure to safely deliver SACT treatment within VCC.	Multiple Risk Domains	04/04/2024	Accepted	No	Velindre Cancer Centre	Digital Services	Chemotherapy Administration (inc Bookings)		Mason-Hawes, David	Lloyd, Gareth	No	No	Work is already underway nationally, led by NWSSP, to secure an extension to the current contract for the 5 NHS Wales organisations (including VUHNST) who use Chemocare. The aim is to secure a 5-year extension of the current contract, to include provision to establish a single, national instance of Chemocare during the period of the new contract.	The current contract for the VCC instance of Chemocare expires in October 2024. Chemocare is used to support the administration of SACT chemotherapy treatments in VCC - an essential tool to safely and effective schedule and track SACT treatments for VCC patients.	Expected - Will occur/reoccur and likely to be frequent.	4 - Major	20	Possible - May occur/reoccur at some time / occasionally.	4 - Major	12	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	4 - Major			04/06/2024			
3371	There is a risk to Quality and patient safety as data integrity of the cold chain monitoring system may be impacted because the primary server needs to be replaced.	Quality	12/04/2024	Accepted	No	Welsh Blood Service	Quality Assurance	QA Laboratory	Cold Chain (Validation & Mapping)	Richardson, Peter	Evans, Michelle	No	No	1. A manual backup of the data has been saved for the system that becomes the roll back to option to restore data. 2. Each Datanode includes one weeks data on the system. 3. Step 1 describes the extraction of a sample data set for verification of integrity during process. "Risk Domain"Ref No"Item / Function/ Risk Summary"Potential Failure Mode(s)"Potential Effects of Failure/Impact of failure"Initial Impact"Potential Cause(s)/ Mechanism(s) of Failure"Initial Likelihood"Current Design Controls (Preventative/ Detection Actions)"Initial Detection"Initial RPN"Risk Treatment Plan & Recommended Action"Responsible Person & Target Completion Date"Impact	Background" Following a PICR INV973 the primary server on the cold chain monitoring system is to be replaced. Situation The following process has been designed in collaboration with the SME from the supplier, with SME from across the WBS including, digital, Validation, System admin, System owner, Operational leads, the RP and QA Systems have been informed of the process throughout this investigation. Aim The aim is to design a process that supports the safe replacement of the primary server whilst ensuring service continues for users and the validation status and data integrity are maintained. Method statement to be completed by the supplier: Method statement to be completed by the supplier and written into the validation documentation that will be	Possible - May occur/reoccur at some time / occasionally.	5 - Critical	15	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	5 - Critical	5	Treat - actions agreed to reduce the level of risk which will be implemented		Adequate	Stable/No Movement	Rare - Would only occur/reoccur in very exceptional circumstances; considered a very remote probability that it could happen / happen again.	5 - Critical	5	11/04/2025			

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Trust Assurance Framework

DATE OF MEETING	9TH MAY 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This paper summarises the next steps for Trust Assurance Framework for April and May.

RECOMMENDATION / ACTIONS	The Committee are asked to **DISCUSS AND NOTE** the Trust Assurance Framework.

GOVERNANCE ROUTE	

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	15TH APRIL

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	15TH APRIL

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Executive Management Board discussed the TAF and endorsed for submission to the Quality, Safety and Performance Committee.

APPENDICES	
1	Trust Assurance Framework

1.   SITUATION

An updated set of Strategic Risks were approved by the Trust Board in January 2024.

2.   ASSESSMENT

Update for April/ May

2.1   It was agreed in Executive Management Board on 15th April that the two risks for focus in Quality, Safety & Performance Committee in May will be strategic workforce risk (TAF 03) and strategic financial stability risk (TAF 08). There will be triangulation with other key papers on the agenda on these matters.

2.2   May reporting cycle actions – as per below, in particular to reference that an approach to action 3 has been agreed in two phases.

2.3   The first is to provide an additional section in the format to include the Integrated Medium Term Plan actions. This mapping will be completed following a series of meetings between the Executive Directors and Director Corporate Governance with support from the Strategic Transformation team. This work will be completed during May for June/July reporting cycle.

2.4   The longer term approach will be to re-orientate the Trust Assurance Framework according to strategic objectives. The template and approach for this to be agreed by October, in order to allow the development of the 2025-2028 Integrated Medium Term Plan and Trust Assurance Framework to progress on this basis during Quarter 3 and 4.

Summary of Actions Taken/ In Plan from Strategic Development Committee, Quality Safety & Performance and Audit Committee:

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	Although issue with lack of risk/assurance resource continues, it has been possible to progress the development work is complete and there is a usable version of the dashboard on SharePoint. Next steps are to migrate the dashboard through the Power Automate Exporting Tool. Expect to be available to start migration by end June.
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Full update in paper in section 2.2 above	Phase 1 – July Committee. Phase 2 – aligned to 2025/6 Integrated Medium Term Plan development
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	Complete – included in May reporting cycle
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional	June 2024 - in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

		Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may include further Board development time etc.	
6	Tracked changes	Tracked changes will be highlighted more clearly to show recent updates. In addition, the cover paper will be developed to include clearer commentary of key changes.	July reporting cycle – This will be automated based on migration to Power BI template as per improvement action 1 above.

3.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**
If yes - please select all relevant goals: • Outstanding for quality, safety and experience   ☒ • An internationally renowned provider of exceptional clinical services   ☐   that always meet, and routinely exceed expectations

• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** All Strategic Risks are related.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**

	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒

The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

All domains are relevant to this work, as the strategic risks span all areas of the Trust business and are imperative to quality and safety.

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text. There are no socio economic impacts linked directly to the current risks in paper.

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com /sites/VEL_Intranet/SitePages/E.asp x*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text
ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	The risks are detailed in the new Trust Assurance Framework dashboard.
WHAT IS THE CURRENT RISK SCORE	NA
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Action plans for strategic risks are included in the Trust Assurance Framework Dashboard.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

SECTION 1

RISK ID		RISK TITLE				STRATEGIC GOAL			RISK SCORE TREND	
RISK LEADS						RISK THEME				

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL		CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL		TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)	RATING		Overall Trend in Assurance	

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			X								

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE			CURRENT RISK LEVEL		RISK TREND	

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control

SECTION 1

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	
RISK LEADS	Steve Ham	Rachel Hennessey	Alan Prosser	RISK THEME	Service Capacity		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD 4	IMPACT 4	TOTAL	16	CURRENT RISK	LIKELIHOOD 3	IMPACT 4	TOTAL	12	TARGET RISK	LIKELIHOOD 2	IMPACT 4	TOTAL	8

SECTION 3

Overall Level of Effectiveness:		RATING	PE	Overall Trend in Assurance		THIS WILL INCLUDE A

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual Service Level Agreement meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Lack of real time data on fating of blood to allow business intelligence data set that links Health Board and activity changes to demand. Addressing this gap would require digital systems to be in place which are out of WBS control. Projects are progressing externally.		A1.1
The demand management for blood still varies across Health Boards and within clinical teams. The Blood Health National Oversight Group work programme continues to address inappropriate use of blood, which impacts demand.		A1.1

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
2515	There is a risk to performance and service sustainability as a result of the staffing levels within Brachytherapy services being below those required for a safe resilient service leading to the quality of care and single points of failure within the service.	15	Risk Decreasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
A1	Exploratory pilot project with Cardiff and Vale Health Board to scope real time digital solution to develop blood fate data set.	Lee Wong	IA	Jul-25	National oversight group is currently discussing with C&V in light of new supplier for All Wales LIMS solution.	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A1.1	Working with DCHW to support the Blood Transfusion Module of the new All Wales LIMS 2.0 , Track Care Lab Enterprise (TCLE).	Lee Wong	IA		Discussions ongoing about funding solutions for blood tracking/fating to patient,	18.4.24	No current funding route identified within LIMS and may need o be considered when the Infected Blood Inquiry (IBI) reports in May 24.	
A2	Blood Health National Oversight Group key work streams are underway identifying inappropriate use of blood.	Lee Wong	PA		Ongoing work under the remit of the BHNOG to support patient blood management initiatives, including	18.4.24	All Wales programmes which will ensure equity of care for patients.	
	review of outpatient activity to determine what could be repatriated back to Health Boards relasing capacity within the outpatient facility and providing care closer to home for the patient	Head of Medical Services			report to be received			
	formal demand and capacity operational group to be established to provide oversight of current and future plans, manage D&C plans and identify areas of concern with mitigations for escalation as appropraite	Head of Medical Services			Key objective for Head of Service onow commenced in role - as at Dec 2023			

SECTION 1

RISK ID	02	RISK TITLE	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	STRATEGIC GOAL	2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	
RISK LEADS	Carl James	Jacinta Abraham	Nicola Williams		RISK THEME	Partnership Alignment	

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD 3	IMPACT 4	TOTAL	12	CURRENT RISK	LIKELIHOOD 2	IMPACT 4	TOTAL	8	TARGET RISK	LIKELIHOOD 2	IMPACT 3	TOTAL	6

SECTION 3

Overall Level of Effectiveness:		RATING	PE	Overall Trend in Assurance						THIS WILL HAVE A GRAPH	

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress				X	PE	Linked through performance framework	E	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in	E	Strategic Development	PA	Regulatory scope re MHRA tbc; clear	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development	PA	Wales Audit Office	E
4.1	South Wales Collaborative Cancer Leadership Group system			X		PE	Agreed to model for next phase	NE	Strategic Development	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards			X		E	Agreed to model for each organisation	PA	Strategic Development	PA	Wales Audit Office/Welsh Government	E
5.2	Partnership with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	QSP	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety		Wales Audit Office/Welsh Government	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further	First line and second lines of defence assurance are in place to a certain extent	
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commissioning and specialist cancer	Replace of CCLG not in place yet so no regional assurance regarding strategic	
Agreement of need for improved regional cancer commissioning (core services)		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF		RISK TITLE	CURRENT RISK	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include			

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Phase 1 complete. Development of Phase 2 of PMF with additional performance measures/quality metrics commenced	Carl James	Mar-24	Design stage commenced	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to provide a range of outcome measures to support view on quality of care	Matt Bunce	Programme outputs to be confirmed	Programme established and staff on-boarded. Progress being made on a number of projects (Food mission; cancer dashboards etc	11/04/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	tbc	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc). Still no commencement date	11/04/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountabilioty arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	April/May 2024	Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage	11-Apr-24	Unknown at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James	tbc subject to the programme dates	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023. Regional programme working	22-Dec-23	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system	The level of assurance should increase
1.9	Establishment of new national commissioning body (bringing	Welsh Government	01-Apr-24	Implementation of new commissioing body well progressed	11/04/2024	Anticipated it will reduce level of risk by providing	

SECTION 1

RISK ID	03	RISK TITLE	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience	RISK SCORE TREND
RISK LEADS	Sarah Morley			RISK THEME	Workforce Supply and Shape	

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	6
	4	4				4	3				2	3		

SECTION 3

Overall Level of Effectiveness: (definitions tab)	7 Levels of Assurance(see	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			x		PE						
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	x			E	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	x			E	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Workforce planning - skills development	Susan Thomas	x			PE	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	x			PE	Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	x			PE	Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
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	Susan Thomas	x			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	x			PE	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	x			PE	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			x	E	Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA
C9	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	x	x	x	E	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	External Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Gaps are evident in understanding agreed service models – both internally and regionally	Development of 3rd Line of defence assurance to be completed	
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity	Mapping of relevant sources of assurance and development of that assurance will be also alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	IA	Mar-24	The annual workplan has been reviewed at the Healthy and Engaged (H&E) Steering Group for Quarters 1 and 2, 2022-23. The Trust has appointed a staff psychologist to support mental health and wellbeing and they have developed a model for a staff psychology service which has been shared at the Healthy and Engaged Steering Group. In addition all elements of the Trust wellbeing offer have been added to the national GWELLA platform and on the Trust intranet allowing them to be more easily accessible for staff. The next H&E meeting was to be on the 28.03.24 but cancelled due to Strike action, this plan will now be agreed in April by the group for 24/25. Task and Finish group has been set up to embed the Values and Behaviour Framework into the recruitment process	19.04.2024	Plan is moniitoted via Health and Engaged Steering group	
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	PA / COMPLETE		The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA / COMPLETE		International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	PA / COMPLETE		A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Sep-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy. Workforce models will be developed inline with the Clinical and Scientific Strategy	19/04/2024	The Clinical & Scietific Strategy is still under dvelopment. Work underway in the interim is described in the Workforce Supply & Shape paper coming to QSP Committee in May 2024	
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Apr-24	Retention plan to be developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. Paper on the plan to be presented to EMB in May	19.04.204		
1.7	Review Exit Interview Process	Susan Thomas	IA / COMPLETE		The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 1

RISK ID	04	RISK TITLE	There is a risk of failure to meet or exceed service expectations without the prevelance of a positive working environment, which is characterised by effective values and behaviours, systems and processes	STRATEGIC GOAL	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	
RISK LEADS	Sarah Morley			RISK THEME	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	9	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	4
	3	4				3	3				2	2		

SECTION 3

Overall Level of Effectiveness:	7 Levels of Assurance(see definitions tab)	RATING	PE	Overall Trend in Assurance	THIS WILL INCLUDE A GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			x								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	Developed Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training steering group	IA	Trust Board reporting on strategy and controls via cycles of business	IA	To be completed as per compliance/ reg tracker updates	IA
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training steering group		Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE	Healthy and Engaged Steering Group and Education and Training Steering Group	PA	Reported through EMB Shape to Strategic Development Committee	IA	Internal Audit Reports	IA
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Workling Group	PA	Executuve Management Board	PA	Internal Audit Reports	IA
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
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	
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture	Mapping of relevant sources of assurance and development of that assurance will sit alongside the development of the key controls	

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INITIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16	12	9	Risk has decreased from initial rating.

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley		May-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in April 2024. This paper also proposes that the conversations continue as routine in person and virtually.	18/04/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley		May-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	18/04/2024	We have received the Trust level data from the 2023 staff survey. The more detailed dahsboards are expected by the end of April. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will ensure action is taken under the appropriate workstream.	
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley		COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Implementation of the Speaking Up Safely Framework	Sarah Morley		Mar-24	The Trust is implementing the Welsh Government Speaking up Safely Framework. This Framework is a mechanism that provides assurance that the correct communication, processes and governance are in place for staff to speak up safely without any fear. Initial project report to be considered by EMB in April	19.04.2024	Initial programme completed - ongoing work to trianguale with wider cultural work	

SECTION 1

RISK ID	05	RISK TITLE	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies,	STRATEGIC GOAL	5 - A sustainable organisation that plays it part in creating a better future for people across the globe.	RISK SCORE TREND
RISK LEADS	Carl James			RISK THEME	Digital Transformation	

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD 4	IMPACT 4	TOTAL	16	CURRENT RISK	LIKELIHOOD 3	IMPACT 4	TOTAL	12	TARGET RISK	LIKELIHOOD 2	IMPACT 4	TOTAL	8

SECTION 3

Overall Level of Effectiveness:		RATING	PE	Overall Trend in Assurance		THIS WILL BE A GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		PE	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Agreed Digital Inclusion plan - C4,C7 - This has now been agreed by EMB/SDC and is no longer a gap in control	Assurance Arrangements for Digital Architecture will need to be established - intent	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team -	
Appropriate external standards for benchmarking need to be agreed (e.g. ITIL, Cyber Essentials, ISO27001) as part of the control framework.		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist started 1st April '24, will close out for May update
3193/3197 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degradation of critical WBS (NHS Wales) supply chain activities	15	Outline Business Case at EMB/SDC in April '24
R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

Action Ref	Action Plan	Ownder	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Nov-22	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	Dec-23	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The	Dec-23	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer IA		Feb-24	Plan approved at EMB/SDC - Quality Impact Assessment being completed. Will look to close action in May update	Dec-23	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer IA		Mar-24	Head of Cyber Security has been appointed from Dec	Dec-23	Dedicated post now in place to lead on cyber - will still be a single point of failure - Request into Trust reserves for a	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service.	Chief Digital Officer IA		Apr-24	Assistant Director of Data and Insight starts in post on 3rd Jan 24. Future model for Data and Insight to be established. Planning paper at April EMB	Dec-23	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer IA		Apr-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security	Dec-23	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer IA		May-24	To be reviewed at May EMB	Jan-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice

SECTION 1

RISK ID	06	**RISK TITLE**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**STRATEGIC GOAL**	1 - Outstanding for quality, safety and experience	**RISK SCORE TREND**	
RISK LEADS	Lauren Fear			**RISK THEME**	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: Refer to 7 Levels of Assurance (see definitions tab)	RATING	E	Overall Trend in Assurance Refer to 7 Levels of Assurance (see definitions tab)	THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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 Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey; Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee; Trust Board	6	Internal Audit Reports; Audit Wales Structured Assessment Programme / Reports; Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee; Trust Board	4	Internal Audit of Board Committee Effectiveness; Audit Wales Structured Assessment; Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Lauren Fear	X			NE	Exercise to be completed	1	Trust Board in Board Development	1		

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
None	Third line of defence in respect of C4 - Board Development Programme	Refreshed programme to be discussed and agreed in February 2024 Board Development session

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
	There are currently no associated operational risks according to the risk appetite to include		

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.0	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Jun-24	Governance, Assurance and Risk (GAR) Programme of work consisting 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session	11.4.24	Impact to be asseessed when programme delviered	
2.0	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.25	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Jun-24	Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams. Good progress made however further embedding required with Senior Leadership Teams.	11.4.26	Impact to be asseessed when delviered	
4.0	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.27	Requirement for C7 to be put in place	
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	4	Jun-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	11.4.28	Impact to be asseessed when programme delviered	
6.0	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	1	Jul-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.29	Impact to be asseessed when delviered	

SECTION 1

RISK ID	07	RISK TITLE		There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience	RISK SCORE TREND
RISK LEADS	Jacinta Abraham	Nicola Williams		Chief Operating Officer	RISK THEME	Patient Outcomes	

SECTION 2

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				4	4				2	4		

SECTION 3

Overall Level of Effectiveness:
7 Levels of Assurance(see definitions tab)

RATING	NE	Overall Trend in Assurance

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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 Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO					As per TAF 01 C12					
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nursing, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NE
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO		X		PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Integrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	NE	VCS Quality & Safety Group / VCS SLT	NA	Integrated Quality & Saefty Group / Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Service level to Board monitoring of national standards delivery eg. NICE	Quality & Safety Tracker continues to be refined - not at its optimum	A1
Service level to Board intergrated dashboards	Quality Metrics under development	A2
Patient reported outcome measures across all SSTs, with service level to Board reporting	PROMa not in place	A3
Robust and consistent administrative processes for referrals and bookings		A4, A5, A6,A7

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable
2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
	Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration							
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	22.3.24	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	22.3.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
A3	Intergrated Quality and Safety dashboards to be developed that align with PMF	Transofrmation, planning, performance and digital	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed	22.3.24	Should reduce risk	Enhanced control and assurance
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Working Group established within VCS, Lead by the VBHC Team & external company PCS	22.3.24	Should long term reduce risk	Enhanced assurance
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Work commenced	22.3.24	Reduce risk	Enhanced control
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24		22.3.24	Reduce risk	Enhanced control
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan developed	22.3.24	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce	1	Mar-26	Opportunities for mult-professional consultant posts being considered	22.3.24	Reduce risk	Enhanced control
A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process being drafted based on benchmarking outcomes and review of national standards	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	22.3.24	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Director / Exec Director Nursing, AHP & HCS	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB.	22.3.24	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed by March 2024, followed by consultation period..	22.3.24	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and	22.3.24	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	

SECTION 1

RISK ID	08	RISK TITLE	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe	RISK SCORE TREND
RISK LEADS	Matthew Bunce			RISK THEME	Financial Sustainability and Long-Term Value	

RISK SCORE (see definitions tab)

INHERENT RISK	LIKELIHOOD	IMPACT	TOTAL	16	CURRENT RISK	LIKELIHOOD	IMPACT	TOTAL	12	TARGET RISK	LIKELIHOOD	IMPACT	TOTAL	8
	4	4				3	4				2	4		

SECTION 3

Overall Level of Effectiveness: 7 Levels of Assurance(see definitions tab)		RATING	E	Overall Trend in Assurance		THIS WILL INCLUDE A TREND GRAPH

KEY CONTROLS / SOURCES OF ASSURANCE

ID	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
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA
FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Scheme of Delegation and Governance Framework for the nVCC to prepare for post financial close	Investment Appraisal assurance process improvement to ensure high quality of business case submissions and education of organisation with regards to appropriate funding routes for service developments and initiatives	F6 (Controls); F4 (Assurance)
	Medicines management requires more clarity on governance, decision making processes and financial implications including links between NWSSP, National forums and impact on local decision making in VCS.	F2

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
3227	There is a risk to financial sustainability as a result of changes during the design development process leading to a design which costs more overall, increasing project costs. [Note added here outside of Datix that this relates to nVCC]	16	Risk Increasing

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group, including WBS Pre-Operative Anaemia project; Value Intelligence Centre and Food Mission	22.3.24	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	tbc
F2	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Ongoing	Pharmacy review has been conducted and will be presented to Exec Management Board early in 2024. Following this a review of medicines management governance (including financial aspects), will be conducted by September 2024.	22.3.24	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability	tbc
F3	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing	Capital financial control procedure approved by Audit Committee	22.3.24	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Criteria have been drafted and Board Reporting Template updated to reflect types of initiatives and sources of funding available for investments	22.3.24	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Mar-24	Cardiff Cancer Research Hub market engagement exercise to identify potential sources of external funding to support development. Strengthening private patient cash collection and pricing	22.3.24	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. The first major programme this has been applied to is the IRS programme. A Scheme of Delegation and Governance Framework needs to be developed for nVCC	22.3.24	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

RISK DESCRIPTORS

RISK NUMBER	RISK THEME/TITLE	DRAFT RISK DESCRIPTION	RISK OWNER
01	Service Capacity	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	**Cath O'Brien** **Rachel Hennessey** **Alan Prosser**
02	Partnership Alignment	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	**Carl James** **Nicola Williams** **Jacinta Abraham**
03	Workforce Supply and Shape	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	**Sarah Morley**
04	Organisational Culture	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	**Sarah Morley**
05	Digital Transformation	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**Carl James**
06	Organisational and Clinical Governance	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**Lauren Fear**
07	Patient Outcomes	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**Nicola Williams** **Jacinta Abraham** **Cath O'Brien**
08	Financial Sustainability	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**Matt Bunce**

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
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

LEVELS OF ASSURANCE DESCRIPTORS

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	**Internal oversight/**specialist control teams, such as**:**	**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:
Risk and control management as part of day-to-day business management	Quality & Safety	External Audit
Staff training and compliance with policy guidance	IT	Regulators & Commissioners
Teams take responsibility for their own risk identification and mitigation	Governance (corporate/Clinical)	Wales Audit Office reviews
		Stakeholder reviews
		Scrutiny from public, Parliament, and the media
Examples of assurance	*Examples of assurance*	*Examples of assurance*
Management Controls / Internal Control Measures	*Board, Committee and Management Structures which receive evidence from*	*Recent internal audit reviews and levels of assurance*
Local management information / departmental management reporting	*Finance reports*	*External Audit coverage*
Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)	*KPI's and management information*	*Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews*
Operational planning / Business Plans - Delivery Plans and Action Plans	*Quality, Safety and Risk reports*	*Patient Feedback / Patient experience feedback*
Governance statements / self-certification	*Training records and statistics*	*Staff surveys / feedback*
Local procedures	*Performance reports*	*Comparative data, statistics, benchmarking*
Exceptions reporting	*BAF, VUNHS risk register*	
Targets, Standards and KPIs	*Policies and Procedures including Risk Management Policy*	
Incident Reporting	*Compliance against Policies*	
Staff Training Programmes		

STRATEGIC GOALS

1 - Outstanding for quality, safety and experience

2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations

3 - A beacon for research, development and innovation in our stated areas of priority

4 - An established 'University' Trust which provides highly valued knowledge and learning for all

5 - A sustainable organisation that plays it part in creating a better future for people across the globe

RISK DESCRIPTORS

Inherent Risk	Score the exposure before any action has been taken to manage it or if existing controls failed entirely
Residual risk	The threat that remains after all existing controls have been applied
Target risk	Where risks are outside acceptable levels, a target risk score is agreed. This is the level that future mitigation that should be achieved which will vary over time

KEY CONTROLS

CONTROL TYPE	DESCRIPTION	EXAMPLES
Preventative	These controls are designed to limit the possibility of an undesirable outcome being realised. The more important it is to stop an undesirable outcome then the more important it is to implement appropriate preventative controls.	- Authorisation limits of and separation of duties - Pre-employment screening of potential staff
Mitigating	These controls are designed to limit the scope for loss and reduce any undesirable outcomes that have been realised. They may also provide a route of recourse to achieve some recovery against loss or damage.	- Passwords or other access controls - Staff rotation and regular change of supervisors - Exposure reduction by installation on hours worked
Detective	Control is designed to locate problems after they have occurred. Once problems have been detected, management can take steps to mitigate the risk that they will occur again in the future, usually by altering the underlying process.	- Periodic performance reporting - Regular review

RISK SCORE

LIKELIHOOD MATRIX

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	01.-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

IMPACT MATRIX

RISK DOMAINS	Impact, consequence score (severity levels) and examples.				
	1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
01 Compliance *Statutory duty/ inspections*	No or minimal impact or breach of guidance/statutory duty	Minor breach of guidance/statutory duty; Reduced performance rating if unresolved; Verbal reports from Regulator	One breach guidance/statutory duty; Challenging recommendations; Observation reports from regulator	Multiple breaches in statutory duty; Enforcement action; Improvement notices	Multiple breaches in statutory duty; Prosecution; Severely critical report
02 Environmental *Environmental impact*	No or minimal impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
03 Financial Sustainability *Including claims*	Insignificant cost increase; Small loss risk of claim remote	Loss of 0.1–0.25 per cent of budget; Claim(s) less than £10,000	Loss of 0.25–0.5 per cent of budget; Claim(s) between £10,000 and £100,000	Loss of 0.5-1.0 percent of budget; Claim(s) between £100,000 and £1million	Loss of >1 per cent of budget; Claim(s) >£1million
04 Information Governance *General Data Protection Regulation (GDPR)*	Minimal privacy impact requiring no or minimal intervention	Minor impact on an individual's privacy	Moderate privacy impact requiring professional intervention; Possible ICO reportable breach; Could result in an event which impacts on a moderate (less than 100) number of patients/donors	Major breach leading to possible larger scale privacy breaches; Likely ICO reportable breach if IG standard not adhered to; Could result in an event which impacts on a major (between 100 and 1000) number of patients/donors	Serious breaches and non-compliance; Definite ICO report required if breach occurs; Could result in an event which impacts on a major (more than 1000) number of patients/donors
05 Partnerships *Relationships with internal and external stakeholders and in working with system partners*	No or minimal issues in establishing and maintaining effective relationships with internal and external stakeholders; No or minimal misalignment of operational actions or strategic approach with system partners; Minimal issues with collaborative working initiatives within our cancer and blood and transplant systems	Minor issues in establishing and maintaining effective relationships with internal and external stakeholders; Minor misalignment of operational actions or strategic approach with system partners; Minor issues with collaborative working initiatives within our cancer and blood and transplant systems	Moderate issues in establishing and maintaining effective relationships with internal and external stakeholders; Moderate misalignment of operational actions or strategic approach with system partners; Moderate issues with collaborative working initiatives within our cancer and blood and transplant systems	Major issues in establishing and maintaining effective relationships with internal and external stakeholders; Major misalignment of operational actions or strategic approach with system partners; Major issues with collaborative working initiatives within our cancer and blood and transplant systems	Failure to establish and maintain effective relationships with internal and external stakeholders; Severe misalignment of operational actions or strategic approach with system partners; Severe issues with collaborative working initiatives within our cancer and blood and transplant systems

RISK DOMAINS	Impact, consequence score (severity levels) and examples.				
	1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
06 Performance and Service Sustainability *Business objectives/projects Service/business interruption*	Failure to achieve minor objective; No or minimal service issue; **Programme/ projects**; Insignificant cost increase; Less than 5 per cent schedule slippage against timescales	Failure to achieve significant/key objective; Minor impact on service. **Programme/ projects**; 1-10 per cent over project budget. 5-10 per cent schedule slippage against timescales	Failure to achieve multiple significant/ key objectives; Moderate impact on service. **Programme/ projects**; 10-25 per cent over project budget. 10-40 per cent schedule slippage against timescales	Failure to achieve crucial objectives; Major impact on service. **Programme/ projects**; 25-50 per cent over project budget. 40-100 per cent schedule slippage against timescales	Gross failure to achieve multiple crucial objectives; Service failure. **Programme/ projects**; >50 per cent over project budget; More than 100 per cent schedule slippage against timescales
07 Quality *Quality/complaints/ audit / GxP*	Peripheral element of treatment or service suboptimal; Informal complaint/enquiry; Temporary insignificant impact upon process or performance with no impact on quality or safety of components produced. Donor/patient/staff discomfort	Overall treatment or service suboptimal; Formal complaint (stage 1) Local Resolution; Single failure to meet internal standards; Temporary minor decline in existing performance or process, no impact on quality or safety of components produced. Donor/patient/staff discomfort, minor interventions required e.g., reassurance.	Treatment or service has significantly reduced effectiveness; Formal complaint (stage 2) complaint; Multiple failures to meet internal standards; Temporary moderate erosion of existing performance or process, with the potential for impact on quality or safety of components produced. Short term harm, donor/patient/staff requiring treatment from medical practioner.	Non-compliance with national standards with significant risk to patients or donors if unresolved; Multiple complaints/ independent review; Multiple failures to meet national standards; Sustained erosion of existing performance or process, tis has an effect on quality or safety of components produced. Donor/ staff admission to hospital required, or increased stay in hospital >3days.	Non-compliance with national standards with severe risk to patients or donors if unresolved; Inquest/ombudsman inquiry; Gross failure to meet national standards; Significant uncontrolled erosion of performance or process which has a serious effect on the quality and safety of components produced. Fatal, life threatening, disabling, prolonged hospitalisation, incapacitating the donor or patient if transfused: (SABRE)
08 Reputational *Adverse publicity/ reputation*	Potential for public concern	Local media coverage; Minor reduction in public confidence	Local media coverage; Moderate reduction in public confidence	National media Coverage with <3 days service well below reasonable public expectation; Major reduction in public confidence	National media Coverage with >3 days service well below reasonable public expectation; Gross loss of public confidence
09 Research and Development	Departure from: Established good practice guidelines, and/or Procedural requirements	Departure from: Applicable legislative requirements, and/or Established Good Clinical Practice (GCP) guidelines, and/or	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "major" and/or "other" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" and/or "major" that leads to recommendations of:	Deficiencies found during regulatory MHRA Good Clinical Practice inspections graded as "critical" that leads to recommendations of: Communication of the critical findings to external parties, for

RISK DOMAINS	Impact, consequence score (severity levels) and examples.				
	1 NEGLIGIBLE	2 MINOR	3 MODERATE	4 MAJOR	5 CATASTROPHIC
	has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan; Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals; For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees; Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions; Infringement Notice; Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution.
10 Safety *Impact on safety of patients, staff or public (physical or 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	Moderate injury requiring professional intervention; Requiring time off work for 4-14 days	Major injury leading to long-term incapacity /disability; Requiring time off work for >14 days	Incident leading to death; Multiple permanent injuries or irreversible health effects

			by 1-3 days	Increase in length of hospital stay by 4-15 days	Increase in length of hospital stay by >15 days	
				RIDDOR/agency reportable incident	RIDDOR/agency reportable incident	RIDDOR/agency reportable incident
				An event which impacts on a number of patients or donors	Mismanagement of patient or donor care with long-term effects	An event which has an effect on a large number of patients or donors
11	Workforce and OD Human resources/ organisational development/ staffing/ competence	Short term low staffing level that temporarily reduces service quality (<1day)	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 Very poor staff attendance 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 Very poor staff attending mandatory training /key training on an ongoing basis

DETAILED DEFINITIONS OF 7 LEVELS OF EVALUATION TO DETERMINE RAG RATING / OPERATIONAL   SUMMARY STATEMENTS OF 7 LEVELS

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time i.e., 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement also of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of several agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

RAG rating	SUMMARY
7	Improvements sustained over time - BAU
6	Outcomes realised in full
5	Majority of actions implemented; outcomes not realised as intended
4	Increased extent of impact from actions
3	Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes
2	Symptomatic issues being addressed
1	Actions for symptomatic issues, no defined outcomes
0	Enthusiasm, no robust plan

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WELSH BLOOD SERVICE QUALITY SAFETY AND PERFORMANCE REPORT

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Peter Richardson, Head of Quality, Safety and Regulatory Compliance, WBS
PRESENTED BY	Alan Prosser, Director WBS & Peter Richardson, Head of Quality, Safety and Regulatory Compliance
APPROVED BY	Steve Ham, Chief Executive

EXECUTIVE SUMMARY	This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between December 2023 and March 2024, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements. The committee's attention is drawn to the following key points:

	- This period saw continued pressure on red cell stock levels, which resulted in several stock alerts being issued. The service requested mutual aid from other UK blood services over the Christmas period but avoided this during January to March 2024. A task and finish group has been set up to identify and address the key underlying factors. - Four Incidents were reported to regulators under the Serious Adverse Blood-Related Events (SABRE) scheme. These included two incidents where donors had been incorrectly assessed as suitable to donate. The Welsh Blood Service team are working with other Blood Services to review and simplify the donor screening process and looking at options to introduce digital solutions for decision support. - Bone marrow and stem cell collection activity has decreased slightly over the reporting period compared with the previous. The Donor Engagement team have commenced targeted recruitments activities for stem cell donors in partnership with educational establishments which have resulted in over 1,500 new donors registering.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee are asked to **NOTE** the information in this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Welsh Blood Service Senior Leadership Team - DRAFT	10/04/2024
Executive Management Board	29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

Page 2 of 28

The Senior Leadership Team at the Welsh Blood Service have considered the report and noted key issues.

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the **"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES	
1	**WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT** **December 2023 to March 2024**

ACRONYMS	
WBS	Welsh Blood Service
WTAIL	Welsh Transplant and Immuno-genetics Laboratories
MHRA	Medicines and Healthcare products Regulatory Agency
IQSH	Integrated Quality & Safety Hub
SAE	Serious Adverse Events
CA/PA	Corrective Action/Preventative Action
SABRE	Serious Adverse Blood Reactions & Events
UKAS	United Kingdom Accreditation Service
DPIA	Data Protection Impact Assessment
JPAC	UK Blood Services Joint Professional Advisory Committee
H&S	Health & Safety
UK NEQAS for H&I	UK National External Quality Assessment Scheme for Histocompatibility & Immunogenetics
PTR	Putting Things Right Regulations

1. SITUATION

This paper is to provide the Quality, Safety & Performance Committee with an update on the key quality, safety and performance outcomes and metrics for the Welsh Blood Service for the period December 2023 to March 2024.

The Quality, Safety & Performance Committee are asked to **NOTE**:

- Performance against the six domains of Quality.
- Issues, corrective actions and monitoring arrangements in place.
- Service developments within WBS.

BACKGROUND

This report is a summary of key operational, quality, safety and performance related matters being considered by the Welsh Blood Service between December 2023 and March 2024, and has been prepared in readiness for Velindre University NHS Trust Board and Committee governance arrangements.

The report also highlights key programmes taking place across the Division.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The main report summarises:

- Key performance outliers and associated actions to resolve.
- Key quality and safety related indicators and remedial action identified.
- Feedback from Donors and the responses to it.
- Regulator and Audit Feedback, assurance and learning themes.
- An outline of key service developments in WBS.

3.1   Triangulated Analysis

The report provides assurance to the Quality, Safety and Performance Committee that WBS is continuing to meet its Quality, Safety and Performance standards. In summary, for the reporting period (December 2023 and March 2024):

- All clinical demand was met for red cells and platelets although over the Christmas period mutual aid was requested due to sustained collections and higher than expected demand from hospitals.

- The service issued notice to hospitals of Blood Shortage Alerts 5 times during December, January, February and March, indicating the supply chain is under particular strain.
- The introduction of targeted campaigns to recruit stem cell donors through the use of buccal swabs is showing great promise with a significant increase in donor recruitment during the reporting period.
- Closure of quality incidents within the required 30 days has remained stable and consistently achieved between 92% and 94% for the whole reporting period.
- During the period 4 Serious Adverse Events were reported to the Medicines and Healthcare products Regulatory Agency (MHRA) via the SABRE portal. No incidents were reported to the Human Tissue Authority.
- 23 concerns were reported during the period, 22 of which were managed within timeline as early resolution as detailed in the report.
- Overall donor satisfaction dipped slightly but continues to exceed target at 95.9% over the reporting period.
- No external regulators have visited WBS during the reporting period. During April 2024 WBS experienced its first audit to the updated general requirements for the competence of proficiency testing providers as set out in ISO 17043:2023. This audit will be reported in more detail during the next reporting period, but the inspectors found very good levels of compliance overall and no serious deviations from the new standards.

3.2 Key Actions / Areas of focus during next period

Quality and safety and donor experience remains at the heart of our service during this period in all aspects of service delivery as well as the well-being of our staff. During the next reporting period the following areas will continue to be a priority:

- Continue to monitor and grow blood stocks by implementing the actions identified by the task and finish group set up in response to the high number of stock alerts issued in the past 12 month.
- Review and consider the findings of the independent review of the Red Cell Immuno-haematology service.
- Continue to work with transfusion labs and clinicians nationally to pursue prudent use across NHS Wales.
- Continue to improve the number and diversity of bone marrow and blood donor volunteers through continued promotion of buccal swabs.

- Implement the identified preventative actions for the incidents relating to donor screening.
- Consider recommendations of the Infected Blood Inquiry report due to be published May 20th 2024.

3.   SUMMARY OF MATTERS FOR CONSIDERATION

4.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☒ ☐ ☐ ☐	
RELATED STRATEGpIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* [STRATEGIC RISK DESCRIPTIONS](#)	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
	[Please include narrative to explain the selected domain in no more than 3 succinct points].
	This report summarises the Welsh Blood Service performance across all six domains of quality and is divided into sections covering each domain.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. Paper is for noting and therefore out of scope of the legislation

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **Source of Funding**: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change**

	Choose an item Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	No specific actions identified
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text *[In this section, explain in no more than 3 succinct points what the legal implications/ impact is or not (as applicable)].*

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

WELSH BLOOD SERVICE - QUALITY, SAFETY & PERFORMANCE COMMITTEE REPORT

December 2023 to March 2024

INTRODUCTION

This paper outlines the key Welsh Blood Service Quality, Safety and Performance related issues being monitored, reviewed and acted upon within the service and is aligned with the Six Domains of Quality as defined by the Institute of Medicine namely:

1. Safety
2. Effectiveness
3. Patient-centeredness
4. Timeliness
5. Equity
6. Efficiency
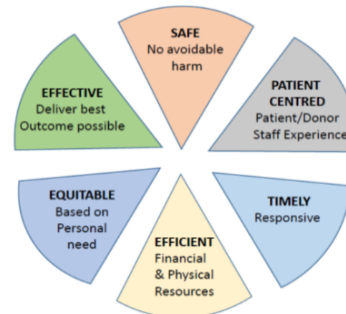
1. Safety

Incidents linked to donors are reported into the Donor Quality and Safety Group and scrutinised at the Divisional Integrated Quality and Safety Hub. These include failed venepuncture where a needle is not properly sited in a vein, and part bags where a donation stops before the full quantity is collected. The All Wales precentage of failed venpuncture events in whole blood donors remained stable and within tolerance during the reporting period. For apheresis, following an increase in venepuncture events, such as pain and/or bruising during the early part of the year the number of incidents has continued to fluctuate during the reporting period, however the precentage of events reported in November has reduced significantly. The increase in events reported in Apheresis has been attributed to new team members undergoing training.

1.1 For reporting purposes, WBS sub-divides incidents into two types:

- **Good Manufacturing Practice (GMP) Incidents**, in which our routine process monitoring and checking identifies non-compliance with expected processes or outcomes and responds to prevent further processing or harm to patients. These are reported into the Q-pulse

electronic Quality Management System and monitored as a critical part of the overall Quality Management System (QMS) in line with regulatory standards.

- **Incidents which may lead to redress or could result in harm to donors, patients, or staff** – these are reported in Datix Cymru for consistency across the Trust.

For the reporting period December 2023 to March 2024:

128 GMP incidents were reported via QPulse. These incidents were all closed, i.e. reviewed and Corrective/Preventative Actions (CAPA) assigned, within 30 days.

Quality incident investigations continue to exceed the target of 90% closed within 30 days. Performance is closely monitored with each (QPulse) incident report being reviewed within a working day of being reported, to ensure all information needed for effective risk assessment and investigation is captured. The review identifies complex investigations that may need multi-disciplinary support to establish a root cause.

All QPulse incidents have been reviewed by Quality Assurance (QA) and all rationales and risks of late reporting have been assessed by the QA team and recorded in QPulse; where the rationale has not been deemed satisfactory this has been fed back to the reporter and relevant department head.

The progress of all actions to address incidents is closely monitored. The Quality Assurance (QA) team send weekly updates alerting owners/managers of actions recorded within QPulse that are likely to breach close-out deadlines.

30 quality related incidents were reported in Datix Cymru; 1 of these (Datix 15637, relating to a temperature deviation in the ambient blood store) was initially classified as a moderate risk, but downgraded to low risk on investigation. It was noted that the original classification did not align with the definitions of harm detailed in the PTR regulations framework. The reporter was advised accordingly.

All other reports were classified as low risk for actual harm.

1.2 Areas of focus:

The WBS Senior Leadership Team continue to focus on the number of incidents overdue for closure within Datix; a sustained improvement was noted from December to February, however at the end of March the total number of records overdue for closure had risen to 13 (from 1 the previous month).

A Task & Finish group was set up earlier this year to investigate the cause of delays within the incident management process. This group has identified several challenges which need to be addressed including a lack of clarity about the process and ownership of the different incident management stages. For example, there is often a significant delay between the date the event was reported and the date the Datix record was opened (reviewed), suggesting managers are not accessing and reviewing the reports in a timely manner. This may, in turn, delay investigation. It has also been noted that some reports have several investigators assigned which could result in a misunderstanding of who owns and is responsible for the investigation.

To address the above issues QA Systems will arrange a series of workshops with relevant departments; these will be designed to ensure the process of reviewing and moving reports through each stage is fully understood and owned by the correct department. It is hoped these workshops will commence in April, but QA capacity may be limited due to staff availability and commencement of the new eQMS project.

5 incidents reported via QPulse had a significant risk rating and were subject to a detailed root cause analysis investigation; one of these was externally reportable and is included in the table under section 1.4:

IR-950 (INV-923), reported externally as SABRE 115. **Lost traceability of a pooled platelet:** Platelet pool sent to a customer hospital without being issued via eProgesa (the Blood Establishment computer system). This error was not noticed at the time of issue.
Status: RCA investigation undertaken. Corrective and Preventative Actions (CAPA) have been agreed and assigned.

IR-981 (INV-953) Red cells not placed in correct storage conditions overnight.
Status: RCA investigation undertaken. CAPA complete, effectiveness checks ongoing.

IR-992 (INV-969) Red cells delivered to wrong hospital; blood was issued correctly but inadvertently packed into a box destined for another hospital. This error was identified by the receiving hospital.
Status: RCA investigation undertaken. CAPA complete, effectiveness checks ongoing – noting the similarity with IR-950 above.

IR-993 (INV-970) Lack of a system retirement plan for GMP critical equipment (semi-automated blood grouping system).
Status: RCA investigation complete. Several contributory factors identified. CAPA agreed and in progress (including execution of a retrospective system retirement plan).

IR-999 (INV-973) Failure of the Environmental Monitoring System back up process (ProLog application).
Status: RCA investigation complete**.** The error was caused by corruption of the data-processing function of the primary server which has since been replaced.

- Main categories of incidents reported via Q Pulse were Blood Pack Incidents (42%), Laboratory Errors (26%).

- The main locations reporting incidents continue to be Distribution (Hospital Services), Manufacturing Laboratory and the Stock Holding Unit (SHU), although it should be noted that some of the issues reported by Manufacturing have originated at donation clinics.

- There were 25 overdue actions recorded in QPulse at the end of the reporting period, which is 16 more than the previous month. Actionees were notified and 16 of these have since been closed.

1.3 Regulatory Inspections

There have been no regulatory inspections within the reporting period. MHRA were due to undertake an inspection of WBS South Wales operations in June 2023, but to date a notification of inspection has not been received.

The United Kingdom Accreditation Service audited the Welsh Assessment of Serological Proficiency scheme in April 2024 against the updated general requirements for the competence of proficiency testing providers as set out in ISO 17043:2023. Further details will be provided in the next reporting period, but do major deviations were reported and the auditors advised that compliance to the newly-updated standards is very good and re-accreditation will be recommended.

1.4 Serious Incidents Reportable to Regulators

There were 4 reportable events submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in this reporting period (see summary table below).

Each incident has been investigated by a multi-disciplinary team involving subject matter experts and members of the Clinical and Quality teams. Root cause analyses and corrective actions have been reviewed by the divisional Integrated Quality and Safety Hub before submission to the relevant regulator. Two investigation reports have since been reviewed by MHRA and closed within the SABRE reporting system, two are still under investigation by the WBS Clinical Governance team.

SLT and MHRA were informed of delays to the submission of 2 confirmatory reports (expected within 30 days of notification). The delays have been caused by complexity of the

investigations and the need for a multidisciplinary approach, along with the ongoing blood collection shortage.

A summary of SABRE incidents reported in this period are included in the table below:

Incident Summary	SABRE reference	Frequency	Notes
Platelet issued to a customer hospital without being recorded via eProgesa (the blood establishment computer system).	115	1	The person undertaking the issuing process was interrupted whilst carrying out a critical task; although interruptions are discouraged, they are unavoidable at times, due to the busy nature of the Hospital Issues department. A gap has been identified versus the process undertaken in the receiving Hospital Blood Bank, i.e. checking donation numbers against the corresponding delivery note. This gap has been rectified through a process update. The Head of Manufacturing & Distribution has introduced regular good practice update sessions for staff, this includes learning from events of this nature.
Donor's tropical virus risk not fully assessed.	116	1	This root cause of this event is similar to previous SABRE reportable events where root cause is attributable to the complexity of the donor assessment process (*see note below).
Donor bled into incorrect blood pack. As the donor had declared taking aspirin within 48 hours of donating their blood was unsuitable for processing into a pooled	117	1	Investigation has identified 16 previous occasions where incorrect pack selection was not identified for donors whose blood was unsuitable for processing into a pooled

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platelet. The selected pack would have allowed processing; however eProgesa prevented this as a failsafe was introduced as part of the most recent system update.			platelet (prior to the computer failsafe being introduced). Investigation into root cause is ongoing, but it is recognised that correct pack selection is reliant on staff choosing the correct pack from two visually similar options.
A donor has previously been assessed as eligible to donate, despite declaring a serious illness (cancer of the kidney).	118	1	This error was detected when the donor called WBS, whilst completing the online donor eligibility quiz, to query why they had been previously accepted to donate. A product recall and lookback were initiated. The donor has been permanently deferred.

* Note: The Standing Advisory Committee on the Care and Selection of Donors (SACCSD) were notified of the WBS concerns with the complexity of decision making using the national guidance on travel-related screening. SACCSD have subsequently agreed to review these guidelines and WBS continues to work with the other UK Blood Services to review and potentially simplify the donor eligibility assessment process. In the meantime the Clinical Services team continue to review donor eligibility assessments each day.

No reportable events were submitted to the Human Tissue Authority during this reporting period.

2. Effectiveness

2.1 Blood Supply

2.1.1 The WBS strives to carefully balance demand with supply, whilst prudently holding enough stock by blood group at its centre in Talbot Green to support the NHS Wales system at times of emergency whilst keeping wastage levels to a minimum. The supply chain is complex and dynamic and is managed carefully on a daily basis by key parts of the operation.

2.1.2 In common with all UK Blood services, the Welsh Blood Service has experienced pressures on blood stocks over the past 2 years, in particular O D Negative red cells. Contributing factors include:

- significant and unexpected variations in demand
- diversion of resources to support the training of newly-appointed vene-puncturists,
- higher than expected levels of short and long term staff sickness,
- a reluctance of staff to volunteer for overtime shifts.
- specific operational issues such as an IT outage, rainwater leaks in mobile collection vehicles and last-minute withdrawal of booked venues.

In addition, the continued spread of West Nile Virus in Europe has led to increases in donor deferrals based on recent travel.

During December and the run up to the extended bank holiday period the service took the difficult and reluctant decision to request mutual aid and was supported by both the Northern Ireland and English Blood Services (total 270 red cell units), to prevent an AMBER alert for NHS Wales.

2.1.3 Since December 2023 various blue alerts (now Pre-Amber) have been sent for O D Negative red cells, and at times these alerts also included O D Positive and A D Negative red cells. The table below shows the dates, blood group, recovery date and duration of days these blue alerts were in place.

Year	Blood Shortage Sent	Group	Alert	Blood Shortage Recovered	Duration in alert (days)
2023	04/12/2023	O D Negative	Blue	25/01/2024	52
2023	18/12/2023	O D Positive	Blue	11/01/2024	24
2024	07/02/2024	O D Positive	Pre Amber	20/02/2024	13
2024	21/03/2024	O D Positive	Pre Amber	08/04/2024	18
2024	21/03/2024	O D Negative	Pre Amber	08/04/2024	18

2.1.4 Supply Chain capacity task and finish group:

In response to the number and duration of alerts issued to hospitals in recent months, a small task and finish group has been set up to look at the factors affecting collection capacity and find effective solutions. The focus has been on registered nurse capacity as a result of staff turnover and the extended training period required to demonstrate competence in donor screening.

With newly recruited staff completing their training and with SLT approval to recruit 2 additional nurses to provide for resilience, the collection team capacity is now returning to the levels needed to maintain collections. Along with a number of additional overtime clinics over the Easter bank holiday and at weekends throughout April, stocks of all blood groups are once again approaching the target levels of 6-7 days' cover. This will give greater assurance as we approach the early and late May bank holidays.

In addition, from May 1st, WBS will introduce a screening test for West Nile Virus which will reduce donor deferrals by over 1000 over the peak summer period when compared with last year.

2.2 Bone Marrow / Stem Cell collections

Bone marrow and stem cell collection activity has decreased slightly over the reporting period with 18 collections being completed between December 2023 and March 2024.

A step-change in donor recruitment since January 2024 has resulted in an additional 1,831 new donors being added to the registry during the reporting period, with over 1,500 of those enrolling in February and March. This increase has been achieved through targeted recruitment activity in partnership with educational establishments and the use of buccal swabs to reach out to non-blood donors. The growth in recruitment has resulted in a slight processing backlog but work is underway to identify a digital solution to deal with the backlog.

2.3 Audit Summary

There were 23 internal audits scheduled for completion between December 2023 and March 2024; this includes Information Governance audits incorporated into the WBS internal audit schedule. These were undertaken by the Trust's Head of Information Governance.

8 of these audits were conducted later than expected due to auditor/auditee availability (these are now complete). The risk from late completion was assessed as low, due to coverage elsewhere within external and internal audits. The 2024-25 audit schedule has been reviewed to reduce the overlap between audits, allowing resources to be reallocated to areas where the risk is greatest.

The 2024/25 schedule has been reviewed by the Head of Quality, Safety and Regulatory Compliance and formally approved by the divisional Integrated Quality and Safety Hub.

2.3.1   Corrective and Preventative Actions Summary:

No critical findings raised.

2 major findings raised:

- **IA55:** ISO 15189 (Technical) audit conducted in Patient Services identified lack of assurance of cell washer and bench cleaning, due to omissions of entries on cleaning records. It is thought that these omissions occurred on days when the equipment was not used. Staff have been reminded of the importance of effective record keeping; monitoring of records completed since December has found all records to be as expected.

- **IA56**: raised against Software Development, due to a systemic breakdown in satisfactory completion of ad-hoc (database amendment) requests via ServicePoint. Issues identified within 5 out of 6 Ad-hoc requests have been observed to be actioned. Target Completion date: 29/04/2024.

Fortnightly meetings are held to discuss any open non-conformances and reminder e-mails are issued, and updates requested during these meeting.

2.3.2 Audit Corrective/Preventative Action (CAPA) Trending:

- No significant trends were identified in this reporting period.

- CAPA findings from December 2023 to March 2024 remain consistent with the 2022/2023 categories.

3. Service-User Centred Feedback

3.1 The introduction of CIVICA across WBS has seen a significant number of survey responses being received from donors about their real time feedback relating to their donation experience. Donor feedback between December 2023 and March 2024 is detailed below and demonstrates that our donor experience scores are consistently above the 95% benchmark.

3.1.1 Donors who have been referred by the Donor Contact Centre to the Clinical Services support team for help with eligibility queries or post-donation care and advice are selected at random for a follow-up survey:

Clinical Services

Responses	1 - The time taken to be contacted following the initial interaction was adequate	2 - The member of the Clinical Services support team introduced themselves in a warm and friendly manner	3 - The member of the Clinical Services support team made me feel at ease	4 - The member of the Clinical Services support team demonstrated knowledge and experience within their	5 - The member of the Clinical Services support team communicated effectively and used appropriate langu	6 - Appropriate and professional responses were given to the questions I raised	7 - I was actively listened to and was given the opportunity to ask questions	8 - Can we improve the service we provide? If yes please use the 'Other' box to tell us how	Overall
	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	Clinical Services	
68	100	100	100	100	100	100	100	97	100
Overall	100	100	100	100	100	100	100	97	100
Benchmarks	95	95	95	95	95	95	95	95	

3.1.2 As part of the Safe Care Collaborative, Donor Adverse Event Reporting project a donor survey was implemented to capture the feedback of donors following an adverse event. Donors who experience an adverse event are encouraged to provide feedback in relation to the information and care provided both during and post the event.

The aim of the Safe Care Collaborative project is to:

- Improve Donor Care Quality and Safety through ensuring the robust reporting and management of donor adverse events.
- Improve staff experience and systems associated with donor adverse event reporting.
- Reduce the pressure on wider healthcare services through the development of robust and clear care pathways, utilising clinical support available at WBS as opposed to unnecessary primary care or accident and emergency departments.
- Respond to all Donor Adverse Event Reactions (DAER) within the next working day of the event for 100% of donors, ensuring appropriate care is provided, by April 2024.

In January 2024 a number of the satisfaction scores fell below the 95% benchmark. Although the sample size was small (n=14) this was raised with the Collection Teams, resulting in overall satisfaction scores for February and March 2024 consistently exceeding 95%.

Donor Adverse Event Reporting (DAER)

Responses	1 - Based on your recent Complication/Adverse Reaction following blood donation, do you feel you receive	2 - Based on your recent Complication/Adverse Reaction, did you receive an explanation regarding why the	3 - Did you understand the explanation given? If answering No, to this question please use the other box	4 - Did you receive aftercare advice verbally from staff?	5 - Did you understand the aftercare advice you were given?	6 - Were you provided with an information leaflet(s) to support the advice given?	7 - Did you find the information leaflet useful? If answering No, to this question please use the other	8 - Did you feel you were cared for with dignity? If answering no to this question, please use the other	9 - Did you have the opportunity to ask questions?
	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)
5	20	52	-	-	-	50	-	-	-
21	90	56	100	82	100	82	100	100	100
Overall	77	55	100	82	100	77	100	100	100
Benchmarks	95	95	95	95	95	95	95	95	95

10 - Were you given a contact telephone number to obtain further support and advice?	11 - Were you informed that you would receive a follow up call?	12 - Did you receive a follow up call as described?	13 - Would the adverse event you experienced put you off donating in the future? If answering Yes to this	14 - Based upon the care you received following your adverse event would this put you off donating in the	Overall
Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	Donor Adverse Event Reaction Survey (DAER)	
-	-	-	-	-	38
100	100	86	89	89	90
100	100	86	89	89	86
95	95	95	95	95	

3.1.3 All donors are given the opportunity to feedback on their experience before leaving a donation session via a table-top electronic survey and or QR code. The overall satisfaction scores run at a consistent 100% well above the benchmark set at 95% as shown in the data attached below:

Collection Services

Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Based on today's visit did you find staff helpful & knowledgeable?	4 - Based on today's visit did you find staff professional, compassionate & caring?	5 - Based on today's visit do you feel you were treated with dignity & respect?	6 - Based on today's visit were you provided with enough information about the donation process?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Based on today's visit did you find a good standard of hygiene & cleanliness?	9 - Based on today's visit did you feel safe?
	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)
4309	98	100	100	100	100	100	100	100	100
Overall	98	100	100	100	100	100	100	100	100
Benchmarks	95	95	95	95	95	95	95	95	95

10 - Based on today's visit do you feel you were offered quality of care?	11 - Based on today's visit are you satisfied with the venue & facilities?	12 - Based on today's visit were you satisfied with the snacks and beverages available to you?	Overall
Compliments and Concerns (East B)	Compliments and Concerns (East B)	Compliments and Concerns (East B)	
100	99	99	100
100	99	99	100
95	95	95	

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3.2 Changes in response to Donor Feedback during the period of December 2023-March 2024.

In response to donor feedback the following actions have been taken:

- Several amends to donor records requesting changes to invitation patterns.
- Introduced changes to the filter options in the new donor portal based on feedback received.
- Clinic reintroduced to Blaenau Ffestiniog in clinic portfoliio at Canolfan Hamdden y Moelwyn
- We have reinstated venues at Rhiwbina, Llanishen and Thornhill into the collection plan to cover Cardiff North. There are also clinics held in Whitchurch and Velindre CC.

3.3 Concerns

3.3.1 In the reporting period of December 2023 to March 2024, 28,183 donors were registered at donation session with 23 concerns being recorded, this constitutes 0.08%. 1 formal concern was received from a whole blood donor regarding communication following inconclusive test results.

All concerns were managed within timeline, with the formal response being issued ahead of the 30-day deadline. Where contact with donor was unable to be achieved via telephone emails had been sent offering donors to contact relevant heads of departments if they wished to discuss their concerns further. No return contacts had been received at time of writing this report. All other concerns were resolved to the donors' satisfaction.

During this reporting period one theme has been noted, as below: -

1. **Concerns raised regarding donation clinics being cancelled at the last minute:**
   All donors have been reached out to, and they expressed appreciation for the communication. Regrettably, the last-minute cancellations were beyond service control.

3.4 WBS continues to invite every blood donor to complete a feedback survey via email in the month after their donation. The feedback highlights are:

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a. During the period December 2023 to March 2024, 3,600 responses were received (21.0% response rate)

b. Donor satisfaction for those who had successfully donated was 95.9%

c. In total 2,949 donors scored themselves as 'Totally Satisfied' and were invited to provide more details (82.8%).

d. Out of 3,600 responses, 59 donors (1.7% of responses) described themselves as 'Dissatisfied' or 'Totally Dissatisfied' and were invited to provide more details. The responses are analysed and followed up by the Collections Leadership team through their monthly operational service group.

e. WBS Business Intelligence team has calculated which survey metrics are statistically important to a positive donation experience. Of the questions asked, research found the measures and the degree of impact each measure has on overall satisfaction.

The new post-donation survey report now acknowledges these measures, helping staff to ensure the service improvements can be put in place, alongside donors, to improve donor satisfaction further.

Measure	Importance	Satisfaction score
Donor experience	40%	95.6%
Donation process comfort	14%	95.9%
Contact centre experience	14%	95.1%
Donation process duration	11%	96.7%
Making a donor feel valued	9%	94.7%
Venue cleanliness	5%	97.5%
Info. available on eligibility	3%	93.8%
Venue accessibility	3%	94.2%

4. Timeliness

4.1 Routine Antenatal Service Turn-around times (90% within 3 working days)

Routine Antenatal testing turnaround performance consistently met target, with monthly performance between 95% and 97% between December 2023 and March 2024

4.2 Reference Serology Turn-around times

Reference Serology 'turnaround' performance remains challenging with between 70% and 75% of results provided within 2 working days during the reporting period.

An specialist external review of the Red Cell Immuno-haematology service has been completed and the recommendations for improvement are under review by the Transfusion Laboratories management team.

4.3 Overdue activity performance trends

The following graph provides an overview of the overdue activity performance trends for incidents and preventive actions overdue for closure over the past year.

Trend of overdue GMP Incidents and Actions

	apr-23	mai-23	jun-23	jul-23	aug-23	sep-23	okt-23	nov-23	des-23	jan-24
Overdue Incidents from Datix	1	2	3	5	3	3	1	0	8	0
Overdue Actions from QPulse	11	15	6	8	16	10	10	11	6	17

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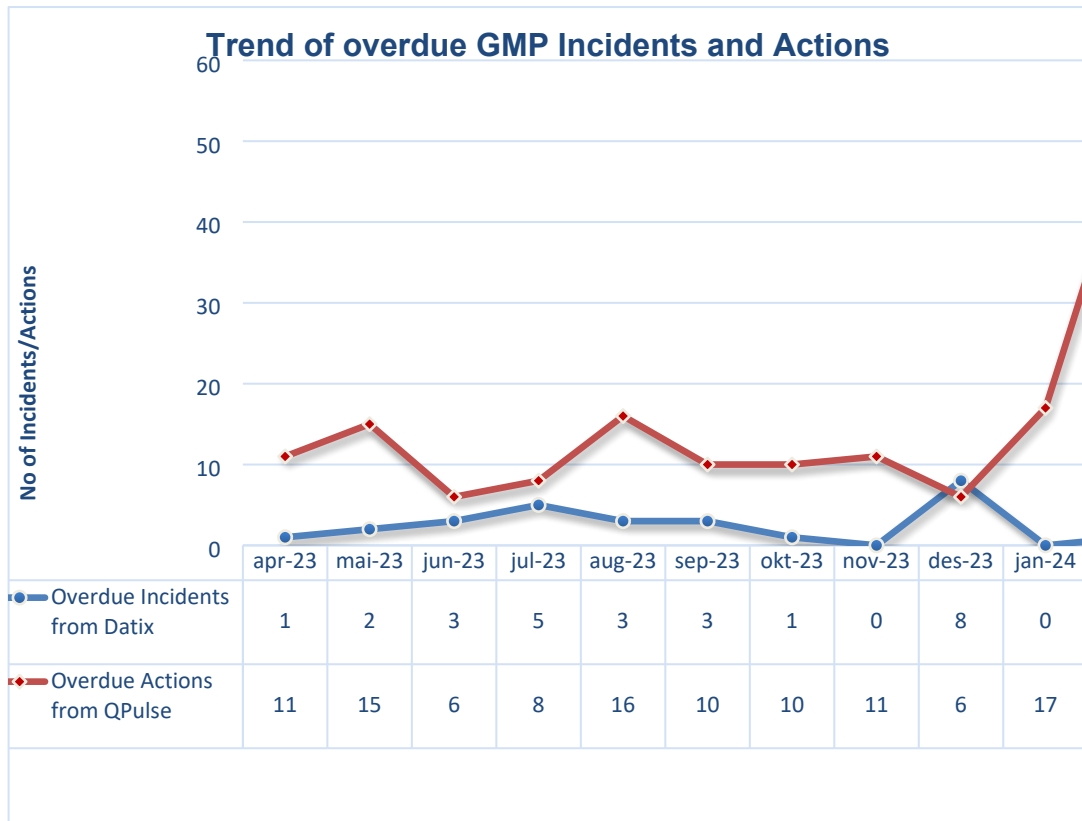
This downward trend in Datix GMP incidents open beyond the expected close out date ended in November. Since this time there has been an overall upward trend, with 6 Datix GMP related incidents overdue at the end of the reporting period, three have since been closed.

QA Triage will continue to engage with incident managers and investigators and share information with departmental managers and SMT, to help drive improvement in timely management of reports.

There were no quality incidents more than 3 months overdue in this reporting period.

4.4 Areas for focus:

A peak in overdue actions was noted in February. The cause of the peak is being examined; some may be due to inaccuracies in the recording of target dates for effectivity checks (which form part of the QA post CAPA monitoring process). This issue has been since been rectified.

QA Triage continue to adopt an 'early engagement' approach with action owners to help ensure deadlines can be met, or risk-based extensions are granted, and the team continue to engage with all operational departments to help recognise and address challenges to late completion.

Quarterly Corrective and Preventative Actions (CA/PA) effectiveness monitoring is ongoing for previously reported significant risk incidents; no concerns have been identified to date.

In addition, the WBS QA Triage Team monitor timely closure of non-GMP incidents reported via Datix Cymru. Where reports have not been progressed or closed in a timely manner the relevant personnel are advised and their Senior Manager is made aware. As described in Section 1.2

A Task & Finish group is investigating the cause of delays within the incident management process and a series of workshops will be held to ensure there is adequate ownership and understanding of the incident management process.

5. Equity

Recent donor feedback continues to indicate demand from donors to return to some of the more remote locations and to visit other locations more frequently. WBS continues to review clinic plans but the reluctance of some organisations to resume on-site collection clinics remains a challenge.

The donor engagement team have embarked on a series of stem cell donor recritment events in partnership with universities, schools and other educational establishments. The early indications are that in addition to a significant inrease in overall recruitment numbers, around 21% of these new donors come from minority ethnic groups.

6. Efficiency

6.1 Whole Blood Collection Efficiency (Target 1.25 units by WTE per hour)

Collection productivity has remained below target part from during January 2024. Contributory factors influencing the recent performance include:

- Reduced clinics duration due to short notice sickness absence.
- High numbers of staff turnover and staff in training has impacted staffing capacity at larger sessions.
- Delivery of Statutory & Mandatory training across all donor teams.
- Staff sickness in North Wales has limited some sessions to 2 donor chairs. Usually, these teams operate 4-6 donation chairs, depending on the venue size.

6.2 Manufacturing Efficiency (392 Components per WTE)

Manufacturing efficiency not met target during the reporting period. This metric reflects the levels of whole blood collections not matching the planned capacity for processing. find

6.3 Manufacturing Losses (Tolerance 0.5%)

Controllable losses remained low and below tolerance during the reporting period

6.4 Time Expired Red Cells (Target 1%)

Red cell expiry remains extremely low and within target, with monthly waste consistently between zero and 0.1%. This is a reflection of the challenges in blood stock levels.

6.5 Time Expired Platelets (Target 10% expired)

Platelet wastage performance continues to improve driven by changes to the production schedule for platelets and ongoing weekly reviews of demand trends. A formal platelet strategy project is now underway with workstreams looking at near to medium term forecasting, clinic planning and longer-term changes driven by clinical research.

Time-expired platelets has remained between 7 and 10% throughout the reporting period

Quality Safety and Performance Committee

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR MARCH 2023/24.

Date of meeting	9/05/24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

Prepared by	Peter Gorin, Head of Strategic Planning and Performance. Rachel Hennessy, Acting Director of Velindre Cancer Services, Sarah Richards, Head of Planning and Performance Services
PRESENTED BY	Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	**THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO MARCH 2023/24 ARE:** **Velindre Cancer Service** **SACT Services:** • At present it is not possible to confirm end of March position. SACT non-emergency performance continues to be challenging. In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group has been established reporting to a weekly SACT GOLD, chaired by Executive Director of Nursing. It is anticipated that these plans will positively affect performance by July 2024. **Radiotherapy Services:** • Radiotherapy performance for March was 94% for Scheduled, 85% for Urgent, 100% for Emergency and 100% for elective delay. All against a 100% compliance target. Improvement continues to be sustained. **Welsh Blood Service:** • All clinical demand was met in March. However, a pre-amber alert was issued on 2nd April following the two Easter Bank Holidays due to pressures on red cell stock and was lifted on 9th April. The service has stood up a Task & Finish Group that is examining key constraints to help stabilise supply and is considering workforce, on boarding/training of new staff, demand and supply, community venues and screening related pressures in the collection clinic model. • The recovery plan for bone marrow volunteer recruitment is showing encouraging results again for March since our launch of buccal swab drives in late January. Performance increased from 735 to 969 for March (against a target of 333). • Since January 2024, 2,022 new stem cell donors have been recruited. Of those who shared their ethnicity, 447 were classed as black, Asian, mixed, or from a minority ethnic background (21% against current population ethnicity data in Wales of 5.8%). **Financial Performance:** • The Trust reported a year end underspend revenue position of £0.030m for 2023-24, achieved the Capital CEL target by spending £31.002m against the £31.005m allocated, and achieved the PSPP target by paying 97.7% (target 95%) of non-NHS invoices within 30 days.

RECOMMENDATION / ACTIONS	**The Quality Safety and Performance Committee is asked to:** • **NOTE and DISCUSS the March 2024 Performance Management Framework** • **NOTE the targeted work being undertake through business continuity arrangements in respect of the delivery of SACT.**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WBS SMT / Performance Review	**15 April 2024**
VCS SLT / Performance Review	**20 April 2024**
Executive Management Board – Run	**29 April 2024**
Summary and outcome of previous governance discussions **The report has been considered and endorsed at the VCS and WBS Performance Review meetings and EMB and is presented to the QSP Committee for information and noting.**	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
1	**Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis**
2	**Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis**
3	**Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis**

ACRONYMS	
VUNHST	**Velindre University NHS Trust**
QSP	**Quality Safety and Performance Committee**
EMB	**Executive Management Board**

SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts

1. SITUATION AND BACKGROUND
VELINDRE NHST PERFORMANCE REPORT FOR MARCH 2024

The following section provides an overview of our Trust-wide performance against key national performance targets and best practice standards through to the end of March 2024 for the Velindre Cancer Centre, the Welsh Blood Service and for VUNHST Corporate Services respectively, as well as incorporating measures of patient and donor satisfaction, staff wellbeing, support functions and financial balance.

1.1 Cancer Centre Services Overview
Radiotherapy

94% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in March, a significant improvement in performance from 80% in February 2024 against a target of 100%.

Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment dropped from 88% in February 2024 to 85% in March 2024 against a target of 100%.

100% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%).

The implementation of the IRS has had an impact on capacity with the replacement of La5 concluding in March 2024, a planned increase in capacity for LA5 is scheduled through March and April, where the implementation of the Halcyon treatment unit breast solution will be fully deployed. The commissioning of LA5 provides resilience to the Halcyon fleet and increases capacity available from 12 hours per day to 22 hours per day by May 2024. As of 29/1/2024, La3 replacement programme commenced in readiness for installation of the first Ethos treatment unit planned for April 2024, thus reducing capacity on the Elekta units from a maximum of 44 hours per day to 34 hours per day.

A further reduction in Elekta capacity is planned from 1 May 2024 where La1 becomes end of life, thus reducing Elekta capacity to 24 hours per day. Plans are in place to mitigate the impact of the linac replacement programme, but this is expected to be challenging for the service.

There will be a stepped increase in Varian capacity as of August 2024 when La3 Varian Ethos becomes clinical.

Where developments/ upgrades, such as Aria 18 (April 2024), Elekta CCP or Identify version 3 are likely to impact on capacity a risk assessment is undertaken identifying appropriate mitigations to reduce the risk of breaching time to radiotherapy targets.

Where demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken and are booked according to clinical priority. Patients are prioritised and offered the first available appointment in response to the clinical urgency of their pathway- whilst considering the patients' needs and in accordance with the Access to treatment procedure.

All failures to meet WG time to radiotherapy targets are investigated at pathway level to identify maximum wait and delay reasoning

Through the All Wales Cancer Performance Management group, it has been established that the three Cancer Centres in Wales have historically utilised inconsistent data definitions for the Emergency Time to Radiotherapy measures. The agreed future definition will include measuring the 24 hour timescale from the point of receipt of the referral to radiotherapy. Velindre Cancer Centre has always adopted this measure, however other centres were measuring the time from when a patient arrived at a respective treatment centre.

SACT

Delivery of non-emergency SACT continues to be challenging. This is as a result of constrained pharmacy capacity against an increase in demand. Annual forecasting for inclusion in IMTP anticipated an increase in demand between 8%-12% over the next 12 months based on outturn at 31st March 2024.

We are not yet able to report the March 2024 position due to the pressures on day-to-day management of patients, therefore data to support the end of March position has yet to be fully validated and is expected to be available towards the middle of May 2024. The position at the end of February 2024 showed an improved position against January 2024. Emergency patients were all treated within the target of 5 days maintaining the 100% performance of the last 12 months. Non-emergency patient performance improved from 64% compliance to 79% compliance, with a drop in breaches from 160 to 95. This was delivered against a background of a continued increase in referrals with 457 patients referred in February, the highest single referral number in month ever recorded by the service. The January 2024 number of 443 referrals was the previous highest. Daily escalation meetings are taking place and patients are being clinically prioritised and will undergo a harm review where deemed clinically appropriate.

In response to this business continuity plans have been initiated. A weekly VCS SACT demand planning group has been established that has developed plans to increase capacity across the service and reports into a GOLD command meeting chaired by Executive Director Nursing, to give Executive oversight and support in respect of SACT performance. It is anticipated that these plans will positively impact performance by July 2024. Work is continuing with Digital Insight team to understand the demand for individual components of the service including oral and parental SACT, pharmacy, nursing and booking.

The greatest risk to achieving and sustaining our required level of performance relates to SACT Pharmacy provision. We have identified a number of mitigating actions. These include buying in pre-prepared SACT, additional third party support and increasing VCC pharmacy capacity to manufacture and dispense treatment agents. The team have been speaking with other SACT providers in Worcester and Swansea as part of a benchmarking exercise and have identified a number of key target areas of service redesign and process review to support improvements in pathway management and reduce waiting times for patients.

The longer term plan regarding TrAMs will provide increased long term resilience.

Pressure Ulcers
No pressure ulcers avoidable or unavoidable were reported for the second consecutive month.

Health and safety incidents
There were three Health and safety incidents for the second consecutive month which is the lowest since May 2023.

Delayed pathways of care
There was one patient with a delay of 19 days due to awaiting a nursing home placement.

Sickness Rate
The sickness rate dropped to 3.89% in the month of March, which is under the Trust 4.7% target.

1.2   **Welsh Blood Service Overview**

All clinical demand was met in March, however, a pre-amber alert was issued on 2nd April due to pressures on red cell stock and was lifted on 9th April. A Task & Finish Group has been established that is examining a number of areas in the collection clinic model.

Performance in quality incidents closed within 30 days continues to exceed target at 94% against a target of 90%. Two adverse events were submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) in March.

1. **SABRE 117: Datix 16313** – A donation unsuitable for use inclusion in a pooled platelet was mistakenly bled into a pack that permits processing into a platelet pool. There was no risk to patient safety as eProgesa prevented the pack from being processed. This restriction was introduced following a system update on 28/01/2024. As part of the incident investigation, it was identified that there were 16 occasions during 2023 when donations were inappropriately included in a pooled platelet, due to being bled into the wrong pack type. There have been no reports of adverse events relating to recipients and the WBS Consultant in Transfusion Medicine has concluded that there was no necessity to conduct a lookback on the affected donations or to notify hospital clinicians.

2. **SABRE 118: Datix 16440** – A donor advised WBS that they had previously declared cancer of the kidney but had been allowed to donate when a permanent donation deferral should have been activated. The permanent deferral is now in place. The investigation into root cause is ongoing and includes a holistic review of SABRE reportable events to analyse trends in root cause.

Donor satisfaction continues to perform strongly in March and remained at 97% (95% target). 6,567 donors were registered at donation clinics and 3 informal concerns were raised (0.04% of all donors registered). All 3 informal concerns were managed as early resolutions and responded to the donor's satisfaction within 48 hours.

All clinical demand for platelets was met representing a strong performance against this metric. Platelet wastage remains on target at 10%. There has been sustained improved performance against the platelet wastage target over the last 12 months which will be further supported by the review of the Platelet Strategy currently underway as part of WBS Futures.

At 1,573, new donor recruitment figures did not meet the quarterly target of 2,750. Throughout this quarter there have been prolonged periods of time where red blood cell stock of certain blood types has been below optimum levels. As such, the service has continued to prioritise regular blood donors with known blood groups to ensure continuity of supply. The result is a reduction in appointment availability for new first-time donors whose blood type is not known.

The total stem cell provision for the service in March was 5 (4 stem cell collections from Welsh donors and 1 cell product imported for Welsh patients) which was just below the service target of 7. The service continues to see a gradual increase in activity for the year with a final total of 53 (48 stem cell collections and 5 lymphocyte collection at year end) against a target of 80.

With the launch of the buccal swab drives in late January, the recovery plan for bone marrow volunteer recruitment is building. Performance increased to 969 for March (against a target of 333). The swab drives and online recruitment together resulted in 827 volunteers being added to the database with another 142 from blood donation sessions.

Reference Serology performance increased in month but remained slightly below target (80%) at 72% for March. Training and development of junior staff continues to influence performance against this measure as not all staff are fully operational to date. Training of 2 recently appointed staff is due to be completed in April 2025 and once completed is expected to have a positive impact upon performance for this measure.

1.2   Workforce and Wellbeing

Sickness
Current rolling sickness absence is 5.17% to March 2024, which is above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. A number of interventions to manage sickness are in place to mitigate the risk to staff wellbeing and there has been a downwards trend in sickness absence over the last 12 months. Work is ongoing with service managers to support staff.

PDAR's (staff appraisals)
Trust wide PADRs this month is 72% (target 85%). This is an improved performance over the last three months.

Statutory & Mandatory Training
Statutory and Mandatory training remains above target at 86% (target 85%) and has been consecutively on target for the whole year to date.

A full summary of workforce interventions to mitigate workforce risks and to support effective Supply and Shape of the workforce is summarised in the Supply and Shape Paper February/March 2024

1.3   Patient and Donor Experience
Velindre Cancer Centre uses two patient satisfaction surveys. In March performance against 'Would you recommend us?' was 96% and 'Your Velindre experience?' was 94% both set against the 85% target.

The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 96% for March which continues to meet the target (95%).

1.4   Digital Services
Limited change in performance in March 2024 when compared with previous months.

Target met (85%) in respect of % of IT incidents resolved within agreed response times. However, slight fall in performance in respect of the resolution of IT service requests, which fell slightly below target (83%).

Digital Service Desk improvement plan agreed – further improvements anticipated through 2024/25. Planning for implementation of a new IT Service Management tool has commenced. Deployment should improve performance across a range of service areas through efficiencies, task automation etc. as well as improve various regulatory and administrative activities – e.g. asset management.

Performance against rolling 12-month position for the number of significant IT business continuity incidents fell slightly in March 2024, increasing from 10 to 11. Overall trend is positive, however further work required to achieve target (6 incidents in a 12-month period). Work remains ongoing to remove / replace legacy IT infrastructure and improve the resilience across both the WBS and VCC sites. However, a significant number of legacy (Windows 7) client devices were removed in Q4 2023/24.

Reporting of performance in respect of the % of employees clicking on internal phishing campaigns/exercises has re-commenced, following the re-start of simulated phishing campaigns in March 2024. A regular calendar of simulated phishing campaigns has been established – data from 3 runs will be used to inform the PMF metric in terms of baseline, target etc.
Reporting arrangements for one indicator are still in development:
- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

A number of new metrics have been drafted, to demonstrate Trust performance against the various objectives set out in the recently-published Digital Strategy. Two **new indicators** are presented this month. A further three indicators will be introduced over subsequent months – see below:
The 5 measures are as follows:
- **% of outpatient consultations performed virtually (DIG.70)**
- **% of donors booking online (DIG.71)**
- % compliance with cyber security statutory & mandatory training – to be reported from May 2024 (April data)
- % of Trust expenditure in digital – to be reported from May 2024 (April data)
- Hours saved through digitisation / automation of paper-based manual processes – to be reported from June 2024 (May data))

1.5 Estates Infrastructure and Sustainability

March has been a busy month Planned Preventive Maintenance (PPM) and reactive tasks which are currently listed as under benchmark of 95% due to a number of staff sickness absences and staff taking end of year annual leave, furthermore the team has been supporting end of year capital works in Velindre Cancer Centre which were time critical for end of year financial spend.

The Trust have appointed a bureau (Team Sigma) to manage the validation of utility bills which will improve the management position. Recent events have hindered the availability of utility data which is largely due to the introduction of Energy Bill Relief Scheme (EBRS) which continues to be an issue with reporting data. This is becoming a month-on-month issue.

There have been some teething issues with the new NHS Wales gas & electricity suppliers. These are being worked through by the Trust and some of the utilities graphs contained in this document may be subject to change as a result of this.

Fire Safety KPIs are at acceptable levels with the exception of training, which is a constant challenge. New initiatives have been rolled out working closely with Education and Development Colleagues which is having a positive impact on performance, there is now sufficient training capacity to meet the needs of the organisation. Fire Safety Manager has continued to work with departments to improve training compliance through bespoke in person scheduling to suit departmental requirements.

Health & Safety Incidents are being reviewed for the annual plan where a pareto analysis is being developed. The item to note is module C training (Violence and Aggression) is currently listed as red, due to this being new course which is currently being rolled out to relevant areas. It is anticipated that this figure will rise with availability of training moving forward with a SMART action plan to address this area. Also, we have a downward motion this month for Violence and Aggression as we have fallen 10%. However there is work being completed to identify which divisions need targeting.

1.6   Finance

The overall final revenue position against the profiled revenue budget for 2023-2024 was underspent by **£0.030m.**

The final approved Capital Expenditure Limit (CEL) for 2023-24 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.** The Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target was achieved for 2023-24.

During March '24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97.7%** for 2023-24, and a Trust position (including hosted) also of **97.7%** compared to the target of 95%.

The Trust fully achieved the savings target of £1.8m during 2023-24, however, during July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status.

As previously disclosed the originally planned underlying surplus to be carried into 2024-25 had reduced from £0.391m to £0.086m as underlying recurrent cost pressures are forecast to exceed recurrent savings schemes. Further assessment of savings and cost pressures has meant that there is now no underlying surplus to carry forward to 2024-25.

In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of £2.5m during 2023-24 which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.

2. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR MARCH 2024

2.1   The Performance Management Framework (PMF) Scorecards, in this Section, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.
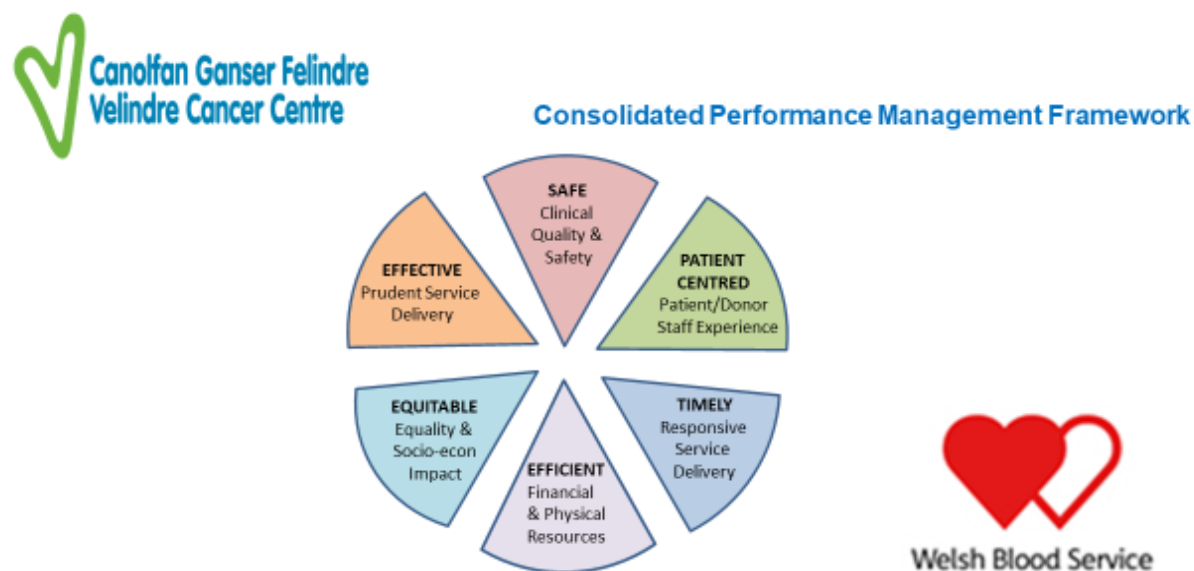
2.2   Navigating our PMF Performance Report
The following PMF Scorecards incorporate hyperlinks to supporting Key Performance Indicator (KPI) data and analysis, enabling switching between the high-level positions to detailed analysis provided in **Appendices 1 to 3**

Each QSF domain in the PMF scorecards is populated with a range of KPIs for VCC and WBS services plus a range of KPIs for Support Services functions. Performance is assessed as either 'within standard' ✔ or 'outside standard' ✘ against any particular target or best practice measure for the current month, plus an assessment of the 15 month 'rolling data trend' seen, as either 'improving' ⬆ or 'stable' ➔ or fluctuating ⬆⬇ or 'declining' ⬇ The actual performance for each KPI is measured against a national standard or local stretch target on a monthly, quarterly or annual improvement basis.

Quality Safety & Performance (QSP) Committee Scorecard as at March (Month 12) 2023/24

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	**National**	**Monthly**	87%	85%	86%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	**National**	**Monthly**	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	**National**	**Monthly**	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA Bacteraemia	**National**	**Monthly**	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA Bacteraemia	**National**	**Monthly**	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa Bacteraemia	**National**	**Monthly**	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp Bacteraemia	**National**	**Monthly**	0	0	1	✗	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	**National**	**Monthly**	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli Bacteraemia	**National**	**Monthly**	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	**National**	**Monthly**	0	0	1	✗	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	**National**	**Monthly**	1	0	0	✓	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	**National**	**Monthly**	100%	100%	99%	✓	→	KPV.08
	Number of National VCS Reportable Incidents recorded with Welsh Government	**National**	**Monthly**	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	**Local**	**Monthly**	0	0	2	✗	↓	KPI.30
	Number of Health and safety incidents recorded	**Local**	**Monthly**	15	0	14	✗	↑↓	H&S.55
	Carbon Emissions – carbon parts per million by volume	**National**	**Annually**	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓	→	EST.06

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 12 (March 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Pathway of Care Delays	National	Monthly	1	0	1	✗	→	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	94%	✗	↓	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	↑	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	121%	✓	↑	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	10%	✓	↓	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	5	✗	↑	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.17%	✗	↑	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%	✗	↑↓	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	96% 94%	✓	→	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	→	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A	✓	→	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	17% 94%	✗	↓	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 85%	✗	→	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	94% 100%	✓	↑	KPV.16

PMF Performance Report March 2023/24

QSF Domain	QSP Committee Performance Scorecard				Performance as at Month 12 (March 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	100% 100%	✓	⬆	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days **February position**	National	Monthly	98%	98%	79%	✗	⬆⬇	KPV.20
	% Patients Beginning Emergency SACT within 5 days **February position**	National	Monthly	100%	98%	100%	✓	⬆	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%	✓	⬆	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	97%	✓	⬆	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.030 m	✓	➡	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£31.00 5m	£31.00 2m	✓	➡	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.543 m	£0.775 m	✗	➡	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.8m	£1.8m	✓	➡	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%	✓	➡	FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	TBA	TBA	N/A	N/A	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.96%	✓	➡	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	5.74%	✓	➡	WOD.80
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	7.50%	✓	➡	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗   Cumulative data trend (15 months) = Improving ⬆ stable ➡ fluctuating ⬆⬇ deteriorating ⬇

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	

If yes - please select all relevant goals:
 • Outstanding for quality, safety and experience   ☒
 • An internationally renowned provider of exceptional clinical services ☐
   that always meet, and routinely exceed expectations
 • A beacon for research, development and innovation in our stated ☐
   areas of priority
 • An established 'University' Trust which provides highly valued ☐
   knowledge for learning for all.
 • A sustainable organisation that plays its part in creating a better future ☐
   for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text

	Scale of Change Please detail the value of revenue and/or capital impact: Click or tap here to enter text Type of Change Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/* *SitePages/E.aspx*	Not required - please outline why this is not required
	PMF report is focused upon monitoring performance against statutory and local stretch targets
ADDITIONAL LEGAL IMPLICATIONS / **IMPACT**	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

Number of VCC Inpatient Falls per month															
Target: 0 Avoidable															**SLT Lead: Head of Nursing**
Current Performance against Target or Standard															**Performance**

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul2 3	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual Number	2	0	4	2	0	3	5	5	3	5	3	6	8	2	5
Avoidable Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

No avoidable falls in March 2024.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

SPC Chart Inpatient Falls per month Target NIL (avoidable)

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months, with a 'special cause' variation of 9 falls in March.

Number of VCC Acquired Pressure Ulcers per month (Inpatients)															

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

Performance

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual Number	0	0	1	0	0	0	2	2	3	0	2	2	1	0	0
Avoidable Ulcers	0	0	0	0	0	0	0	1	0	0	0	1	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

There were 0 avoidable pressure ulcers in March 2024.

Service Improvement Actions – Immediate (0 to 3 months)

-Identified members of the nursing team to receive individual teaching/updates by the TVN. -Updated communications in the daily Big 4	**Timescale:** End of January 2024	**Lead: Ward Manager**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

SPC Chart Acquired Pressure Ulcers per month Target NIL

SPC Chart Analysis
The SPC chart shows common cause or normal variation, apart from Sept '22 over the last 15 months

KPI Indicator WOD.19

Statutory and Mandatory (S and M) Training Compliance														

Target: 85%													**SLT Lead: WOD Business Partner**	

Current Performance against Target or Standard

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	88	87	87	87	87	88	88	88	87	86	86	86	86	85	86
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

SPC Chart Analysis

The SPC chart shows common cause or normal variation averaging 86.5% against the 85% target, with the target being met for the last year.

Performance

Assessment of current performance, set out key points:
- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Continue to support managers in monthly 121's ensuring compliance is regularly reviewed	Ongoing	People and OD Team

Expected Performance gain - immediate
Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The Education and Development team will proactively work on the Stat. & Mandatory compliance framework in the All Wales network		Head of OD
The Senior Business Partners will report trends and updates monthly at division performance meetings highlighting hotspot areas for improvement.	Monthly	People and OD Senior Business Partner

Expected Performance gain – longer-term
Maintain and continue to improve on statutory and mandatory training compliance across the Trust and within the independent divisions.
Having well trained and developed workforce will ensure the safe and quality delivery of services across the Trust.

Risks to future performance

Set out risks which could affect future performance
- Future predicated concerns from IPC (i.e. COVID or outbreaks of other contagious illnesses) may affect staffing levels and ability to release staff to undertake training.

KPI Indicator KPV.07

Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)		
Target: NIL		**SLT Lead: Clinical Director**
Current Performance against Target or Standard		**Performance**

Incidence of Potentially (avoidable) Hospital Acquired Thromboses (HAT)

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Hospital Acquired Thromboses	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0
Target Nil	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assessment of current performance, set out key points:
On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve.	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Healthcare Acquired Infections (Inpatients)	
Target: NIL	**SLT Lead: Head of Nursing**
Current Performance against Target or Standard	**Performance**

Incidence of Healthcare Acquired Infections for the period Jan 2023 to March 2024

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
C.diff	1	0	0	1	0	0	0	0	0	1	0	1	0	0	0
MRSA	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
E.coli	3	1	0	1	0	1	1	0	1	0	0	0	0	0	0
Klebsiella	1	0	0	1	1	0	1	1	0	0	0	0	0	0	1
Pseudo Aerugi	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Gram Neg	4	1	0	3	1	1	3	1	1	1	0	0	0	0	1

Assessment of current performance, set out key points:
- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
- Reviewing individual cases using an MDT approach to identify any lessons to be learnt and training.	**To be completed within 2 weeks of positive result**	**IPCT**

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department		
Target: 100%	**SLT Lead: Clinical Director**	
Current Performance against Target or Standard	**Performance**	

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
VCS Hand Hygiene						100%	100%	99%	99.6%	100%	99%	100%	97.5%	98.9%	98%
WBS Hand Hygiene						100%	99.2%	99%					99.8%	99%	100%
Trust Hand Hygiene						100%	100%	99%					98.6%	99.4%	99%
IPC Validation						100%	100%	100%	99.4%	100%	96%		100%		99%
Target 100%	0	0	0	0	0	100%	100%	100%	100%	100%	100%		100%	100%	100%

Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by Department based on 20 weekly hand hygiene observations over the month

Plus Infection Prevention Control Team Validation Audits % compliance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: IPC
• Weekly validation audit by IPCT		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead: IPC
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

-

Number of National Reportable Incidents(NRIs) recorded with Welsh Government in a calendar month															
Target: NIL and as a % of Overall Activity (to be agreed)															

Current Performance against Target or Standard

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24
Actual NRI Recorded															
% NRI over VCS Activity															
Target NRI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target % NRI														TBA	TBA

[Currently under development]

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

SLT Lead:

PMF Performance Report March 2023/24

Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL		SLT Lead: Peter Richardson

Current Performance against Target or Standard	Performance

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	0	2	0	0	2	0	1	2	1	0	4	1	0	1	2
Target	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Performance

Assessment of current performance, set out key points:
Two adverse events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in March.

SABRE 117: Datix 16313 – A donation unsuitable for use inclusion in a pooled platelet was mistakenly bled into a pack that permits processing into a platelet pool. There was no risk to patient safety as eProgesa prevented the pack from being processed. This restriction was introduced following a system update on 28/01/2024.

As part of the incident investigation, it was identified that there were 16 occasions during 2023 when donations were inappropriately included in a pooled platelet, due to being bled into the wrong pack type.
There have been no reports of adverse events relating to recipients and the WBS Consultant in Transfusion Medicine has concluded that there was no necessity to conduct a lookback on the affected donations or to notify hospital clinicians.

SABRE 118: Datix 16440 – A donor advised WBS that they had previously declared cancer of the kidney but had been allowed to donate when a permanent donation deferral should have been activated. The permanent deferral is now in place. The investigation into root cause is ongoing and includes a holistic review of SABRE reportable events to analyse trends in root cause.

Incidents Reported to Regulator/Licensing

Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
0	2	0	1	2	1	0	4	1	0	1	2

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
The completion of Corrective Actions and Preventative Actions (CAPA), in respect of SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub.

Operational Managers are exploring opportunities to share learning through formal staff engagement sessions, to promote discussion | Progress is reported Monthly into the WBS Integrated Quality & Safety Hub. | Peter Richardson |

Expected Performance gain – immediate - N/A		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve Actions have been/will be introduced as outcome of Root Cause Analysis of these incidents is known.	**Timescale:**	**Lead:**
Expected Performance gain – longer-term - N/A		
Risks to future performance		
N/A		

KPI Indicator H&S.55

Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division															
Target: 0															

SLT Lead: Carl James

Current Performance against Target or Standard - Level

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
VCC	5	2	9	4	3	4	6	9	6	4	7	4	5	3	3
WBS	3	3	6	2	10	1	9	6	8	7	4	2	5	6	11
Corporate	0	0	0	2	0	1	0	2	0	0	0	0	0	0	3

Performance - remains stable

Service Improvement Actions – Immediate (0 to 3 months)

Actions	Timescale
All incidents investigated. H&S incident investigation training complete	

Expected Performance gain
Improved identification root causes VCC & Corporate
Improved data quality in incident records

Service Improvement Actions – tactical (12 months +)

Actions: As above	Timescale:

Expected Performance gain

Risks to future performance
 Incomplete incident investigation – ongoing monitoring

PMF Performance Report March 2023/24

KPI Indicator EST.06

% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025	**SLT Lead: Asst. Director of Estates**

Current Performance against Target or Standard	**Performance**

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual Number	212.01	179.31	187.06	130.20	111.83	86.13	85.33	86.37	85.36	105.00	117.56	137.40			
Target (-3% from previous year emissions)	217.2733	189.9079	194.9325	160.9681	130.2845	95.03259	99.91858	95.86	102.66	132.22	187.67	205.74			

Performance

Assessment of current performance, set out key points:
- Carbon footprint data comprises of electricity and gas
- The comprehensive carbon footprint (including procurement) is submitted to Welsh Government in September 2023.
- Issues have been raised during the transition form British Gas to EDF & Total Energies. Notably, meter reads. Therefore, these and consumption graphs for the previous 2 months may be subject to change and January's figures are incomplete

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Decarbonisation Action Plan • Site Based Sustainability Implementation Plan	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – immediate
Ongoing communication and engagement with staff to reduce consumption.
Amendments to the BMS across all sites for better controls.
Integration of Sigma into the billing & consumption verification process to better monitor carbon emissions.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• Continuing monitoring • Improvement to monitoring energy through the BMS	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term
Reduced carbon footprint
Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

Set out risks which could affect future performance
-

Chart — Carbon Emissions (Tonnes CO₂E) vs Financial Years (2018-2019 Totals, 2019-2020 Totals, 2020-2021 Totals, 2021-2022 Totals, 2022-2023 Totals). Legend: Carbon Emission Totals; Reduction-2% against Baseline.

We are currently 'on track' (blue line) to meet the Target of -16% Carbon Footprint/Emissions (Orange line) Statutory Regulations reduction by 2025 against 2018/19 baseline – measure carbon parts per million by volume

EFFECTIVENESS

KPI Indicator KPV.05

Number of Pathway of Care Delays															

Target: NIL		**SLT Lead: Head of Nursing**

Current Performance against Target or Standard		**Performance**

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual PoCDs Number	0	1	1	1	4	3	8	3	3	3	3	2	3	1	1
Days Delayed							32	19	43	73		5			19
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Assessment of current performance, set out key points:
There was 1 Pathway of Care delay reported in March2024

Patient 1: Delayed Transfer of Care with a delay of 19 days due to awaiting a nursing home placement.

Number of Pathways of Care Delays Target NIL

SPC Chart Analysis
The SPC Chart shows 'special cause' or exceptional variations in May and July for pathways of care delays.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer.	**Timescale:**	**Lead: Matthew Walters Operational Senior Nurse**
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve Meeting with Llais Cymru to discuss/address delays affected by social services and how Llais may be able to support improvement work in this aspect.	**Timescale:**	**Lead: Matthew Walters Operational Senior Nurse**
Expected Performance gain – longer-term		

Risks to future performance
Set out risks which could affect future performance

% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals, with no mutual aid required from NHSE	
Target: 100%	**SLT Lead: Jayne Davey / Georgia Stephens**
Current Performance against Target or Standard	**Performance**

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	106	103	104	104	97	110	105	102	95	101	107	97	109	106	94
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Performance

Performance reduced and was below target in March and is attributed to insufficient collections against demand. Factors affecting performance include a single exceptionally high demand week and the Easter bank holiday.

The average weekly demand in March was 1391 compared to February average of 1343 units per week.

PLEASE NOTE: this metric is under active review as part of the review of the WBS KPI's.

% Red Cell Demand Met

Apr-23 104%, May-23 97%, Jun-23 110%, Jul-23 105%, Aug-23 102%, Sep-23 95%, Oct-23 101%, Nov-23 107%, Dec-23 97%, Jan-24 109%, Feb-24 106%, Mar-24 94%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
The service constantly monitors the availability of blood for transfusion through its daily 'Resilience Group' meetings which include representatives from all departments supporting the blood supply chain. At the meetings, business intelligence data is reviewed and facilitates operational responses to the challenges identified.	Daily **Lead:** Jayne Davey / Georgia Stephens

Expected Performance gain - immediate.
Reviewed daily to support responses to changes in demand.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
T&F group set up to review capacity to collect whole blood and identify actions to increase it in the short and longer term.	TBC **Lead:** Jayne Davey

Expected Performance gain – longer-term   N/A

Risks to future performance

Set out risks which could affect future performance.
N/A

SPC Chart Red Blood Cell Demand Target 100%

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. Performance continues to fluctuate. However, the overall trend shows performance exceeding target.

Time Expired Red Blood Cells - number of red blood cells, excluding paediatric bags, which have a time expired, as % of the total number of red blood cell bags		
Target: Maximum Wastage 1%		SLT Lead: Georgia Stephens

| Current Performance against Target or Standard | | Performance |

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	0.21	0.05	0.02	0.05	0.7	0.42	0	0.02	0	0	0	0	0.01	0.01	0
Target Max 1%	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0

Performance

Assessment of current performance, set out key points:
There was excellent performance of this metric in March 2024, with no Red Cell expiry recorded.

Red cell shelf life is 35 days, with all blood stocks stored in blood group and expiry date order and issued accordingly.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale	Lead:
Balanced stocks for each blood group are managed through the daily Resilience meetings where priorities are set as needed. This supports the recovery of specific blood groups when they are at lower level but also minimises excess collections to minimise wastage. Robust stocks management system in place.	Daily (BAU)	Georgia Stephens

Expected Performance gain - immediate.
Continued effective management of blood stocks to minimise the number of wasted units.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale	Lead:
N/A		Georgia Stephens

Expected Performance gain – longer-term.
N/A

Risks to future performance
High stock levels lead to a risk of increased time expiry.

Time Expired Red Cell

SPC Chart Time Expired Red Blood Cells Target 1%

SPC Chart Analysis

The SPC chart shows common cause variation over the last 6-month period, with one 'special cause variation' in the month of May. However, the average performance of 0.15% remains well within the maximum 1%
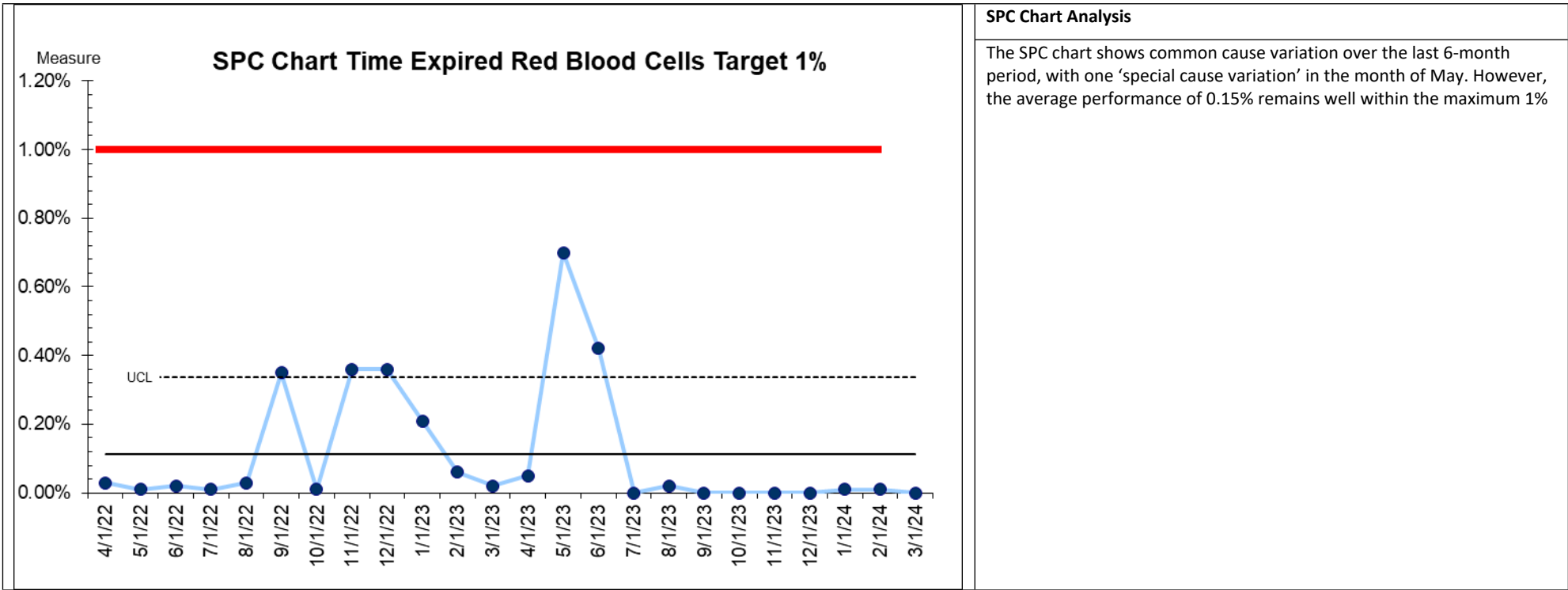
Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals															
Target: 100%														SLT Lead: Jayne Davey / Georgia Stephens	

Current Performance against Target or Standard															
	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	141	168	133	127	117	114	120	125	121	122	115	125	115	118	121
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

% Platelet Demand Met

NB: A value over 100% indicates sufficiency in supply over the month, whilst a value less than 100% would indicate shortage of platelets. High values will also increase time expiry of platelets.

Performance

Assessment of current performance, set out key points:
All clinical demand for platelets was met in March, representing continued strong performance against this metric.

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days.
Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.

Lead: Georgia Stephens
Timescale: Ongoing – Business As Usual

Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs. Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q1 2024/25

Timescale: Q1 2024/25

Lead: Georgia Stephens

Expected Performance gain – longer-term.
Optimised clinic collection plan for Apheresis and a forecasting tool to inform decisions around pooled platelet manufacture.

Risks to future performance
Fluctuations in platelet demand.
Advances in clinical practice and patient care which affect the platelet demand (if not communicated to WBS)

SPC Chart Analysis

SPC Chart Platelet Demand Target 100%

The SPC chart shows common cause or normal variation over the 15-month period. The average performance of 130% consistently exceeding the 100% target.

Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured	
Target: Maximum Wastage 10%	**SLT Lead: Georgia Stephens**
Current Performance against Target or Standard	**Performance**

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	23	25	20	10	8	9	12	12	11	11	10	10	9	7	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10

Performance

Assessment of current performance, set out key points:
At 10% performance deteriorated but met target for March for this metric. This is expected variance in this metric.

An overall improved performance has been sustained since April 2023 (as demonstrated by SPC chart).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead:
a. Daily monitoring of the 'age of stock' as part of the 'Resilience' meetings. b. A Platelet Strategy is being developed. This will sit under WBS Futures under the Lab Services Modernisation Programme. c. Develop a forecasting tool to inform decisions around pooled platelet manufacture. This action has been delayed due to insufficient capacity within the Business Intelligence Team.	Georgia Stephens **Timescale:** Daily (BAU) Timelines to be confirmed as part of WBS Futures

Expected Performance gain – immediate.
Controlled platelet production leading to reduced wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation	Q1 2024/25 **Lead:** Jayne Davey/ Georgia Stephens

Time Expired Platelets

(Bar chart values: Apr-23 10.00%, May-23 7.72%, Jun-23 9.00%, Jul-23 12.00%, Aug-23 12.00%, Sep-23 11.00%, Oct-23 11.00%, Nov-23 10.00%, Dec-23 10.00%, Jan-24 9.00%, Feb-24 7.00%, Mar-24 10.00%)

NB: Platelet production takes account of the average expected issues and is a balance to ensure sufficiency of supply where production occurs 2.5 days before platelets are available for issue. This means in shortage there tends to be over production. Decreasing production would reduce waste but increase the probability of shortage, which in turn may create a need to rely on mutual aid support.

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of work with the revised platelet strategy
expected to be delivered in Q1 2024/25

Expected Performance gain – longer-term.
Platelet expiry reduction using a risk-based approach, balancing
platelet expiry against ability to supply platelets for clinical needs.

Risks to future performance

Set out risks which could affect future performance.
Unexpected increases in clinical need - noting unexpected spike in
demand may require imports.
Future Bank holidays.

SPC Chart Analysis

The SPC chart which shows a significantly improved performance,
sustained since Apr. 2023.

SPC Chart Time Expired Platelets Target Max Wasteage 10%

Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target		
Target: 80 per annum		**SLT Lead: Deborah Pritchard**
Current Performance against Target or Standard		**Performance**

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Cumulative Actual	23	26	32	3	6	12	18	21	26	33	35	38	45	48	53
Cumulative Target p/a	70	77	80	7	14	21	28	35	42	49	56	63	70	77	80

Performance

4 Peripheral Blood Stem Cell (PBSC) collections and 1 import for a Welsh patient totalling 5 cell provisions for March is below Service target.

The financial year end total collections is 54 (against a target of 80) made up of 49 PBSC and 5 Donor Lymphocyte Infusion (DLI) collections.

The Service continues to experience a cancellation rate of approx. 25%-35% on average compared to 15% -20% for pre COVID levels. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

Stem Cell Collections

Legend: Stem Cell Collection in Wales — Stem Cell Projected Forecast

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
The WBMDR five-year strategy, re-appraising the existing collection model and its ambition, is being developed to support the ongoing development of the WBMDR. This is part of WBS Futures programme. A recovery plan has been implemented to improve recruitment of new donors to the Register which over time will increase the number of collections see KPI.20	**Timescale:** Q1 **Lead:** Deborah Pritchard

Expected Performance gain - immediate. As above

Service Improvement Actions – tactical (12 months +)

Implementation of the five-year strategy.	**Timescale:** 2024/25 **Lead:** Deborah Pritchard

Expected Performance gain – longer-term.
Improved recruitment of new donors to the Register which over time will increase the number of collections

Risks to future performance

Set out risks which could affect future performance.
Identified risks are being managed.

Staff Sickness levels against Target	
Target: National 3.54% Local Stretch Target 4.70%	**SLT Lead: WOD Director**
Current Performance against Target or Standard	**Performance**

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	6.24	6.36	6.22	6.06	5.99	5.84	5.71	5.70	5.75	5.70	5.63	5.50	5.35	5.28	5.17
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National 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	3.54	3.54

Assessment of current performance, set out key points:

There is a continued decline in sickness stats as the People and Relationship Team continue to support managers in the application of the MAWW policy.

Short-term absence remains relatively low across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Quarterly random sickness audits to be undertaken • ICT (closed) • RD&I(closed • Private Patients (Closed)	Ongoing	Head of Workforce
Detailed analysis of anxiety/stress/depression and other psychiatric illness to be undertaken		Head of Workforce

Expected Performance gain - immediate

Regular monitoring against the application of the policy will ensure our staff are supported and encouraged to improve their health and areas where there are concerns are provided with immediate interventions to improve practice.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months	30/04/2024	Head of OD
• Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan	Ongoing	Head of OD and Trust Board

SPC Staff Sicknesss National Target 3.54% Local 4.7%

SPC Chart Analysis

The SPC chart shows an improving trend over the last 7 months. However, the overall average 6.2% sickness level remains higher than the 3.54% target

	Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		

Expected Performance gain – longer-term
The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.

Risks to future performance

Set out risks which could affect future performance
- Not having enough staff available due to sickness absence could impact on delivery of services across the Trust
- Staff who feel unsupported during absence may chose to leave the organisation increasing turnover

Performance and Development Reviews (PADR) % Compliance															

Target: 85%															SLT Lead: WOD Director

Current Performance against Target or Standard — **Performance**

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	77	74	73	73	72	73	74	74	74	71	72	74	74	74	72
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Assessment of current performance, set out key points:

Since the implementation of the Pay Progression Policy over a year ago there has been no noticeable improvement in the progress towards achieving the target for PADR's. A full review of the policy, process and procedure is scheduled to take place by the People and OD Team in their work plan for 2024.

SPC Chart Analysis

The SPC chart shows a stabilising trend over the last 7 months. However, averaging 72%, consistently falling short of the 85% target.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	Timescale:	Lead:
Regular monthly monitoring and action plans are in place for hotspot areas.	Monthly	People and Relationship Team People and Development Trainers POD Senior Business Partners
PADR training for managers who undertake the process. SLT at all divisions are regularly reported to on compliance against targets, with action plans drawn up for hotspot areas	Quarterly / Monthly	

Expected Performance gain - immediate

With targeted interventions in hotspot areas that are continually preforming significantly below the expectations this should see a growth in the overall compliance within the Trust.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
The People and OD Team plan to launch a PADR review programme this year, considering the policy, procedure and current best practice in relation to annual reviews and performance management.	April 2025	Head of OD
NHS Wales are currently reviewing the All Wales Capability Policy for management of performance considers.	April 2025	Head of Workforce

Expected Performance gain – longer-term

A review of the current procedure will hopefully unlock the issues in relation to completing regular performance reviews and developing robust policies for performance management will ensure Staff and Managers are fully aware of Trust expectations to personal performance.

Risks to future performance

Set out risks which could affect future performance
- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

% of Patients that Rate Experience at Velindre at Good or above		
Target: 85%		**SLT Lead: Head of Nursing**
Current Performance against Target or Standard		**Performance**

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Would you recommend us? %	93	96	95	95	98	96	97	97	95	95	94	95	89	97	96
Your Velindre Experience? %	84	86	82	82	68	71	91	94	63	83	87	95	98	94	94
Target CIVICA 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

TARGET RATIONALE to ensure consistency
Friends and Family (would you recommend us?) target = good or above (Good + very good)

Very Good 92.45% = Good 3.77% = 96.22%

Your Velindre Experience target = good or above (good + very good +excellent)

Excellent (10/10) 74.47 + Very good (9/10) 14.89% + Good (8/10) 4.26 = 93.62%

Reset Target to CIVICA 85%

Performance

Assessment of current performance, set out key points:
There are two surveys used in VCC – 'Would you recommend us?' and 'Your Velindre Experience'.
The 'Would you recommend us?' survey uses categories such as Very good, good etc
The Your Velindre experience survey uses 0-10 in the question about rating VCC

Question 1: Overall, how was your experience of our service?

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	49	92.45%
Good	2	3.77%
Neither good nor poor	0	0.00%
Poor	1	1.89%
Very poor	1	1.89%
Don't know	0	0.00%
Total	53	100%

Question 10: Using a scale of 0 to 10 where 0 is very bad and 10 is excellent, how would you rate your overall experience?

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
10 (Excellent)	35	74.47%
9	7	14.89%
8	2	4.26%
7	0	0.00%
6	0	0.00%
5 (Neutral)	2	4.26%
4	0	0.00%
3	0	0.00%
2	0	0.00%
1	0	0.00%
0 (Very Bad)	1	2.13%
Total	47	100%

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback Directorates to develop plans to increase response rate. Q+S team to work with each directorate to provide further analysis on responses CIVICA working group established with attendees from each directorate Q+S team to review the difference in positive percentages for both surveys	**Timescale:** Ongoing Ongoing Ongoing	**Lead:** Head of Nursing/SLT SLT/Directorate Managers SLT/Directorate Managers Q+S manager
Expected Performance gain – immediate Introduction of the Civica Implementation group across VCC to increase participation across the teams		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback. This is currently ongoing.	**Timescale:** December 2023	**Lead:** Head of Patient Engagement
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance • insert text		

% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic															
Target: 95%															**SLT Lead: Jayne Davey**
Current Performance against Target or Standard															**Performance**

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	97	97	95	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3	96.7	96.5
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Assessment of current performance, set out key points:
At 96.5%, donor satisfaction is above target for March. In total there were 1,071 respondents to the donor survey, 183 from North Wales (scoring satisfaction at 97.6%), and 877 from South or West Wales (scoring satisfaction at 95.5%).

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
Findings are reported at Collections Services Monthly Performance Meetings (OSG) to address any actions for individual teams. 'You Said, We Did' actions are also reported.	Business as usual, reviewed monthly **Lead:** Jayne Davey

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	
Following analysis of the donor satisfaction survey from the Service Improvement team there are nine metrics statistically linked to the donor satisfaction score. These metrics are now being explored to evaluate if improvements can be made in these areas	**Timescale:** Q4 2023/24 **Lead:** Andrew Harris

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.
N/A

Donor Satisfaction

Number VCC formal complaints received under Putting Things Right within 30 days															
Target: 85%															

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	0	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:
- 100% of concerns for March responded to within the 30 day PTR time frame

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate
New Patient Experience and Concerns manager in post since June 2023 promoting instant access to deal with early resolutions or PTR concerns.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale															
Target: 100%													SLT Lead: Edwin Massey		

Current Performance against Target or Standard | **Performance**

WBS	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	100	100	N/A	N/A	N/A	N/A	N/A	N/A	N/A	100%	100%	N/A	N/a	N/A	N/A
Target 100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Assessment of current performance, set out key points:
The 1 formal concern received in February was closed in March ahead of the 30-day deadline (02/04/24).

% Responses to Concerns closed within 30 Working Days

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:** Ongoing
– Continue to monitor this measure against the '30 working day' target compliance. – Continued emphasis of concerns reporting timescale to all staff involved in concerns management reporting. – Work closer with relevant departments to ensure proactive and thorough investigations and learning outcomes. – Adherence to Duty of Candour requirements.	**Lead:** Edwin Massey

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:** Ongoing
Continue to monitor and have oversight of concerns management in line with PTR.	**Lead:** Julie Reynish

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

NB:
Performance against target only shown the month when a formal concern has been raised.
Under Putting Things Right (PTR) guidelines, organisations have 30 working days to address/close formal concerns. This can result in concerns being received and subsequently closed within separate reporting periods.

TIMELINESS

KPI Indicator KPV.14

Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	
Target: 80% within 14 Days and 100% within 21 Days	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Scheduled Elective RT COSC within 14 & 21 days

6% of RT patients (Mar) (13) breached the 100% referral to treatment within 21 days target

94% of RT patients (Mar) (36 + 162=198) met the 100% referral to treatment within 21 days target

Only 17% of RT patients (Mar) (36) met the 80% referral to treatment within 14 days target

Performance

Assessment of current performance, set out key points:
Ongoing challenges post DHCR in establishing a fully validated position. Validation resources currently insufficient to address range of issues identified.

Number of referrals	210	
treated within 14 days of referral (80% target)	37	17%
treated within 21 days of referral (100% target)	198	94%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		Lead:
Retraining for clinical teams to ensure categorising of the referrals is correct.	Ongoing	Helen Payne/Tom Rackley
Additional validation resources to be provided.	Ongoing Complete	Helen Payne Kathy Ikin
Care Path implemented and streamlining booking processes		

Expected Performance gain – immediate
Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale: October 2023	Lead: Tom Rackley
Pathway change group in place to address changes in process to meet revised patient journey timings with SST leads.		

Expected Performance gain – longer-term
Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance
Linac replacement programme which has commenced

Sickness absence levels in radiotherapy workforce

SPC Chart Analysis
The SPC chart analysis is not possible until well over 6 month's performance data available using the new Quality Performance Indicators to ensure the results are statistically valid.

Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	
Target: 80% within 2 Days and 100% within 7 days	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Current Performance against Target or Standard

Scheduled Urgent RT COSC within 2 & 7 days

15% of RT patients (Mar) (8) breached the 100% referral to treatment

85% of RT patients (Mar) (6 + 41 = 47) met the 100% referral to treatment within 7 days target

11% of RT patients (Mar) (6) met the 80% referral to treatment within 2 days target

SPC Chart Analysis

The SPC chart analysis is not possible until we have well over 6 month's performance data available using the new Quality Performance Indicators to ensure the results are statistically valid.

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals		55
treated within 2 days of referral (80% target)	6	11%
treated within 7 days of referral (100% target)	41	85%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		
As scheduled above.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

| Actions: what we are doing to improve	Helen Payne/	April 2024
Implementation of revised Urgent Symptom Control definition	Thomas Rackley	

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
-

PMF Performance Report March 2023/24

Emergency Radiotherapy Patients Treated Within 1 Day	
Target: 80% within 1 Day and 100% within 2 Days	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Current Performance against Target or Standard:

Emergency RT COSC within 1 day

6% (1) RT patient (Mar) treated within 48 hours

94% of RT patients (Mar) (21) met the 100% referral to treatment within 1 day target

SPC Chart Analysis

The SPC chart analysis is not possible until we well over 6 month's performance data available using the new Quality Performance Indicators to ensure the results are statistically valid.

Performance:

Assessment of current performance, set out key points:

Target Achieved

Number of referrals	22	
80% treated within 1 day of referral	21	94%
100% treated within 2 days of referral	22	100%

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
• As scheduled above.	

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	
Target: 80%	**SLT Lead: Head of Radiation Services / Clinical Director**
Current Performance against Target or Standard	**Performance**

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment.
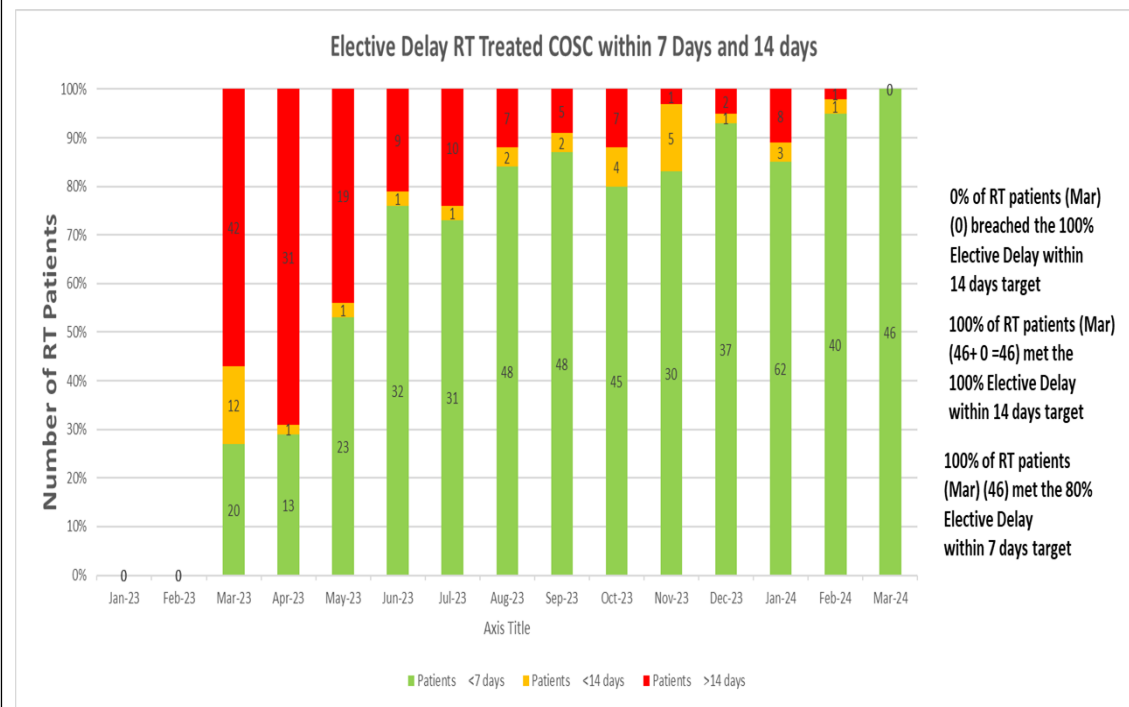
Elective Delay RT Treated COSC within 7 Days and 14 days

0% of RT patients (Mar) (0) breached the 100% Elective Delay within 14 days target

100% of RT patients (Mar) (46+ 0 =46) met the 100% Elective Delay within 14 days target

100% of RT patients (Mar) (46) met the 80% Elective Delay within 7 days target

SPC Chart Analysis
The SPC chart analysis is not possible until we well over 6 month's performance data available using the new Quality Performance Indicators to ensure the results are statistically valid.

Assessment of current performance, set out key points:
Issues as Scheduled elective patients above

Number of referrals	46	
treated within 7 days of referral (80% target)	46	100 %
treated within 14 days of referral (100% target)	46	100 %

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
• As scheduled above.	

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	
•	

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

Non-Emergency SACT Patients Treated Within 21-Days

| Target: 98% | SLT Lead: Head of Medicines Management and SACT |

Current Performance against Target or Standard

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	97	98	98	93	90	90	94	92	90	98	85	90	64	79	N/A
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98
More than 21 days	9	9	8	26	40	40	25	32	35	10	57	29	160	95	
Within 21 days	336	388	409	343	354	378	370	380	323	414	329	251	283	362	

The number of patients scheduled to begin non-emergency SACT treatment in Dec 2023 was 280.

Parenteral Attendances (excludes patients on single agent oral SACT regimens; emergency and non-emergency)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22 Attendances	2,165	2,105	2,166	2,315	2,259	2,186	2,105	2,242	2,270	2,269	2,101	2,392
2022/23 Attendances	2,297	2,297	2,336	2,302	2,558	2486	2463	2572	2297	2455	2162	2557
2023/24 Attendances	2,233	2,554	2,657	2,529	2,712	2,510	2,688	2,819	2,432	2760	2625	

Performance

February position:

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	70	15	3	7

The longest wait was 55 days.
Demand continues in excess of predicted levels.
Pharmacy capacity remains the main challenge to delivering required activity levels to meet demand.

All patients within a Trial are booked within Trial timeframes.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve:	Timescale	Lead
Increased pharmacy production capacity through: 1) Reconfiguration of accommodation to deliver increased aseptic capacity following capital approval received December 2023. Build completion expected March 2024. Capacity increase expected July 2024.	31/07/2024	BT
2) Agreed increase on mobile unit from 14 to 20 patients daily x 2 days weekly.	31/05/2024	BT
3) provide cleaning provision from operations to allow for potential release pharmacy staff on weekends to produce additional regimens	31/07/2024	MD/MRM

Expected Performance gain – immediate

Not until July 2024

Service Improvement Actions – tactical (12 months +)

SPC Chart Non Emergency SACT within 21 days Target 98%

Actions: what we are doing to improve	Timescale:	Lead:
• Nursing: international nurse recruitment and preceptorship recruitment	01/05/24	AB
• Develop outsource model in advance of TrAMS implementation	TBC	BT
• Realign working patterns at outpatient clinics to maximise daily throughput.	31/05/24	NH/CM

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- Resource to deliver future growth across nurse/pharmacy/bookings not yet articulated/ secured; demand planning required.
- Current vacancies within SACT booking team
- Recent increase and complexity of in-patient SACT demand has impacted on pharmacy capacity to support day case workload

SPC Chart Analysis
The SPC chart shows a reduced performance in January with an upturn in February 2024.

Emergency SACT Patients Treated Within 5 Days															
Target: 100%														SLT Lead: Head of Medicines Management and SACT	
Current Performance against Target or Standard														Performance	

VCC	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	100	75	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	100	100	100	
More than 5 days	0	1	0	0	0	0	0	2	0	0		1	0	0	
Within 5 days	8	3		5	0	12	10	5	8	4		7	9	8	

Performance

February position
Target achieved

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale: Continuous	Lead: AB
• Continue to balance demand and ring fencing chairs with capacity.		

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
 •

SPC Chart Emergenct SACT within 5 days Target 100%

SPC Chart Analysis
The SPC chart shows a fluctuating process starting to stabilize with average 100% against the 100% target, however note small numbers involved.

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Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample															
Target: 90%										SLT Lead: Georgia Stephens					

Current Performance against Target or Standard

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	97	96	96	96	95	98	97	96	96	96	92	95	97	96	97
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

Antenatal Turnaround Times

Performance

Assessment of current performance, set out key points:
At 97% the turnaround time performance for routine Antenatal tests continued to exceed target in March 2024.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	**Timescale:**
Efficient and embedded testing systems are in place. Continuation of existing processes are maintaining high performance against current target.	Ongoing **Lead:** Georgia Stephens

Expected Performance gain - immediate.
Business as usual, reviewed daily.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	**Timescale:**
N/A	 **Lead:**

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance

SPC Chart Antenatal Turnround Time 3 days Target 90%
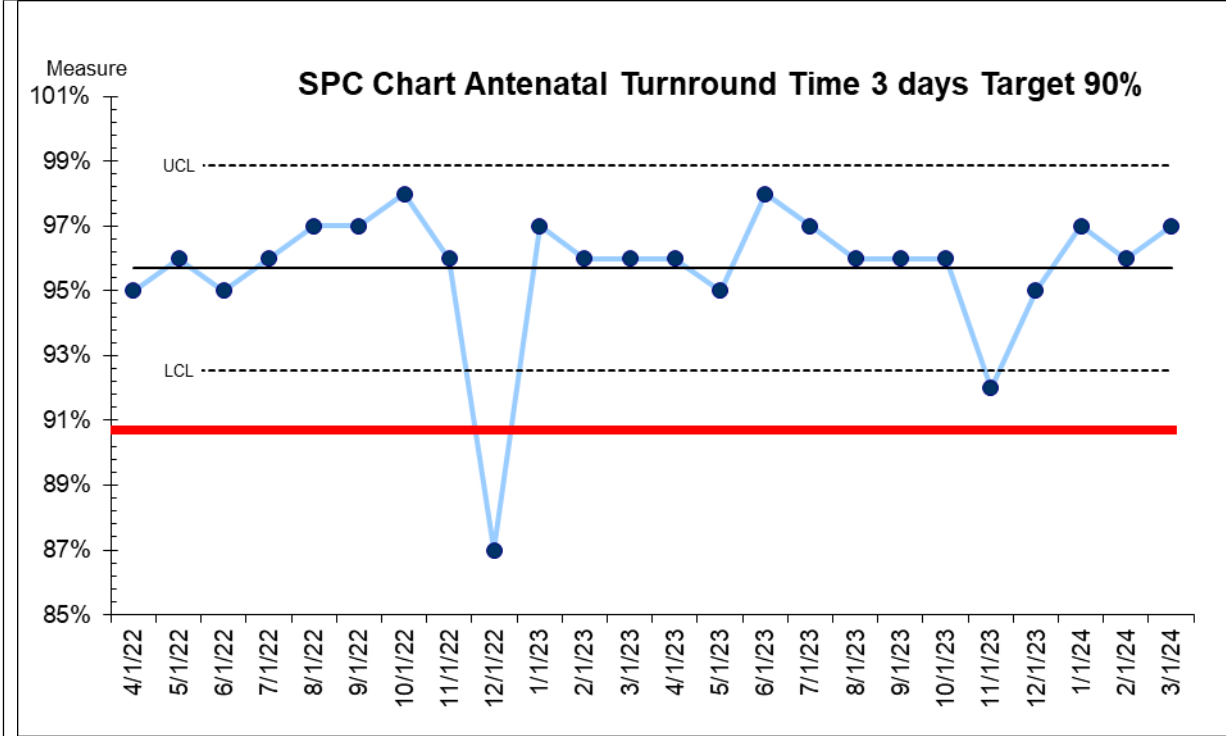
SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 15-month period. However, whilst the performance decreased in November it remained above target, the average performance continued to exceed the 90% target and improved further in January.

% Antenatal -D & -c quantitation results provided to customer hospitals within 5 working days														

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

Performance

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	96	60	92	97	98	97	98	99	100	99	100	98	100	92	100
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90

There was excellent performance during Quarter 3 for Antenatal -D & -c quantitation Turnaround Times within 5 working days. At 100% in January 2024, 92% in February and 100% in March 2024, performance averaged 97% in quarter 3, meeting target and showing consistent high performance.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	Timescale:	Lead:

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
N/A		

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

Anti D & -c Quantitation

	Qtr 1 Jun-23	Qtr 2 Sep-23	Qtr 3 Dec-23	Qtr 4 Mar-24
	98%	94%	98%	97%

Anti D & -c Quantitation Turnaround — Target

Anti D & C Results within 5 days Target 90%

SPC Chart Analysis

The SPC chart shows common cause or normal variation during the first and third quarter, with a special cause dip in performance in quarter four 2023. However, the average performance of 95% exceeds the 90% target overall in Q3 2023.

EFFICIENT

Financial Balance – Revenue Position													
Target: Net Zero Trajectory													

SLT Lead: Director of Finance

Current Performance against Target or Standard

Performance

Trust Position (core)	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual £k	64	1	4	2	4	5	7	7	17	9	15	25	30
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	NIL

Trust-wide Revenue Position as at March 24

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	(43.594)	(43.590)	0.004
RD&I	(0.114)	(0.000)	0.114
WBS	(21.734)	(21.514)	0.220
Sub-Total Divisions	**(65.442)**	**(65.104)**	**0.338**
Corporate Services Directorates	(14.027)	(14.517)	(0.491)
Delegated Budget Position	**(79.469)**	**(79.622)**	**(0.152)**
TCS	(0.744)	(0.613)	0.131
Health Technology Wales	(0.117)	(0.115)	0.001
Trust Income / Reserves	80.330	80.381	0.050
Trust Position	0.000	0.030	0.030

The core Trust has reported a £0.005m underspend on the in-month position for March '24, which gives a cumulative final unaudited underspend position of £0.030m for 2023-24.

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the options were considered to contribute c£2.5m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

The core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead: M Bunce

NHS Wales Financial Pressures Contribution

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust worked with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This reduced the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.537	

Actions addressed through Divisional Action Plans		
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
•		
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		

Financial Balance – Capital Expenditure Position														
Target: Expenditure in line with Capital Forecast									SLT Lead: Finance Director					
Current Performance against Target or Standard									Performance					

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual(Cum)	27.8	1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m	24.6m	31.0m
Target £31.005m CEL		1.389m	1.637m	5.646m	10.333m	8.683m	11.326m	14.277m	19.331m	20.672m	22.987m	24.6m	31.0m

Capital Position as at March 2024

	Approved CEL 2023/24 £m	Actual Spend 2023/24 £m	Year End Variance 2023/24 £m
All Wales Capital Programme			
nVCC – Enabling Works	10.896	10.881	0.015
nVCC – Project costs	3.257	3.257	0.000
nVCC – Advanced Design Works	3.882	3.882	0.000
nVCC – Advanced Works	0.898	0.898	0.000
nVCC – Advanced Design Works	1.229	1.229	0.000
nVCC – Whitchurch Hospital Site	0.000	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	7.613	0.213
IRS Satellite Centre (RSC)	0.147	0.145	0.002
Digital Priorities Investment Fund	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.168	0.000
Digital Cyber Security	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.095	(0.010)
Digital DPIF - EPMA	0.100	0.100	0.000
Digital WHAIS	0.250	0.246	0.004
Capital Year End Spend	0.257	0.252	0.005
Establish Microfludic Technology (WBS)	0.112	0.104	0.008
Total All Wales Capital Programme	29.322	29.099	0.223
Discretionary Capital	1.683	1.903	(0.220)
Total	31.005	31.002	0.003

The final approved Capital Expenditure Limit (CEL) as at March 2024 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

During December the Trust was awarded £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP, and £0.051m for cyber security.

In January the Trust was awarded £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ring-fenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January.

The Trust was provided with £3.257m for the nVCC related project costs and £0.112m towards Establishing Microfluidic Technology in WBS during February.
Finally in March the Trust was provided a further £1.229m towards advanced design works associated with the nVCC.
Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG during this September, with the caveat that the funding will be re-provided in future years.
The discretionary allocation of £1.683m for 2023-24 and represented an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in

expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and was re-allocated based on Divisional priorities. In addition, a further £0.250m was ring-fenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the 14th February. The £0.250m was also released and redistributed against prioritised schemes within the Trust which could be delivered before the 31st March.

NHS – All Wales Capital Prioritization
The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust completed a prioritisation form for all schemes included within the IMTP which were presented to EMB shape on the 18th March, and submitted to WG alongside the IMTP on the 28th March.

Year-end Performance
The actual total expenditure for 2023-24 on the All-Wales Capital Programme schemes was £29.099m against an agreed CEL of £29.322m. With WG agreement £0.213m was released from the IRS scheme back to discretionary, which is following the Trusts discretionary providing £0.248m to support the IRS implementation phase in prior years. .
Spend on Discretionary Capital to March was £1.903m.
The Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:** XX/XX/XX	**Lead:** AN Other
Expected Performance gain – longer-term		
Risks to future performance		

Usage of Overtime Bank and Agency Staff within Budget	
Target: Spending within budget	**SLT Lead: Finance Director**
Current Performance against Target or Standard	**Performance**

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.323	88	77	86	75	109	117	83	95	68	90	75	(120)
Target (per IMTP) £0.543M Forecast	543	115	115	115	58	50	50	16	16	8	0	0	0

The spend on agency for March'24 was £(0.120)m (Feb £0.075m), which gives a cumulative full year spend of £0.775m (£1.323m 2022/23).

During March a review of agency committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.

Per the IMTP the Trust is aiming to decrease the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues may continue to prove challenging

Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

Spend & F'cast 23-24 — Av. Spend 22-23 — Av. Spend 21-22

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve • Actions addressed via Divisional action plans	**Timescale:**	**Lead:** Matthew Bunce
Expected Performance gain - immediate		

Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve •	**Timescale:**	**Lead:**
Expected Performance gain – longer-term		

Risks to future performance
Set out risks which could affect future performance •

Cost Improvement Programme delivery against plan		
Target: Savings in line with Forecast CIP		**SLT Lead: Finance Director**
Current Performance against Target or Standard		**Performance**

Trust Position	22/23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual	1.300	0.084m	0.108m	0.087m	**0.132m**	0.137m	0.137m	0.254m	0.167m	0.167m	0.172m	0.172m	1.8m
Target £1.8M Forecast		0.084M	0.084m	0.084m	0.172m	0.172m	0.172m	0.172m	0.1727m	0.172m	0.172m	0.172m	1.8m

Overall VUNHST Cost Improvement Programme £1.8M

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the £0.391m of underlying surplus which had been carried forward from 2022/23.

Service redesign and supportive structures continues to be a key area for the Trust which is about focusing on finding efficiencies in the ways that we are working. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of vacancies and sickness
The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Work will continue with procurement colleagues next year to identify further opportunities to deliver savings through the supply chain.

Cummulative monthly savings achieved compared to target

■ Cumulative Achieved Savings ■ Cumulative Target Savings

Public Sector Payment Performance Target Non NHS Invoices paid within 30 days														
Target: 95%														**SLT Lead: Finance Director**
Current Performance against Target or Standard														**Performance**

	22/23	Apr 23	My 23.	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Trust Position													
Capital & Revenue Invoices	95	98	98	99	98	96	98	97	98	98	98	98	98
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95

Performance

During March '24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97.7%** for 2023-24, and a Trust position (including hosted) also of **97.7%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue into 2024-25 in order to maintain performance.	31/03/2024	M Bunce

Expected Performance gain – longer-term.
Ensured compliance

Risks to future performance

Set out risks which could affect future performance

EQUITABLE

% of Workforce not declared Welsh Language Listening/Speaking capability															
Target: TBA%															

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	-	-	11.63	-	-	10.30	-	-	9.81	-		9.41			7.50
Target %	-	-	0%	-	-	0%	-	-	0%	-					

Performance

Assessment of current performance, set out key points:
- Welsh Language declaration 'not stated' recorded quarterly
- Target agreed as 0% non-declaration

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Trust

Welsh Language (Listening/Speaking)

31-Mar-24

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1149	1746	65.81%
1 - Entry/ Mynediad	243	1746	13.92%
2 - Foundation / Sylfaen	69	1746	3.95%
3 - Intermediate / Canolradd	41	1746	2.35%
4 - Higher / Uwch	52	1746	2.98%
5 - Proficiency / Hyfedredd	61	1746	3.49%
Not Stated	131	1746	7.50%
Grand Total	**1746**	**1746**	**100%**

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
- insert text

Mean Gender Pay Gap – Annual															
Target: TBA%															

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Performance

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	-	-	13.45	-	-	-	-	-	-	-					
Target TBA%	-	-	TBA	-	-	-	-	-	-	-					

Assessment of current performance, set out key points:
- Gender pay gap position recorded as at March 2023
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Trust
Gender Pay Gap
31st Mar 2023

Gender	Mean Hourly Rate	Median Hourly Rate
Male	£22.25	£17.94
Female	£19.26	£16.84
Difference	£2.99	£1.09
Pay Gap %	13.45%	6.10%

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Diversity of Workforce – % Black, Asian and Minority Ethnic people														

Target: TBA% — **SLT Lead: Director of Workforce and OD**

Current Performance against Target or Standard | **Performance**

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	-	-	5.18	-	-	4.56	-	-	5.45	-		5.62			5.96
Target TBA%		-	TBA	-	-	TBA	-	-	TBA	-					

Assessment of current performance, set out key points:
- Staff ethnic origin recorded quarterly
-

Trust Ethnic Origin 31-Mar-24			
Ethnic Origin	**Headcount**	**%**	**BAME %**
Asian	55	3.15%	**5.96%**
Black	21	1.20%	
Chinese	12	0.69%	
Mixed	16	0.92%	
Other	10	0.57%	
White	1531	87.69%	
Unspecified	71	4.07%	
Not Stated	30	1.72%	
Grand Total	**1746**	**100%**	

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

Diversity of Workforce – % People with a Disability within workforce														
Target: TBA%														

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Jan 23	Feb 23	Mar 23	Apr 23	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Actual %	-	-	4.63	-	-	4.9	-	-	4.9	-		5.33			5.74
Target TBA%	-	-	TBA	-	-	TBA	-	-	TBA	-					

Performance

Assessment of current performance, set out key points:
- Staff disability recorded quarterly
-

Trust

Disability

31-Mar-24

Disability	Headcount	%
No	1442	85.38%
Not Declared	46	2.72%
Prefer Not To Answer	13	0.77%
Unspecified	148	8.76%
Yes	97	5.74%
Grand Total	**1746**	**103%**

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text •	XX/XX/XX XX/XX/XX	AN Other AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
- insert text
-

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Susan Thomas, Deputy Director of W&OD Chris Moreton, Deputy Director of Finance
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Matthew Bunce, Executive Director of Finance
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The workforce issues in delivering the correct Supply and Shape of the Workforce is the ability to (1) recruit and retain the workforce (2) ensure a work environment that supports staff's wellbeing (3) develop effective service and workforce plans. The emerging risk is the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness. The paper key priorities, noting the action taken, those delivered and issues and risk mitigation in the action plan. In summarising each priority, the

	current level of assurance is provided with an overall assurance level provided

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the workforce supply and shape updates and associated financial impacts as outlined within the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29TH APRIL
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
4 – Increased extent of impact from actions	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
	No Appendices

1.   SITUATION/BACKGROUND

The People Strategy articulates the key priorities and focus for its delivery:
- Attraction and Retention
- Wellbeing and Equalities
- Education and Learning
- Workforce supply and shape

- Leadership and succession

This report concentrates on delivery against those key priorities, noting the action taken, those delivered and issues and risk mitigation in the action plan. In summarising each priority, the current level of assurance is provided. The paper also references the financial implications of the workforce risk.

This paper will also perform the function of illustrating the activity in relation to TAF 03.

2.   ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

2.1   Attraction and Retention

Attraction and Retention
Actions Delivered Qtr. 4 23/24
- Participated in International Recruitment – 13 new nursing recruits from overseas   - Promoted Velindre as an employer of choice, a recruitment and retention task and finish group has implemented the following: - VCC/WBS careers page   - Targeted job videos   - Implemented a recruitment policy   - Links with Centre for Learning and School of Oncology to promote Velindre as Employer of Choice   - Understand the retention issues though exit process analysis   - Implemented our 'pre-exit' interview process   - Retention toolkit being utilised   - Working Together sessions taken place to gain engagement from staff on culture and retention themes in Velindre   - Croeso Induction Programme in place with bi-lingual focus, supporting the implementation of our Welsh Culture plan
Actions planned Qt1 24/25
- Working with NWSSP to implement a recruitment modernisation process to improve time to hire rates thus reducing agency spend and improving vacancy rates. Ongoing programme to September 2024   - Widening access programme agreed April – September 2024:

- Engagement with local schools/collages on career options, promoting us an a bi-lingual employer to support Welsh speakers into the workplace
- Disability Confident Level 2 renewed to set benchmark for how to support people with disabilities to join our workforce
- Agreement to support Army veterans and Nursing Cadets into the workplace signed

- Ongoing Deep dive in rec hotspots to triangulate data and focus on local supportive interventions

- Retention plan to be developed – to be agreed via committee in June 2024

Issues	Mitigation
- Agency spend ongoing	- Task and Finish group established to look at more defined monitoring, targeted action plan to be developed
- Strike impacting on business continuity, focus has been diverted - Roles and responsibilities in these areas are multi professional – service and workforce planning requires engagement and collaboration with all parties. Potential ongoing strike action will deviate attention to other areas of the business	
Levels of assurance	
4 – Increased extent of impact from actions	

2.2 Wellbeing and Equalities

Wellbeing and Equalities	
Actions delivered Q4 2023-24	
- EAP retendered and taken on by Vivup. - NHS Staff Survey results received and reported to EMB. - Speaking Up Safely Task and Finish Group concluded the roll out of the national framework. - Strategic Equality Plan 2024-28 developed and approved. - Welsh training provided to Reception staff and marked Mandatory on Job Descriptions where relevant.	
Actions planned Q1 2024-25	
- Wellbeing Project Coordinator starts (funded by NHS Charities Together). - Noddfa to be furnished (funded by NHS Charities Together). - Develop annual action plan to implement the Strategic Equality Plan. - Submit first WRES data set and receive report back. - Receive Divisional NHS Staff Survey results and initiate local actions. - Launch NHS Wales health and Wellbeing Framework.	
Issues	**Mitigation**
- Stress is biggest reason for sickness absence - Collaboration and engagement with service and workforce is key in addressing issues	Wellbeing Project Coordinator will play a part in addressing this.
Levels of assurance	
4 – Increased extent of impact from actions	

2.3 Education and Learning

Education and Learning
Actions delivered Q4 2023-24
• Education Strategy Audit undertaken and report received. • Health Care Support Worker group established.
Actions planned Q1 2024-25
• People Development Policy to be approved. • Education Strategy Audit implementation plan to be approved. • Start review of Performance and Development Review process.
Issues
• Engagement and collaboration with workforce is key to ensure actions are proactively taken forward
Levels of assurance
4 – Increased extent of impact from actions

2.4 Leadership and Succession

Leadership and Succession
Actions delivered Q4 2023-24
• Trust Values approved. • 7th Cohort on Inspire.
Actions planned Q1 2024-25
• Approve Behaviour Framework and embed into People Processes. • Launch new Values and Behaviour Framework. • Scope a programme of Fundamentals of Management. • Run Learning at Work Week.
Issues/Mitigation
• The Values and Behaviour Framework represent aspects of the culture of the trust and it will take time for people to understand where they can develop their styles at work to better encapsulate Caring, respectful and Accountable. • Key requirement for this to be led by Executive Management Board
Levels of assurance
4 Increased extent of impact from actions

2.5 Supply and Shape

Supply and Shape
Actions Delivered Qtr. 4 23/24
- Implementation plan for the People Strategy   - Regular reporting and monitoring of work plans by Senior Leadership Teams, Executive Management Board and the Quality Safety and Performance Committee via monthly workforce dashboards and this paper quarterly respectively   - Ongoing infrastructure of workforce planning training embedded via the Trust management and leadership Inspire Programme   - Review of workforce plans and education commissioning monitoring via the Trust People and OD Steering group
Action Planned Qtr. 1 24/25
WBS   - Plasma for Medicines – WG approval and confirmation on funding expected in May 2024. Digital Modernisation Programme – BECS Business case approved on 12/4. Tender will now be issued to procure a new BECS system with supplier awarded contract in Q4.   - Laboratory Services Modernisation – Three main areas established with various supporting workstreams. RCI phase 1 – review completed March 2024. Phase 2 to commence. Laboratory Testing and Automation and Platelet strategy work continuing.   - Collection Service Modernisation – Paper provided to SLT on impacts of the OCP Phase 1. Lessons learnt identified. Phase 2 commencing in May 2025 holding stakeholder briefings with Collections Teams   **VCC**   - TrAMS There are delays in the National TrAMS Programme, National Programme is working with WG on a solution. VCC TrAMS working group has been set up and meets monthly OCP 1 completed, OCP 2 paused until service model has been agreed. National programme submitting a Business case to WG and post approval completion of project will be Dec 2025   - IRS & SRU All posts within radiotherapy have been filled, there remain challenges with key medical physics posts due to limitations in the market. Velindre Communications colleagues are supporting this work. Links are established with SRU operational recruitment and this is complete   - Pathway Programme a review of the pathway Programme plan is being undertaken, to ensure objectives are being met and clarity around future measurable. It is envisaged that as part of the review for Velindre Futures , the pathway programme will formally report into VF Board

Issues	Mitigation
- No dedicated workforce planning resource currently to support service - Engagement and collation with the service is key – focus is often on operational pressures rather than planning - Dependency on national initiatives impacting on deliverables	Request via IMTP pending
Levels of assurance	
3 Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes	

3. The Associated Financial Risks to Workforce Supply and Shape

The financial risk associated with workforce supply and shape will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available. Funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners.

Pay Budget 2023/24

The full year pay budget as at end of March 2024 is £90.518m based on 1,653 WTE. The Trust has reported cumulative spend for 2023-24 of £89.587m on pay t resulting in a year end underspend of £0.931m. The pay costs include the costs of agency staff, on-call and overtime.

Pay Award

The Trust received full funding from WG during 2023-24 for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July, and the Medical Pay award paid in October (c£0.7m). However, whilst the Trust received full funding to support the pay award during 2023-24 WG are yet to confirm whether the allocation was provided on a recurrent basis, which if not confirmed during 2024-25 could lead to an underlying shortfall being carried into next financial year.

The Trust has previously received full funding for the one off recovery pay award which was paid in June.

Agency

The cumulative full year spend on agency for 2023-24 was **£0.775m** (£1.323m 2022/23) a cost reduction of £0.548m.   Per the IMTP the Trust has been reducing the reliance on the use of agency during 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and plans are in place to recruit substantive and establish a more a administration bank.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below		
If yes - please select all relevant goals:		
• Outstanding for quality, safety and experience		☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		☒
• A beacon for research, development and innovation in our stated areas of priority		☒
• An established 'University' Trust which provides highly valued knowledge for learning for all.		☒
• A sustainable organisation that plays its part in creating a better future for people across the globe		☒
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning	

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Covid staff costs that may not be fully covered by WG or Commissioner income Ongoing premium cost of agency
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Individual elements of work described in this paper may be subject to EQIA.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*This is reflected in the Trust Assurance Framework Risk 03*
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED

31ST MARCH (M12)

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of March 2024. The three main issues are highlighted below: 1. **Key Financial targets / KPIs** • The core Trust reported a small underspend in its final revenue position for 2023/24.

	• The Trust achieved the PSPP target of paying 95% of Non-NHS invoices within 30 days for 2023-24. • The Trust achieved the Capital CEL target for 2023-24 by spending £31.002m of the £31.005m Capital budget allocated. **2. LTA Income & Covid Recovery / Planned Care Capacity** • The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to cover the costs of the investment made in the additional capacity. As expected, the final LTA income position based on activity delivered for 2023/24 confirmed that the income did cover the cost of the additional capacity made to date. **3. NHS Wales Financial Pressures** • In response to the letter received from the Health Minister which detailed the financial pressures that was being faced by NHS Wales, the Trust identified costs savings proposals to the sum of £2.537m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit. *Please note that due to the financial year the month 12 WG monitoring return letter which normally accompanies the report was not available in time for this meeting.*

RECOMMENDATION / ACTIONS	**The Quality, Safety and Performance Committee** is asked to **NOTE** the contents of the March 2024 financial report, (noting that the figures provided are unaudited at this stage)

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board (EMB)	29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
• The finance report was received and noted at the Executive Management Board.	

7 LEVELS OF ASSURANCE
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed. N/A

APPENDICES	
Appendix 1	Trust Finance Report – March 2024
Appendix 2	TCS Finance Report – March 2024

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for 2023-24.

1.2 The key financial targets information included within this report relates to the Core Trust (Including Health Technology Wales (HTW)). The financial position reported does not include NHS Wales Shared Services Partnership (NWSSP) as it is directly accountable to Welsh Government (WG) for its financial performance. The Balance Sheet / Statement of Financial Position (SoFP) and cash flow provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Total Actual 2023-24
Revenue	Variance	0.005	0.030
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6.392	31.002
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.1%	97.7%

2.2 Revenue Budget

The overall position against the profiled revenue budget for 2023-24 was an underspend of **£0.030m**.

Long Term Agreement (LTA) Contract Performance

Velindre Cancer Service (VCS) Contract income had recovered during the period to a level that sufficiently funds the capacity investments made to date.

NHS Wales Financial Pressures

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the following options were considered to contribute c£2.5m cost reduction to the overall NHS position and were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust worked with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This reduced the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.537	

As detailed in the table above the core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

2.3 Savings

The Trust fully achieved the revised savings target of £1.8m during 2023-24. Following a review of the savings plan, £0.305m additional non-recurrent savings schemes were

Page 4 of 8

identified to replace several recurrent schemes that had been assessed as non-deliverable i.e. Red Status.

Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service leads to implement changes.

The procurement supply chain saving schemes have again been affected by procurement team personnel changes and capacity constraints and current market conditions during 2023-24.

2.4   PSPP Performance

The Final PSPP performance for the whole Trust for was 97.7% against a target of 95%, with the performance against the Core Trust excluding NWSSP also achieving a target of 97.7% for 2023-24.

2.5   Covid Expenditure

Covid Programme Costs

In line with the WG approval letter the Trust only drew £0.053m of funding from WG towards PPE costs for 2023-24.

Covid Recovery and Planned Care Capacity

The final position for 2023/24 confirms that the contract performance had recovered to a level that sufficiently funds the capacity investments made to date.

2.6   Reserves

The financial strategy for 2023-24 enabled the establishment of recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £0.305mof planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25.

In addition to the above reserves, each year the Trust holds an emergency reserve of £0.522m which was not utilised in the period and per previous agreement by the Board this was provided to WG on a non-recurrent basis to support the NHS was financial position during 2023-24.

2.7   **Financial Risks**

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken

by the Trust all risks were either been managed or mitigated for 2023/24.

A recurrent risk had emerged in terms of the Trust receiving full funding for the 2023-24 pay award. WG provided the funding requirement during 2023-24 but are yet to confirm whether it was provided as a recurrent allocation. Indicative figures suggested that the gap could have been up to c£0.300m, however latest intelligence suggests that this could be a lot less or even removed completely.

There are still several risks that may impact from 2024-25 with the material risks being uncertainty around the Whitchurch site security costs and operational cost pressures as highlighted within the main finance report.

2.8 Capital

All Wales Programme

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) Projects the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG in September, with the caveat that the funding will be re-provided in future years. The Trust was provided funding award letters to support all Capital project requirements for 2023-24.

Other Major Schemes in development that are detailed in the main finance report were included within the IMTP submission to WG.

Discretionary Programme

The discretionary allocation of £1.683m represented an increase of 16% on the £1.454m provided during 2022-23.

The allocation of the discretionary programme for 2023-24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB in August.

Yearend Performance
The core Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

2.9 Cash

In order to support a cash flow pressure during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG.
The Trust eventually received all funding to support the pay awards that were processed during 2023-24.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	08 - Trust Financial Investment Risk
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply

Domain	Select
Safe	☒
Timely	☒
Effective	☒
Equitable	☒
Efficient	☒
Patient Centred	☒

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	N/A

FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.030m** ensuring that the target was met for 2023-24. The Trust also achieved the Capital (CEL) target for the period.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED 31 MARCH 2024

**QUALITY, SAFETY AND PERFORMANCE
COMMITTEE
09/05/2024**

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 2023-24.

2. Background / Context

The draft Trust IMTP Financial Plan for the period 2023-2026 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2023-24 to 2025-26 to Welsh Government on the 31 March 2023.

- For 2023-24 the Plan included;
  - an underlying **Surplus of £0.684m** brought forward from 2022-23,
  - FYE **of new cost pressures / Investment** of -**£17.514m,**
  - offset by **new recurring Income** of **£16.221m,**
  - and Recurring FYE **savings schemes** of **£1.000m,**
  - Allowing **a £0.391m surplus position** to be carried into 2023-24.

- The Trust has a carry forward underlying surplus of £0.684m, which relates to the 2022-23 discretionary uplift funding that was held due to the uncertainty of WG funding support for the increase in energy prices and to cover the possible LTA income shortfall risk against the Covid capacity cost investment.

- The balance of the underlying surplus is forecast to reduce year-on-year as cost pressures increase over the 3-year planning period. IMTP planning assumptions assumed that a £0.391m underlying surplus will be c/fwd into 2024-25.

- **In order to achieve the c/fwd underlying surplus of £0.391m the savings target set for 2023-24 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**

2

IMTP Underlying Revenue Position +'ve Surplus / -'ve Deficit
Velindre Trust £Ms
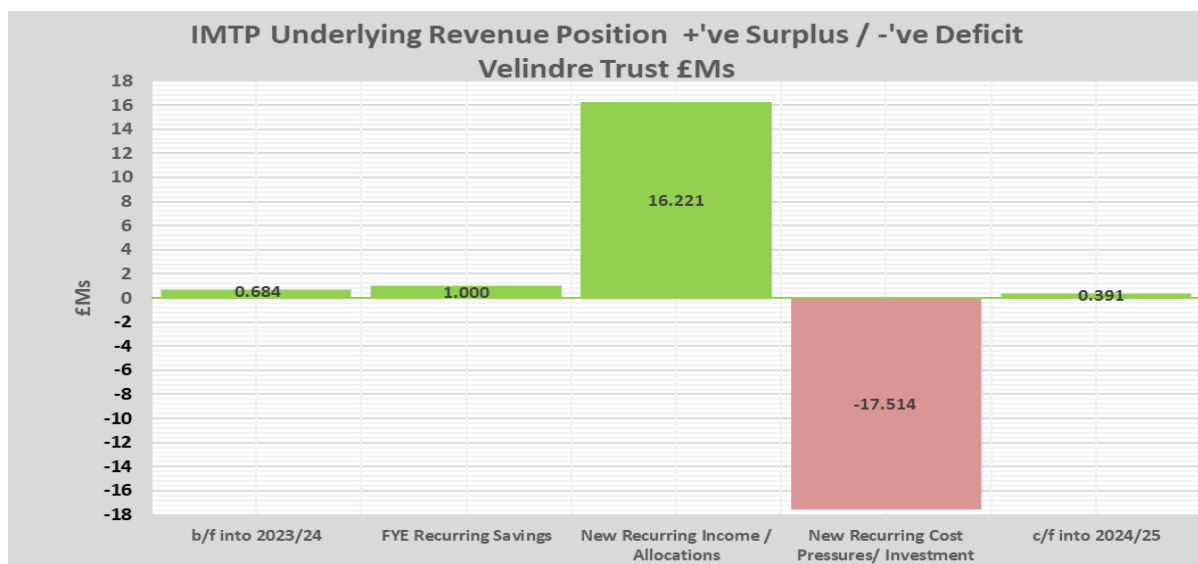
Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2023/24	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.684	1.000	16.221	-17.514	0.391

3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Total Actual 2023-24
Revenue	Variance	0.005	0.030
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	6.392	31.002
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.1%	97.7%

Performance against Planned Savings Target

3

	Unit	Current Month £m	Total Actual 2023-24
Efficiency / Savings	Variance	0.000	0.000

Revenue

The core Trust has reported a **£0.005m** underspend on the in-month position for March '24, which gives a cumulative final unaudited underspend position of **£0.030m** on revenue for 2023-24.

Capital

The final approved Capital Expenditure Limit (CEL) for 2023-24 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.** The Trust reported actual total Capital spend of **£31.002m** ensuring that the Trust CEL target was achieved for 2023-24.

The Trust's final CEL position and in year movement is provided below:

	£m Opening	£m Movement	£m Current
Discretionary Capital	**1.683**	**-**	**1.683**
All Wales Capital:			
nVCC - Enabling Works	10.896	-	10.896
nVCC - Advanced Design Works		3.882	3.882
IRS	10.326	(2.500)	7.826
Digital Priority Investment	0.164	-	0.164
RSC Satellite Centre	1.347	(1.200)	0.147
Digital DPIF Cyber Security		0.051	0.051
nVCC - Advanced Works		0.898	0.898
Digital DPIF RISP		0.168	0.168
Digital DPIF Cyber Security (2)		0.085	0.085
Digital DPIF EPMA		0.100	0.100
Digital WHAIS		0.250	0.250
Priority Year end Spend		0.257	0.257
nVCC Project Costs		3.257	3.257
Microfluidic Technology (WBS)		0.112	0.112
nVCC Advanced Design Works		1.229	1.229
Total All Wales Capital	**22.733**	**6.589**	**29.322**
Total CEL	**24.416**		**31.005**

PSPP

During March '24 the Trust (core) achieved a compliance level of **98%** of Non-NHS supplier invoices paid within the 30-day target, which resulted in a cumulative core Trust compliance figure of **97.7%** for 2023-24, and a Trust position (including hosted) also of **97.7%** compared to the target of 95%.

Efficiency / Savings

The Trust fully achieved the savings target of £1.8m during 2023-24, however, during July additional £0.305m non-recurrent savings schemes were identified to replace several recurrent schemes that had been assessed as non-deliverable i.e. Red Status.

4

Revenue Position

2023/24 Financial Position			
£0.030m Underspent			
Type	Full Year Budget (£m)	Full Year Actual (£m)	Full Year Variance (£m)
Income	(207.558)	(208.716)	1.158
Pay	90.518	89.587	0.931
Non Pay	117.040	119.099	(2.059)
Total	0.000	(0.030)	0.030

The overall final revenue position against the profiled revenue budget for 2023-2024 was an underspend of **£0.030m.**

4.1 Revenue Position Highlights / Key Issues

NHS Wales Financial Pressures

On the 31st July the NHS Wales Chief Executive Judith Paget wrote to all NHS organisations, which reaffirmed the requirement to outline the actions requested by the Minister for Health and Social Services to reduce the forecast NHS Wales financial deficit in 2023-24. In response to the financial pressures faced by the system, the Trust was asked to identify options to support the delivery of a reduction in the overall NHS Wales deficit.

In response to the letter the Trust has reviewed its cost control mechanisms and implemented Enhanced Monitoring arrangements which ensured savings delivery to meet the Trust's financial plan, oversee cost control mechanisms and assess choices / options and impacts of further cost saving opportunities. Following a review of the financial plan and savings position, an extraordinary Board meeting on the 09th August considered the further options for Velindre to contribute towards reducing the financial pressures in the system. The following financial improvement options were submitted to WG on the 11th August in line with Trust Board agreement.

Title	In year 2023/24 financial impact £m	Description of Option / Choice
VCS Contract Protection	1.250	The Trust worked with Commissioners to assess the opportunity to relinquish the LTA income protection which was agreed as part of the LTA/ SLA with the Trust Commissioners. This reduced the costs of VCS services for the Trust's Commissioners providing a contribution towards the wider deficit reduction of c£1.250m across all LHBs during 2023-24.
Energy	0.537	Energy costs reduced in year by £0.537m from the forecast presented at the IMTP planning stage, which was released to support the NHS deficit on a non-recurrent basis.
Review Utilisation of Reserves and Commitments (Inc Emergency Reserve)	0.500	The emergency reserve was not required to support service during the period and so was offered up to support the NHS deficit on a non-recurrent basis
Medicines Management	0.250	The Trust continues to work with NWSSP Medicines Unit to evaluate the use of generics / biosimilars which could deliver potential savings to our Commissioners. The savings passed through to Commissioners will be net of any internal resource costs required to deliver the change.
Total	2.537	

As detailed in the table above the core Trusts final contribution to support the NHS financial position was £2.537m for 2023-24.

5

Suspension of expenditure recharges to Charity 2023-24

Like in 2022-23 the Trust has accumulated £1.5m of non-recurrent income during 2023-24 from several sources including significantly higher levels of bank interest, and over performance of plasma and private patient income.

The Trust receives funding from the Charity which supports the supplementation of cancer services, the administration of the funds and investment in research and development. Given the c£1.5m of extraordinary non-recurrent income generated the level of Trust expenditure funded by the Charity in 2023-24 was reduced by £1.5m.

Underlying Position

As highlighted above in the IMTP Financial plan the Trust brought forward a surplus of £0.684m from 2022-23 and is forecast to reduce year-on-year as additional cost pressures arise over the 3-year planning period.

The expected underlying surplus to be carried into 2024-25 had reduced from £0.391m to £0.086m following the inability to enact several savings schemes, which resulted in the underlying recurrent cost pressures forecast exceeding the recurrent savings schemes. Further recent assessment of savings and cost pressures has meant that there is now no underlying surplus to carry forward into 2024-25

Income Highlights / Key Issues

Other Income

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises.

VCS and WBS overachievement from Private Patient, Drug Rebate, SACT Homecare, and Plasma sales.

VCS Long Term Agreement (LTA) Contract Performance

The Trust's Medium-Term Financial Plan assumed that the funding for Covid recovery and planned care capacity will flow through the LTA marginal contract income from our commissioners for 2023-24, however there was a risk that activity levels may have been high enough to recover the costs of the internal level of investment made to support the planned care backlog capacity. The final position for 2023/24 confirms that the contract performance had recovered to a level that sufficiently funds the capacity investments made to date.

The tables below set out the year-end LTA Income performance:

Comparison to Base Contract Value per Commissioner	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Hywel Dda (7A2)	0.283	-0.011	0.272	-4%
Swansea Bay (7A3)	0.294	0.011	0.305	4%
Cardiff & Vale (7A4)	15.036	1.240	16.276	8%
Cwm Taf Morgannwg (7A5)	13.221	0.809	14.030	6%
Aneurin Bevan (7A6)	17.344	1.222	18.566	7%
Powys (7A7)	0.758	0.162	0.920	21%
WHSSC	2.633	0.310	2.943	12%
Total	**49.569**	**3.742**	**53.311**	**8%**

Financial Performance Per Contract Currency	Base Contract Value £m	Outturn Variance £m	Outturn £m	Variance (%)
Radiotherapy	17.929	-0.321	17.608	-2%
Nuclear Medicine	0.923	-0.036	0.887	-4%
Radiology Imaging	2.840	0.592	3.432	21%
Preparation for Systemic Anti-Cancer Therapy	2.594	0.207	2.801	8%
Delivery of Systemic Anti-Cancer Therapy	5.935	1.073	7.008	18%
Ambulatory Care Services	1.235	0.259	1.494	21%
Outpatient Services		2.161	11.390	23%
Inpatient Admitted Care	9.229	-0.193	8.691	-2%
Total	**49.569**	**3.742**	**53.311**	**8%**

VCS Contract income recovered to a level that sufficiently funds the capacity investments made to date (£3.5m).

Pay Highlights / Key Issue

The Trust received full funding from WG during 2023-24 for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July, and the Medical Pay award paid in October (c£0.7m). However, whilst the Trust received full funding to support the pay award during 2023-24 WG are yet to confirm whether the allocation was provided on a recurrent basis, which if not confirmed during 2024-25 could lead to an underlying shortfall being carried into next financial year.

During the period the Trust received full funding for the one off recovery non-consolidated pay award which was paid in June.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work will continue into 2024/25 to update the likely cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which was achieved during the period ensuring that the overall Trust financial position was achieved for 2023-24.

Non-Pay Key Issues

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost improvement Plan (CIP). The Trust IMTP savings target for each division was set as VCS £0.950m, WBS £0.700m and Corporate £0.150m for 2023-24.

4.2 Pay Spend Trends (Run Rate)

As of March 2024, the current staff in post is 1,603 WTE, (119 WTE increase from the 1484 WTE as at April 2023). The current number of vacancies is 50 WTE, which represents a vacancy rate of 3.2% (4.1% February) against the budget of 1653 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each Divisional vacancy factor savings target.

Vacancies throughout continues to reduce, particularly due to the recruitment of 17wte Nurses during February via the international recruitment scheme. The reduction in vacancies can be seen in the historic trend as demonstrated in the chart below which covers from April 2022 to March 2024:
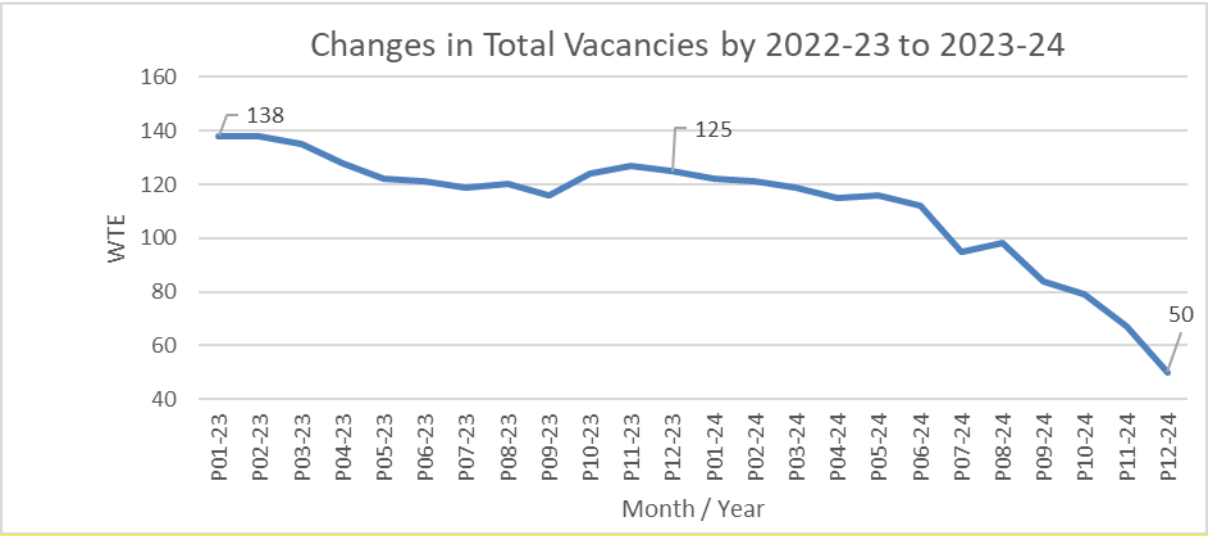
The total Trust vacancies as of March 2024 is 50wte (February 67wte), VCC (25wte), WBS (8wte), Corporate (7wte), R&D (6wte), TCS (2wte) and HTW (2wte).

Changes in Vacancy rate (%) 2022-23 to 2023-24
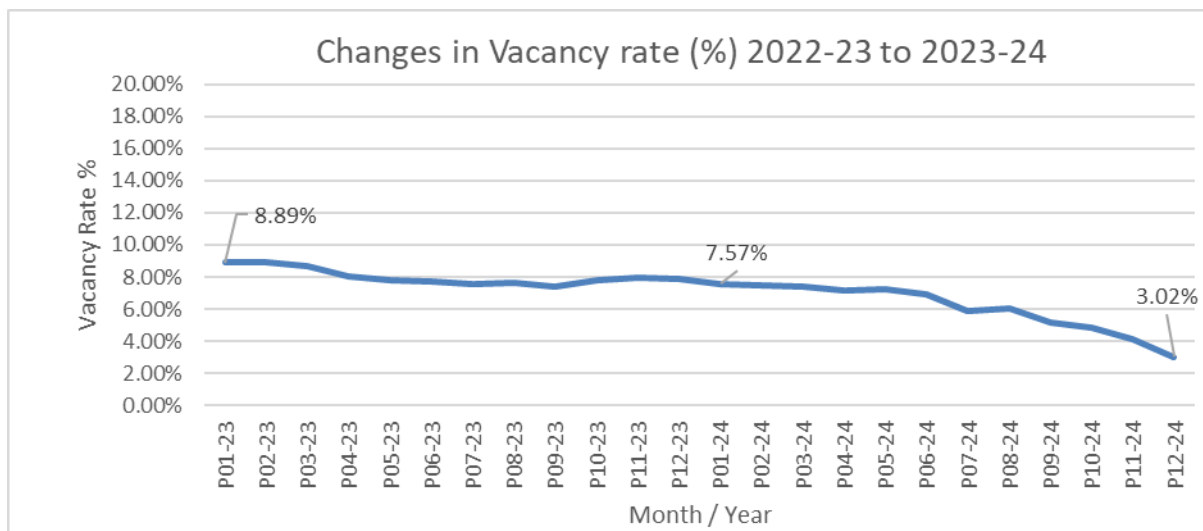
Per the IMTP the Trust has been reducing the reliance on agency throughout 2023-24 by recruiting staff required on a permanent basis. The Trust has been transitioning the Radiotherapy, Medical Physics and Estates staff into substantive positions within the Trust, which is following investment decisions in these areas, with expectation that some costs will maintain in the short term to support where there continues to be vacancies. Agency within Admin and Clerical are largely supporting vacancies and whilst there is ambition to fill these posts, recruitment issues and sickness levels may continue to prove challenging.

Per the IMTP The Trust is aiming to remove the reliance on agency by the second quarter of next financial year.

Actual / F'cast Pay Spend 23/24 and Average actual 22/23 & 21/22
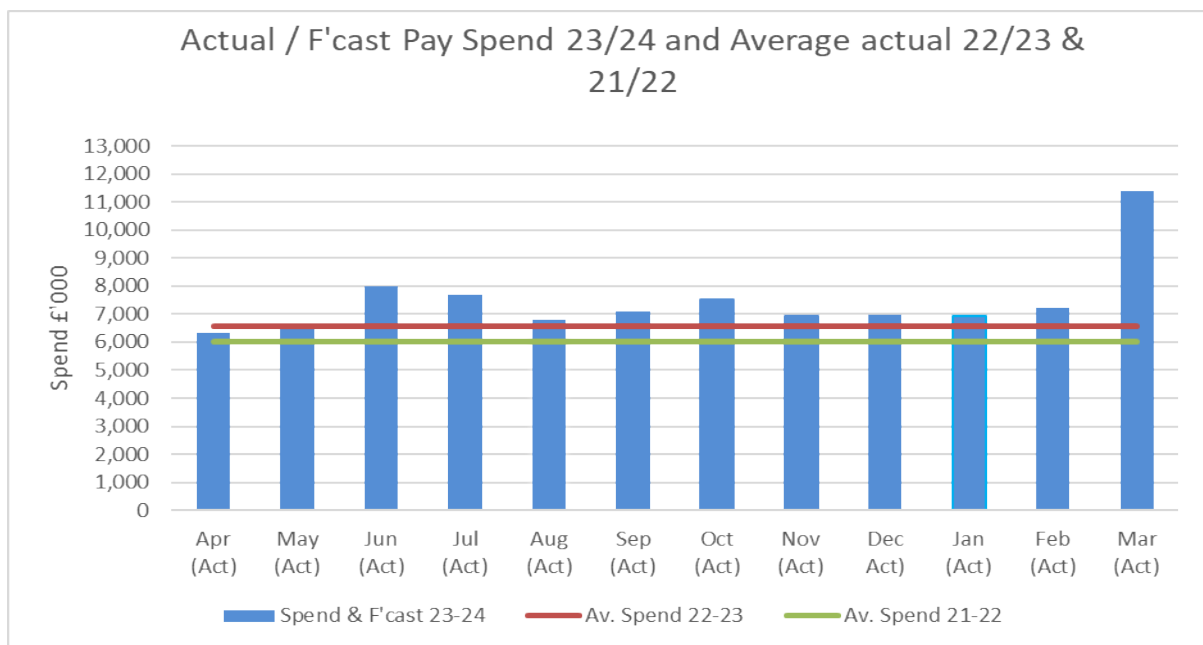
*The spike in pay during June relates to the non-consolidated recovery pay award.
*The Spike in pay during July relates to the 5% AFC consolidated pay award backdated to April 2023.
*The Spike in pay during October relates to the 5% Medical consolidated pay award backdated to April 2023.
* The additional 6.3% pension contribution funded via WG of c£4m explains the surge in pay during March.
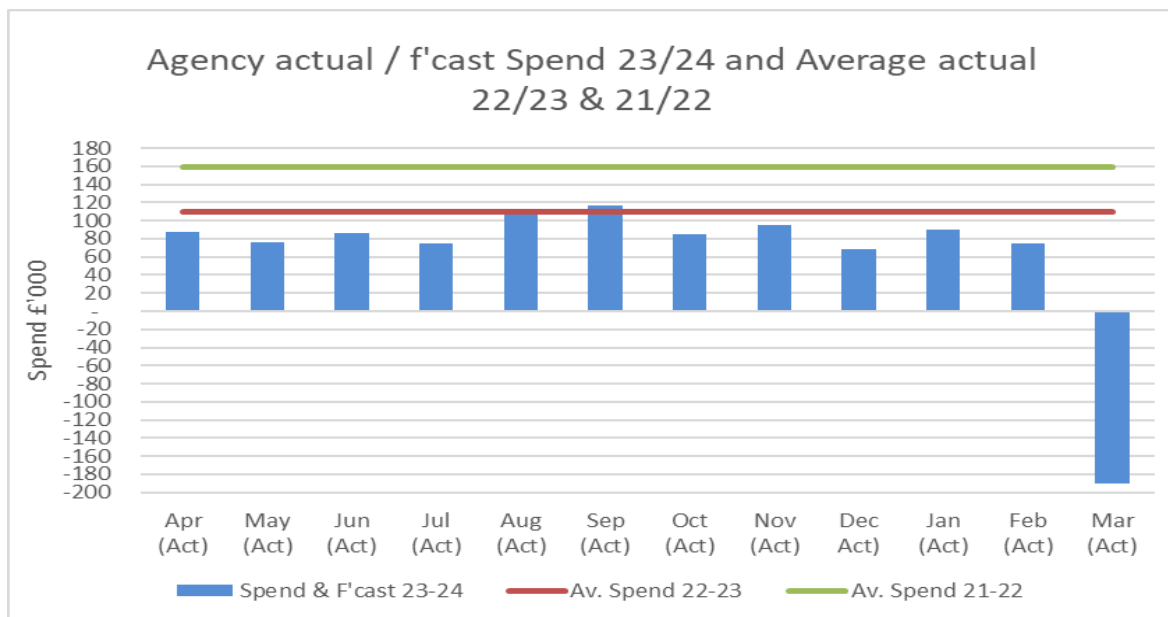
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Agency actual / f'cast Spend 23/24 and Average actual 22/23 & 21/22

The spend on agency for March'24 was **£(0.120)m** (Feb £0.075m), which gives a cumulative full year spend of £0.775m (£1.323m 2022/23).

During March a review of agency committed orders was undertaken which resulted in several receipted orders being identified as no longer being required. This generally occurs when agency staff leave before their agreed term and the orders need to be closed, consequently a credit is released back into the revenue position.

Changes in Total WTE 2022-23 to 2023-24

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Changes in Actual WTE 2022-23 to 2023-24 By Division

[Line chart showing WTE by Division from P01-23 to P12-24. VCC WTE (blue) rises from 779.85 to 815.28 to 882.40. WBS WTE (red) from 411.39 to 405.077 to 417.80. Corp WTE (green) from 160.03 to 182.05 to 222.49. R&D WTE (purple), TCS WTE (cyan), HTW WTE (orange) with values 51.20 and 23.91. Y-axis labelled WTE, X-axis labelled Month / Year.]
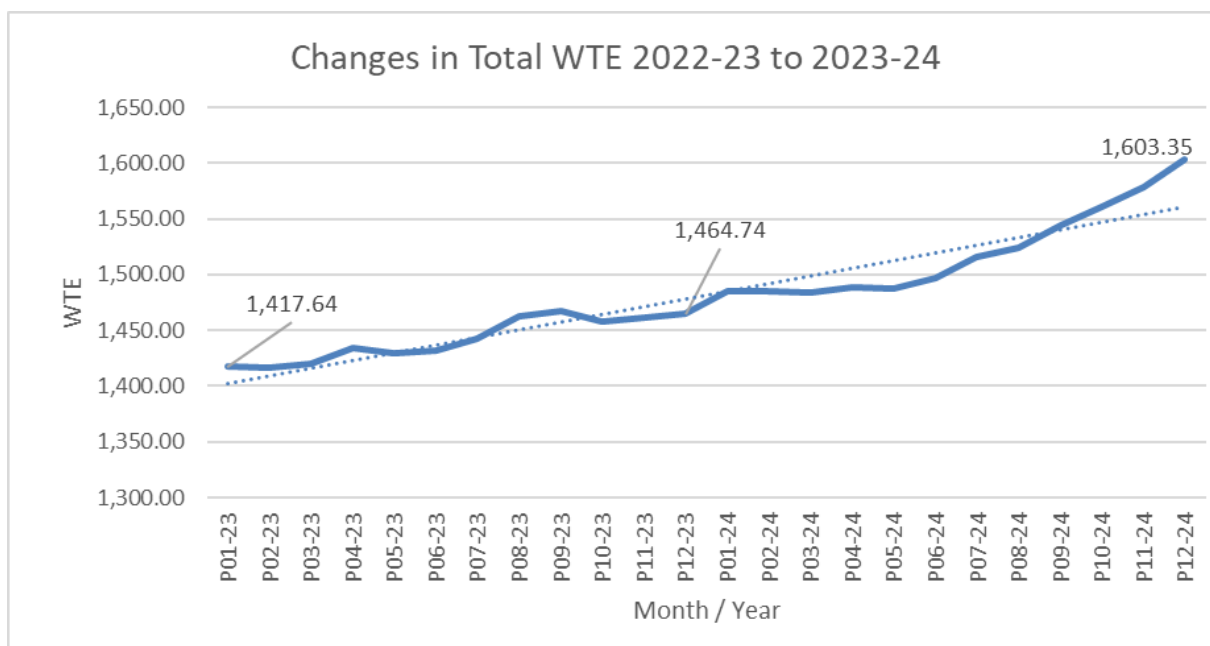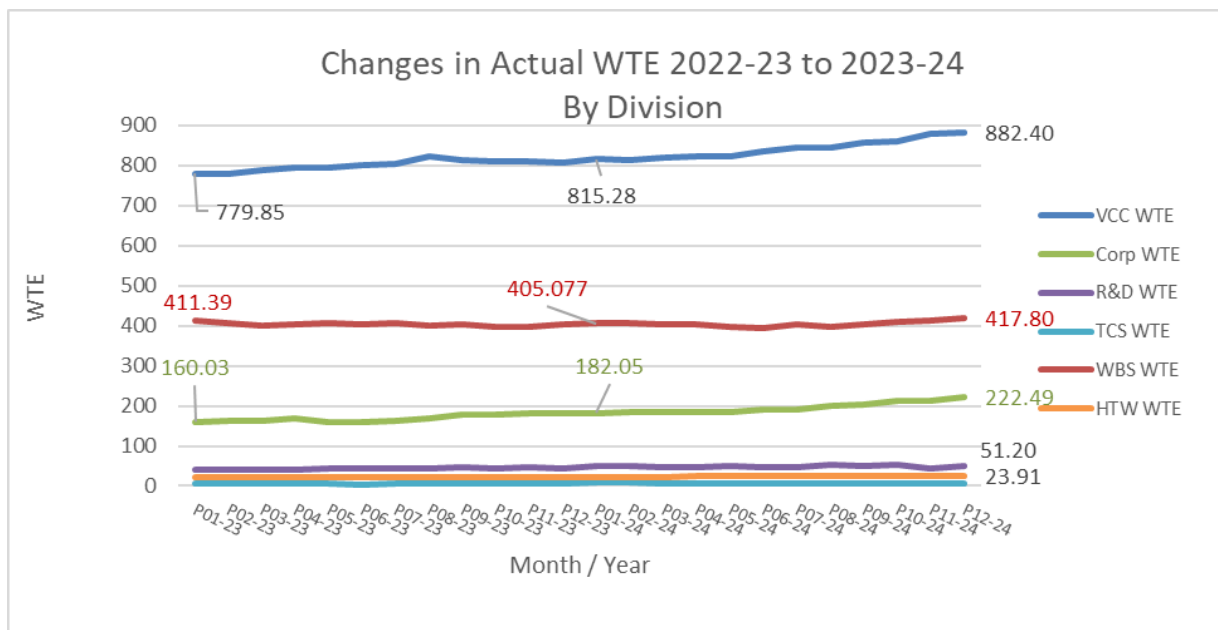
4.3 Non-Pay

The Average non-pay spend for 2023/24 was £9.9m per month which is a £1.4m increase from the previous whole year average. Largest movement is in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month. Non-Pay expenditure has significantly increased over the past 2 years (c20%) which has been largely drive by drug spend, commercial blood products (wholesaling), along with an increase in energy prices and genera inflation.

Monthly Non Pay Spend 2023-24 compared to Average 22-23 & 21-22

[Bar chart showing Monthly Non Pay Spend for 2023/24 (grey bars) from P01-24 to P12-24, with reference lines for 2021/22 (blue, ~£8,000,000) and 2022/23 (orange, ~£8,500,000). Bars range from around £8.5m rising to £14,000,000 at P12-24.]

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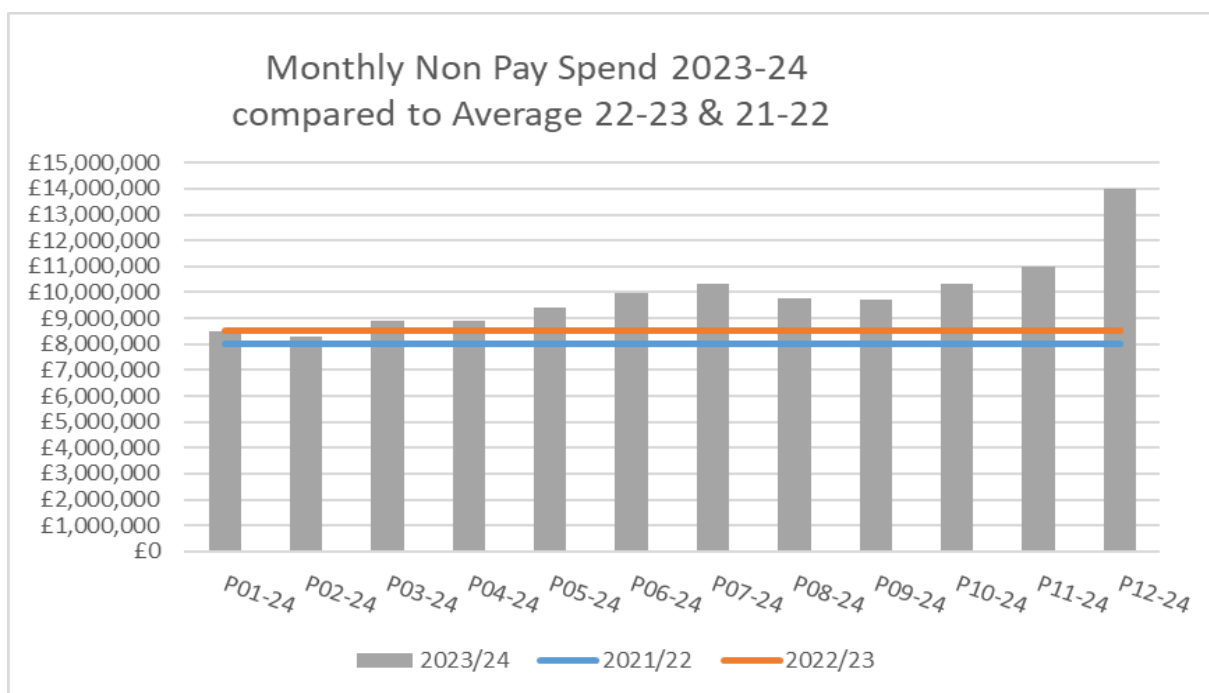
4.4 Covid-19

Covid Programme Costs

Last year there was clear expectation from WG that following issue of their Covid de-escalation letter that organisations would be extricating themselves from many of the Covid response costs. Therefore, WG have only committed to cover the financial costs of certain ongoing Covid response and national programme costs as set out in the Director General of Health & Social Services letter dated 22nd December 2022. These programme costs will include support towards mass vaccination, and the provision of PPE which will be funded to the Trust based on actual spend during 2023/24.

The Trust only drew funding from WG towards PPE costs of £0.053m for 2023-24. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

Covid Recovery and Planned Care Capacity

Committed investment in Velindre Cancer Services capacity was a recurrent sum of £3.5m made in 2021-22 and 2022-23 using WG Covid funding which ceased from 1st April 2023. The income to fund this additional capacity flows from Commissioners via performance related LTA contracting income which is dependent on activity levels being delivered above the 2019-20 baseline contract. The LTAs approved by LHBs in June 2023 included a level of income protection for the Trust. Recognising the financial pressures faced by the system in NHS Wales, the Trust Board decided in August to relinquish the income protection arrangements to contribute to the reduction of the NHS Wales planned deficit. This was formally communicated with Commissioners and transacted following updated LTAs in September.

The Trust's Integrated Medium-Term Financial Plan assumed that activity levels may not be sufficient to recover all the £3.5m investment made to support the planned care backlog capacity. The final position for 2023-24, however confirmed that the contract activity performance recovered sufficiently to cover the £3.5m investment.

Whilst the gap in funding has recovered since the IMTP planning stage for this financial year, work is continuing to review all Covid recovery investment within Velindre Cancer Services, with a view to understanding the direct capacity related benefits and mitigations such as reducing, removing, or repurposing these costs.

4. Savings

The Trust established as part of the IMTP a savings requirement of £1.800m for 2023-24, £1.000m recurrent and £0.800m non-recurrent, with £1.275m being categorised as actual saving schemes and the balance of £0.525m being income generation.

The Divisional share of the overall Trust savings target has been allocated to VCS £0.950m (53%), WBS £0.700m (39%), and Corporate £0.150m (8%).

Following an in depth assessment of savings schemes in July, several schemes were assessed as non-deliverable and RAG rated red. The impacted schemes largely relate to workforce and the

supply chain with non-recurrent replacement schemes having been identified to ensure that the overall target is achieved for 2023/24.

Failure to enact several recurrent savings schemes and replacing with those that are non-recurrent in nature has removed the underlying surplus of £0.391m position that had been carried forward from 2022-23.

Service redesign and support service structures continue to be a key area for the Trust where it is focusing on to find efficiencies in the ways we are working, ensuring the appropriate staff are undertaking each activity. Whilst this remains a high priority the ability to enact change has been challenging due to both the high level of activity growth and sickness limiting the capacity of service leads to implement changes.

The procurement supply chain saving schemes have again been affected by both procurement team capacity constraints and current market conditions during 2023-24, where we have seen a significant increase in costs for both materials and services. Whilst delivery was not achieved this year work will continue with procurement colleagues to identify further opportunities to deliver savings through the supply chain as we move into 2024-25.

It is extremely important that Divisions continuously review and monitor their current savings schemes, and where risks to delivery or significant variances are identified that alternative schemes are implemented, or mitigations put in place to ensure that the Savings target is met each year.

ORIGINAL PLAN	TOTAL £000		F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	950		950	0
			100%	
WBS TOTAL SAVINGS	700		700	0
			100%	
CORPORATE TOTAL SAVINGS	150		150	0
			100%	
TRUST TOTAL SAVINGS IDENTIFIED	1,800		1,800	0
			100%	

Scheme Type	TOTAL £000		F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes				
Establishment Control (N/R) (Corporate)	75		75	0
Procurement Supply Chain (R) (WBS)	100		0	(100)
Collection Team Costs Reduction (R) (WBS)	10		10	0
Collection Team Costs Reduction (NR) (WBS)	8		8	0
Establishment Control (R) (WBS)	60		60	0
Reduced use of Nitrogen (R) (WBS)	55		0	(55)
Reduced Research Investment (R) (WBS)	25		25	0
Stock Management (NR) (WBS)	125		125	0
Reduced Transport Maintenance (NR) (WBS)	30		30	0
Demand Planning - Volume Driven Benefits (NR) (WBS)	137		137	0
Service Workforce Re-design (R) (VCS)	50		0	(50)
Establishment Control (NR) (VCS)	175		175	0
Non Pay Controls - Rationalisation of Service (NR) VCS	150		150	0
Reduction in use of Agency - Radiation Services (R) (VCS)	125		125	0
Reduction in use of Agency - Radiation Services (NR) (VCS)	50		50	0
Procurement Supply Chain (R) (VCS)	100		0	(100)
Total Saving Schemes	**1,275**		970	(305)

Income Generation	TOTAL £000		F'cast Full Year £000	F'cast Variance Full Year £000
Bank Interest (R) (Corporate)	75		75	0
Sale of Plasma (R) (WBS)	150		150	0
Expand SACT Delivery (R) (VCS)	200		200	0
Private Patient Income (R) (VCS)	50		50	0
Private Patient Income (N/R) (VCS)	50		50	0
NEW Medicines at Home (N/R) (VCS)			150	150
NEW Sale of Plasma (NR) (WBS)			155	155
Total Income Generation	**525**		830	305

TRUST TOTAL SAVINGS	1,800		1,800	0
			100%	

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Cummulative monthly savings achieved compared to target

- Cumulative Achieved Savings
- Cumulative Target Savings
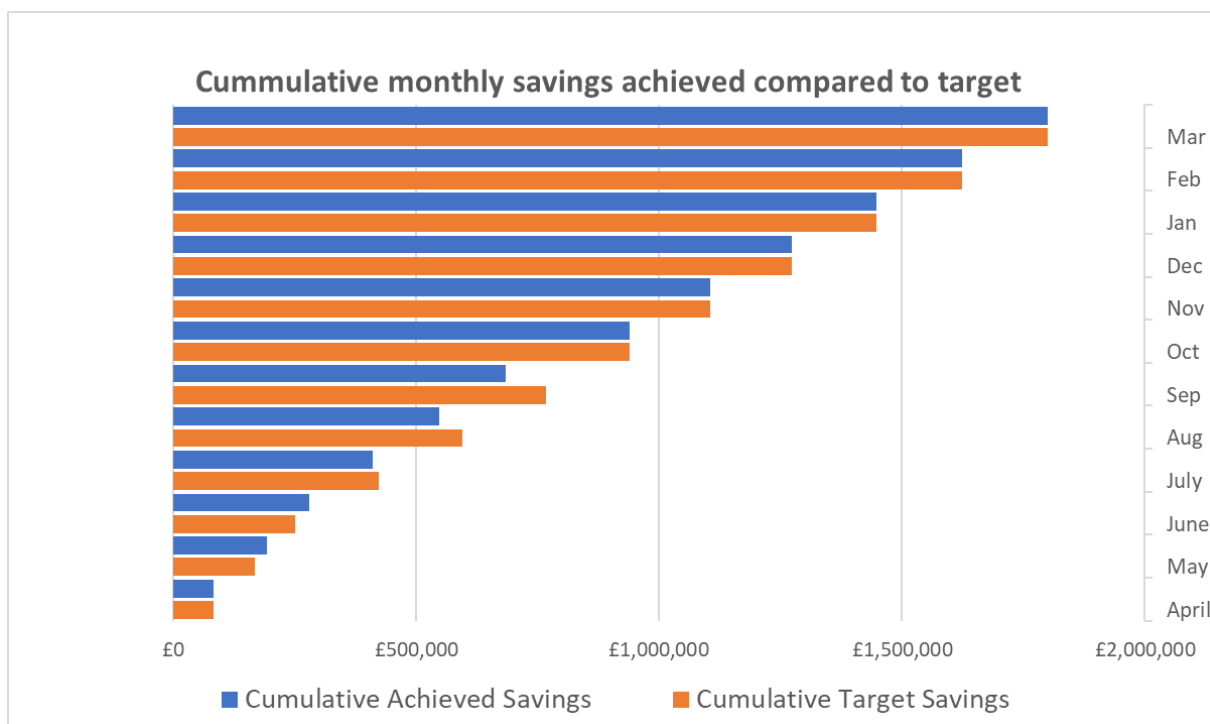
5. Reserves

The financial strategy for 2023-24 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. These assumptions have largely held, apart from the non-delivery of £0.305m of planned recurrent savings which have been replaced by non-recurrent schemes and removal of the planned c/fwd of a recurrent surplus into 2024-25.

As well as the planned reserves further, un-planned non-recurrent reserves had arisen during the year as financial pressures built into the IMTP financial plan reduced (e.g. energy costs) or been mitigated and income levels improved above the plan, including Bank Interest, cancer services activity recovery above plan, balance sheet provisions not required, Plasma Sale income (commercial) and Private Patient Income (Commercial) above plan.

In addition to the above reserves, each year the Trust holds an emergency reserve of £0.522m which was not utilised in the period and per previous agreement by the Board this was provided to WG on a non-recurrent basis to support the NHS Wales financial position during 2023-24.

6. Risk & Opportunities Assessment

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2023-24, however following actions taken by the Trust all risks were either been managed or mitigated for 2023/24.

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The remaining key financial risks & opportunities relating to 2024-25 as highlighted to Welsh Government are provided below:

Risks

2023/24 Pay Award – c£0.300m

The Trust received full funding from WG during 2023-24 for the recurrent impact of the 1.5% (c£1.2m), 5% (c£3.5m) AFC consolidated pay award which was processed in July and the Medical Pay award paid in October (c£0.7m). However, whilst the Trust received full funding to support the pay award during 2023-24, WG are yet to confirm whether the allocation was on a recurrent basis, which if not forthcoming could lead to an underlying shortfall being carried into next financial year.

Trust wide - Management of Operational Cost Pressures – *Risk mitigated for 2023/24 / Risk 2024/25.*

Whilst there are several cost pressures within the service Divisions these have been manged from within normal budgetary control procedures or through utilisation of the Trust non-recurrent reserve during 2023/24. The recurrent impact of these cost pressures for future years has removed any underlying surplus and has been considered as part of the 2024-25 to 2026-27 IMTP process with an increase savings target required to offset the cost pressures.

VCS - NEW RISK - Whitchurch Site Security – *Risk mitigated for 2023/24 / Risk 2024/25.*

There are a number of annual revenue costs that the Trust will inherit on the transfer of the Whitchurch land and hospital building as well as future costs of disposal / development. The annual costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT).The Trust does not currently have any identified agreed funding route for these costs, but its expectation, based on discussions between Trust Officers and WG Officials, is that WG will fund these costs.

The site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) and the make safe cost for the Whitchurch Hospital is estimated at between £1.65m - £2.73m (Exc VAT).

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the costs implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer will be dependent on completion of the WG formal process for transfer which is currently anticipated to take place before the 31st March 2024. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the residual Whitchurch estate can be disposed of or developed. This £0.640m cost pressure together with other revenue cost pressures relating to the nVCC over the next 4 years could lead to the Trust failing to meet its Financial breakeven requirement.

Opportunities Pipeline

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The Trust has identified some initial opportunities that could be explored but these require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.

Title	Scope	Total value Opportunity £'m	2024/25 ambition £'m	2025/26 ambition £'m	V&S Board Category	Programme Complexity
Pre-Operative Anaemia Pathway Project	Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively, and offered treatment with intravenous Iron as required prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.	tbc	tbc	Tbc	Pathway	3
Medicine Unit Supply	Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners	Tbc	0.500	0.500	Medicines Management	3
Workforce Re-design	Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.	Tbc	0.000	0.250	Workforce	4
Procurement	Continue to work with procurement and divisions on a regular basis to review non pay	0.400	0.200	0.200	Procurement & Non-pay	2

	spend and cost improvement opportunities above savings target					

7. CAPITAL EXPENDITURE

Administrative Target
- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *And to ensure the Trust does not exceed its External Financing Limit*

	Approved CEL 2023/24 £m	Actual Spend 2023/24 £m	Year End Variance 2023/24 £m
All Wales Capital Programme			
nVCC - Enabling Works	10.896	10.881	0.015
nVCC - Project costs	3.257	3.257	0.000
nVCC - Advanced Design Works	3.882	3.882	0.000
nVCC - Advanced Works	0.898	0.898	0.000
nVCC - Advanced Design Works	1.229	1.229	0.000
nVCC - Whitchurch Hospital Site	0.000	0.014	(0.014)
Integrated Radiotherapy Solutions (IRS)	7.826	7.613	0.213
IRS Satellite Centre (RSC)	0.147	0.145	0.002
Digital Priorities Investment Fund	0.164	0.164	0.000
Digital DPIF -RISP	0.168	0.168	0.000
Digital Cyber Security	0.051	0.051	0.000
Digital Cyber Security (2)	0.085	0.095	(0.010)
Digital DPIF - EPMA	0.100	0.100	0.000
Digital WHAIS	0.250	0.246	0.004
Capital Year End Spend	0.257	0.252	0.005
Establish Microfludic Technology (WBS)	0.112	0.104	0.008
Total All Wales Capital Programme	29.322	29.099	0.223
Discretionary Capital	1.683	1.903	(0.220)
Total	31.005	31.002	0.003

The final approved Capital Expenditure Limit (CEL) as at March 2024 was **£31.005m**. This represents all Wales Capital funding of **£29.322m**, and Discretionary funding of **£1.683m.**

During September the Trust was awarded £3.882m in respect of advanced design works in nVCC.

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During December the Trust was awarded £0.898m towards nVCC advanced works, £0.168m from the DFIF fund for RISP, and £0.051m for cyber security.

In January the Trust was awarded £0.085m for cyber security, £0.100m for EPMA, £0.250m for WHAIS (previously ringfenced from discretionary) and £0.257m towards the year end prioritised Capital Scheme list which was submitted to WG on 12th January. The allocation has provided funding to support the following prioritised schemes.

Scheme	Amount £'000s
Abdominal Compression	35
Centrifuge Sorvall	7
Hand and Foot Monitor	25
Microplate Reader	6
Phase Contrast Material for Transport of Frozen Products	40
PRRT	35
QPCR Machine (PC-DCR Machine)	75
Radiological Equipment Test Instrument	16
Replacement Blood Gas Analyser	18
Total	**257**

The Trust was provided with £3.257m for the nVCC related project costs and £0.112m towards Establishing Microfluidic Technology in WBS during February.

In March the Trust was provided a further £1.229m towards advanced design works associated with the nVCC.

Following the delays in both the nVCC and Radiotherapy Satellite Centre (RSC) the Trust returned £2.5m of funding for the IRS programme, and £1.2m for the RSC project to WG during this September, with the caveat that the funding will be re-provided in future years.

The discretionary allocation of £1.683m for 2023-24 and represented an increase of 16% on the £1.454m provided during 2022/23.

The allocation of the discretionary programme for 2023/24 was agreed at the Capital Planning Group on the 11th July and endorsed for approval by the Strategic Capital Board on the 14th July and formally approved by EMB on the 31st July.

Within the discretionary programme £0.340m had been ring fenced to support the nVCC enabling works and project costs. Following slippage in expenditure against the enabling works budget this funding has now been re-provided to the discretionary programme and was re-allocated based on Divisional priorities. In addition, a further £0.250m was ringfenced to support WHAIS with the Trust only receiving confirmation of funding from WG on the 14th February. The £0.250m was also released and redistributed against prioritised schemes within the Trust which could be delivered before the 31st March.

NHS – All Wales Capital Prioritisation
The Trust received notification from WG in November 2023 that the NHS Infrastructure Investment Board (IIB) have agreed a framework for investment decision making that will provide a common basis for prioritisation of capital schemes. The review and prioritisation for 2023/24 is required due to the challenging financial climate, an oversubscribed capital backlog and need to ensure alignment with the Duty of Quality which came into force in April 2023. Consequently, the Trust

completed a prioritisation form for all schemes included within the IMTP which were presented to EMB shape on the 18th March and submitted to WG alongside the IMTP on the 28th March.

Yearend Performance

The actual total expenditure for 2023-24 on the All-Wales Capital Programme schemes was £29.099m against an agreed CEL of £29.322m. With WG agreement £0.213m was released from the IRS scheme back to discretionary, which is following the Trusts discretionary providing £0.248m to support the IRS implementation phase in prior years. .

Spend on Discretionary Capital to March was £1.903m.

The core Trust reported actual total Capital spend of £31.002m ensuring that the Trust CEL target of £31.005m was achieved for 2023-24.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The latest draft position of schemes that will be included in the IMTP for 2024-25 is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2024-25	2025-26	2026-27	2027/28	Further Years	Total All Wales Schemes
	£m	£m	£m	£m	£m	£m
All Wales Approved Schemes						
TCS nVCC enabling works		1.547				1.547
Integrated Radiotherapy Solution (IRS)	5.164	2.040	15.800	0.839		23.843
Radiotherapy Satellite Unit	11.265					11.265
Total Approved Capital Schemes	**16.429**	**3.587**	**15.800**	**0.839**	**0.000**	**36.655**
All Wales Unapproved Schemes						
TCS nVCC	15.791	11.000	36.962	1.741		65.494
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.086	0.688	0.680	0.400		2.854
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	0.970	0.064	0.064	0.203		1.301
Talbot Green - Infrastructure	0.303	1.346	10.633	10.640	19.707	42.629
WBS Fleet Replacement		0.373	1.112	1.285		2.770
WBS Asset Replacement	0.100	0.494	0.121		1.560	2.275
First Floor Ward Ventilation	0.370					0.370
Condition Survey Recommendations	0.250	0.200	0.150			0.600
BECS Blood Mangagement System	0.100	0.200	0.200	1.000		1.500
Total Unapproved Capital Schemes	**23.184**	**14.457**	**50.522**	**15.269**	**21.267**	**124.699**
Total All Wales Capital Plans	**39.613**	**18.044**	**66.322**	**16.108**	**21.267**	**161.354**

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8. BALANCE SHEET / Statement of Financial Position (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.

Due to the financial year end the balance sheet is currently will not be ready for presentation until the accounts are completed at the end of April 24.

9. CASH FLOW (Includes Hosted Organisations)

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.

As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation with Covid and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however have now issued the additional stock and the £4.5m was repaid to WG during February '23.

In order to support cash flow pressures during October the Trust drew down £8.881m of Public Dividend Capital (PDC) from WG. In addition, whilst the Trust was waiting to receive confirmation of the 2023-24 Pay award allocation, WG provided an interim payment of c£10m during February which equates to 90% of the pay award for the whole Trust with the final 10% being provided during March 24.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

Due to the financial year end the Cash Flow is currently will not be ready for presentation until the accounts are completed at the end of April 24.

DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
VCC	(43.594)	(43.590)	0.004
RD&I	(0.114)	(0.000)	0.114
WBS	(21.734)	(21.514)	0.220
Sub-Total Divisions	**(65.442)**	**(65.104)**	**0.338**
Corporate Services Directorates	(14.027)	(14.517)	(0.491)
Delegated Budget Position	**(79.469)**	**(79.622)**	**(0.152)**
TCS	(0.744)	(0.613)	0.131
Health Technology Wales	(0.117)	(0.115)	0.001
Trust Income / Reserves	**80.330**	**80.381**	**0.050**
Trust Position	0.000	0.030	0.030

VCS

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**76.919**	**77.749**	**0.830**
Expenditure			
Staff	**50.197**	**50.113**	**0.084**
Non Staff	70.316	71.226	(0.909)
Sub Total	**120.513**	**121.338**	**(0.825)**
Total	**(43.594)**	**(43.590)**	**0.004**

VCS Key Highlights/ Issues:

The final reported financial position for Velindre Cancer Services as at the end of March 2024 was an underspend of **£0.004m.**

Income surplus of **£0.830m**. Considerable overachievement on Private Patients drugs due to both activity and the VAT savings from delivery of SACT homecare. This is offsetting and providing a significant surplus above the divisional management savings target. Other income

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overachievements are in areas such as Catering and project income which are offset with non-pay costs.

VCS reported a year end underspend of **£0.084m** against staff. Vacancies with the division continue to reduce with VCS filing 10 vacancies in October across various departments including outpatients, Complementary Therapies, SACT day care and 3 posts within Radiotherapy. Vacancies this year had been particularly high especially within in Nursing budgets, this along with recruitment challenges, has offset both the vacancy savings target and the requirement to support posts appointed into without funding agreement i.e. Advanced recruitment and Capacity investments. The international recruitment scheme has been used to help fill current vacancies in Nursing with 17wte having been recruited during February and March.

Non-Staff Expenditure reported an overspend of **£(0.909)m** which is a result of the divisional management savings target, along with increased activity pressures which can be linked to activity contract performance in areas such as PICC and SACT following treatment returning to Nevill Hall.

WBS

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	29.588	30.193	0.605
Expenditure			
Staff	18.127	18.145	(0.018)
Non Staff	33.195	33.562	(0.367)
Sub Total	51.322	51.707	(0.385)
Total	(21.734)	(21.514)	0.220

Key Highlights/ Issues:

The final reported financial position for the Welsh Blood Service at the end of March 2024 was an underspend of **£0.220m**.

Income overachievement of **£0.605m**. Targeted income generation on plasma sales through increased activity which is exceeding planned expectations and creating opportunities to support divisional investment. Plasma sale income is being partly offset by lower than planned Bone Marrow activity.

There has been a lack of growth in the bone marrow registry which was largely impacted during the pandemic and is still yet to see signs of recovery. WBS are continuing to run campaigns in order to try and grow the panel in sites such as schools and universities, and also raise awareness through advertising on platforms such as social media, however the annual target underachieves by c40%.

Staff reported a **£(0.018)m** overspend. Vacancies are offsetting the divisional Vacancy target of £0.450m and helping to supported posts recruited without identified funding source. This includes advanced recruitment and service developments which have been incurred as a divisional cost

pressure particularly in relation to Component development where no WHSSC funding has been secured.

Discussions ongoing within WBS SMT to either secure additional funding to support these posts or looking at options to migrate staff into vacancies to help mitigate the current risk exposure.

Non-Staff reported an overspend of **£(0.367)m** . Venue hire costs pressures c£10-£15k per month previously funded by WHSSC, are being partly offset by reduced spend from lower activity releasing non-recurrent benefits linked to reduced production volumes. Trust and Divisional savings plans are phased into the position and contributed to the overspend.

Corporate

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	7.125	6.781	(0.344)
Expenditure			
Staff	16.739	16.340	0.399
Non Staff	4.412	4.958	(0.546)
Sub Total	21.151	21.298	(0.147)
Total	(14.027)	(14.517)	(0.491)

Corporate Key Highlights / Issues:

The final reported financial position for the Corporate Services division at the end of March 2024 was an overspend of **£(0.491)m**.

The £1.5m agreed suspension of recharges to the Charity was reflected within the Corporate Position at the financial year end resulting in an underachievement on income, which offset the significant over achievement on bank interest during 2023-24.

Staff reported a £0.399m underspend. Several vacancies have been carried throughout the year across the division particularly within finance. This offset the Divisional cost of agency and the divisional savings target set against non-pay.

Non pay overspend largely related to the divisional savings target and the increased running costs associated with the ageing hospital estate.

RD&I

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**3.757**	**3.925**	**0.168**
Expenditure			
Staff	**3.217**	**3.037**	**0.180**
Non Staff	**0.654**	**0.889**	**(0.234)**
Sub Total	3.871	3.925	(0.054)
Total	(0.114)	(0.000)	0.114

RD&I Key Highlights / Issues

The final reported financial position for the RD&I Division at the end of March 2024 was an underspend of **£0.114m**.

Trials activity crystallising in March resulted in significant income and expenditure be recognised at the financial year end.

Overall underspend is a result of the pay award funding not being factored into the position until the financial year end.

TCS – (Revenue)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**0.000**	**0.144**	**0.144**
Expenditure			
Staff	**0.693**	**0.676**	**0.017**
Non Staff	**0.051**	**0.080**	**(0.029)**
Sub Total	0.744	0.757	(0.012)
Total	(0.744)	(0.613)	0.131

TCS Key Highlights / Issues

The final reported financial position for the TCS Programme at the end of March 2024 was an underspend of **£0.131m.**

The underspend was a result of accrued interest on the Escrow bank account.

HTW (Hosted Other)

	Full Year Budget £m	Full Year Actual £m	Closing Variance £m
Income	**1.677**	**1.626**	**(0.051)**
Expenditure			
Staff	**1.545**	**1.528**	**0.018**
Non Staff	**0.248**	**0.214**	**0.035**
Sub Total	1.794	1.741	0.052
Total	(0.117)	(0.115)	0.001

HTW Key Highlights / Issues

The final reported financial position for Health Technology Wales at the end of March 2024 was **a** small underspend of **£0.001m.**

HTW programme costs are funded directly by WG.
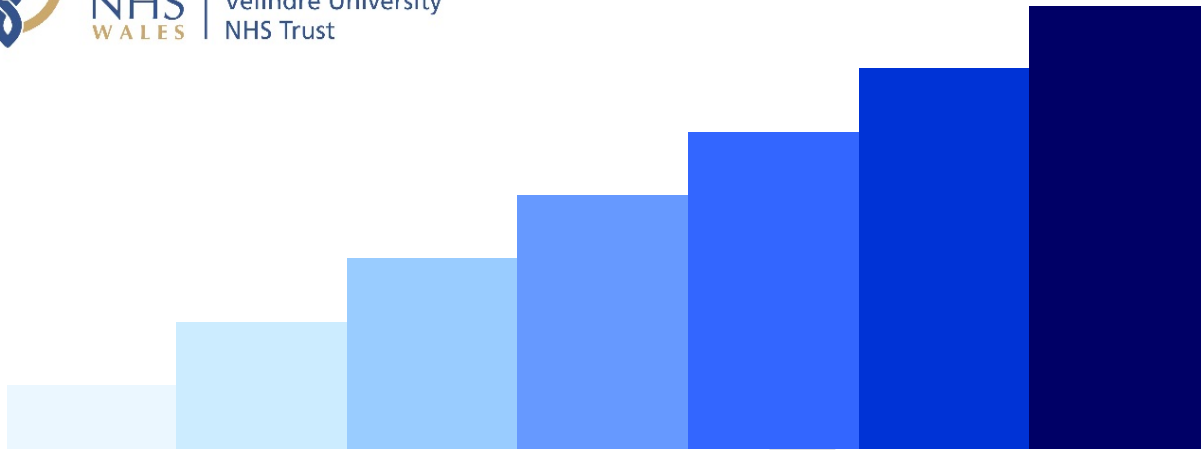
TCS PROGRAMME
FINANCE REPORT 2023-24

Period Ending 31st March 2024

Contents   Page

1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2023-24, outlining spend against budget for the financial year 2023-24.

1.2 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the TCS Programme Delivery Board and Trust Board.

2. EXECUTIVE SUMMARY

2.1 The final financial position for the TCS Programme for the year 2023-24 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	2023-24 Full Year		
	Budget	Forecast	Variance
Capital	£20.163m	£20.162m	£0.001m
Revenue	£0.785m	£0.756m	£0.030m
Total	**£20.948m**	**£20.918m**	**£0.030m**

2.2 The overall outturn for the Programme is an underspend of £0.030m for the financial year 2023-24 against a budget of £20.948m.

2.3 Additional capital funding of £1.229m was allocated by WG to the ADDA Project for this financial year in March 2024.

2.4 The current financial risks associated with the TCS Programme are:

• There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

• There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG.

3. BACKGROUND

3.1 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 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.

3.2 By 31st March 2023, the Welsh Government (WG) had provided a total of £42.377m funding (£40.084m capital, £2.293m revenue) to support the TCS Programme. In addition, the Trust provided £0.264m from its discretionary capital allocation and £0.380m non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018-19, increased to £0.420m thereafter.

3.4 The current funding provided to support the TCS Programme in 2023-24 is £18.934m capital and £0.785m revenue, as outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding
Initial Allocation (as at 1st April 2023)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£0	£0
ADDA	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£10.896m**	**£10.896m**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£3.257m	£3.257m
ADDA	£6.009m	£6.009m
Whitchurch Hospital Site	£0	£0
Total	**£9.266m**	**£9.266m**

Current Allocation (as at 31st March 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£10.896m	£10.896m
nVCC Project	£3.257m	£3.257m
ADDA	£6.009m	£6.009m
Whitchurch Hospital Site	£0	£0
Total	**£20.163m**	**£20.163m**

Sources of Revenue Funding
Initial Allocation (as at 1st April 2023)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0	£0	£0.300m
nVCC	£0	£0	£0	£0	£0
SDT	£0.180m	£0.131m	£0	£0	£0.311m
Total	**£0.420m**	**£0.191m**	**£0**	**£0**	**£0.611m**

Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0	£0	£0.028m	£0	£0.028m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0	£0	£0.009m	£0	£0.009m
Total	**£0**	**£0**	**£0.133m**	**£0.041m**	**£0.174m**

Current Allocation (as at 31st March 2024)

Project	LHB Commissioners	Trust Reserves	WG Pay Award	Escrow Interest	Total Funding
PMO	£0.240m	£0.060m	£0.028m	£0	£0.328m
nVCC	£0	£0	£0.096m	£0.041m	£0.137m
SDT	£0.180m	£0.131m	£0.009m	£0	£0.320m
Total	**£0.420m**	**£0.191m**	**£0.133m**	**£0.041m**	**£0.785m**

4.   CAPITAL POSITION

4.1   The current capital funding for 2023-24 is outlined below:

- Enabling Works Project   £10.896m
- nVCC Project   £3.257m
- ADDA   £6.009m
- Whitchurch Hospital Site   £0
  Total   **£20.163m**

4.2   The capital position as at 31st March 2024 is outlined below, with a total spend of £20.162m for 2023-24 against a budget of £20.163m.

Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Enabling Works Project	£10.896m	£10.251m	£0.645m
nVCC Project	£3.257m	£3.874m	-£0.618m
ADDA	£6.009m	£6.009m	£0
Whitchurch Hospital Site	£0	£0.027m	-£0.027m
Total	**£20.163m**	**£20.162m**	**£0.001m**

4.3   Further capital funding of £1.229m was allocated to the ADDA Project by WG for 2023-24 in March 2024.

4.4   There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

5.   REVENUE POSITION

5.1   The revenue funding for 2023-24 is outlined below:

- PMO   £0.328m
- nVCC Project   £0.137m
- SDT Project   £0.320m
  Total   **£0.785m**

5.2   The revenue position as at 31st March 2024 is outlined below, with a total spend of £0.756m for 2023-24 against a budget of £0.785m.

Revenue Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
PMO	£0.328m	£0.320m	£0.008m
nVCC Project	£0.137m	£0.136m	£0.002m
SDT Project	£0.320m	£0.300m	£0.019m
Total	**£0.785m**	**£0.756m**	**£0.030m**

5.3   Revenue funding of £0.041m has been provided to the nVCC Project for Project Delivery and Judicial Review cost from interest incurred from the Escrow Account.

5.4   The 2022-23 one-off pay recovery payment was paid out in June 2023, with funding provided by WG in June 2023 via the Trust. Funding has also been provided by WG to cover the recurrent pay award for 2023-24 paid out in August 2023.

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The run rate indicates that the majority of costs were incurred within the first half of the financial year.

EW Project Cash Flow 2023-24
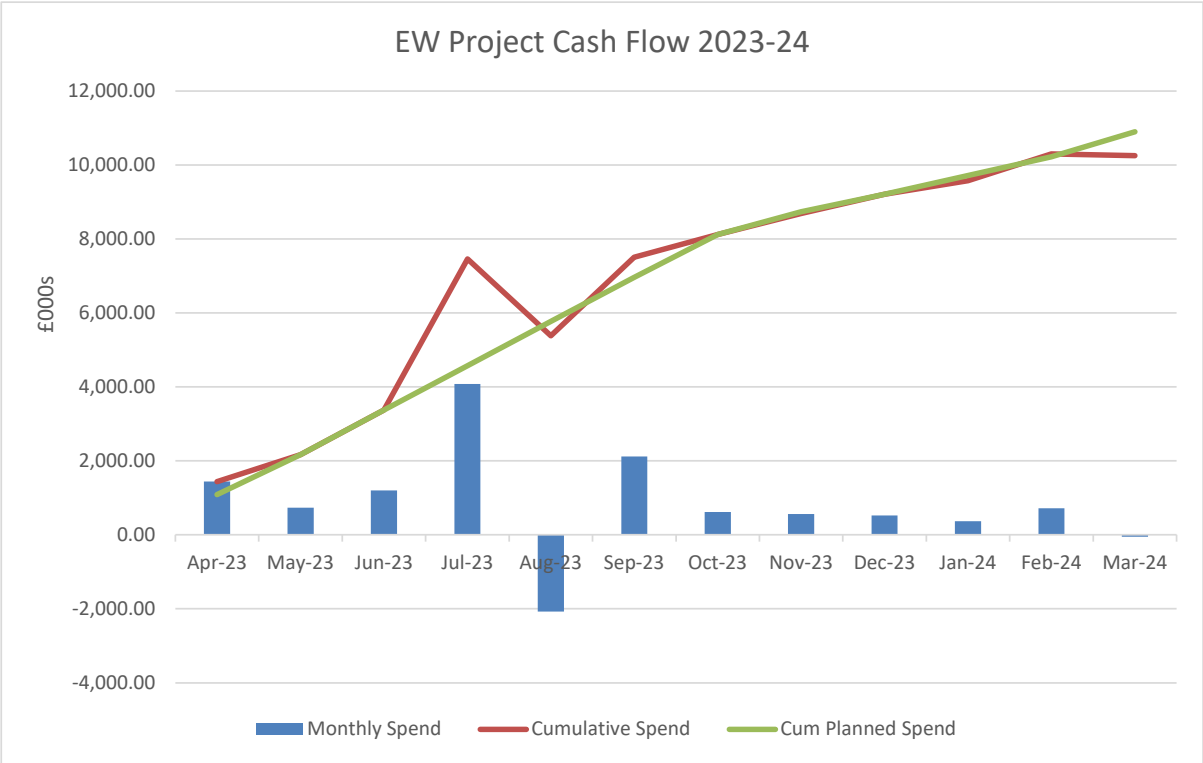
6.2 The capital cash flow for the **nVCC Project** is outlined below. Actual spend is higher than planned spend due to the increased costs associated with the delay in financial close.

nVCC Project Cash Flow 2023-24
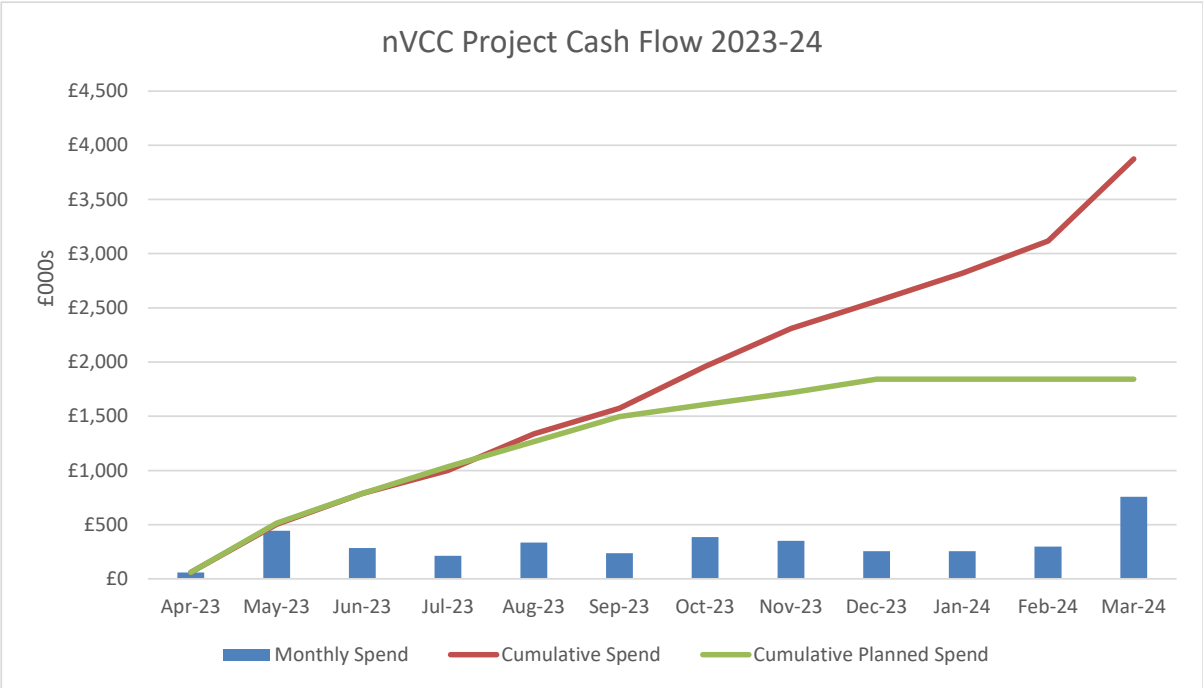
6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The revenue funding for the PMO for 2023-24 is £0.328m. £0.240m of this has been provide from NHS Commissioners' funding, £0.060m from the Trust Reserves, and £0.028m from WG 2022-23 for pay awards.

7.3 There has been no capital funding requirement for the PMO in 2023-24.

7.4 The revenue position for the PMO as at 31st March 2024 is shown below, showing a total spend of £0.320m for the year against a budget of £0.328m.

PMO Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.316m	£0.307m	£0.009m
Non Pay	£0.013m	£0.013m	£0
Total	**£0.328m**	**£0.320m**	**£0.008m**

7.5 The underspend of £0.008m has been returned to Trust Reserves.

Enabling Works Project

7.6 In February 2022, the Minister for Health and Social Services approved the Enabling Works FBC. This has provided capital funding of £28.089m in total, with £10.896m provided in 2023-24.

7.7 The Project's financial position for 31st March 2024 is shown below. This reflects an underspend of £0.645m against a budget of £10.896m for this financial year. The underspend will offset capital overspend elsewhere within the TCS Programme.

Enabling Works Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.230m	£0.286m	-£0.056m
Non-Pay	£10.667m	£9.965m	£0.702m
Total	**£10.896m**	**£10.251m**	**£0.645m**

7.8 There are four new elements that require additional funding from WG, which were not known at the time of establishing the Enabling Works FBC, totalling £2.900m. This additional capital funding will require Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum. The elements are:

- Water Main Diversion £0.850m inc VAT
- S278 Works – Longwood Drive £1.200m inc VAT

- Off Site Habitat Creation   £0.400m inc VAT
- HV Intake Room   £0.450m inc VAT
  - **Total**   **£2.900m inc VAT**

7.9   The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2023-24

Description		Annual Budget £	Annual Forecast £	Annual Variance £
PAY				
	Project 1b - Enabling Works FBC	229,841	286,327	-56,486
Pay Capital Total		**229,841**	**286,327**	**-56,486**
NON-PAY				
EF02	Utility Costs	2,873,927	2,118,971	754,955
EF03	Supply Chain Fees	375,000	558,016	-183,016
EF04	Non Works Costs	312,505	409,519	-97,013
EF05	ASDA Works	3,813,893	2,284,906	1,528,987
EF06	Walters D&B	3,033,982	4,659,110	-1,625,128
EF07	Other (Decant Works, Surveys & Investigations, IM&T etc.)	0	0	0
EF08	Section 278	0	0	0
EFQR	Quantified Risk	257,245	512	256,733
EFQS	QRA - SCP	0	-65,439	65,439
EFRS	Enabling Works FBC Reserves	0	-763	763
Enabling Works FBC Project Capital Total		**10,666,552**	**9,964,833**	**701,719**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**10,896,393**	**10,251,160**	**645,233**

7.10   There is currently one financial risk associated with the Enabling Works Project:

- The four new elements to the Enabling Works Project require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

New Velindre Cancer Centre Project
Capital

7.11   The nVCC Project has been allocated capital funding of £3.257m for 2023-24 by WG in January 2024.

7.12   The capital financial position for the nVCC Project for 31st March 2024 is shown below, with an overspend of £0.618m. This overspend is offset by an underspend in the Enabling Works Project.

nVCC Capital Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£1.164m	£1.153m	£0.011m
Non-Pay	£2.093m	£2.721m	-£0.629m
Total	**£3.257m**	**£3.874m**	**-£0.618m**

7.13   The spend relates to the following activities:

nVCC OBC Project Capital Budget & Spend Summary 2023-24

Description	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY			
Project Leadership nVCC OBC	213,691	226,260	-12,569
Project 2a - New Velindre Cancer Centre OBC	950,370	926,859	23,511
Pay Capital Total	**1,164,061**	**1,153,119**	**10,942**
NON-PAY			
nVCC OBC Project Delivery	63,963	60,864	3,099
Work Packages			
VC08 Competitive Dialogue - Dialogue & SP to FC	1,828,788	2,404,090	-575,302
VC10 Legal Advice	32,398	13,314	19,084
VC11 S73 Planning	14,437	14,437	0
VC12 nVCC FBC	153,216	207,667	-54,451
VCRS nVCC OBC Reserves	0	20,945	-20,945
nVCC Project Capital Total	**2,028,839**	**2,660,453**	**-631,614**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**3,256,863**	**3,874,435**	**-617,572**

7.14   There are currently no capital financial risks to the Project.

Revenue

7.15   The revenue funding for the nVCC Project for 2023-24 is £0.137m, provided from WG for pay awards and interest incurred from the Escrow account. The latter supersedes the proposed request for revenue funding of £0.030m for nVCC Project Delivery and £0.011m for the Judicial Review.

7.16   The revenue financial position for the nVCC Project for 31st March 2024 is shown below, reflecting an underspend of £0.002m for the year against a budget of £0.137m.

nVCC Revenue Expenditure	2023-24 Full Year		
	Budget	**Forecast**	**Variance**
Pay	£0.096m	£0.096m	£0
Project Delivery	£0.030m	£0.028m	£0.002m
Judicial Review	£0.011m	£0.011m	£0
Total	**£0.137m**	**£0.136m**	**£0.002m**

7.17   The Judicial Review matter is now closed, with the final costs being submitted in July 2023. The final cost in 2023-24 is £0.011m, with a total cost for this matter of £0.138m.

7.18   There are no revenue financial risk associated with the nVCC Project at present.

Advanced Design Delivery Agreement (ADDA)

7.19   The ADDA Project reflects the commercial agreement between the Trust and SACYR for advance design services that covers RIBA stage 4 design / design not falling under the nVCC MIM Project bid deliverables and including masterplan amendments. In addition, it covers design costs associated with the Value Engineering exercise. The RIBA Stage 4 direct costs have been incurred (including management team) in the sum of £5.111m, for which funding has been provided by WG.

7.20 The Project includes the Advanced Works Agreement, which received funding of £0.898m from WG in early January 2024.

7.21 The capital financial position for this Project for 31st March 2024 is shown below, with a total spend of £6.009m against a budget of the same for the year.

ADDA Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Non-Pay	£6.009m	£6.009m	£0
Total	**£6.009m**	**£6.009m**	£0

7.22 The spend relates to the following activities:

ADDA Capital Budget & Spend Summary 2023-24			
Description	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY			
Project 2b - Advanced Design Development Agreement	0	0	0
Pay Capital Total	**0**	**0**	**0**
NON-PAY			
Work Packages			
AD01 Advanced Design Development Agreement	5,110,995	5,110,995	0
AD02 Advanced Works Agreement	898,457	898,458	-1
nVCC Project Capital Total	**6,009,452**	**6,009,453**	**-1**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**6,009,452**	**6,009,453**	**-1**

7.23 There are currently no financial risks for this project.

Whitchurch Hospital Site

7.24 The achievement of the EPSL from NRW required the granting of a habitat Licence on elements of the residual Whitchurch Hospital estate by Cardiff and Vale University Health Board. In order for the Trust to receive the habitat Licence from Cardiff and Vale University Health Board (C&VUHB), it agreed in principle to accept the formal transfer of the residual estate. The Trust is currently undertaking the required legal and technical diligence. With regards technical diligence, asbestos and condition surveys are being commissioned by the Trust to meet its obligations. The cost of the surveys is funded by securing additional funding from WG as part of the Enabling Works FBC Addendum.

7.25 The capital financial position for the Whitchurch Hospital Site Project for 31st March 2024 is shown below, with an overspend of £0.027m. This is offset by an underspend in the Enabling Works Project.

Whitchurch Hospital Site Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Non-Pay	£0	£0.027m	-£0.027m
Total	**£0**	**£0.027m**	**-£0.027m**

7.26 The spend relates to the following activities:

Whitchurch Hospital Site Capital Budget & Spend Summary 2023-24

Description	Annual Budget £	Financial Year Annual Forecast £	Annual Variance £
PAY			
Project 2c - Whitchurch Hospital Site	0	0	0
Pay Capital Total	**0**	**0**	**0**
NON-PAY			
Work Packages			
WS01 Advisory Services	0	20,300	-20,300
WS02 Prelimiary Works	0	6,495	-6,495
WSRS Whitchurch Hospital Site Reserves	0	0	0
nVCC Project Capital Total	**0**	**26,795**	**-26,795**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**26,795**	**-26,795**

Service Delivery and Transformation Project

7.27 The revenue funding for the Project for 2023-24 is £0.180m from NHS Commissioners' funding, £0.131 from Trust reserves, and £0.009m from the WG 2022-23 one-off recovery payment funding. The resulting budget is £0.320m for this financial year.

7.28 There is no capital funding requirement for the Project in 2023-24.

7.29 The SDT Project revenue position for 31st March 2024 is shown below, showing a total spend of £0.300m for the year against a budget of £0.320m.

SDT Expenditure	2023-24 Full Year		
	Budget	Forecast	Variance
Pay	£0.281m	£0.273m	£0.009m
Non-Pay	£0.038m	£0.028m	£0.011m
Total	**£0.320m**	**£0.300m**	**£0.019m**

7.30 The underspend for year of £0.019m has been returned to Trust Reserves.

8.   KEY RISKS AND MITIGATING ACTIONS

8.1 The current two financial risks associated with the TCS Programme are outlined below:

- There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works FBC Addendum.

- There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from WG.

9.   TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such

as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

9.2   Appendix 3 provides cumulative report to 31st March 2022. The report for the financial year 2022-23 is currently being produced.

9.3   The cumulative report shows a total spend for the TCS Programme of £30.352m (£26.481m Capital, £3.871m Revenue).   The total pay costs for this period were £11.303m.

9.4   The spend to 31st March 2022 for each Project within the Programme is summarised below.
Programme Management Office £1.656m
Project 1 Enabling Works £10.559m
Project 2 nVCC..£13.234m
Project 3a Integrated Radiotherapy Solution.............£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.385m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.266m
Project 7 Decommissioning £0m

9.5   The five deliverables with the highest spend during this period are:

Project Control..£4.390m
Feasibility Studies...£2.734m
Planning and Design £2.669m
Outline Business Case (inc revision and approval)......£2.456m
Project Agreement..£1.838m

APPENDIX 1: TCS Programme Budget and Spend as at 31st March 2024

TCS Programme Budget & Spend 2023-24

CAPITAL	Year to Date Budget Jan-24 £	Year to Date Spend Jan-24 £	Year to Date Variance Jan-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC OBC	178,076	183,970	-5,895	213,691	225,596	-11,905
Project 1b - Enabling Works FBC	200,534	256,251	-55,717	229,841	293,393	-63,552
Project 2a - New Velindre Cancer Centre OBC	791,975	772,925	19,050	950,370	942,152	8,218
Capital Pay Total	**1,170,585**	**1,213,146**	**-42,561**	**1,393,902**	**1,461,142**	**-67,240**
NON-PAY						
nVCC OBC Project Delivery	42,209	42,209	0	63,963	62,963	1,000
Project 1b - Enabling Works FBC	9,516,402	9,323,789	192,613	10,666,552	10,611,674	54,877
Project 2a - New Velindre Cancer Centre OBC	0	1,818,868	-1,818,868	2,028,839	2,011,868	16,971
Project 2b - Advanced Design Development Agreement	4,780,452	4,761,986	18,466	4,780,452	4,780,452	0
Project 2c - Whitchurch Hospital Site	0	13,535	-13,535	0	13,535	-13,535
Capital Non-Pay Total	**14,339,062**	**15,960,386**	**-1,621,324**	**17,539,805**	**17,480,492**	**59,313**
CAPITAL TOTAL	**15,509,647**	**17,173,533**	**-1,663,886**	**18,933,707**	**18,941,634**	**-7,927**

REVENUE	Year to Date Budget Jan-24 £	Year to Date Spend Jan-24 £	Year to Date Variance Jan-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
nVCC Pay Award	83,413	83,413	0	96,408	96,408	0
Programme Management Office	259,366	259,354	12	315,656	315,644	12
Project 6 - Service Change Team	230,927	230,927	1	281,219	281,219	1
Revenue Pay Total	**573,707**	**573,694**	**13**	**693,283**	**693,271**	**13**
NON-PAY						
nVCC OBC Project Delivery	25,390	23,987	1,403	30,000	30,000	0
nVCC OBC Judicial Review	11,000	11,000	0	11,000	11,000	0
Programme Management Office	6,324	3,174	3,150	12,644	12,656	-12
Project 6 - Service Change Team	24,542	17,542	7,000	38,411	38,412	-1
Revenue Non-Pay Total	**67,257**	**55,703**	**11,553**	**92,055**	**92,068**	**-13**
REVENUE TOTAL	**640,963**	**629,397**	**11,566**	**785,339**	**785,339**	**0**

APPENDIX 2: TCS Programme Funding for 2023-24

Description	Funding Type	
	Capital	**Revenue**
Programme Management Office	**£0**	**£0.328m**
Commissioner's Funding		£0.240m
Trust Revenue Funding		£0.060m
WG One Off Pay Award 2022/23 Funding		£0.006m
WG Recurrent Pay Award Funding		£0.022m
Enabling Works FBC	**£10.896m**	**£0**
2023-24 CEL from Welsh Government funding for Enabling Works FBC approved in February 2022	£10.896m	
New Velindre Cancer Centre OBC	**£3.257m**	**£0.137m**
WG One Off Pay Award 2022/23 Funding		£0.019m
WG Recurrent Pay Award Funding		£0.077m
Escrow Interest		£0.041m
2023-24 CEL from Welsh Government funding for nVCC Project approved in January 2024	£3.257m	
Advanced Design Development Agreement	**£6.009m**	**£0**
2023-24 CEL from Welsh Government funding for ADDA approved October 2023	£3.882m	
2023-24 CEL from Welsh Government funding for AWA approved January 2024	£0.898m	
2023-24 CEL from Welsh Government funding for ADDA approved March 2024	£1.229m	
Whitchurch Hospital Site	**£0**	**£0**
Funding for Whitchurch Hospital Site to be provided by WG	£0	
Radiotherapy Satellite Centre	**£0**	**£0**
No funding requested or provided for this project to date		
SACT and Outreach	**£0**	**£0**
No funding requested or provided for this project to date		
Service Delivery, Transformation and Transition	**£0**	**£0.320m**
Commissioner's Funding		£0.180m
Trust Revenue Funding		£0.131m
WG One Off Pay Award 2022/23 Funding		£0.002m
WG Recurrent Pay Award Funding		£0.007m
VCC Decommissioning	**£0**	**£0**
No funding requested or provided for this project to date		
Total	**£20.163m**	**£0.785m**

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2022

SPEND PER PROJECT PER YEAR

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Intergrated Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH PROJECT ACROSS ALL YEARS

Legend:
- Programme Management Office
- Project 1 - Enabling Works
- Project 2 - nVCC
- Project 3a - Integrarted Radiotherapy Solutions
- Project 3b - Digital Strategy
- Project 4 - RT Satellite
- Project 5 - Outreach Centres
- Project 6 - Service Delivery, Transformation and Transition
- Project 7 - Decommissioning

SPEND FOR EACH YEAR ACROSS ALL PROJECTS

£328,459 £2,398,448
£6,428,671
£6,167,590
£3,924,181
£2,928,426
£4,267,262
£3,909,063

Legend:
- 2014-15
- 2015-16
- 2016-17
- 2017-18
- 2018-19
- 2019-20
- 2020-21
- 2021-22
- 2022-23
- 2023-24
- 2024-25
- 2025-26

TOTAL SPEND BY PROJECT TO DATE	£30,352,092
Programme Management Office	£1,655,897
Project 1 - Enabling Works	£10,559,242
Project 2 - nVCC	£13,234,264
Project 3a - Intergarted Radiotherapy Solutions	£1,049,380
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£385,490
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,266,123
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£11,048,740
2	Mott MacDonald	£5,614,021
3	DLA Piper	£3,398,669
4	Non Pay Costs	£1,043,962
5	Price Waterhouse Coopers	£848,084

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

<table>
<tr><td colspan="2" align="center">Quality and safety Performance Committee</td></tr>
<tr><td colspan="2" align="center">2023-24 Quarter 4 Quality & Safety Report</td></tr>
</table>

DATE OF MEETING	9th May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	DISCUSSION
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Trust Quality & Safety Team
PRESENTED BY	Tina Jenkins, Interim Director Nursing, Quality & Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science

EXECUTIVE SUMMARY	The Velindre University NHS Trust Quality and Safety Quarter 4 2023-2024 report covers the period 1st January 2024 to 31st March 2024 and describes the key outcomes, trends and themes in respect of: Complaints; Redress; Claims; Duty of Candour; Safety Alerts; Information Governance; Infection Prevention & Control; and Safeguarding.
	The report includes reporting data for the quarter and to provide appropriate contextualisation, two-year comparison data. Report highlights include: • **37** concerns were received; **18** Velindre Cancer Service (0.0003% of patient contacts excluding therapies and telephone contacts); **19** Welsh Blood Service (0.0009% of donors attending). **29** (79%) were managed successfully as an early resolution (verbally resolved within 48 hours), and **8** (21%) as formal complaints under Putting Things Right Regulations (2011). 16 formal concerns were closed within the quarter, 81% of PTR concerns were investigated within 30 working days.

	3 concerns took longer than 30-working days to resolve. Two cases were linked to one patient, and included complex issues that required an in-depth investigation.
	• **432** incidents were reported: **8** relating to Corporate Services, **358** Velindre Cancer Service and **66** the Welsh Blood Service. **430** incidents after the initial management review were graded as no or low harm, **1** incident was graded moderate, and **1** incident graded as severe and is being managed in line with Duty of Candour and Nationally Reportable Incident procedures.
	• The severe incident related to a delay in the provision of radiotherapy to treat a patient with cord compression.
	• The moderate incident related to a patient being lost to follow up following brachytherapy.
	• There is a key theme within Velindre Cancer Service relating to communication regarding appointments within e.g. appointment time, location, or type (face-to-face vs. telephone) changing without the patient being informed by phone or letter. Patients are reporting having significant difficulty contacting Velindre Cancer Service particularly relating to SACT bookings and medical secretaries.
	• There is a similar theme in Welsh Blood Service with a number of donors advising that they are being turned away from appointments, and of communication and appointment issues. Collection teams have undertaken Customer Care training and have been reminded about following protocols for donor acceptance when arriving late or when clinics are running over.
	• Overall satisfaction for both Welsh Blood Service **(98%)** and Velindre Cancer Service **(96%)** remain high.
	• **4** applications for Deprivation of Liberty Safeguards were made - an increase of 33% from quarter 3. This demonstrates the impact of the weekly visits to the ward by the Practice Educator, as well as the ongoing Mental Capacity Act/ Deprivation Of Liberty Safeguards training.

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		• The Redress caseload increased by 40% and 8 new Inquests were opened during the quarter in addition to an increase of pre-claim notifications.

RECOMMENDATION / ACTIONS	To *DISCUSS* the Quarter 4 Quality & Safety report and its findings.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality & Safety Group	23rd April 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS This is the last report in this format. As of Q1, the previously agreed new reporting arrangements will come into effect.	
EXECUTIVE MANAGEMENT BOARD	**29TH APRIL 2024**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Increase in redress and inquest discussed and the importance of timely action plan development and evidence of learning.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

APPENDICES	
1	Quarter 4 Trust Quality and Safety Report.

TRUST STRATEGIC GOAL(S)	

Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:

YES - Select Relevant Goals below

If yes - please select all relevant goals:
- Outstanding for quality, safety and experience ☒
- An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒
- A beacon for research, development and innovation in our stated areas of priority ☐
- An established 'University' Trust which provides highly valued knowledge for learning for all. ☒
- A sustainable organisation that plays its part in creating a better future for people across the globe ☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	

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TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximized and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Source of Funding: Other (please explain) The report contains details of legal claims against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided, all of which has the potential for adverse financial consequences. **Type of Funding:** **Revenue** Financial impact of the Trust claims is outlined in the Claims Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.shar epoint.com/sites/VEL_Intr anet/SitePages/E.aspx*	Not required - please outline why this is not required
	A quarterly outcome report
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	In addition to litigated claims, the Trust is responsible for addressing Part 6 of the Putting Things Right Regulations. This places an onus on the Trust to ensure that concerns are properly investigated and appropriate Redress remedies offered. When both a breach of duty and harm and/or loss have been identified, amounting to a qualifying liability, the Trust is required to make a suitable financial offer within the PTR threshold (i.e. up to the maximum limit of £25,000). Concerns (consisting of complaints, incidents and claims), have legal and financial implications, as outlined above.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

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RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
	The theme of increasing concerns and incidents relating to administrative processes at Velindre Cancer Service which is resulting in a poor experience and harm to some patients. This risk has been identified previously and is documented upon the Divisional Risk Register.

Quarter 4, Trust Quality and Safety Report

1st January 2024 – 31st March 2024

CONTENTS

1. EXECUTIVE SUMMARY

Quarter 4- At a Glance.

Number of Concerns Raised Q 4	Number managed as Early Resolution	Number managed under Putting Things Right (PTR)	Compliance with PTR timescales
37	29 (78%)	8 (22%)	81%

98% Donor Experience Score	**96%** Patient Experience Score	**90** Compliments	**0** Ombudsman Concern	**0** New Claims
2 Duty of Candour Incidents	**0** Never Events	**1** National Reportable Incident	**1** Patient Safety Alert	**0** External Assurance Reviews

1
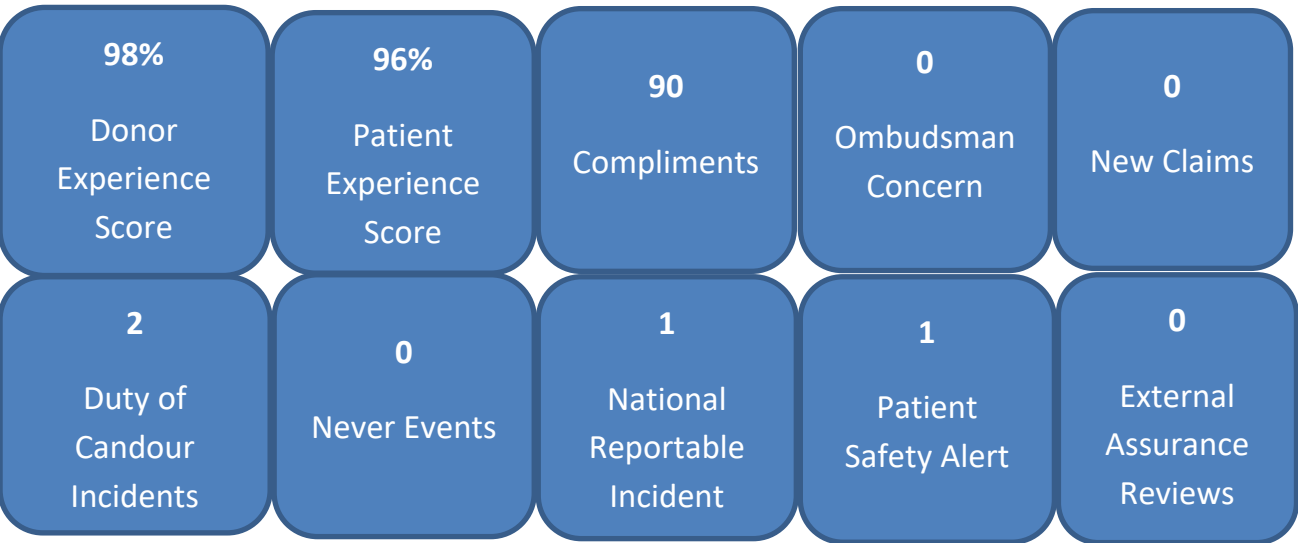
Healthcare Associated Infection Measures

C. Difficile	MRSA Bacteraemia	MSSA Bacteraemia	E.Coli Bacteraemia	Klebsiella Sp.
2	0	0	0	1

Safeguarding

Adult safeguarding reports	Child safeguarding reports	MARAC	Professional concerns	Deprivation of Liberty applications
1	0	0	1	4

2. INTRODUCTION

The Trust 2023/2024 Quality and Safety Quarter 4 Report provides an overview and analysis of Quality and Safety activity and performance during 1st January 2024 – 31st March 2024, to provide assurance that the Trust is both fulfilling its legislative requirements in line with the Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), Information Governance, Safeguarding and Infection prevention and Control Standards and maintains a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person Centred Care.

3. QUARTER 4 QUALITY AND SAFETY INDICATORS OVERVIEW

(Concerns, Compliments, Claims, Incidents, Safety Alerts, Safeguarding and Infection Prevention and Control.)

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023/2024						
	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Compliments	*51*	*26*	*63*	*77*	*94*	*90*
CONCERNS						
Early Resolution						
(resolved within 48 hours)	*24*	*24*	*45*	*34*	*35*	*29*
Trust Putting Things Right (PTR) (Formal)						
Number Received (Trust wide)	9	11	11	*21*	*20*	*8*
% Acknowledged within 48	100%	100%	100%	100%	100%	100%
% PTR closed within 30 days	44% (4)	100%	100%	95 %	100%	81%
%PTR closed after 30 days	55% (5)	0%	0%	5% (1)	0%	19%
Welsh language concerns	0	1	0	0	0	0
Total number of Concerns	33	35	56	55	55	37

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OMBUDSMAN						
New	0	1	0	0	1	0
Open	3	3	4	4	2	1
Closed	3	1	0	0	2	1
REDRESS						
New	1	2	1	1	1	3
Open	3	4	5	5	4	4
Closed	1	0	0	1	2	1
CLAIMS						
New	0	1	0	2	0	0
Open	6	5	5	5	6	5
Closed	1	2	0	0	1	1
INQUESTS						
New	1	0	1	4	4	2
Open	5	5	4	3	6	8
Closed	1	1	0	2	2	1
INCIDENTS REPORTED						
Corporate	2	2	3	3	0	8
VCS	385	501	473	502	395	358
WBS	67	74	89	86	52	66
National Reportable Incidents	3	2	0	2	1	1
IR(ME)R reported incidents	5	7	4	2	0	1
Total opened during quarter	462	586	569	595	447	432
SAFETY ALERTS RECEIVED						
Pharmaceutical alerts	31	37	33	45	32	45
Patient safety alert	2	1	1	1	2	1
Patient Safety Notice	2	1	0	0	0	0
Medical Device	0	3	3	3	2	5
Estates and facilities	3	14	14	7	7	7
Field Safety Notice	0	0	0	2	1	0
Welsh Health Circulars	7	3	5	4	4	1
Total received during quarter	45	59	56	62	48	59
SAFEGUARDING						
Adult reports	4	2	5	4	4	1
Child reports	1	1	1	0	2	0
Allegations of Abuse involving Trust treatment or Services at VCS	0	0	0	0	1	0
MARRAC Referrals	0	1	0	0	0	0
Concerns about Trust	2	0	3	1	1	0
Deprivation of Liberty	7	1	2	3	1	4
HEALTHCARE ASSOCIATED INFECTIONS						
Clostridioides *difficile*	1	1	0	0	2	2
Gram Negative Bacteraemia	2	4	3	5	1	1
Staphylococcus Bacteraemia (including Meticillin Resistant)	1	1	0	0	0	0

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4. QUARTER 4 TRUST CONCERNS, EXPERIENCE AND FEEDBACK

Concerns Summary

4.1 Trust

Number of Concerns	Early Resolution	Putting Things Right	Reopened	Compliments
37	29	8	0	90

There were 37 concerns raised during quarter 4, which is a 31% reduction in concerns raised in comparison to the previous quarter. The reduction in concerns raised are in relation to the Velindre Cancer Service.

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023/2024	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
Compliments	51	26	63	77	94	90
CONCERNS						
Early Resolution						
(resolved within 48 hours)	24	24	45	34	35	29
Trust Putting Things Right (PTR) (Formal)						
Number Received (Trust wide)	9	11	11	21	20	8
% Acknowledged within 48	100%	100%	100%	100%	100%	100%
% PTR closed within 30 days	44% (4)	100%	100%	95 % (20)	100%	81%
%PTR closed after 30 days	55% (5)	0%	0%	5% (1)	0%	19%
Welsh language concerns	0	1	0	0	0	0
Total number of Concerns	33	35	56	55	55	37

Concerns Received over 2 year period 01.01.2022-31.03.2024 by Sub Type
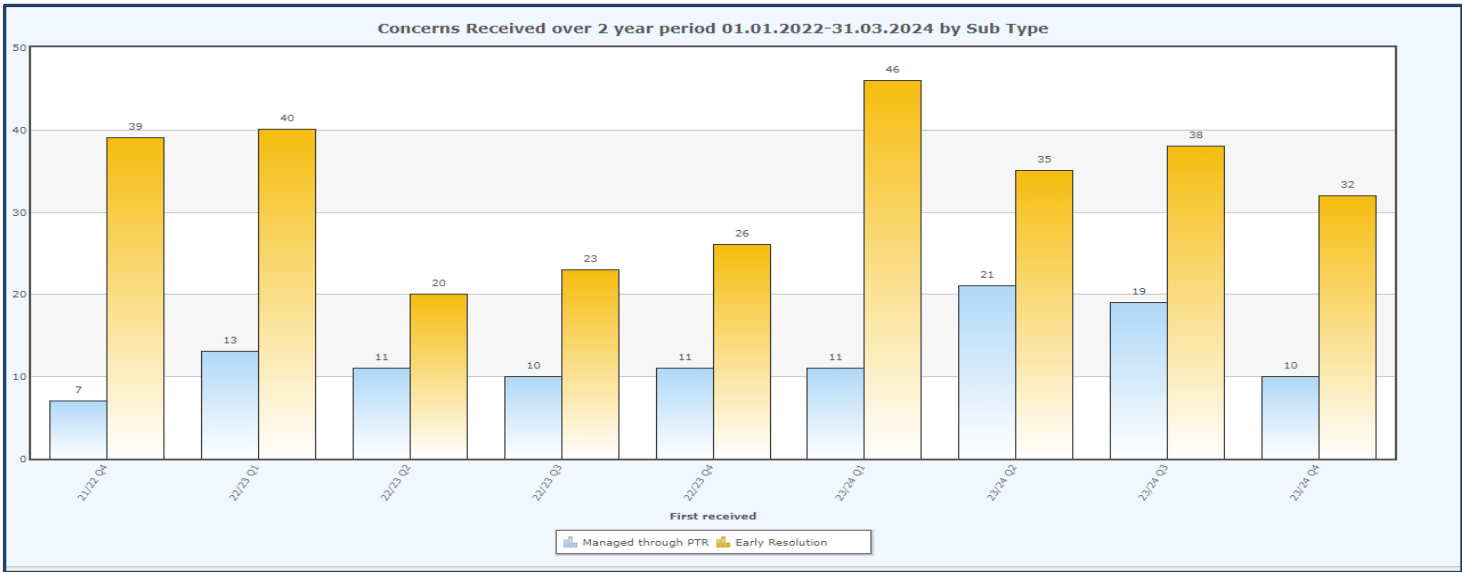
Concern management performance compliance remains high, with all concerns being acknowledged within 48 hours, and **81%** of PTR concerns being investigated and closed within 30 working days. A Concerns audit was initiated during quarter 4 where 30% or 5 (whichever comes first) Putting Things

4

Right and Early Resolution Concerns were audited to ensure Datix Cymru data fields were completed correctly. This quarterly audit will form part of the new Corporate Quality and Safety annual audit plan in the future.

It is evident through thematic review that concerns are rising relating to **communication** with the patient regarding **appointments**.

Q4 Complaints Received - By Division

Concerns Received over 2 year period 01.01.2022-31.03.2024 by Theme (Top 5)

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Q4 Concerns Received by Theme and Division

Primary Location - TAG : Division by Locations

Velindre Cancer Centre — values: 1, 1, 3, 1, 4, 4, 3, 1

Welsh Blood Service — values: 2, 6, 3, 4, 2, 1, 1

Legend: Access (to Services) | Admissions | Appointments | Attitude and Behaviour | Clinical Treatment/Assessment | Communication Issues (including Language) | Equality | Medication | Other | Patient Care

Q4 Concerns Closed by Division and Sub Type

Primary Location - TAG : Division by Locations

Velindre Cancer Centre — 15, 8

Welsh Blood Service — 18

Legend: Managed through PTR | Early Resolution

4.2 Velindre Cancer Service Concerns Summary

Total Number of Concerns 18	Early Resolution 11	Putting Things Right 7	Reopened 0	Compliments 90	Patient experience score 96%

4.2.1 Velindre Cancer Centre Concerns Themes and Learning

Identified concern and learning themes during this period relate to **appointments**, **patient communication** and **treatment planning,** with several specific trends being evident and are highlighted below**:**

- The theme around communication and appointments, highlighted in previous reports, continues. Patients report difficulty contacting departments particularly medical secretaries (phones not being answered and voicemails are not returned). In relation to appointments – patients continue to report

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lack of communication around SACT and outpatient appointment date, location, and time changing without appropriate communication. A meeting was held with the Director of Cancer Services and Head of Medical Records in quarter 4 to discuss the issues and an improvement plan has been put in place.

- A recurrent theme around the length of time patients are waiting resulted in the lowest patient satisfaction score to waiting in outpatients dept and radiotherapy. The scoring for "How did you find the waiting time in your recent visit" has been reviewed and adjusted as it was negatively scoring the "about right" response. This has now been made a positive score which has therefore shown an increase in the overall percentage.
- Feedback from the previous quarter has been received regarding the monitoring and management of blood glucose while patients are on SACT resulting in requests for blood glucose to be added to Chemocare as a mandatory test to overcome the problem. Nursing and pharmacy are keen to develop a working group to take the work forward and require medical support to progress. During Q4 SLT initiated a review into what resources are needed for VCC to be compliant with national guidance.

Additional learning identified and shared during the quarter is included below:
- Isolation cubicle for patients requiring to isolate to receive SACT now available in Rhosyn Day Unit
- Therapies pilot being undertaken – contacting patients 1 week post discharge from First Floor ward to identify if they need additional therapies support at home. This allows earlier signposting to community services and prevents readmission to hospital
- NEWS Cymru rolled out across VCC which sees strengthened ANP clinical support services for unwell patients across the site with a robust referral criteria, and to call the Rapid Response Team (2222) for NEWS 9 or above.
- Improved patient experience and safer working environment for staff within the brachytherapy department by ensuring relevant staff only allowed within the area (historically used a corridor between areas of the hospital).
- Outpatients Dept. continue to review ways of improving waiting times – reviewing clinic appointment times to ensure lines up with clinician working times; additional clinic room available due to OPD manager office move; Band 4 Assistant Practitioners now trained and competent in undertaking SACT ambulatory pump disconnection which reduces waiting times for these patients.
- Clinical audit - Data highlighted that during the COVID 19 pandemic not all recurrent/progressive glioblastoma patients had biopsies. It was discussed and agreed that due to the nature of the disease and prognostic factors patients didn't always require a biopsy if no treatment options available. This has led to a change in practice.
- Reminder to ensure Oncology Outpatient Note completed before moving on to the next patient in clinic.
- Discussed the benefit of having an Acute Oncology Service consultant present in Cardiff & Vale, this would be equally beneficial in other Health Boards.
- SOP for Breast cancer patients receiving immunotherapy (new treatment for SST). Ongoing work being undertaken by immunotherapy team to develop pathways & relationships with the Health Board teams (e.g., respiratory, endocrinology etc.)
- To consider as an SST less fit patient having 30 in 5 weekly fractions
- Stereotactic Radiosurgery Guidelines and pathway to be developed and circulated across SSTs by neuro SST. This should include criteria around imaging required, clinical reviews and

timescales of these prior to SRS. Registrars will lead on this with consultant input. To be reviewed and agreed in next meeting.
- Reminder to get up to date staging scans prior to Stereotactic Radiosurgery, should be looking to have a CT 4-6 weeks max before treatment.
- Support required for Foundation 2 junior doctors in completing admission proforma, pattern noted in TEP and VTE risk assessments not completed in admission proforma's completed by F2 doctors.
- Advanced Nurse Practioner and Review Radiographer shadowing programme to increase understanding and awareness of roles, scopes of practice, and departments.
- Update information on internet regarding accommodation on First Floor Ward
- Hyperglycaemia service improvement project including adoption of JBDS guidelines
- Include SST in to Datix medical hierarchy – to allow identify themes and trends for each SST
- Undertake ongoing SBP (spontaneous bacterial peritonitis) audit to ensure VCC SBP rates from paracentesis are in line with national rates. Work undergoing to identify national rates.
- Palliative care ANP's undertaking teaching sessions for First Floor night nursing staff to educate on PRN medication.
- Tissue Viability Nurse undertaken a review of Nimbus mattresses available in VCC and ensure their appropriate storage.
- Lying and standing BP being undertaken on all patients on admission to the ward as a baseline
- Poster in each bed are in First Floor ward to educate patients and families on falls and appropriate footwear and nightwear.

You said	We did
Later appointments for the Therapies Clinics	Evening clinic set up
More vegan options on the menu	Catering have facilitated this
Waiting room seating area feels crowded	Chairs repositioned to feel more spacious

4.3 Welsh Blood Service Concerns Summary

Early Resolution	Total Number of Concerns	Putting Things Right	Reopened
18	18	1	0

Total Number CIVICA Surveys Completed	Donor Experience Scores
3365	98%

18 concerns were received during quarter 4 and were all resolved as early resolution concerns. There were no concerns managed as Putting Things Right during quarter 4.

4.3.1 Welsh Blood Service Concerns Themes and Learning

Top concern themes and opportunities for improvement this quarter were identified and relate to **appointment & communication** issues which are shared at a divisional level for consideration and to address. Further learning and improvement areas following concerns have led to:

- an ongoing Service Improvement Project (SIP) to address the issues raised relating to the lack of signage at sessions. All signage is being reviewed so is taking some time to come to complete.
- Clinical Services and Communications team working in collaboration with each to develop a form of words to update WBS website for donors waiting pre surgery/operations.
- Clinical Services support team have been tasked with reviewing the acceptance/deferral criteria of website including the on-line quiz to identify other possible gaps
- Planning department, apologised for cancellations at short notice explaining that there are very often no staff resources to call on in North Wales due to geographical constraints. Donor was provided with link to booking system for other possible options of donation sessions near own area so much less traveling involved.
- Planning is working on resourcing other venues in the geographical area of NW. Moving forward DCC staff when calling a Collection team will confirm with that team who they are calling. Moving forward DCC staff when calling a Collection team will confirm with that team who they are calling.
- DCC Manager to ensure All donors booked at this venue are made aware of parking requirements by SMS message on day of donation. donor happy with outcome of conversation

Further examples of how the Welsh Blood Service listened to their complainants and resolved as early resolution are detailed in the below, "you said, we did" table:

You Said	We Did
Feedback received in relation to blood donation sessions being cancelled and re-booked resulted in blood collections not able to be accommodated.	Donor Contact Centre staff will now confirm with the specific Collection team the re-scheduled and planned donor attendance.
Donor raised several concerns regarding customer care issues.	The Donor was very pleased with the offer and approach from the Operation's Manager, who agreed to meet the Donor at their next appointment to discuss and resolve the issues raised.
Feedback from donors highlighted a theme in relation to the lack of vegan and gluten free snacks. The service has these options available, however, it is evident that these options need to be more advertised.	Posters advertising the gluten free and vegan options available, have been developed through the 5-minute improvement project by our North Wales teams.

4.4 Patient and Donor Experience Feedback
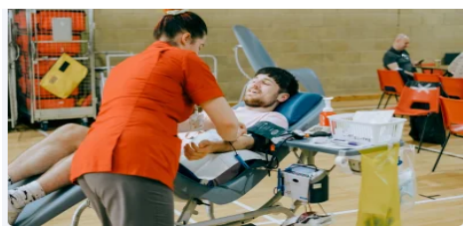
Utilising all patient and donor feedback is of great benefit to our service and assists in understanding both successes and further opportunities to improve. To both effectively capture and trend our patient and donor experience, and share feedback with patients, their families, donors and staff across the service in line with the requirements of the Duty of Quality (2023), work has been undertaken to capture and share feedback received both through our CIVICA experience surveys through the development of 'always on reporting' public facing internet page, the collection of compliments through the Datix Cymru system, and

through the development of our 'Wall of Thanks'. These developments have proved beneficial to service improvements as can be demonstrated through the following examples:

Welsh Blood Service
The number of survey responses for Quarter 4 totalled 3365, a significant increase in comparison to quarter 3 responses. Welsh Blood Service have worked hard with the Collections teams to help staff understand how valuable collecting donor feedback is to inform service improvements and donor satisfaction.

Welsh Blood Service Wall of Thanks

East A

"I was unable to donate blood again due to having poor veins. Staff were amazing and supportive towards me, made me feel at ease as I also have a phobia with needles. Staff sat with me afterwards as I was gutted I couldn't donate. I will definitely keep trying."

Bangor

"Diolch i'r holl staff am fod mor glên. Hefyd mor braf cael staff Cymraeg i helpu."

Platelets

"The biggest joy of the platelet donation process is that the team know me (and the other donors) which makes for a very relaxed and welcoming environment. Thank you."

West

"I always enjoy my blood donation sessions, I actually look forward to seeing the lovely team of staff and feeling I have done something worthwhile. Thank you, you are a fantastic team."

East B

"Fantastic staff as always,

3365 donors provided feedback:

Welsh Blood Service CIVICA Heat Map

Location	Responses	1 - On a scale of 1-5 how satisfied are you with your overall experience within the collection clinic to	2 - Based on today's visit did you find staff welcoming & friendly?	3 - Based on today's visit did you find staff helpful & knowledgeable?	4 - Based on today's visit did you find staff professional, compassionate & caring?	5 - Based on today's visit do you feel you were treated with dignity & respect?	6 - Based on today's visit were you provided with enough information about the donation process?	7 - Based on today's visit did you receive adequate emotional & physical support?	8 - Based on today's visit did you find a good standard of hygiene & cleanliness?
		Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A	Compliments and Concerns East A
Bangor Team	247	98	100	100	100	100	100	100	100
Donation Clinic (TG)	28	100	100	100	100	100	100	100	100
East A	561	98	100	100	100	99	100	100	100
East B	563	97	100	100	99	100	100	100	100
East C	543	98	100	100	99	100	100	100	100
West Team	839	99	100	100	100	100	100	100	100
Wrexham Team	588	98	99	100	100	100	100	100	100
	Overall	98	100	100	100	100	100	100	100
	Benchmarks	95	95	95	95	95	95	95	95

Velindre Cancer Service

Velindre Cancer Service Wall of Thanks

"To all at radiotherapy, thank you for your kindness and support."

"The staff in our café always make such an effort! They are all fab!"

"To all the staff at Reception, LA4 and LA2, thank you so very much for your care and kindness not only to me but the other patients that visit Velindre. You are amazing."

"For the past many weeks I have been a patient at Velindre, under the care of Oncologist Dr Louise Harris. This is a note to express my sincere gratitude for the care generally, which has been beyond measure in its excellence.

397 patients provided feedback. The patient feedback data gets shared monthly with all the Departments who have participants and is also included in the Quality safety management Group reports. Furthermore, the data will be included in the new Directorate reports that are being sent out on a bi-monthly basis.

Satisfaction score: 97%

Feedback about your experience
- Being listened to: 98%
- Speaking Welsh: 93%
- Waiting times: 92%

Feedback about your experience
- Being well cared for: 98%
- Receiving assistance when needed: 98%
- Patient understood their care: 97%

Feedback about your experience
- Care explained in an understandable way: 98%
- Patient involved in decisions: 99%

Velindre Cancer Service CIVICA HEATMAP

Service	Responses	1 - Overall, how was your experience of our service?	2 - Did you feel that you were listened to?	3 - Were you able to speak Welsh to staff if you needed to?	4 - How did you find the waiting time in your recent visit?	5 - Did you feel well cared for?	6 - If you asked for assistance did you get it when you needed it?	7 - Did you feel you understood what was happening in your care?	8 - Were things explained to you in a way that you could understand?	9 - Were you involved as much as you wanted to be in decisions about your care?	10 - How would rate your overall experience? 0 is very bad and 10 is excellent.	Overall
		VCC - Friends and Family	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	Your Velindre Experience	
Clinical Psychology	3	-	100	100	100	100	100	100	100	100	100	100
Clinical Trials	54	-	100	86	96	100	100	100	99	100	93	97
Communications & Engagement	1	100	-	-	-	-	-	-	-	-	-	100
Medicine	2	0	100	100	25	100	100	100	100	100	90	82
Nuclear Medicine	11	100	-	-	-	-	-	-	-	-	-	100
Nursing	82	100	100	90	94	100	100	100	100	100	98	98
Outpatients	125	93	87	97	78	90	88	85	90	89	84	89
Pharmacy	8	100	-	-	-	-	-	-	-	-	-	100
Radiology	9	100	100	100	100	100	100	100	100	100	100	100
Radiotherapy	98	97	100	97	100	100	100	100	100	98	98	99
SACT	1	-	100	100	100	100	100	100	100	100	100	100
Welfare rights	3	100	-	-	-	-	-	-	-	-	-	100
	Overall	96	98	92	93	98	98	97	98	98	94	96
	Benchmarks	85	85	85	85	85	85	85	85	85	85	92

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4.6 COMPLIMENTS

90 written compliments were recorded in Datix Cymru for Quarter 4, which is a slight decrease from 94 in Quarter 3. To support this the more effective capture of compliments on Datix, a range of staff communications have been issued and training user guides developed by the corporate Quality and Safety Team. This has led to an increase in the capture of the compliment themes in the Datix system with more detail as shown below whereby some compliment themes were in more than one category.

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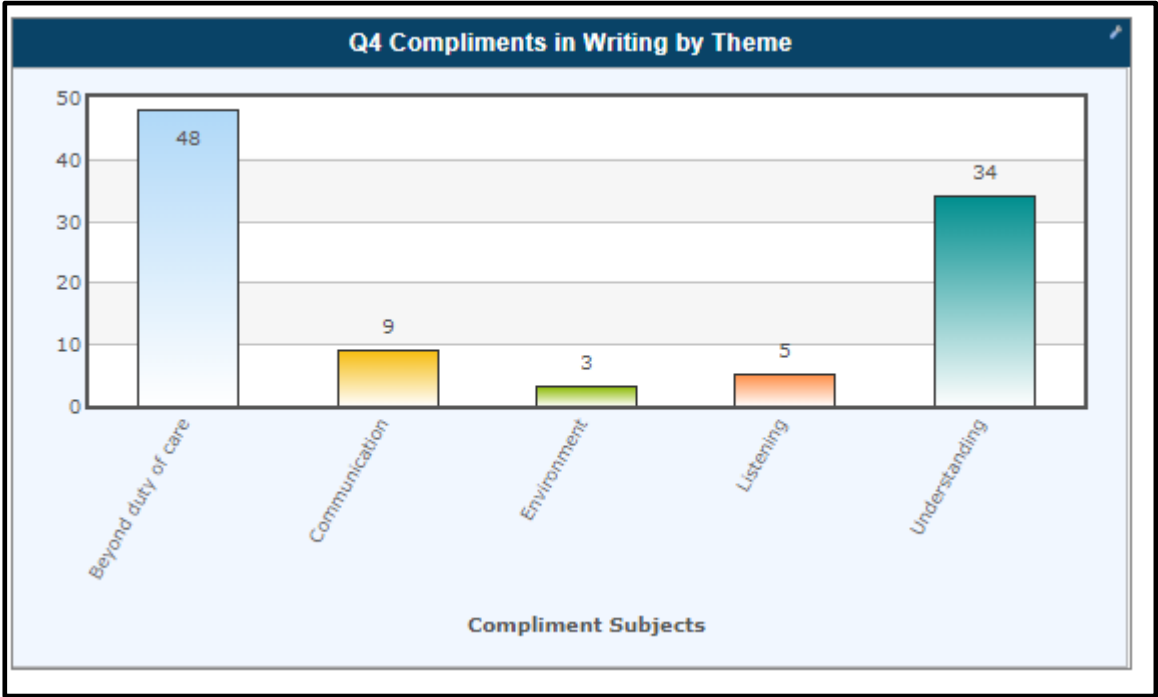
5. PUBLIC SERVICE OMBUDSMAN OF WALES (PSOW)

At the end of the reporting period:

- 0 new Ombudsman cases were opened.
- 1 Ombudsman case was closed.
- 1 Ombudsman case remains open

The graph run below displays Ombudsman cases opened within the last 2 years:

Analysis of Ombudsman Cases for Q2 2022/2023 - Q4 2023/2024

No of Ombudsman cases

	Q2 2022 /2023	Q3 2021 /2023	Q4 2021 /2023	Q1 2023 /2024	Q2 2023 /2024	Q3 2023 /2024	Q4 2023 /2024
New	3	0	1	0	0	1	0
Open	6	3	3	4	4	2	1
Closed	0	3	1	0	0	2	1

Ombudsman Themes from Q2 2022 - Q4 2024

Theme	Value
Lack/Poor...	5
Delay in referral/follow ups	2
Failure to Treat/Delay in diagnosis	6
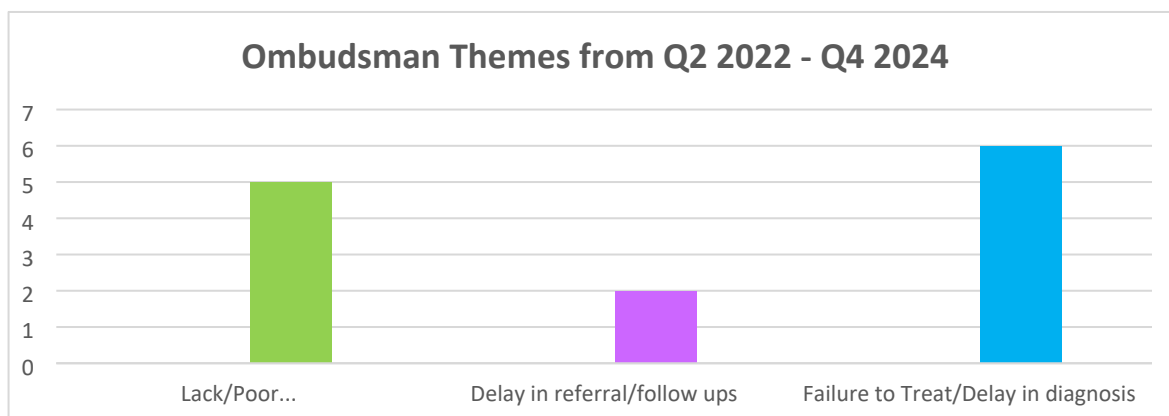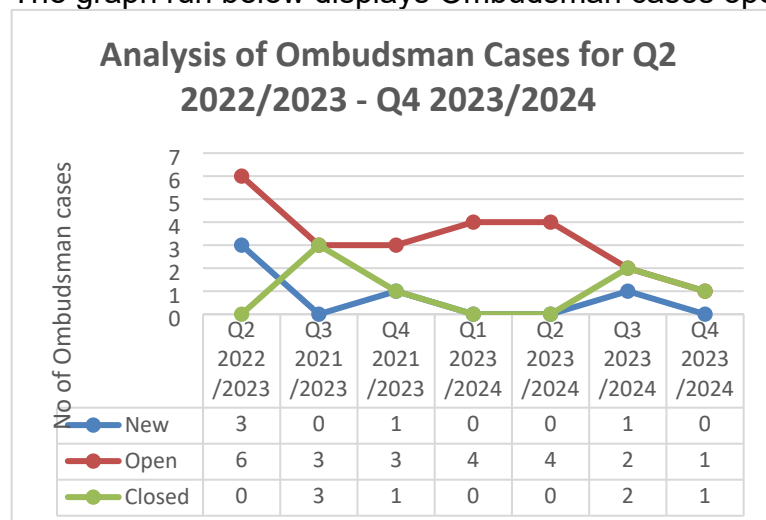
Please note that in some instances, the figures for themes comprise of more than one theme per complaint.

Issue of Ombudsman's Final Report

One final investigation report was issued under s27 of the Public Services Ombudsman (Wales) Act 2019 against both Velindre University NHS Trust and Aneurin Bevan University Health Board. (Under S27 there is no requirement for the Ombudsman to publicise a report).

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Summary: The matter was initially investigated under the Putting Things Right process, following concerns received in relation to the initial telephone consultation that took place to discuss treatment options. The Putting Things Right investigation considered that the treating clinician had appropriately considered the options available and the treatment, however, given the risks involved, it was felt that treatment would not be in the patient's best interest. Following the issue of the Trust's response, concerns were raised with the Ombudsman.

Outcome/Recommendations relating to Velindre University NHS Trust: In conclusion, the Ombudsman felt that the patient should have been offered treatment and that a more balanced explanation involving the risks and benefits should have been discussed and documented. In this regard, the Ombudsman upheld the complaint. Although it was felt that treatment was unlikely to have made a difference, the Ombudsman considered that this had created a level of uncertainty which, in itself, was an injustice for the patient. The Ombudsman made the following recommendations:

- To apologise for the failings identified in the report and
- To review its documentation and communication relating to the decision taken and for staff to be reminded of relevant national guidelines.

The Trust accepted the Ombudsman's recommendations and, during the reporting period, issued a letter of apology for the failings identified. Any learning arising from the review will be shared with relevant staff and provided to the Ombudsman during Q1 2024/2025. It is envisaged that any learning will be captured in the next quarterly report.

Closed Case:
One Ombudsman case was closed, after it was identified that responsibility for concerns raised against a GP practice lay with Swansea Bay University Health Board, rather than Velindre University NHS Trust. The matter was discontinued against the Trust by the Public Service Ombudsman in Wales.

6. REDRESS

At the end of the quarter:

- 3 new Redress cases had been opened
- 1 case was closed
- 4 cases remained under investigation

REDRESS THEMES FOR Q4 2024

- Delay in treatment 14%
- Failure to obtain consent 15%
- Failure to follow up 14%
- Failure to assess and treat 57%

Comparison of Redress Cases - Analysis from Q1 2021 - Q4 2024

New — Closed — Open
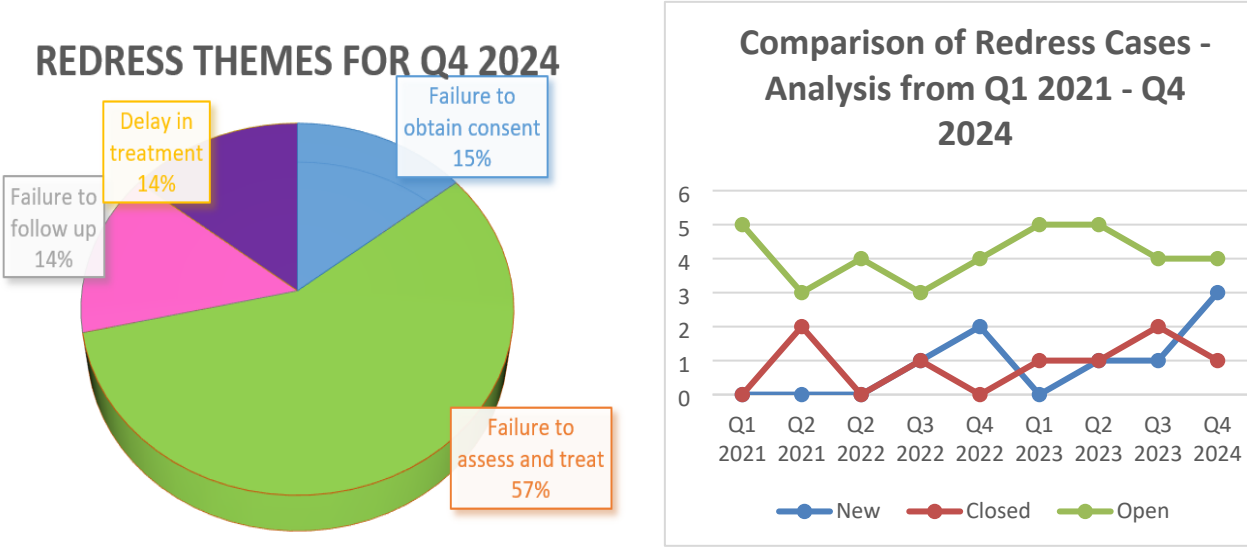
Closed Case: Following the Welsh Risk Pool reimbursement received in relation to the Redress case below, the matter was closed in March 2024.

Case Summary - Welsh Blood Service	Main Learning Points
Failure to recognise and treat arterial bleed following donor donation.	Following a qualifying liability, staff have been reminded of the importance of identifying a suspected arterial bleed. • **Training** has been implemented to improve skills and knowledge. • **Standard** operating procedures have been revised. • **Reminder** to staff of recording accurate clinical information. • **Update** to donation training package, now includes the key criteria for identifying an arterial bleed.

New Redress Case Summary	Progress
Failure to review the patient's blood results identified that there was a missed opportunity to have initiated treatment.	The Trust Putting Things Right Panel identified that a breach of duty had occurred for failing to review the patient's blood results. The matter is currently being investigated under Redress arrangements to establish if harm has occurred as a result of the breach of duty identified.

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Failure to identify the patient's deteriorating symptoms following a call made to the Systematic Anti-Cancer Treatment (SACT) Helpline.	The Trust Putting Things Right Panel determined that a breach in the Trust's duty of care had occurred for the failure to have arranged a clinical review of the patient, following the call made to the SACT Helpline, concerning a deterioration in the patient's clinical symptoms. The patient required urgent admission to hospital. The matter is currently being investigated under the Redress arrangements to establish if harm has occurred as a result of the breaches of duty identified.
Missed opportunities to treat patient following signs and symptoms associated with neutropenic sepsis	The Putting Things Right investigation identified missed opportunities to treat the patient for symptoms relating to neutropenic sepsis. The Trust Putting Things Right Panel determined that a breach of duty existed for the failure to have treated the patient for neutropenic sepsis. The patient was admitted to hospital. The matter is currently being investigated under the Redress arrangements to establish if harm has occurred as a result of the breaches of duty identified.

7. CLAIMS

During the reporting period:-
- No new claims were opened
- At the end of the quarter, 5 claims remain under investigation
- 1 claim was withdrawn/closed.
- 1 Learning from Events Report was approved during Q4.

Comparison of claims analysis between Q1 2021 - Q4 2024

No of Claims

	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2024
New	0	2	0	2	0	0	0	1	0	2	0	0
Closed	2	5	3	0	0	1	1	2	0	0	1	1
Open	11	3	6	8	8	7	6	5	5	5	6	5

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Comparison of Themes for Personal Injury Claims Q1 2021 - Q4 2024

	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2024
Slip, Trip, Fall	2	1	1	1	1	0	0	0	0	0	0	0
Data Protection Breach	1	0	0	0	0	0	0	0	0	0	0	0
Manual Handling	1	0	0	0	0	0	0	0	0	0	0	0
Defective Equipment	1	2	1	2	2	2	1	1	1	1	1	1

Comparison of Clinical Negligence Themes from Q1 2021 - Q4 2024

Legend: Failure to clinically assess and treat; Delay in clinical assessment; Record Failure; Failure to refer; Inappropriate consent; Treatment complications; Misreporting; Incorrect treatment; Missed/Failure to Diagnose

Percentage of Personal Injury Themes Q1 2021 - Q4 2024

Slip, Trip, Fall, 33%
Data Protection Breach, 17%
Manual Handling, 17%
Defective Equipment, 33%

CLINICAL NEGLIGENCE CLAIMS THEMES ANALYSIS Q4 2023/2024

Delay in clinical assessment, follow up and treatment 50%
Inadequate clinical assessment/failure to treat appropriately 25%
Failure to diagnose 25%

Financial Liability: It is estimated that the Trust's financial liability for claims during the Q4 reporting period amounts to £1,801,576.23. This estimation has seen a significant rise from previous quarterly reporting. The reason for this is due to one clinical negligence claim being set down for trial.

Learning from Events – Approved during quarter

Case Summary - Velindre Cancer Centre	Outcome	Learning from Events Report
The Claimant suffered a myocardial infarction during treatment. It is contended that there was a failure to perform an Electro Cardiogram (ECG) on review.	A Learning from Events Report was submitted to the Welsh Risk Pool in December 2023, for approval of learning, the outcome of which is awaited.	**Vulnerabilities:** • Lack of record keeping. • Trust personnel, who are not factual witnesses, to refrain from make misplaced comments/admissions. **Learning:** • Circulation of updated annotated clinic template • Training NEWS, Sepsis and SACT rolled out to staff personnel, including monitoring and surveillance.

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		- Staff awareness BIG 4 circulation on the importance of record keeping. - Update to NEWS/Sepsis Policy - Update to NEWS Chart in line with All Wales. - Implementation of NEWS Cymru Audit (Observation Chart) - Clinical supervision mandated from 2024. - Reflective Practices undertaken by Trust personnel - Learning Brief - Case discussion and awareness shared at - Senior Medical Staffing Committee - Site Specific Team Lead meeting - Quality and Safety Management Group - VCS Resuscitation Committee

8. INQUESTS

During Quarter 4, the Trust continues to see a rise in the number of inquests involving Trust personnel.
- 2 new inquests were opened (relating to Schedule 5 Notices)
- 1 inquest was closed
- 8 inquests remain ongoing
- No inquest hearings were held during the reporting period
- 1 inquest has been listed for inquest hearing in July 2024.

Inquest Comparison from Q1 2021 - Q4 2024

During Quarter 4, two Schedule 5 Notices were issued against the Trust by His Majesty's Coroner in relation to two new inquest proceedings.

9 INCIDENTS

Patient safety incidents are any unintended or unexpected incidents, which could have, or did, lead to harm for one or more patient's/ donor's receiving healthcare. Incidents are reported and managed within the Datix Cymru system, with all reported incidents being reviewed at service level, through Quality and Safety leads.

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9.1 Quarter 4 Trust Incident Summary

Incidents reported	Corporate Services	Velindre Cancer Service	Welsh Blood Service
432	8	358	66

No/ Low Harm	Moderate Harm	Severe Harm
430	1	1

Incidents Reported over 2 year period 01/01/2022 to 31/03/2024 by Division
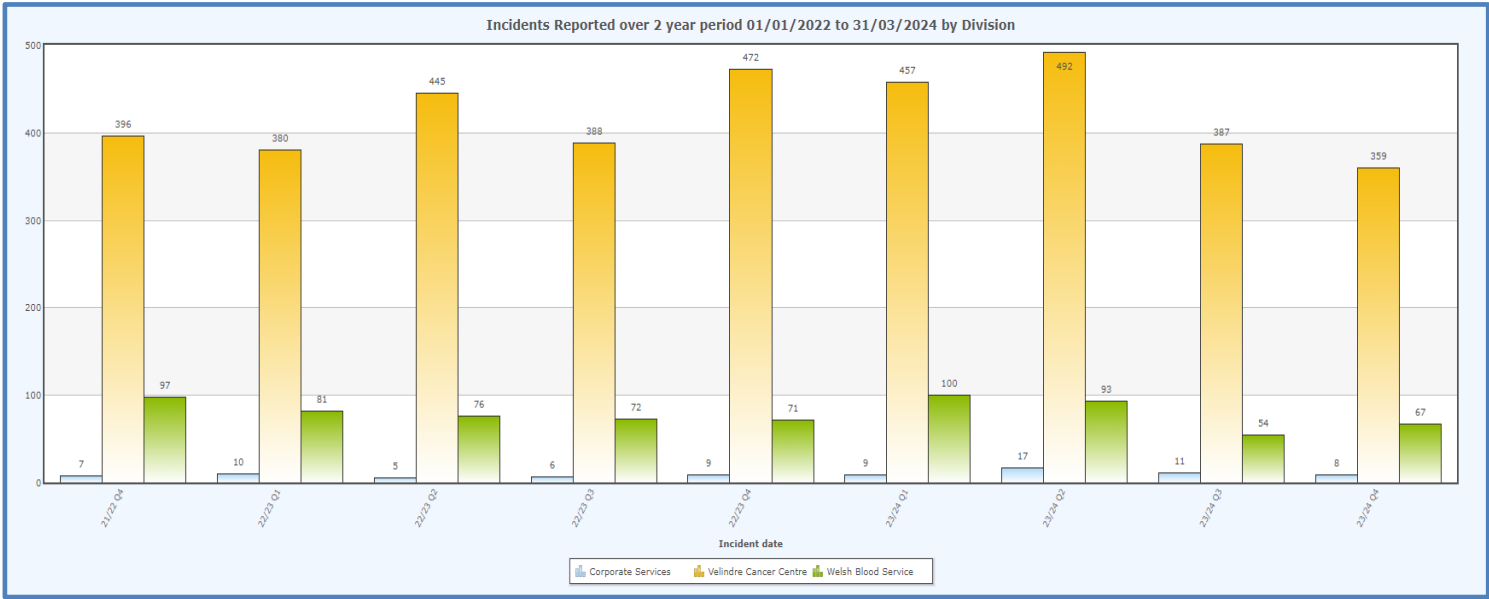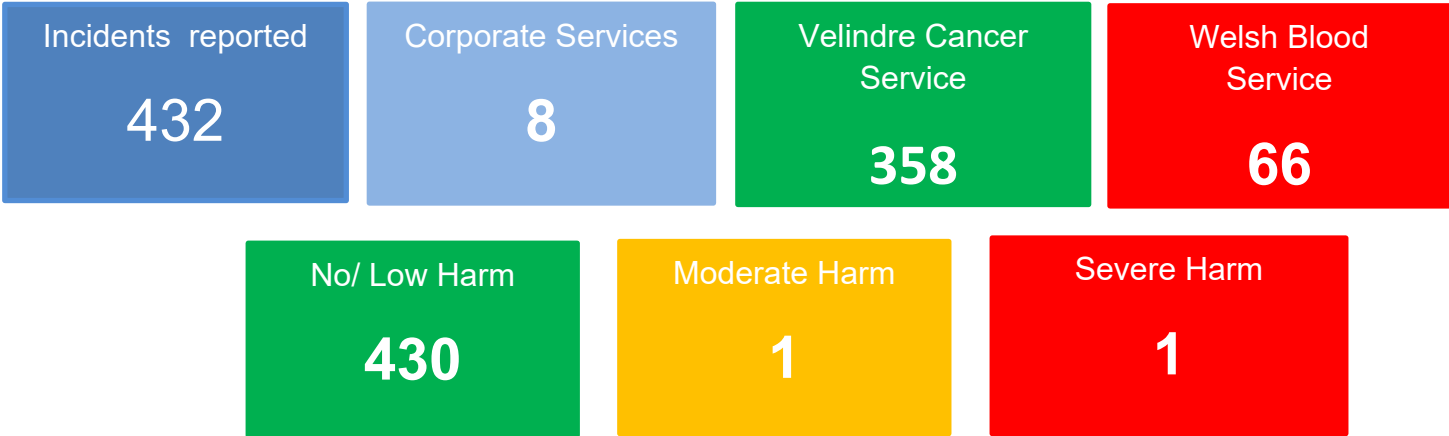
During the quarter, 505 incidents were closed because of collaborative efforts from corporate and divisional teams.

259 incidents remain open in the system with 162 remaining open longer than 30 days which is a significant reduction from 271 in the last quarter. A focused review of incidents open over 30 days has taken place in Velindre Cancer Centre with a marked improvement within operational services and radiation services. The numbers within SACT services remain high but there is a further plan in place to address this.

Please see charts below for further breakdown.

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Open Incidents over 30 days by Division (Datix Cymru)

- WBS: 8
- VCC: 151
- Corporate: 3

Open Incidents open over 30 days by No. of days open

- 31 to 60 days: 45
- 60 to 90 days: 27
- Over 90 days: 90

Open Incidents by No. of Days Open

- Total Over 30 days: 162 — 62,5%
- Total Under 30 days: 97 — 37,5%
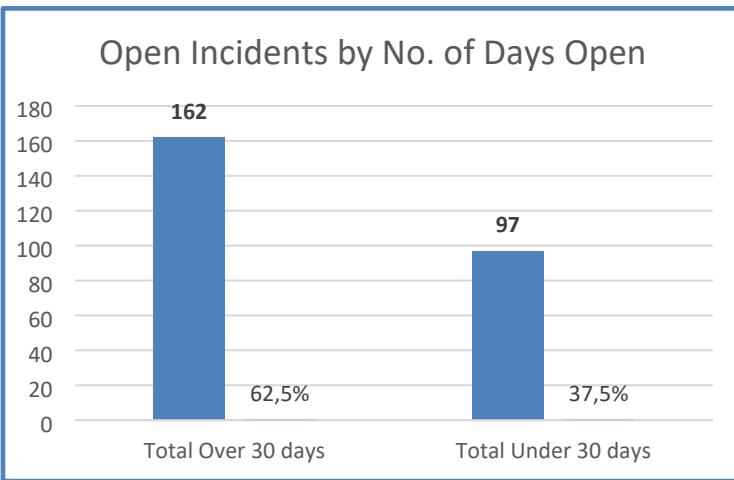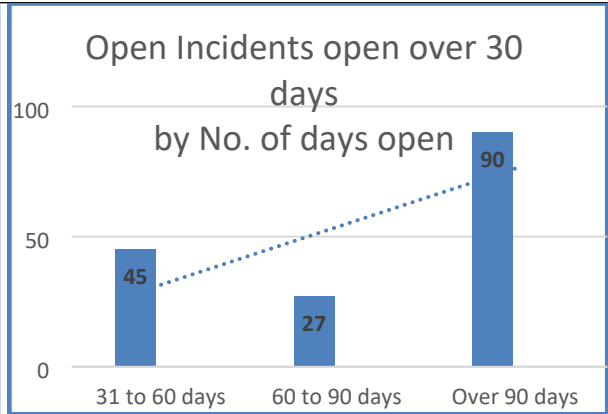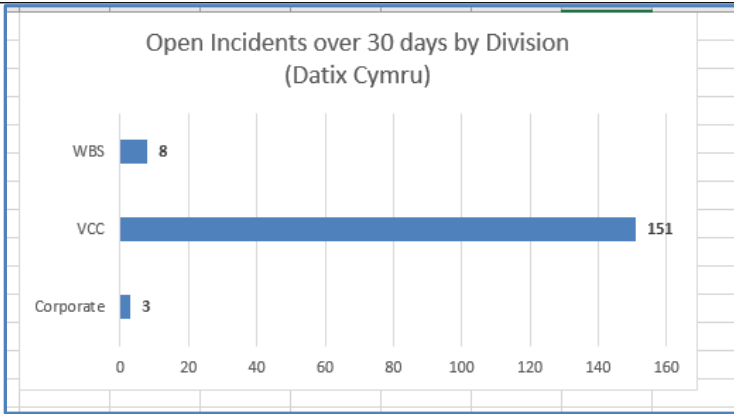
Quarter 4 Trust wide Incident reporting trends

@last quarter Trustwide Incidents by Theme

Classification	Value
Access, Admission	5
Accident, Injury	48
Assessment, Investigation, Diagnosis	19
Behaviour (including violence and agg...	6
Communication	34
Equipment, Devices	26
Ill health (work related)	1
Infection Prevention and Control	1
Information Governance, Confidentiality	7
Information Technology	11
Infrastructure (including staffing, f...	17
Medication, IV Fluids	31
Pressure Damage, Moisture Damage	20
Records, Information	13
Safeguarding	1
Transfer, Discharge	6
Treatment, Procedure	186

The highest recorded number of incidents appear within Treatment and Procedure which is to be expected and primarily Radiotherapy activities. The Trust are aware that a number of these incidents are a repeated trend and are in relation to:

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- A known international manufacturer fault with the radiotherapy system that at this time cannot be resolved, but methods of mitigation are being considered.
- Capture of radiotherapy event reports that do not meet the criteria of an incident, which will be reviewed within the next quarter.

9.2 Incident Themes and Learning Opportunities

Velindre Cancer Service

- Monitoring and management of SACT patients' blood glucose work has commenced to address a theme, by considering the adaptation of the current Chemocare system to include Mandatory Blood Glucose Testing. To achieve this, a working group is being established and a medical lead identified.

- Management of unwell patients in radiotherapy, remedial action is currently being considered by the service area.

9.3 EXTERNALLY REPORTED INCIDENTS

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) Reportable

There was **1 (IR(ME)R)** incidents reported as a breach during the quarter which relates to an incorrect ANT tattoo used as reference for imaging. An investigation is underway

9.3.2 NATIONAL REPORTABLE INCIDENTS (NRI).

There was **1** Nationally Reportable Incident which related to Velindre Cancer Service. The incident was graded Moderate initially and regraded as **Severe** following the receipt of further clinical information as the level of potential harm evident aligned with severe definition**.** The incident relates to delay in the provision of radiotherapy to treat a patient with cord compression. This incident also reached the threshold to trigger the Duty of Candour procedures.

This incident was reported and managed in line with the All-Wales Incident and Reporting Management Policy (2023) and an investigation commissioned.

Welsh Blood Service Externally Reportable Events

The below summarises all WBS adverse events which were reported to MHRA via the SABRE incident reporting portal. Serious Adverse Blood Reactions and Events (SABRE) is the MHRA's online system for reporting blood safety incidents. If the WBS quality system fails to pick up an event at the time occurred and the problem is discovered later in the cold chain, especially if a unit has been issued, it is considered SABRE reportable.

A summary of all SABRE reportable incidents for 2023 was submitted to the January 2024 Trust Integrated Quality & Safety Hub. The root cause of some events was challenged, and these have been reviewed and CAPA revised accordingly. This included:

- The need to ensure ageing equipment is replaced in a timely manner; to be raised via Business Planning group.
- The need to ensure staff are reminded of their responsibility not to interrupt critical tasks/allow themselves to be interrupted and reasons why this is important.

This was addressed via laboratory and collections operational teams; interactive learning sessions will be held with relevant staff groups.

There were **no** adverse events were reported to regulators in January and **one** adverse event was reported to regulators in February:

- SABRE: Registered Nurse selected wrong option in relation to Tropical Virus risk.
  Status: Under investigation. Confirmatory report due to be submitted to SABRE on 14/03/23.

To note:
- It is recognised that staff undertaking donor assessment will become distracted from time to time when working in a 'live' environment.
- The focus for preventive action is therefore on reducing complexity within the donor assessment process.
- There are no concerns regarding the quality of training and assessment of CCAs and RNs. Staff involved in similar events have been fully able to describe and demonstrate the correct process in a 'non-live' training environment.

A further SABRE report has been submitted in March involving the incorrect selection of blood pack type for donors who are unsuitable for pooled platelets due to taking aspirin/non-steroidal anti-inflammatory drugs. This has resulted in 16 donations being inappropriately utilized for pooled platelets.

Status: under investigation. Changes applied during the recent eProgesa Delta release will prevent any such units being processed into platelets.

Two adverse events were reported to regulators in March:

- Incorrect selection of blood pack type for donations unsuitable for pooled platelets. This event was highlighted by Manufacturing as they were unable to process a unit due to changes applied during the recent eProgesa Delta release; this is an intentional preventive measure. Further investigation has identified 16 donations that were potentially processed into pooled platelets prior to the failsafe being introduced, which presents a risk to recipients.
  Status: Under investigation; overdue for submission of the SABRE confirmatory report (due 03/04/24).

- Donor advised Donor Contact Centre they had previously declared an issue of exclusiona but had been allowed to donate. The donor has been permanently deferred and a product recall initiated.
  Status: Under investigation; submission of the SABRE confirmatory report due 13/04/24).

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10. DUTY OF CANDOUR

Table below refers to the incidents that have triggered the act since its inception in April 2023: *Duty of Candour Incident Summary*:

Duty of Cabdour Incidents 23/24 by Classification

Legend: Access, Admission | Assessment, Investigation, Diagnosis | Communication | Medication, IV Fluids | Monitoring, Observations | Nutrition, Hydration | Treatment, Procedure

X-axis: Date NHS Body first became aware that DoC was triggered (Jul, Aug, Sep, Oct, Dec, Jan)
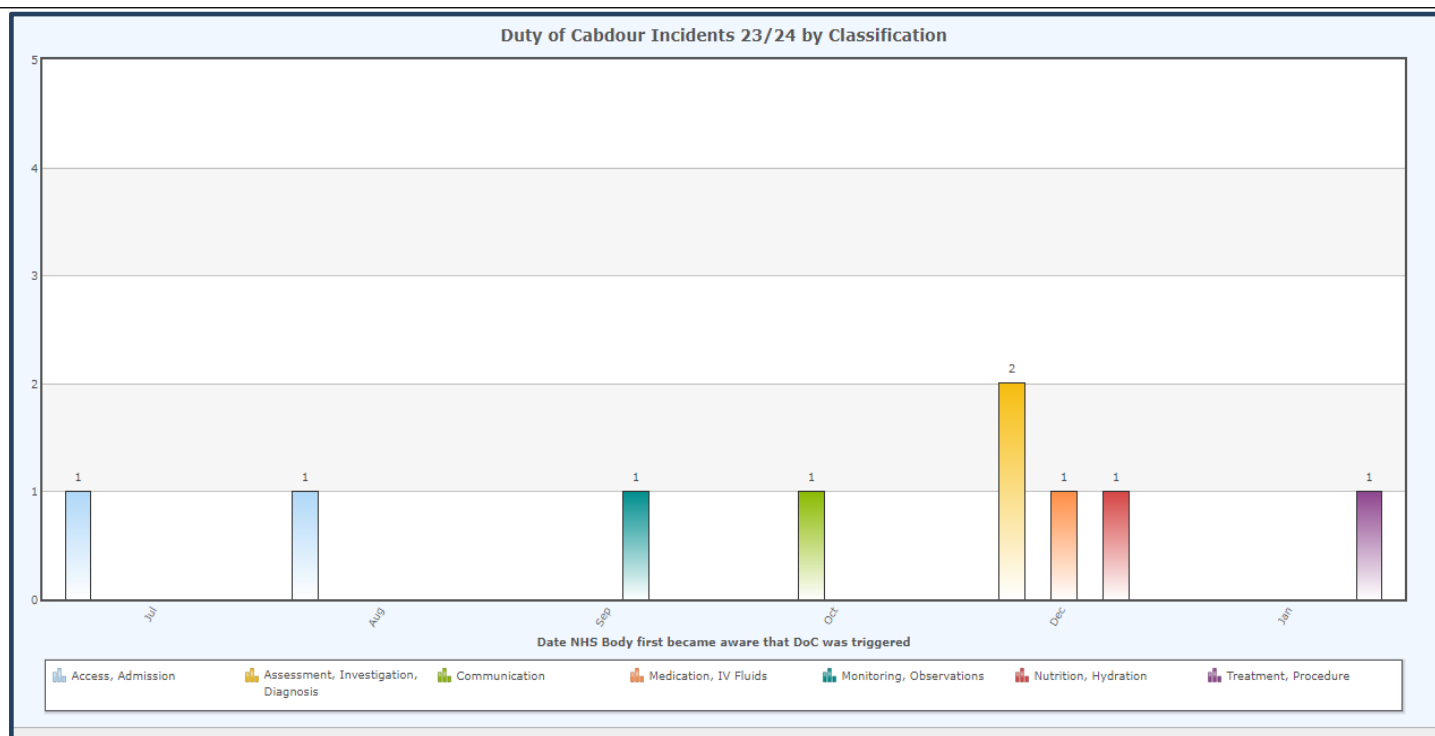
20 Patient/Service User incidents were reported as being initially graded when reported as Moderate harm or above. Following the initial management review **18** of the incidents were graded as no or low harm and rationale provided as to why the grading was changed. **1** incident remained graded as Moderate to trigger the Duty of Candour procedures during January 2024. The other Incident graded as Moderate did not meet the criteria to trigger the Duty of Candour as did not relate to care delivered.

To further improve reporter harm assessments, changes have been made to the Datix Cymru system to add clear harm definitions that align with the Duty of Candour definitions within the Datix Cymru incident system, this change was welcomed and accepted as a system enhancement that will be beneficial for users across Wales.

Two Duty of Candour incidents were reported and managed in line with the Duty of Candour procedures:

The severe incident related to delay in the provision of radiotherapy to treat a patient with cord compression.

Immediate make it safe actions:
- Urgent communications issued to inform clinicians of incident and importance of ensuring robust referral processes are in place.
- Duty of Candour procedures evoked.
- Investigation team formed.

An investigation is currently underway to understand the root causes of the incident and produce recommendations to future occurrences.

The moderate incident related to a patient being lost to follow up following Brachytherapy.

Immediate make it safe action:

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- Urgent review of Brachytherapy follow up procedure

11. SAFETY ALERTS

During the quarter, the Trust received **59** safety alerts, as per below table:

Velindre University NHS Trust Quarterly Indicators for 2022/2023 – 2023/2024						
	Q3 22/23	Q4 22/23	Q1 23/24	Q2 23/24	Q3 23/24	Q4 23/24
SAFETY ALERTS RECEIVED						
Pharmaceutical alerts	31	37	33	45	32	45
Patient safety alert	2	1	1	1	2	1
Patient Safety Notice	2	1	0	0	0	0
Medical Device	0	3	3	3	2	5
Estates and facilities	3	14	14	7	7	7
Field Safety Notice	0	0	0	2	1	0
Welsh Health Circulars	7	3	5	4	4	1
Total received during quarter	45	59	56	62	48	59

11.1 OPEN ALERTS – actions underway

National Patient Safety Alert 2023/010: Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. Such equipment is only utilised within the cancer service, and in response a Bed Rail risk assessment has been completed and a bed rail Procedure is being drafted and once complete will be reviewed by Health and Safety Lead and approved at Integrated Care Operational Group.

12. SAFEGUARDING

Safeguarding Summary

Types of Report
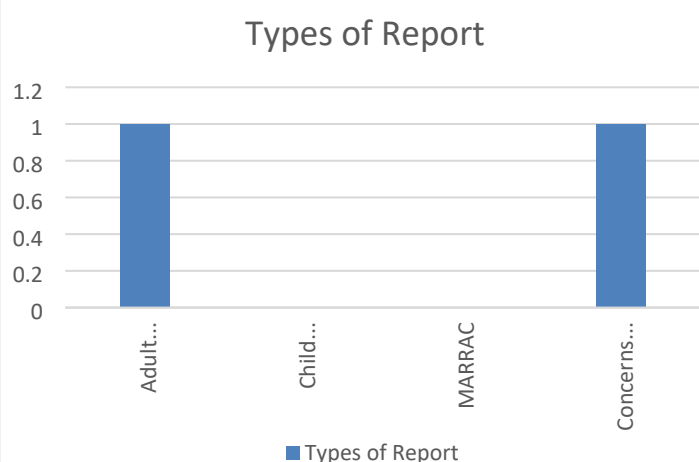
1 Duty to Report was raised to local authority in line with the Wales Safeguarding Procedures, raised by the Trust's Tissue Viability Nurse and related to the management of a patient's wound and possible breach of duty in care by a district nurse team. The information was also shared with the Health Board's corporate safeguarding team and the family encouraged to raise their concerns with the relevant putting things right team.

Following submission, an adult at risk meeting was held by the local authority. It was a very positive meeting, and significant learning for the district nurse team identified The team apologised to the patient and family and requested support from the Trust Tissue Viability Nurse in facilitating a training session on the management of specific cancer related wounds.

25

One new professional concern was received, relating to an issue that occurred in an employee's personal life. A similar concern has been previously raised against this employee. Following that previous investigation, the member of staff has been receiving regular support from their line manager. A risk assessment has been undertaken and there are no transferable risks to the organisation. The Section 5: Allegations/Concerns Raised Against a Person in a Position of Trust is still ongoing, as Local Authority are awaiting further information before they feel an outcome decision can be reached.

DOLS Applications

2021/22	2022/23	2023/24

(Bar chart: DOLS Applications by month, Apr–Mar, y-axis 0 to 6)
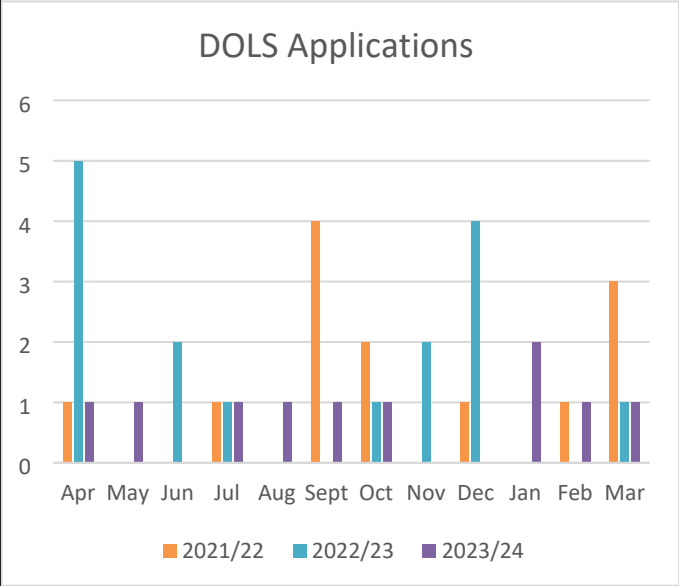
4 applications for Deprivation of Liberty Safeguards were made, an increase of 33% compared to quarter 3. This demonstrates the impact that the weekly visits to the ward by the practice/educator for Mental Capacity Act / Deprivation of Liberty Safeguards is making, as well as the ongoing Mental Capacity Act/Deprivation of Liberty Safeguards training that has been delivered during this time.

There has been a further example of collaborative working to support a patient living with a learning disability in their ongoing chemotherapy treatment. Following a discussion with the consultant in charge of the patient's care, the carers and family, it was agreed that the patient would have bloods taken at home and then only attend the cancer centre for treatment. No further issues have been raised regarding the patient declining treatment.

The Trust has been successful in securing further funding from Welsh Government to support the Mental Capacity Act / Deprivation of Liberty Safeguards Clinical Practice Educator role. This means that we can continue to provide in house bespoke training to our staff and build on the guidance provided to staff to support patients who have been deemed to lack capacity.

Safeguarding training compliance remains a priority. Whilst there are improvements in the figures for Mental Capacity Act / Deprivation of Liberty Safeguards training level 2, Dementia Training Tier 2, Ask & Act Group 2 and safeguarding children and adults' level 3. The overall compliance rating is currently 66.5%. This is in part due to the no renewal status being removed from PREVENT Wrap training. Whilst this has impacted on our figures it is in accordance with the Home Office's recommendation that this training is renewed every 3 years. The training has been well received with very positive feedback.

13. INFECTION PREVENTION & CONTROL

Healthcare Associate Infections Quarter 4

HCAI Review to end March 2024						
Month	**C. *difficile***	**Bacteraemia cases**				
		MRSA	**MSSA**	**E. coli**	**P. aeruginosa**	**Klebsiella species**
	2022-23 total no. of cases = 2	2022-23 total no. of cases = 0	2022-23 total no. of cases = 2	2022-23 total no. of cases = 6	2022-23 total no. of cases = 0	2022-23 total no. of cases = 1
Q1.	1	ZERO	ZERO	2	ZERO	2
Q2.	ZERO	1	ZERO	2	ZERO	3
Q3.	2	ZERO	ZERO	1	ZERO	ZERO
Jan-2024	ZERO	ZERO	ZERO	ZERO	ZERO	ZERO
Feb-2024	1	ZERO	ZERO	ZERO	ZERO	1
Mar-2024	1	ZERO	ZERO	ZERO	ZERO	ZERO
Total:	**5**	**1**	**0**	**5**	**0**	**6**

Clostridioidies *difficile* - There were two case of toxin positive Clostridioides *difficile* during the reporting period deemed healthcare associated, an RCA is underway to ascertain if there is any learning.

E.coli bacteraemia - There was one case during the reporting period. While an RCA is still underway for this case there is no evidence of transmission, poor clinical practices, or environmental hygiene standards.

14. Information Governance

Introduction - Information Governance can be considered as the way in which an organisation manages the information processes and procedures and forms a key component of integrated governance and assurance arrangements along with Clinical Governance, Risk Management, Research Governance, Financial Governance and Corporate Governance. It formally links data quality management, records management, information management, information sharing, information security (including ICT security), risk management, ethics, openness and transparency into an integrated approach and covers a wide spectrum of requirements including procedures and processes to ensure data integrity, availability, security and confidentiality and the collection, storage and dissemination of information.

Incidents and Investigations Total number of incidents for the quarter **plus** a 2 year run graph displaying the themes and trends.

Reported to the ICO – it is a legal requirement to report certain types of incident to the ICO, e.g. where a personal data breach is likely to result in a high risk to the rights and freedoms of individuals.

Root Cause Analysis – where the cause of the incident is not immediately clear and may be required, the Head of IG to conduct a more in depth investigation, especially relevant where a report to the ICO is made.

Subject Access Requests – the legal right for a data subject to request their own data, the Trust must respond within 1 month of the date of request, unless the request is complex or technical in its nature, in which case a further 2 months may be granted.

Data Protection Impact Assessments/Data Processing Agreements – it is a requirement to report activity to Senior Trust Management via established governance routes so that Assurance is gained that the Trust is complying with its statutory legal obligations. The IG Toolkit assesses annual compliance with this requirement.

Training Attainment – the minimum standard for compliance is 75%, 85% exceeds the minimum requirement and is the aim for attainment.

Incidents – 1st January 2024 – 31st March 2024

Service	DATIX Incidents	Incidents Reported outside DATIX	Total Incidents	Reported to ICO	Investigation			Investigation		
					Low Risk / No Harm	Root Cause Analysis	Total	Open	Closed	Total
Corporate Services	0	0	0	0	0	0	0	0	0	0
Velindre Cancer Services	9	0	9	0	9	0	9	1	8	9
Information Technology	2	0	2	1	1	1	2	0	2	2
WBS	4	0	4	0	4	0	4	2	2	4
TCS	0	0	0	0	0	0	0	0	0	0
Total Trust	**15**	**0**	**15**	**1**	**14**	**1**	**15**	**3**	**12**	**15**

Analysis Table for Incidents – 1st January 2024 – 31st March 2024 – VCC

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
15653 - Papers found in laptop bag prior to issue to new user	1	1	0	1	0
15622 - Technical issue - record keeping in WCP – under investigation by Digital Team (not IG related)	1	1	0	1	0
15521 – Record keeping standards in the medical record – IG guidance provided at Induction	1	1	0	1	0
15390 – loss of ID Badge	1	1	0	1	0
15355 – loss of Dictaphone – Dictaphone found	1	1	0	1	0
15725 – IG unable to view record – no longer IG	1	1	0	1	0
15887 – records/information sent to wrong recipient - email misdirection	1	1	0	1	0
15922 – staff records/information inappropriately accessed - Workstation able to be viewed by patients - advice provided to area lead to mitigate risk	1	1	0	1	0

16073 – records/information inappropriately divulged - Incorrect paperwork processes (two patients information in one consent form) – unable to access IG element. Radiotherapy to investigate further	1	0	1	0	0
Total	**9**	**9**	**1**	**8**	**0**

Analysis Table for Incidents – 1st January 2024 – 31st March 2024 – WBS

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
15537 – access to CCTV due to theft on Talbot Green site	1	1	0	1	0
*15946 – Donor ID issue – reported to Police	1	0	1	0	0
*16426 – Donor paperwork not returned to WBS HQ in line with current process – paperwork located 24 hours later and returned	1	0	1	0	0
16634 – Yellow bag containing the donation records were left in the clinic overnight	1	1	0	1	0
Total	**4**	**3**	**2**	**2**	**0**

* Not able to complete IG elements until the investigation has been undertaken by appointed investigators

Analysis Table for Incidents – 1st January 2024 – 31st March 2024 – Information Technology

Reason	Number of Incidents	IG Actions complete	Open	Closed	Reported to ICO
*15419 - Theft of Laptop	1	1	0	1	1
16263 – Unable to access call recordings due to technical issue with call matching – trialled a fix and implemented	1	0	0	1	0
Total					

*Awaiting response from ICO, IG actions complete in DATIX

Subject Access Requests – 1st January 2024 – 31st March 2024 - VCC

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	14	11	78.50%
February	12	9	75%

Month	13	1*	7.69%

* Subject to amendment as the deadlines for many requests received in March 2024 have not yet been reached, an update will be provided in April 2024 report

Subject Access Requests – 1ˢᵗ January 2024 – 31ˢᵗ March 2024 - Corporate

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	0	0	N/A
February	1	1*	100%
March	0	0	N/A

* request for 5,000 emails – assessed as excessive request, despite requests, individual not able to reduce request, therefore deemed manifestly unreasonable

Subject Access Requests – 1ˢᵗ January 2024 – 31ˢᵗ March 2024 - WBS

Month	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
January	8	8	100%
February	12	12	100%
March	11	11	100%

Data Protection Impact Assessment (DPIA) Activity – 1ˢᵗ January 2024 – 31ˢᵗ March 2024

DPIA Number	Date of Initiation	Subject	Division	Department	Notes	Status	DPA Number (if needed)
2024-002	16 Jan 24	WBS Call Recording	WBS	Collections	15.3.24 - DPIA reviewed by DPO sent back to service area. Expected completion – 31/3/24	Ongoing	2024-001
2024-004	2 Feb 24	MacMillan Data Sharing	VCC	Welfare Rights	Initial work commenced on 2/2/24 15.3.24 - hastened progress	Ongoing	2024-002
2024-005a	9 Feb 24	Cardiff Foodbank	VCC	Welfare Rights	18.3.24 – Data Processing Agreement template sent to Foodbank legal team for review. DPIA hastened 15.3.24	Ongoing	
2024-005b	21 Feb 24	Personal Radiation Dosimetry System	VCC	Medical Physics	13.3.24 – initial meeting held to set scope of DPIA 4.4.24 – 1ˢᵗ draft received from project lead	Ongoing	2024-007
2024-006	22 Feb 24	E Job planning software for Medics	VCC	Medical Business	25.3.24 – DPA executed. DPIA requires finalisation prior to processing start in May 24.	Ongoing	2024-006

2024-007	28 Feb 24	Single sign on platform for WBS/VCC	Corporate	Digital	26.3.24 - requested update - project lead on leave until 8.4.24	Ongoing	Not yet
2024-008	7 Mar 24	Finance Audit Portal	Corporate	Finance	4.4.24 - Project Lead to finalise DPIA post meeting with DPO on 15.3.24	Ongoing	N/A
2024-009	29 Feb 24	Secure Door Access System	VCC	Operational Services	8.3.24 - reviewed initial draft 26.3.24 - requested update	Ongoing	N/A
2024-010	11 Mar 24	Customer Relationship Management System	Corporate	Fundraising	3.4.24 - DPIA reviewed, no untoward issues for first 6 pages, next steps to complete the remainder of the DPIA to use for the ITT.	Ongoing	In due course
2024-011	11 Mar 24	LOOP Staff roster system	VCC	Quality and Safety	4.4.24 – initial meeting planned with Anna Harries for 15.4.24	Ongoing	In due course
2024-012	13 Mar 24	Automated Leavers Process	Corporate	Workforce and OD	20.3.24 - Meeting held and DPIA reviewed, next meeting 8 Apr 24 to finalise the DPIA.	Ongoing	N/A
2024-013	14 Mar 24	Social Prescribing – wellbeing workshops at National Museum Wales	VCC	Arts in Health	26.3.24 – requested DPO details for NMW to link to move forward	Ongoing	In due course
2024-014	21 Mar 24	Medicode	Corporate	Digital	3.4.24 – DPIA received on 2.4.24 and reviewed, requested clarification of supplier access to the system in order to assess information security measures	Ongoing	In due course

Non-Trust DPIA Activity 1st January 2024 – 31st March 2024

Date of Initiation	Lead Body	Subject	Division	Department	Notes	Status
26.3.24	Welsh Government	Welsh Race Equality Standards (WRES)	Corporate	Workforce and OD	18.1.24 – DPO reviewed WRES business case at request of HEIW, requested DPIA to be completed by the Data Controller - WG 28.3.24 – DPIA reviewed in conjunction with WG and HEIW – approved	Complete
13.2.24	UK Health Security Agency	FAIR Blood Donor Survey	WBS	RD&I	13.2.24 – UKHSA initiate DPIA 14.2.24 – background documents reviewed by UK Forum DPO's request amendments to the proposed draft DPIA and escalate to UKHSA Level 2 DPIA due to high volume processing of special category personal data 26.3.24 – DPIA reviewed, request changes a indicated on 14.2.24.	Ongoing

Data Processing Agreement (DPA) Activity – 1st January 2024 – 31st March 2024

DPA Number	Date of Initiation	Subject	Division	Department	Supplier	Notes	Status	DPIA Number (if produced)
2024-001	16 Jan 24	WBS Call Recording	WBS	Collections	Oak Telephony	DPIA required as a result of IG Audit. Expected completion – 31/3/24	Ongoing	2024-002
2024-002	2 Feb 24	MacMillan Data Sharing	VCC	Welfare Rights	MacMillan	14.3.24 - DSA updated with information for Schedule 2 and 3 and returned to Macmillan for comment and input of data into Schedule 2	Ongoing	2024-004
2024-003	19 Feb 24	Accommodation provision – international nurses	VCC	Workforce	True Cardiff Ltd	12.3.24 - Finalised	Completed	n/a
2024-004	19 Feb 24	Digital Strategy Consultancy	Corporate	Digital	Perago	29.2.24 – Finalised	Completed	n/a
2024-005	19 Feb 24	ePMA Consultancy	Corporate	Digital	Perago	Finalised on 29/2/24	Completed	2023-043 – for overall ePMA project
2024-006	22 Feb 24	eJob Planning Software	Corporate	Medical Business	L2P	25.3.24 - Finalised	Completed	2024-006
2024-007	21 Feb 24	Personal Radiation Dosimetry System	VCC	Medical Physics	Supplier to be identified	Supplier yet to be identified under FindaTender – 41593 – initial meeting with lead w/c 11/3/24. DPIA under review as of 4.4.24	Not Yet Started	2024-005
2024-008	27 Feb 24	Employee Assistance Programme	Corporate	Workforce	SME HCI Ltd	27.3.24 – Finalised	Complete	2023-064
2024-009	4 Dec 23	WHAISIT	WBS	WTAIL	VH BIO	26.3.24 - IDTA/DPA - Hastened by DPO	Ongoing	2023-062
2024-010	9 Feb 24	Foodbank Project	VCC	Welfare Rights	Cardiff Foodbank	18.3.24 - Welfare Rights Team informed that DPA needed to be sent to owner of Foodbank for approval by legal team, next review requested for early April 2024.	Ongoing	2024-005a
2024-011	15 Mar 24	Homecare Pilot Service Evaluation	VCC	Medical Business	Servier	26.3.24 –Finalised	Complete	2022-065

Training Statistics by Division for the Trust – 31st March 2024

% Compliance Standards	% attainment
Minimum Standard	75%
Target Standard	85%

Division	% attainment
TCS	86.36%
RD&I	96.36%
WBS	91.99%
VCC	80.39%
Corporate	82.82%
Trust Overall	84.46%

2-year Trend Analysis and Monthly ESR Compliance.

Trust IG and Cyber Training Compliance Mar 22-Mar 24

IG Workshops and Induction - Q4 2021/22 - Q4 2023/24
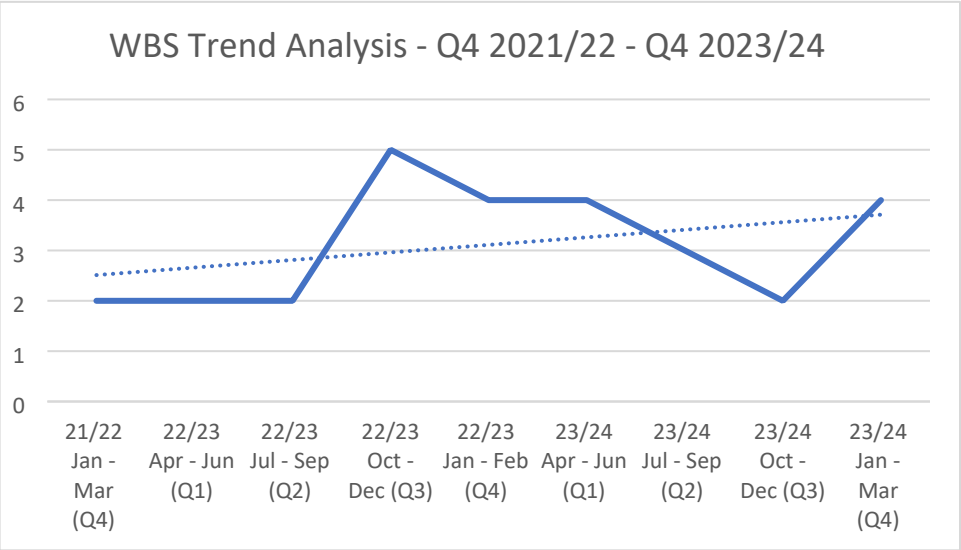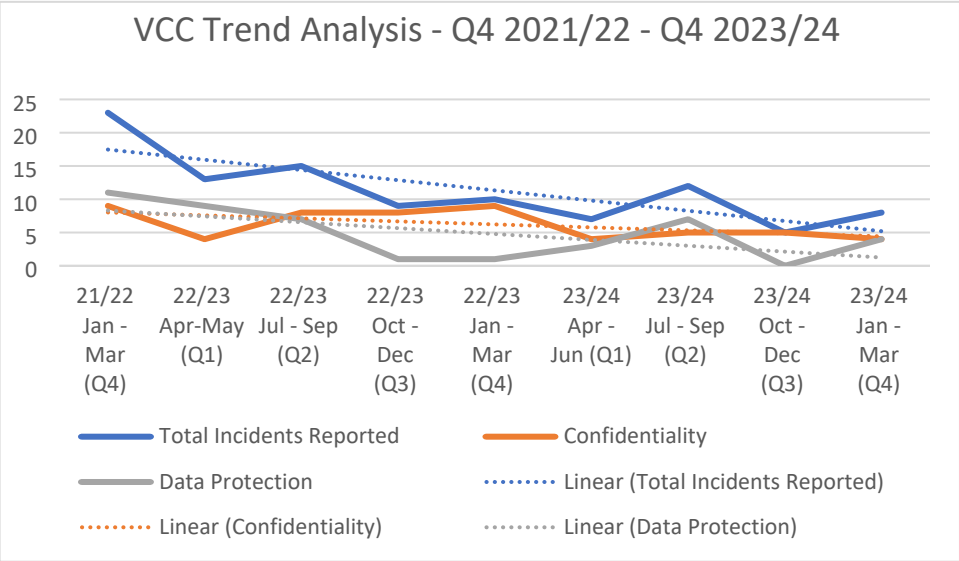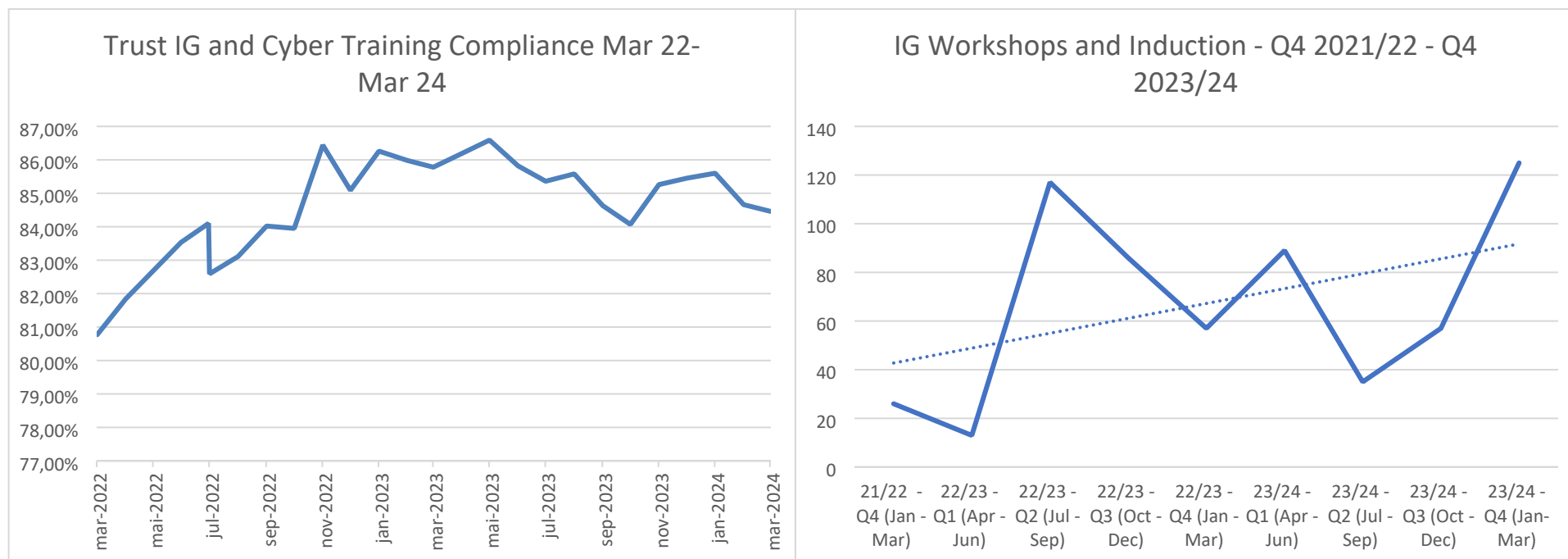
Assurance and Analysis

Positive assurance
1. Training continues to be delivered via inductions and specific workshops.
2. International Nurses received a bespoke training package on 25th March 2024.
3. Recent UK wide cyber incidents in March 2024 have meant an update to the training package to include "how a similar incident could affect the Trust and how to mitigate its impact".
4. SOP for use of email undergoing socialisation as of early April 2024. Deadline for responses 18th April 2024.
5. IAR paper that was submitted to EMB Run on 29th Feb 24 has been approved. Aim is to commence work in the corporate area.
6. IG training planed for Bank IO's on 19th April 2024.

Analysis, themes and learning
1. IG Training compliance for the Trust for Mar 24 stands at 84.46% (target is 85%). 2 year trend analysis indicates overall downward trend from June 2023 (compliance 86%). Analysis indicates that the replacement ESR training package is the cause, raised with DHCW. DHCW state that work to correct is in their IMTP Q3/4 2024/25.
2. The "offer" to support divisions across the Trust remains extant. As of 31st March 2024; **262** Staff are non-compliant against the established workforce of **1,702,** giving a compliance rate of **84.46%**. This data does not include those on Maternity leave or on Long Term Sick.
3. DATIX 16263 (Unable to access call recordings due to technical issue with call matching) – RCA Analysis underway as whilst initial assessment of harm is low, there is a requirement to ensure Caldicott Guardian concurs with the assessment as well as recording the timeline in order to prevent similar occurrences in the future.

4. Data Processing Agreement (DPA) activity in March 2024 increased due to requirement to achieve year end activity, assessment is that if possible project leads to identify requirement as early as possible to ensure that requirements are planned in at the commencement of the project.

Comments

1. Cyber incidents and the risk from data loss, unauthorised loss etc remains high with focus by criminals and state actors on third party supply chain. The recent experience in NHS Scotland (patient data released on the dark web) serves as a reminder as to the risk.
2. Increased training provision is anticipated to increase awareness at the beginning of an individual's employment in Velindre, all sessions are full in WBS/HQ/VCC and in accordance with the Croeso programme.
3. Procurement training will be added to induction provision – NWSSP Procurement team will lead that element of training, this is to address compliance requirements and to provide support as procurement regulations are changing in mid-2024.

Delivery of standard, risks to delivery and mitigation

1. IG Audit programme in WBS recommences on 13th May 2024 as BAU activity.
2. Reviews across VCC required to ensure a similar assessment of compliance can be undertaken for 2024. Two reviews from 2023 will be repeated to ensure that where recommendations were accepted that they have been implemented.
3. The all-Wales IG policy is being presented for endorsement at the All-Wales Medical Directors Group in mid-May to provide senior oversight (most Med Directors are Caldicott Guardians) prior to presentation for sign off by the Trust/HB concerned. Intent to begin review process immediately to ensure that Cyber risk included in a reiteration in 3-4 months' time to ensure the policy is as future proofed as possible.
4. SAR process in VCC will continue to require additional support during 2024.

Safe	Timely	Effective	Efficient	Equitable	Person Centred
Evidence that Staff recognise their responsibilities in respect of Legislation, Codes of Practice and Trust Policy.	All incidents, reports and SAR's are submitted and/or responded to within required timescales	All IG incident reports have been completed appropriately and where feedback is received it is acted upon.	IG support is accessed at the correct point in any process (data protection by design and default) and where needed for incident management	The principles of Caldicott, Confidentiality and Data Protection are based on the European Convention on Human Rights and Article 8 of the Human Rights Act 1998	Evidence that the Caldicott and data protection principles have been adhered to in all reports made across the Trust. A fair approach has been taken in relation to allegations of any wrongdoing by members of Staff

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15. CONCLUSION

The triangulation of data this quarter has identified a theme of continued concerns and incidents relating to communication with Velindre Cancer Service patients:

- In SACT, changes to the time, location and type of appointment (face to face vs. telephone) not being communicated to patients.
- VCS patients report difficulty in contacting departments, with calls not voicemails not being returned
- Concerns continue around information given in medical appointments

The Division is focusing on learning and improvement opportunities, with several service reviews being undertaken to address these ongoing communication issues.

Welsh Blood Service have also seen a trend in concerns related to appointments.

Overall satisfaction scores for both Welsh Blood Service and Velindre Cancer Service remain high, with the exception of Velindre Cancer Service waiting times (77%).

Compliance with Putting Things Right timescales for concern responses is 100%.

Compliments from patients are now being captured in Datix, providing opportunities to share positive feedback with colleagues.

Positive reporting culture – incident reporting remains high, demonstrating a willingness to raise issues and an understanding of the importance of this.

2 incidents in Velindre Cancer Service triggered the Duty of Candour, having been assessed as having potentially caused moderate or above harm to patients.

1 incident concerned a missed opportunity to reduce a dose of chemotherapy.

1 incident concerned provision of Total Parenteral Nutrition to a patient.

Both incidents are currently subject to investigation, to identify learning and opportunities for improvement.

16. PRIORITIES FOR QUARTER 1, 2024-25

- Divisions to focus on reviewing departmental incidents raised via the Datix system and that have been open for over 30 days, to successfully investigate and close any outstanding incidents.
- To further analyse incident investigation outcomes to identify further opportunities for learning
- To strengthen investigations and to effectively capture and address learning identified from concerns, incidents and patient/ donor feedback during Quarter 4 2023-24.
- To further develop collaborative working opportunities to optimise quality and safety outcomes and support learning and continuous improvement.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Private Patient Service Improvement Group Highlight Report & Improvement Plan Update

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Gareth Mitchell, Directorate Support Officer, CSMO
PRESENTED BY	Rachel Hennessy, Interim Director, Velindre Cancer Services
EXECUTIVE SPONSOR APPROVED	Nicola Williams, Executive Director Of Nursing, AHPs and Health Science

REPORT PURPOSE	FOR NOTING

ACRONYMS	
VUNHST	Velindre University NHS Trust
EMB	Executive Management Board
VCC	Velindre Cancer Centre
SLT	Senior Leadership Team
PPS	Private Patient Services

1. PURPOSE

This paper is to advise the Quality, Safety & Performance Committee of the highlights from the Private Patient Improvement Group held on the 25th April 2024 and the updated private patients improvement plan with revised delivery dates.

2. BACKGROUND

Following receipt of an External Private Patient review report identifying critical areas for improvement with the Velindre Cancer Centre's Private Patient service it was agreed by both the Executive Management Board and Audit Committee that a Private Patient Improvement Group would be established to drive through and oversee the required improvements.

The Executive Director of Nursing, AHP and Health Science was asked to provide Executive leadership to the Group and take on the role as Senior Responsible Officer (SRO). The role was accepted on the provision that appropriate delivery support would be allocated as identified by the SRO.

3. PRIVATE PATIENT IMPROVEMENT PLAN

The Private Patient Improvement Plan was scrutinized in light of provision issues with the external provider (detailed below). Considering this, revised target dates have been added alongside RAG ratings and, where deemed necessary, the relocation of action owners. Two further points are expected to be closed, subject to the attaining of evidence for closure.

The two actions arising from the internal audit review of private patients were achieved during this meeting i.e. prioritise the open actions and review delivery dates.

4. HIGHLIGHT REPORT

The following are additional highlights from the meeting.

ALERT / ESCALATE	External Provider The commitment of expenditure under which Liaison support was acquired has been exhausted. Board approval for further financial commitment for support (8-10 weeks) is in progress, following delays at an operational level. As a consequence of this, Liaison have not been engaging with the Private Patient work and, as a result, the delivery dates within the improvement plan are no longer achievable and have needed to be revised. This has also affected timescales relating to the approval of the Private Patients Policy, Practicing Privileges Policy and Private Patients Brochure.

████	Finance are confident that this will be resolved within two weeks and that Liaison will re-engage with the Trust once this is resolved to address the outstanding actions. There is however, a risk in relation to this. Establishment of a VCC Medical Advisory Committee This action is overdue by two years and the Improvement Group were advised that there was no clear plan in place. This was discussed at the Executive Management Board (29th April 2024) and the Trust Executive Medical Director agreed to establish the Committee so that the requirements of the proposed revised Private Patients policy can be fully enacted.
ADVISE	Improvement Plan: The improvement plan was scrutinised in detail and timescales revised in light of the Liaison situation. The actions were prioritised as requested by Internal Audit. The updated Improvement Plan is attached in *Appendix 1*. Automated billing processes: An urgent meeting is required to complete the final automated billing processes to ensure a sustainable model going forward.
ASSURE	Internal Audit Report The report was shared with the group wherein it was widely accepted.
INFORM	There were no items for information.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

CLINICAL AUDIT PLAN

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	SARA WALTERS, VCS CLINICAL AUDIT MANAGER DR EDWIN MASSEY, WBS MEDICAL DIRECTOR
PRESENTED BY	Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The clinical audit plan ensures the organisation develops a robust and structured approach to clinical audit in 2024/25. The audit plan outlines both the strategic approach and intended annual clinical audit cycle. The three key developments within the clinical audit plan for 2024/45 are, • AMaT, a centralised clinical audit registration and management tool is being fully rolled out

	across VUNHST. Use of AMaT allows for improved reporting of audit activity, monitoring of actions and learning from audits, and monitoring of audit activity all which strengthen the governance structures around clinical audit.
	• Improvement in the triangulation of quality and safety and clinical audit through divisional quality hubs, Integrated Quality and Safety Group, and the development of quality and audit dashboards. This ensures that themes identified through concerns, incidents, patient experience, and risks influence potential audits.
	• Plans to expand on WBS clinical audit programme to ensure all clinical and scientific areas of WBS are represented within the plan.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to **APPROVE** the Clinical Audit Plan.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board RUN	**29/04/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Clinical Audit Plan was ENDORSED at Executive Management Board RUN	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended *Full clinical audit plan completed for 2024/25. Identified actions and improvements required throughout the plan such as appointment of clinical lead, development of quality and audit dashboard, and expansion of AMaT*

Page 2 of 6

APPENDICES	
1 2	VUNHST Clinical Audit Plan 2024/25 NHS Wales National Clinical Audit and Outcome Review Plan for 2023/24

1. SITUATION/ BACKGROUND

The purpose of this paper is to provide the Quality, Safety and Performance Committee with the Trust Clinical Audit Plan and seek approval of the plan. This Annual Trust Clinical Audit plan will represent an overview of the Velindre Cancer Centre and Welsh Blood Service Clinical Audit Strategic approach and Programme of work for 2024/25.

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

2.1 NHS Organisations delivering clinical activity are required to develop a clinical audit programme which needs to be reflective of the service provided and aligned with the Organisational strategic direction, and reflective of themes identified through the quality and safety agenda. See VUNHST Clinical Audit Plan 2024/25 Appendix 1.

2.2 In order to ensure that these clinical audits contribute to the overall priorities of the organisation, and clearly improve patient and donor care, there needs to be a process of strategic planning, prioritisation, and triangulation. The resources for clinical audit are finite so the projects that have been proposed need to be reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan for 2022/23, Appendix 2), VUNHST should provide the resources to enable their staff to participate in all audits, reviews, and national registers of relevance to the service, included in the annual plan.

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒

• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☒
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☒
• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* <u>*STRATEGIC RISK DESCRIPTIONS*</u>	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The audits outlined in the plan align with all the quality domains. The quality domain each audit aligns with is outlined in the plan.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	
	This is a programme of planned audits as opposed to a policy or guideline	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This is a programme of planned audits as opposed to a policy or guideline

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	**Choose an item**
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

CLINICAL
AUDIT
PLAN
2024/2025

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT PLAN 2024/2025

1. INTRODUCTION

Clinical Audit is a core component of the Quality and Safety Framework for the Trust. It ensures that as an organisation we can provide Safe, Timely, Effective, Efficient, Equitable and Person-centred care through learning and continuous service improvement, to meet the requirements of The Health and Social Care (Quality and Engagement) (Wales) Act 2020 and Duty of Quality 2023.

It is vital that the organisation develops a robust and structured approach to Clinical Audit for 2024/25 through the provision of a Clinical Audit plan that describes both the strategic approach and intended annual clinical audit cycle.

The purpose of this document is to provide the Quality, Safety and Performance Committee with the proposed Trust Clinical Audit Plan for Velindre Cancer Service and the Welsh Blood Service 2023/24 for consideration and approval.

2. BACKGROUND

2.1 NHS organisations delivering clinical activity are required to develop a clinical audit programme which needs to be reflective of the service provided and aligned with the organisational strategic direction.

2.2 VUNHST is committed to delivering effective clinical audit in all the clinical services it provides. This is essential to continually evolve, develop and maintain high quality patient and donor centred services. The resources for clinical audit are finite, so the projects that have been proposed are continuously reviewed and prioritised in a systematic way.

2.3 In line with national guidance (NHS Wales National Clinical Audit and Outcome Review Plan 2022/23), VUNHST should provide the resources to enable their staff to participate in all audits, reviews, and national registers of relevance to the service, and ensure these are included in the annual plan. The details of the NHS Wales National Clinical Audit Plan can be found in Appendix 3

3. KEY REQUIREMENTS TO ACHIEVE A TRUST CLINICAL AUDIT PLAN

3.1 The necessary structures should be in place to support and complete engagement included in the Trust Clinical Audit plan.

3.2 A Clinical Lead for each of the divisions is required to provide clinical leadership and act as a local champion and point of contact for national audits and external relationships.

3.3 The full audit cycle should be completed and findings and recommendations from audit should link directly into a quality improvement programme.

3.4 The learning from clinical audit should be shared across the organisation, and communicated to staff and patients, and be used to improve the quality of care.

4. GOVERNANCE AND REPORTING

4.1 The Executive Medical Director has overall responsibility for the development of a Trust Clinical Audit Plan and ensuring that this is aligned to the Trust strategic priorities.

4.2 The overall responsibility to complete the annual clinical audit programme for each division is delegated to the Divisional Directors.

1

4.3   Within each division there is a Clinical Audit or Quality Improvement manager with responsibility for the following:

- Ensuring that all Clinical Audit Activity within their division is registered
- Ensuring there is full participation in national clinical audits as required.
- Ensuring the clinical audit programme meets all clinical, statutory and commissioning requirements e.g. implementation of National Institute for Health and Care Excellence (NICE) guidance.

4.4   A highlight report of Clinical Audit activity from each division should be presented to the respective Quality & Safety groups at quarterly intervals.

4.5   Escalating any areas of concern to the respective Senior Leadership Team within each division should occur at quarterly intervals.

4.6   The outputs of this Clinical Audit plan will feature within the Trust Annual Clinical Audit Report, which is endorsed by both the Trust Quality, Safety, and Performance Committee, and the Trust Audit Committee and then finally approved by Trust Board. This ensures that there are clear lines of communication with full board engagement in the consideration of audit, the review of its findings and the necessary quality improvements to follow.

4.6   Any national audit that provides benchmarking information should be highlighted.

4.7   An escalation process should exist for any areas of risk identified through participation of local or national audit e.g. using the risk registers within each division to assess, document and mitigate risk as appropriate.

4.8 AMaT

AMaT is a web-based Audit Management and Tracking tool to streamline all of auditing requirements into one simple, easy-to-use system.

Implementation has been a stepped approach; the clinical audit module is now fully implemented. All clinical audit activity within VCS is captured via AMaT, projects have been added retrospectively and now all new proposals are registered via the system. AMaT produces reports regarding audit activity, outcomes and learning which strengthens governance structures around clinical audit.

There are plans to extend the use of AMaT for registering clinical audit to the Welsh Blood Service. This will ensure all clinical audit activity is capture in a centralised system across the Trust.

Moving forward AMaT will allow tailored reports that focus on the learning from audit, it will support the quality and safety function as assurance levels and associated risks can be documented. The system also facilitates SMART action planning and reaudit.

The clinical audit annual report will demonstrate outputs from AMaT, including audit activity and guidance compliance. It will also document key successes, key concerns and post project impact where available.

2

5.0 IMPACT OF KEY STRATEGIC AREAS OF DEVELOPMENT ON THE TRUST CLINICAL AUDIT PROGRAMME 2024-24

5.1   Positioning of Clinical Audit within the Trust Quality and Safety Framework

The Trust Quality and Safety Framework has strengthened the position of clinical audit and ensures that there is alignment strategically with the quality and safety agenda across the Trust. The establishment of Quality Hubs has been instrumental in linking in key individuals and pieces of work, to ensure there is coordination, oversight, and triangulation of outcomes. As part of the development of a Quality cycle, there will be a project management infrastructure to strengthen its clinical effectiveness arrangements including Clinical Audit.

5.2   Positioning of Clinical Audit within the National Clinical Framework (NCF)

The National Clinical framework has Quality Statements for a number of Clinical Networks and disease areas including Cancer and End of Life. This will be a set of clinical priorities that can be used to benchmark against, using Clinical Audit and Quality Improvement to drive change. The NCF also promotes the principles of prudent health and use of quality management systems, in line with our Trust QSF and Trust Value Based Healthcare principles.

5.3 Trust Integrated Quality and Safety Group

The establishment of this Trust group has helped to centrally position Clinical Audit to ensure that all Clinical Audit Activity is captured and that it is informed and influenced by the triangulation of all available sources of Quality data. The Business Intelligence system to support this triangulation is in its early stages but aims to eventually have a live dashboard that can be interrogated.

High level incidents and themes from complaints that have been identified by the group for inclusion in the planned programme include communication to patients including Diabetes: Glycaemic control, the treatment helpline, Pre SACT documentation and MDT referrals. Work on developing projects around some of these issues are underway and will be added to the plan in due course.

In addition, the group provides a feedback mechanism so that learning can be shared, and issues identified can be escalated.

5.4 Trust Clinical Scientific and Strategic Board

The establishment of the CSSB will provide a strong focus for prioritisation of Clinical Audit, learning from Clinical Audit Outcomes and the benchmarking of Clinical Audit findings, in line with the development of a Clinical and Scientific Strategy.

5.5 Trust Value Based Healthcare Programme

The embedding of Value in Health principles across the Trust will shape the focus for Clinical Audit in reducing harm and variation in clinical pathways and also considering the equity of care across the system.

VBH Clinical leads will be appointed for each division and will help support the triangulation of clinical audit within the organisation.

3

6.0 INTERNAL AUDIT OF TRUST CLINICAL AUDIT PROCESS AND GOVERNANCE

An internal audit undertaken in January 2023 sought to provide the Trust with assurance that Velindre University NHS Trust has effective processes in place to embed a culture of clinical audit best practice and continuous quality improvement in all services. Overall, a **'*Reasonable*'** assurance rating was reported across all 5 objectives (Strategy, Plans, action plans, monitoring and learning). The recommendations from the audit have all been addressed and the appropriate actions completed.

SUMMARY

The Trust Clinical Audit Plan seeks to provide assurance that there is a systematic process for prioritising and delivering clinical audit across Velindre Cancer Centre and the Welsh Blood Service. The clinical audit programme is well established within Velindre Cancer Centre given its patient facing role and is largely focused to date on the activity of the Site Specific Teams as well as full compliance on national audits.

VELINDRE CANCER CENTRE CLINICAL AUDIT PROGRAMME

Canolfan Ganser Felindre
Velindre Cancer Centre

7.1   Definition of Clinical Audit at Velindre Cancer Centre (VCC)

The universally accepted definition for both national and local clinical audit as defined by the National Institute for Health and Clinical Excellence (NICE) in their 'Principles for Best Practice in Clinical Audit' is:

"a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery."
NICE, 2002

7.2   Principles of the Clinical Audit Process at VCS

7.2.1   Within Velindre Cancer Centre (VCC) there is a comprehensive and wide-ranging audit programme that has been developed in conjunction with Site Specific Teams (SST's), Directorate managers, and the Quality & Safety/Improvement Team.

7.2.2   In line with best practice highlighted in a number of key documents including *Clinical Audit: A simple guide for NHS Boards & Partners (Healthcare Quality Improvement Partnership)* and *NHS Wales National Clinical Audit and Outcome Review Plan 2022/23* the VCS programme covers the following areas;

   ✓ Involvement in National Audits and Outcome Reviews
   ✓ Quality and Safety – Audits undertaken in response to serious incidents/adverse incidents/near-misses/complaints, to ensure corrective actions taken to prevent a recurrence have been implemented
   ✓ Cancer Peer Review Outcomes
   ✓ Professionally led and/or SST lead audits - to ensure healthcare professionals are enabled to participate in clinical audit in order to satisfy the demands of their relevant professional bodies (for example, for revalidation and professional development)
   ✓ Internal 'Must Do' Audits based on high risk/high profile/tier one target areas etc.

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7.2.3   The VCS audit programme is signed off by the VCS Quality and Safety Management Group (QSMG) and the Senior Leadership Team.

7.2.4   The VCC programme for 2024/25 is shown in appendix 1.

7.3   National Audits

A new national centre of excellence to strengthen NHS cancer services by looking at treatments and patient outcomes right across the country has been established. The National Cancer Audit Collaborating Centre will deliver five new national cancer audits in breast cancer (primary and metastatic), ovarian, pancreatic, non-Hodgkin lymphoma and kidney cancer alongside the existing Lower Gastrointestinal, Upper Gastrointestinal, Prostate and Lung audits.

The Welsh Cancer Network (WCN) supports NHS Wales' participation in National Cancer Audit and have published A Cancer Improvement Plan for NHS Wales 2023-2026 which sets out the ambition for Wales to improve cancer patient outcomes and reduce health inequalities.

Historically data has been extracted from Canisc for cancer specific information, radiotherapy & SACT data by the WCN. With the transition to cancer dataset forms the WCN are finding the treatment data has gaps where organisations have transitioned from one system to another, or lack of resources have impacted organisations ability to translate information from source systems to Canisc Welsh Clinical Portal (WCP) eforms designed to collect audit data. Therefore, the WCN are working closely with the Health boards and Cancer Centres to obtain this information for submission to the National audits.

The long term ambition is to transition to a process where this treatment information (radiotherapy & SACT data) is pulled from a central national dataset.

7.4   Dissemination of audit results and learning from audit outcomes.

7.4.1   The Multidisciplinary Site Specific Teams take ownership for the internal audit results and discuss and report these at the regular team meetings. All this data feeds into the VCC Clinical Audit Annual Report which is validated by the Quality Senior Management Team and reported to the Trust Quality, Safety, and Performance Committee,

7.4.2   The results and learning from audits are available for all AMaT users to view.

7.4.2   Virtual events

There are two virtual presentation events per year, these are dedicated to the SSC (Student Selected Component) projects that are undertaken by medical students under clinical supervision. These projects make up the majority of the SST's clinical audit programme. The virtual events are scheduled during the last week of the SSC 6-week block. This provides an opportunity for students to present their work at a multidisciplinary forum sharing any areas of learning with the organisation. The presentations are judged by an expert panel and the winning presenters receive a prize.

7.5   Areas of development for VCC

- Identify a clinical lead for audit.
- Develop a robust governance process including the sign off of audit proposals at a directorate level and reporting of audit projects back through to the directorate ensuring accountability and ownership of audit projects at a directorate/ department level.

5

- Strengthen the quality hubs to ensure projects are reviewed to ensure alignment with SST/ IMTP/ QI objectives.
- Strengthen the quality hubs to ensure learning from audit projects are disseminated and any identified improvements undertaken.
- Annual Trust Clinical Audit and QI events to share learning and foster a culture of clinical effectiveness and improvement through the VCS Grand Round events.
- Ensure all audit activities are brought together maximising the systems we have in place for example, Tendable (ward based audits such as falls equipment checks, and AMaT.
- Development of Quality & Safety Dashboard to include clinical audit activity and will be available for each SST
- A programme of work is being developed around Medically lead IR(ME)R17 audits and will be added to the plan in due course. This is in line with the HIW inspection of nuclear medicine recommendations.

8. WELSH BLOOD SERVICE (WBS) CLINICAL AUDIT PROGRAMME

8.1   Clinical audit at the WBS is fundamental in ensuring the provision of safe, timely, effective, efficient and person-centred care and interventions. It covers the care of patients receiving a transfusion or transplant, the care of the volunteer donors who support them and the diagnostic support provided for patients, e.g. during pregnancy and the neonatal period.

8.2   When carried out in accordance with best practice standards, clinical audit:
- Identifies and celebrates areas of best practice and service excellence
- Identifies areas of learning and improvement
- Provides assurance of compliance with clinical standards

8.3   A number of clinical audit activities are already embedded into WBS processes which demonstrate a commitment to sustain and improve safe and high quality of care for all of our donors and ensures the safety of the blood supply chain and recipients.

8.4   At the WBS the clinical audit function is led by the Head of Nursing (but this post is currently vacant) reporting to the Medical Director and supported by the multidisciplinary teams for blood transfusion and diagnostics (Blood Health and transfusion laboratories)..

8.5   Clinical Audit findings, learning and improvements are reported to the relevant clinical governance group and hence to the Trust Quality, Safety and Clinical Governance Structure. The audits support the WBS strategy and the Futures program..

8.6   The WBS is committed to clinical audit and continues to embed and expand both electronic systems and programmes of clinical audit across the division to enable the provision of high quality, safe, timely, effective, efficient and person-centred care with a strong lens upon continuous improvement and learning.

8.7   Participation in External Audits

The Blood Health Team (BHT) at the WBS contributes to the prioritisation, design and coordination of national audits relating to transfusion medicine across Wales on behalf of the Blood Health National Oversight Group (BHNOG) The BHT completes all-Wales analysis and contributes to the action plans from specific audits and from the ongoing monthly performance indicator data for individual hospitals to ensure provision of safe and high quality transfusion interventions.

8.8   Participation in U.K/ European Audit and Benchmarking Activities

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The Blood Health Team undertake sub analyses of UK wide National Comparative Audits in the field of blood transfusion and work with the BHNOG individual Health Boards and if the audit is relevant to patients with cancer the VCC. The National Comparative Audit program is supported by the four nations of the UK and typically has a high uptake in Wales.

The WBS also participates in international audits of practice, initiating surveys and audits that are priorities for Wales. We are members of the European Blood Alliance (EBA) and the worldwide Biomedical Excellence for Safer Transfusion (BEST) Collaborative.

9.0   Please see the Appendix for full details on the Clinical Audit Programme 2024/25:

Welsh Blood Service Clinical Audit Programme 2024/25 Appendix 1
Velindre Cancer Centre Clinical Audit Programme 2024/25 Appendix 2
NHS Wales National Clinical Audit and Outcome Review Plan 2024/25 Appendix 3

7

APPENDIX 1

Welsh Blood Service Clinical Audit Programme 2024-25

Audit	Aim	Frequency
Blood Donation		
Blood Donor Pre-venepuncture Skin Decontamination	To prevent bacterial contamination of blood and blood products effective pre-venepuncture skin cleansing is of paramount importance. To ensure that the arm cleansing techniques are in line with both evidence based practice and regulatory requirements	Monthly & Quarterly Validation Audits
Blood Donor Points of Care	To ensure compliance with points of care UK evidenced based donation care principles to maximise donor outcomes.	Quarterly & Annual Validation
Blood Donation Hand Hygiene	To ensure compliance with W.H.O 5 moments of hand hygiene to maintain donor, staff and recipient safety.	Monthly with Quarterly Validation
Blood Donor Adverse Event Report Management Audit	To ensure the provision of safe, effective, efficient and equitable donor care provision in the event of a donor adverse event occurrence.	Monthly
Blood Donation Clinical Standards	A suite of clinical audits will be developed and introduced within the Tendable Clinical Audit System across the Division to ensure that donor care provision aligns with evidence-based practice standards.	Quarterly
Blood Transfusion		
National Comparative Audit (UK)	a) Bedside Transfusion Audit (March 2024) b) Audit of NICE Quality Standard QS138 (October 2024)* c) Major Haemorrhage audit (Spring 2025) These are audits of practice undertaken by Health Boards and Trusts in the UK against national guidance. The Blood Health Team facilitates these audits and provides a national report for Wales from the findings. *Unable to determine at this point the uptake to this audit as a consequence of utilisation of the QS138 insight tool.	3 Specific point audits commencing on the dates stated
Major Haemorrhage Protocol Activations in Health Boards (Wales)	To promote appropriate use of blood and alternatives to blood. Including monitoring use of O D positive red cells in emergencies before the blood group of the recipient is known, preserving stocks of O D Neg for the patients who need them (females of childbearing potential).	Quarterly
Blood Health National Oversight Group	To provide an ongoing measure of practice from each of the Health Boards (HBs) in Wales for the use of O D negative red cells (ODneg) as a percentage of all red cells ordered (target <12%), wastage of O	Monthly

1

(BHNOG) Performance Indicators (Wales)	Dneg as a percentage of total ODneg (<10%). Wastage of platelets as a percentage of total issues (<12%)	
Clinical Insight Audits (Wales)	a) Where does O D Neg go? (June 2024) b) Where does surgical blood go? (Autumn 2024) c) All Wales Transfusion record audit (Sept 2024) d) QS 138 Quality insights e) Consent to transfusion survey (TBC – end of 2024) f) Reaudit of Platelet use in Haematology – (TBC – end 2024.)	Annual Ad-hoc Ad-hoc Quarterly Ad-hoc Every 2 years
Transplantation		
Stem Cell Donor recovery and satisfaction	Every donor undertakes a satisfaction survey	Quarterly
Stem cell dose provision	The doses provided are audited against the doses requested	Quarterly
Kidney/Pancreas transplant waiting list long-term suspensions from	Number of local patients on the National organ transplant waiting list that are suspended for over 12 months	Annual
Number of kidney/pancreas transplant patients with unexpected positive crossmatch	Number of patients where a transplant does not proceed because of an unexpected positive crossmatch	Annual
Number of transplants that proceed on the basis of a virtual crossmatch	Number of patients that proceed to transplant on the basis of a virtual crossmatch	Annual
Stem Cell Donor Pre-venepuncture Skin Decontamination	Peripheral blood stem cell donor skin decontamination is audited in the same manner as blood donors	Quarterly

2

Diagnostic laboratory service		
Re-audit: Out of Hours Red Cell Immunohematology (RCI) Referrals	An audit to look at the appropirateness and timeliness of supporting referrals for diagnostic testing out of hours	October 2024
Re-audit of Antenatal Anti- D sampling, quantification & reporting practice in D negative women in Wales	A reaudit to see if the changes made to the provision of testing and antenatal advice have improved compliance.	October 2024
Audit of the practice of HLA and HPA selected platelet provision in Wales	An audit as part of the process in improving the provision of platelets for patients in Wales including matched platelets	July 2024
Coeliac Disease HLA genotyping Reporting	An audit on the compliance with best practice guidelines on HLA genotyping reporting	April 2024

3

APPENDIX 2

Velindre Cancer Centre Clinical Audit Programme 2024/25

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
National Audits						
Safe Effective Equitable Person-centred	National audit of lung cancer	The National Audit focuses on four main areas relating to lung cancer; the number of lung cancer cases within the UK, the range of treatments used, regional variations in these treatments and variations in outcomes	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Effective Equitable Person-centred	National Prostate Cancer Audit	Looking at diagnosis, management and treatment of every patient newly diagnosed with prostate cancer in England and Wales, and their outcomes.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Efficient Equitable Person-centred	NOGCA - National Oesophago-gastric Cancer Audit	To evaluates the process of care and the outcomes of treatment for all OG cancer patients, both curative and palliative.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Person-centred	National Bowel Cancer Audit	The Audit's main aim is to improve the quality of care and survival of patients with bowel cancer.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Person-centred	National Kidney Cancer Audit (NKCA).	The audit process will look at diagnosis and treatment, and how patients are managed.	SST Lead Clinical Audit Dept	National Audit	Ongoing (Annual)	Ongoing (Annual)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Timely Effective Person-centred	National Audit of Metastatic Breast Cancer (NAoMe).	Focus will firstly be on improving the completeness of key data items, including recording of cancer recurrence. Initial priorities of the audit will be establishing the baseline from which change in practice and outcomes can be measured. To reduce variation in practice and improve aspects of care and outcomes highlighted as important within the scoping work.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Person-centred Equitable	National Audit of Primary Breast Cancer (NAoPri)	The audit will examine the generality of breast cancer care and also focus on a number of important challenges. These include the care of younger patients, the diagnosis and treatment of patients with more aggressive triple negative cancers, and the needs of smaller groups of patients, including men.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Person-centred	National Ovarian Cancer Audit (NOCA)	This new audit, drawing on the work of a feasibility pilot audit which began in 2019, will produce granular information on diagnosis, treatment and surgery, to allow us to assess how to improve care in England and Wales, and create better results.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Timely Effective Person-centred	National Pancreatic Cancer Audit (NPaCA)	The audit will be a really important tool, helping to accelerate national efforts to improve the care and treatment of patients diagnosed with pancreatic cancer.	SST Lead Clinical Audit Dept.	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Timely Effective Person-centred	UK Renal Oncology Collaborative	Audit of outcomes in Renal Cancer	Consultant	National	Ongoing	Ongoing
Safe Timely Effective Person-centred	National project on the use of 2nd line carboplatin /pemetrexed after 1st line osimertinib in locally advanced/met EGFR variant positive NSCLC.	National review of outcomes and use of 2nd line carboplatin /pemetrexed after 1st line osimertinib in locally advanced/met EGFR variant positive NSCLC.	Consultant	National	April 2024	March 2025
Equitable Person-centred	UK NACEL (National Audit for Care at the End of Life) Audit	NHS Benchmarking project	SPCT	National Audit	Ongoing (Annual)	Ongoing (Annual)
Continuous Monitoring – Quality and Safety and Must Do's						
Safe Effective Patient centred	Death within 30 days SACT, 30/90 of Radiotherapy	Review patients who die within 30 days of SACT, 30 days of palliative radiotherapy and 90 days of curative radiotherapy	Mortality Team SST's	Patient safety	Ongoing (Monthly)	Ongoing (Monthly)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Patient centred	Mortality reviews	Review the care inpatients who die at Velindre received.	Mortality Team	Patient safety	Ongoing (Weekly)	Ongoing (Weekly)
Patient centred. Equitable	CIVICA: All Wales palliative and eol experience questionnaire	Independent service to allow patients to feedback their experiences.	Palliative Care	Users views	Ongoing	Ongoing
Patient centred Timely	Re- audit Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	To ensure the patient's wishes are respected, decisions reflect the best interest of the individual and benefits are not outweighed by burdens. A DNACPR decision is clearly recorded and communicated between health professionals.	Consultant	National guidance	Ongoing 2 yearly (next audit due 2024)	Ongoing 2 yearly
Timely Person-centred	All Wales Patient experience framework	To evaluate patients experience at VCC to identify areas from improvement	Patient experience Manager	Users views	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective	Safeguarding documentation audit	To provide measure compliance with the All Wales Safeguarding Procedures.	Safeguarding Lead	All Wales guidelines	TBC	TBC
Safe Timely Person centred Effective	Metastatic spinal cord compression (MSCC)	To measure compliance with the standard for referral and assessment for metastatic spinal cord	Physiotherapy	Local & National Guidelines	Ongoing (6 monthly)	Ongoing (6 Monthly)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Timely Person centred Effective	Pressure Sores	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Person centred Effective	Slips/Trips/Falls	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Timely Person centred Effective	Nutritional Screening including Protected Meal times & fluid balance compliance	To provide evidence to support safe effective care in relation to the health care standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Person centred Effective	Heat Pads	TBC	TBC	TBC	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective Person centred	Health, Safety, Fire & Security	To ensure health, safety and security of the ward is being maintained	First Floor, OPD, SACT, SACT Neville Hall. SACT PCH, R&D	Tenable audits	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective Person centred	Quality Assurance Walk	To ensure that the clinical area is delivering quality care within an appropriate clinical environment (e.g. assessment of the floor and sinks)	First Floor, OPD, SACT, SACT Neville Hall. SACT PCH, R&D	Tenable audits	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective Person centred	Patient Centred Care	To ensure that patient centred care is being delivered and involving patients in the care planning process	First Floor, OPD, SACT, SACT Neville Hall. SACT PCH, R&D	Tenable audits	Ongoing (Monthly)	Ongoing (Monthly)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Timely Effective	Equipment Checks	To ensure equipment is in good working order e.g. commodes	First Floor, OPD, SACT, SACT Neville Hall. SACT PCH, R&D	Tenable audits	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely	ANTT	To ensure that clinical staff are maintaining aseptic non touch technique as required when performing clinical tasks e.g. medication administration or wound dressings	First Floor, OPD, SACT, SACT Neville Hall. SACT PCH, R&D	Tenable audits	Ongoing (Monthly)	Ongoing (Monthly)
Timely Person centred Effective	Mouth care bundles	Ensure compliance with good practice and all Wales standards	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Timely Person centred Effective	Sepsis Six compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Timely Person centred Effective	Rapid Response to Acute Illness (RRAILS) – National Early Warning Score (NEWS) compliance	Tier 1 target - To provide evidence to support safe effective care in relation to the health care standards	Acute Oncology ANP	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective Equitable	Oxygen spot-check	To measure compliance with local/national guidelines	Nursing Ward Manager	Quality assurance	Ongoing (Monthly)	Ongoing (Monthly)
Safe Timely Effective	Catheter associated Urinary Tract Infections (CAUTI)	To measure compliance with all elements for insertion and maintenance of bundles for urinary catheters	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Timely Effective	Visual Infusion Phlebitis (VIP) Score – Chemotherapy Inpatient Unit (CIU)	To measure compliance with all elements for insertion and maintenance of bundles for peripheral vascular cannula and central venous catheters	Ward Manager	Local & National Guidelines	Ongoing (Daily)	Ongoing (Daily)
Safe Effective Efficient	Patient data for MRSA/ MSSA/ C diff/ E Coli/ CAUTI/ Bacteremia/CPO	Tier 1 target - To monitor infection rates for all Healthcare Associated Infections (HCAIs)	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Methicillin Resistant Staphylococcus Aureus (MRSA) Screening	Tier 1 target - To measure compliance with screening for MRSA	Nursing Ward Manager & IPC Team	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Hand hygiene	Tier 1 target - To measure hand hygiene compliance against World Health Organisation (WHO) 5 Moments of Hand Hygiene	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Weekly)	Ongoing (Weekly)
Safe Effective Efficient	Personal Protection Equipment (PPE)/Isolation	To monitor compliance with PPE (donning and doffing) Fit testing compliance	IPCT with support from dept. champions	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Environment/ commodes/ sharps/ waste/ linen	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits	Infection Prevention & Control	Local & National Guidelines	Ongoing (Annual)	Ongoing (Annual)
Safe Effective Efficient	Enteral feeding Audit	To monitor against National Standards for IPC (inclusive of key audits- environmental, commodes/ sharps / clinical practice audits)	Infection Prevention & Control	Local & National Guidelines	Ongoing (Annual)	Ongoing (Annual)
Safe Effective Efficient	High level decontamination	To monitor against National Standards for decontamination	Infection Prevention & Control	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Timely Patient centred Equitable	Pathways of Care delays	Tier 1 target	Nursing Ward Manager	Local & National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Patient centred Safe	Chaperone audit	To ascertain current practice of documentation regarding the offer of a chaperone	Nurse CAD	SI/VCC Guidelines	TBC	TBC
Timely Efficient Safe	Record Keeping Audit	Record keeping audit every 6 months to look at compliance to our record keeping guidelines. To then feedback to team and make adjustments/give further education as indicated.	AHP	National guidelines	February 2022	6 monthly
Safe Effective Efficient	WAASP Quality Audit	To highlight any inaccuracies in WAASP scoring by comparing WAASP tools completed by nursing staff against how they should be scored based on information from medical notes, nursing documents and patient reports.	AHP	NICE Guidelines Patient Safety VCC Guidelines	November 2022	Ongoing (Annually)
Timely Efficient Safe Equitable	NEWS Cymru audit	The NEWS Cymru audit will set out to monitor the compliance of the completion of the chart and whether the necessary interventions and clinical responses are being actioned.	Nurse	Local/National Guidelines	Monthly	Monthly
Timely Efficient Safe Equitable	All Wales Critical Care Outreach Audit (Burden of Acute Illness Audit)	Prospective data collection comparing with all Wales data	Nurse	Local/National Guidelines	Monthly	Monthly

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Equitable Patient centred	Key worker Audit	To review compliance of patients with document key worker	CNS Manager CAD	Key performance indictor	April 2024	Monthly
Equitable Person-centred	All Wales Care Decisions Guidance and priorities for end of life care	Care Decisions for the Last Days of Life guidance was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.	SPCT	National Audit	Ongoing (Annual)	Ongoing (Annual)
Safe Equitable Efficient	Consent Audit (Including Audit of all Wales consent form 4 (best interests)	To identify if consent forms are available to view and to ascertain completeness of the information	Clinical Audit Dept.	Clinical risk	Ongoing (Annual)	Ongoing (Annual)
Medical Directorate						
Breast Malignancies SST						
Safe Effective Efficient	An audit of the use of palliative and curative radiotherapy for patients with breast cancer with brain metastases	To assess outcomes for breast cancer patients with brain metastases	SPR Medical Student SSC	SSC	March 2024	May 2024
Safe Effective Efficient	HER2 + neoadjuvant treatment and outcomes	An audit to investigate the outcomes of patients treated with neoadjuvant systemic therapy for HER2 + breast cancer .	Consultant Medical Student SSC	SSC PROMS	March 2024	July 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	Neoadjuvant carboplatin, paclitaxel, EC pembro – outcomes	(PCR rate c/w trial, immunotherapy toxicity)	Consultant Medical Student SSC	SSC	March 2024	July 2024
Safe Effective Efficient	An audit of rates of interstitial lung disease in patients with HER-2 positive secondary breast cancer on second and later line treatment with Enhertu (Trastuzumab deruxtecan).	To ascertain the rates of interstitial lung disease, in HER2 positive patients receiving second line Enhertu.	Consultant Medical Student SSC	SSC	March 2024	July 2024
Gynaecological Malignancies SST						
Safe Effective Efficient	Treatment outcomes following image-guided brachytherapy in cervical cancer.	To review treatment outcomes following brachytherapy	Consultant Medical Student SSC	SSC	March 2024	May 2024
Safe Effective Efficient	A service evaluation to examine outcomes of post-treatment MRI scans after chemoradiotherapy for cervical cancer.	To review post treatment MRI scans after chemoradiotherapy for cervical cancer	Consultant Medical Student SSC	SSC	March 2024	May 2024
Person-centred Safe Effective Efficient	Patient information leaflets and Royal College of Radiologists radiotherapy consent forms: how well do they match, and can they be harmonised?	To review and compare patient information leaflet and consent forms, gaining a patients perspective	Consultant Medical Student SSC	SSC	March 2024	May 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient Timely	Treatment Response of Patients With Advanced Epithelial Ovarian Cancer to Maintenance Chemotherapy Based on Mutation Status	To assess the extent of response in patients who have received the maintenance chemotherapy regimen of bevacizumab and olaparib for advanced high-grade epithelial ovarian cancer, based on the mutation status of their disease.	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	How do post operative CT scans change the management of stage 3 endometrial cancer	To review post operative CT scans to assess if	Consultant Medical Student SSC	SSC	March 2024	May 2024
Safe Effective Efficient	Late Effects of Radiotherapy Gynae-oncology – Survey	To evaluate patient's experience of the Gynae-oncology Late Effects Clinic.	Consultant	Users views	September 2020	Ongoing
Head & Neck SST						
Safe Effective Efficient	Retrospective review of the recurrent, progressive, or metastatic head and neck cancers treated by first line of systemic treatment	To look at the management of and compare the outcomes of the recurrent, progressive, or metastatic head and neck cancers(with positivePDL, CPS >1) treated by PEMBROLIZUMAB or chemotherapy as first line of systemic treatment in VCC over the past 5 years.	SPR Consultant	Key Indicators of Practice Clinical Effectiveness VCC Guidelines	January 2023	December 2024
Safe Effective Efficient	Predicting radiotherapy doses to the dentoalveolar structures	A service review of estimated and actual radiation dosimetric distribution to the maxilla and mandible for patients receiving radiotherapy for tumours of the parotid gland in Velindre Cancer Centre (VCC).	Consultant Medical Student SSC	SSC	March 2024	May 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	A review of pre-treatment FDG PET-CT imaging for high-risk, locally advanced head and neck malignancies	This project aims to review how PET-CT imaging undertaken in this context between January 2020 to December 2023, changes staging compared to conventional imaging and therefore potential alteration of subsequent management plan.	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	An audit into the recurrence of oropharyngeal cancer on contralateral side to original cancer after being treated with radiotherapy to lymph nodes on ipsilateral side only.	To ascertain recurrence rates and outcomes,	Consultant Medical Student SSC	SSC	March 2024	May 2024
Safe Effective Efficient	An Audit of unilateral radiotherapy in contrast to bilateral radiotherapy, in terms of survival and Local recurrence rate and risk of contra-lateral disease recurrence.	This project would be to audit and review the cases treated with unilateral radiotherapy and compare the survival, local recurrence rates and risk of contra-lateral disease recurrence	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	A review of patients thyroglobulin levels who have radio-iodine ablation	To look at what happens to the patients who have radio-iodine ablation and the thyroglobulin doesn't become undetectable on the super-sensitive assay – i.e. is it relevant if just very low level.	Consultant Medical student	Local concern	May 2024	September 2024
Lung Malignancies SST						
Safe Effective Efficient	Incidence and reporting of spinal insufficiency fractures following radiotherapy in lung cancer patients	To assess Incidence of new insufficiency fractures that occur in the 1st year after radiotherapy for lung cancer. Rates of detection and reporting, including use of	Consultant Radiographer Medical Student SSC	SSC	May 2024	July 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
		terminology such as 'radiotherapy-related insufficiency spinal fracture.				
Safe Effective Efficient	A service evaluation of patients in South East Wales who complete a full 2 year course of palliative immunotherapy for advanced lung cancer (current knowledge gap regarding best practice)	Exploring characteristics and outcomes of patients with advanced NSCLC who compete 2 years of palliative pembrolizumab	Consultant Medical Student SSC	SSC	March 2024	July 2024
Safe Effective Efficient	Patient outcomes/survival/toxicity with sotorasib for locally advanced/metastatic NSCLC with a KRASG12C variant	To review patients who are receiving maintenance treatment with Durvalumab, with particular focus on treatment delivery (in line with NICE guidance) and patient outcomes (survival and toxicity).	Consultant Medical Student SSC	SSC NICE	May 2024	July 2024
Safe Effective Efficient	A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales	To review the time taken between initial presentation of each patient and the liquid biopsy being taken. To review whether the patients had their ctDNA test before or after tissue biopsy was taken?	Consultant Medical Student SSC	SSC	March 2024	May 2024
Palliative Care SST						
Safe Effective Efficient	To what extent is the Information in a treatment escalation plan shared	To review the extent to which information in patient TEPs is communicated to other healthcare professionals in different care settings, and if it has been communicated, whether this information was used to inform future decisions.	Consultant Medical Student SSC	SSC	May 2024	July 2024

Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Urology SST						
Safe Effective Efficient	Clinical Outcomes for Bladder Cancer Following Bladder Preservation Treatment	This audit aims to review the data from patients at Velindre Cancer Centre who have undergone bladder preservation treatment as opposed to radical surgical treatment in order to highlight and compare the outcomes for these patients. The audit will follow on from previous data collected up until April 2014. This will allow further analysis into the relative successes of these treatment options within this cancer centre and may have further implications for adjusting guidance and recommendations for patients in the future.	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	Review of outcomes for definitive, non-surgical treatment of muscle invasive bladder cancer.	To review 3-year outcomes of patients receiving definitive non-surgical treatment (radiotherapy) of bladder cancer.. Patients will be categorised as to whether they received neo-adjuvant chemotherapy, concurrent chemotherapy, BCON or radiotherapy alone. Outcome measures will include survival, local recurrence, and distant recurrence.	Consultant Medical Student SSC	SSC	May 2024	July 204
Safe Effective Efficient	Multi centre audit of treatment and survival outcomes in Renal cancer	To ascertain overall survival and grade of toxicities	Consultant CAD	Key indicator of practice	May 2021	Ongoing

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	The 5-year biochemical control and long-term outcomes of locally advanced node-positive prostate cancer patients treated with hormonal therapy and radiotherapy	The primary objective is to assess the biochemical control rates at 5-years. Furthermore, it hopes to examine the long-term survival rates and patterns of disease recurrence. Additionally, it will identify any potential predictors of favourable outcomes, in relation to demographics, baseline characteristics and any tumour markers that may have impacted treatment response	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	Standard Radiotherapy prostate 60gy/20# PROMS and outcome	Prospective data collection for Standard Prostate radiotherapy 60gy/20# PROMS and outcome.	Radiographer	PROMS	March 2023	March 2024
UGI SST						
Safe Effective Efficient	A service evaluation of the oesophageal and gastric cancer referral pathway	To review outcomes of patients receiving new systematic and/or radiotherapy-based treatments	Consultant Medical Student SSC	SSC Project	May 2024	July 2024
Colorectal SST						
Safe Effective Efficient	Real world data on BRAF mutated metastatic colorectal cancer patients In South east Wales treated with encorafenib and cetuximab (NICE Licenced 2021)	Compare clinical data to published results in similar cohort of patients (BEACON), correlate severity and range of toxicities to published results (BEACON).	Consultant Medical Student SSC	NICE	January 2024	May 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	Rectal contact Radiotherapy	To Evaluate the selection criteria, and outcomes for patients who are treated with contact radiotherapy for rectal cancer	SPR Consultant	NICE	April 2021	September 2022
Neuro-oncology SST						
Safe Effective Efficient	Assessing Post-Metastatic Resection Care: Evaluating the Impact of Revised NICE Guidelines on Treatment Strategies, Patient Recurrence, and Outcomes in University Hospital Wales and Velindre Cancer Centre.	Evaluating the Impact of Revised NICE Guidelines on Treatment Strategies, Patient Recurrence, and Outcomes in	Consultant Medical Student SSC	SSC Project NICE Guidelines	March 2024	May 2024
Skin SST						
Safe Effective Efficient	An audit of the clinical effectiveness of Cemiplimab for advanced squamous cell carcinoma of the skin and of Avelumab for advanced Merkel cell cancer	To ascertain outcomes of patients receiving Cemiplimab for advanced squamous cell carcinoma of the skin and of Avelumab for advanced Merkel cell cancer, including toxicity.	Consultant Medical Student SSC	SSC	March 2024`	May 2024
Safe Effective Efficient	Evaluation of the impact of radiological involvement and tertiary imaging review in a newly established complex melanoma multidisciplinary team meeting.	To assess the impact of radiological involvement in a newly established complex melanoma multidisciplinary team meeting.	Consultant Medical Student SSC	SSC	March 2024`	May 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Other Sites/Services						
Safe Effective Efficient	An Audit of DPYD Testing in Velindre Cancer Centre	Collate a bank of patients who were found to have a DPYD variant following DPYD genomic testing across a 6-month period. - Assess the timeline of DPYD testing	Consultant Medical Student SSC	SSC	May 2024	July 2024
Safe Effective Efficient	Review of Immunobuddies and the IO forum	To obtain users views of immunobuddies and the IO forum	Consultant Medical Student SSC	SSC Users views	March 2024	May 2024
Safe Effective Efficient	Evaluation of the benefits of the Day 8 call back for patients receiving SACT capecitabine.	To evaluate the benefit of the Day 8 ring back for SACT patients, reviewing a minimum of 100 patients. To compare the usefulness in patients with and without DPD deficiency. To explore whether the helpline is identifying any unreported adverse effects or problems taking medication. To investigate the potential effects of patient characteristics on ability to take medication correctly. To consider whether the helpline remains an appropriate use of time and resources.	Consultant Medical Student SSC	SSC	March 2024	May 2024
Safe Effective Efficient	Audit of organ toxicity in patients receiving checkpoint inhibitor immunotherapy	To review toxicity in immunotherapy patients, To evaluate incidence and reporting. To explore the correlation between baseline tests and the development of toxicities whilst on ICI treatment	Consultant Medical Student SSC	SSC	May 2024	July 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	Measuring the Impact of Carcinoma of Unknown Primary (CUP) Service Intervention in Terms of Patient Experience	The aim of this project is to undertake a service evaluation looking into both PROMs (patient reported outcome measures) and PREMs (patient recorded experience measures), with the intention of improving caregivers understanding of when it is most beneficial to capture patient feedback and determine effective and suitable methods to ascertain feedback, with the aim of improving patient care and experiences.	Consultant Medical Student SSC	SSC PROMS PREMS	May 2024	July 2024
Safe Effective Efficient	An evaluation of the IO toxicity service	To obtain users views of the IO toxicity service	Consultant Medical Student SSC	SSC	March 2024	May 2024
Integrated Care Directorate						
Breast SST						
Timely Safe Effective Efficient	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	To ensure all adjuvant breast cancer patients eligible to receive adjuvant bisphosphonate with zoledronic acid are managed safely and equally within the treatment pathway	CNS CAD	NICE Guidelines	January 2021	October 2024
Colorectal SST						
Safe Effective Efficient	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	To identify how frequently this is occurring and if we can identify if there are any factors such as dose or number of cycles	SACT Lead Nurse CAD	Clinical Risk	April 2023	September 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
		administered which can help us anticipate which patients are more at risk.				
Other Sites/Services						
Safe Effective Efficient	Diabetes: Glycaemic control	TBC	Ward Manager	Incident	March 2025	March 2026
Safe Effective Efficient	Treatment helpline	To review the treatment helpline compliance with local and national standards	SACT Nurse	Incident	March 2025	March 2026
Safe Effective Efficient	Cancer Unknown Primary (CUP) Patient Survey	To capture patients experience of the CUP service	CNS	Users views	February 2023	Ongoing
Safe Effective Efficient	Treatment Escalation Plan (TEP) Audit	To assess the completeness of the documentation of the TEP form	Nurse	Local guidelines	March 2024	October 2024
Safe Effective Efficient	MDT Ref	TBC	Manager	Local concern/ incident	January 2025	December 2025
Safe Effective Efficient	Audit of 2222 calls at Velindre Cancer Centre	In line with the RCUK quality standards all 2222 calls must be audited and reviewed to ensure practices are adhered to and any lessons can be learnt from events in order to improve patient care and safety	Nurse		March 2024	Ongoing

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	Pre SACT Documentation	To assess the completeness of the documentation of pre SACT documentation	SACT Lead Nurse Lead Prescriber	NRI SACT Prescribing guidelines	November 2024	March 2025
Timely Safe Effective Efficient Patient Centred	Single Cancer Pathway – Treatment Pathway Review	Review the treatment pathways for all SST's for patients who receive first definitive treatment at VCC. This will include a retrospective look at what the processes were and how long they took and what the impact of the new pathways will be on service capacity and demand.	Service Improvement	National guidelines	Ongoing	Ongoing
Safe Effective Efficient	SBP (spontaneous bacteria peritonitis) rates	To audit SBP (spontaneous bacteria peritonitis) rates compared to the national average	Nurse	Patient safety	April 2024	March 2025
Safe Effective Efficient	VCC TPN patient service evaluation and outcome analysis: An audit of historical cases between January 2021 and January 2024.	To Improve TPN provision, patient safety and management in VCC.	AHP	Clinical Effectiveness NICE Guidance Patient Safety VCC Guidelines	February 2024	July 2024

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	All Wales Critical Care Outreach Audit (Burden of Acute Illness Audit)	The national acute deterioration group are conducting a 'burden of acute illness' audit to demonstrate the number of patients with elevated NEWS at any one time within each health board acute site and Velindre Cancer Centre. The results derived from this national audit will be used to inform future guidance for the management of acute deterioration.	Nurse	All Wales	March 2024	June 2024
Safe Effective Efficient	An audit to evaluate the clinical appropriateness of spinal braces for patients with MSCC admitted to VCC in line with NICE guidance 2023 and the South Wales Spinal Network Clinical guidelines for MSCC 2023.	To determine the number of patients with MSCC attending VCC for RT who have been recommended to have a spinal brace.To determine the appropriateness of the recommendation for spinal bracing in line with current guidelines.To determine the number of patients with clear instructions for use and ongoing management of the recommended spinal brace.	AHP	NICE	February 2024	July 2024
Radiation Services Care Directorate						
Safe Effective Efficient	Local Safety Standard for Invasive Procedure (LOCSSIP)	To evidence of compliance with the WHO Surgical Safety checklist and VCC/NICE guidelines	Radiation services	NICE Guidance WHO	Ongoing (Annual)	Ongoing (Annual)
Safe Effective Efficient	Is the occurrence of Radiotherapy Human Error related to Group Affective processes within the Radiotherapy team?	To explore affect and group affect processes within the specific Radiotherapy team following a human error	Radiotherapy	Patient safety	May 2020	Ongoing

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	CT PA requests	To create a robust pathway for suspected PE	Radiographer	Local concern	April 2021	On going
SACT & Medicines Management						
Safe Effective Efficient	Medication safety thermometer	To measure compliance of the completion of the 'drug allergy section' on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Medication safety thermometer	To measure compliance of the completion of the VTE risk assessment on the medication chart against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Medication safety thermometer	To measure compliance of the completion of 'medicines reconciliation within 24 hours of admission against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Medication safety thermometer	To measure the number of unintentional missed/ omitted medication doses within a 24 hour period against national standards.	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Medication safety thermometer	To measure the number of missed doses for 'high risk medications' against national standards.

High-risk medication includes antimicrobials, anticoagulants, opioids, anticonvulsants and oral SACT. | Pharmacy | National Guidelines | Ongoing (Monthly) | Ongoing (Monthly) |

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Quality Domains	Project title	Main Objectives	Lead	Selection Criteria	Anticipated Start date/ Frequency	Anticipated completion date
Safe Effective Efficient	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the indication for treatment is documented either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the duration of treatment is recorded either on the medication chart / in medical notes	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether the antimicrobial is prescribed in accordance with the trust guidelines / C&S or following microbiology advice	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Antimicrobial Stewardship – Start Smart Then Focus (SSTF)	To determine whether a senior review was carried out at 48 / 72 hours, and documented on the medication chart / medical notes (including outcome of review).	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)
Safe Effective Efficient	Hospital Acquired Thrombosis	WG Tier 1 target – To identify the number of potentially avoidable Hospital Acquired Thrombosis (HATs)	Pharmacy	National Guidelines	Ongoing (Monthly)	Ongoing (Monthly)

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Appendix 3

NHS Wales National Clinical Audit and Outcome Review Plan 2022/23 Appendix 3

<u>NCAORP Plan 2022/23</u>

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

POLICY MANAGEMENT REVIEW AND COMPLIANCE STATUS: MARCH 2024 TO APRIL 2024

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	The purpose of this report is to provide the Quality, Safety and Performance Committee with an update on the policy compliance work undertaken from March 2024 to April 2024 and provide assurance on the continuing progress that has been made. As at April 2024, of the **111** policies under review **71 (63.96%)** are in date and **40 (36.03%)** have passed their review date. Of the 40 policies that have passed their review date, **10 (25%)** are classified as All Wales Policies. Two (2) policies have been archived since the previous report. The percentage of compliance has risen by **9.09%** since reporting in February 2024.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: a) **NOTE** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. b) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board	29/04/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

The Executive Management Board is asked to:

a) **REVIEWED** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.
b) **NOTED** the level of assurance in relation to Trust-wide Compliance and the plans for improvement.
c) **ENDORSED** the **Policy Management Review Compliance Status Report** for submission to the May 2024 Quality, Safety and Performance Committee.

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

ACRONYMS

FCO	Freedom of Information and Compliance Officer
WOD	Workforce and Organisational Development

APPENDICES

Appendix 1	Planning Performance and Estates Update April 2024
Appendix 2	Health and Safety Update April 2024
Appendix 3	Quality and Safety Update April 2024
Appendix 4	Digital Update April 2024
Appendix 5	Workforce and Organisational Development Status April 2024

1. SITUATION

1.1 The purpose of this report is to provide **ASSURANCE** to the Quality, Safety and Performance Committee on the continuing progress that has been made on the current policy compliance status between March 2024 and April 2024.

1.2 A permanent Freedom of Information and Compliance Officer was appointed at the end of September 2023 and collaborations with the divisions to increase compliance is ongoing.

The Quality, Safety and Performance Committee is asked to:

a) **NOTE** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

2. BACKROUND

2.1 The Document Control Register is regularly reviewed with collaborative engagement undertaken with each of the respective policy leads on a regular basis. The purpose of the ongoing collaborative engagement exercise is to confirm and validate the following:
- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

3.2 The importance of planning the review of the policy *in advance* of its review date to ensure it remains in date has been highlighted to each of the policy leads during the audit review. The Document Control Register has been updated to incorporate a trigger point to help facilitate this. As part of the continuous life cycle of a policy, there will never be a fixed static point as a result, during the last 4 months further policies fell outside of their review date.

3. ASSESSMENT

3.1 In relation to the provision of **ASSURANCE**, as at April 2024, of the **111** policies under review **71 (63.96%)** are in date and **40 (36.03%)** have passed their review date. Of the **40** policies that have passed their review date, **10 (25%)** are classified as All Wales Policies.

3.2 Table 1 highlights the progress made by each Division in reviewing their policy position between March 2024 - April 2024 and shows the current position of policies outside of their review date, split between Trust policies and All Wales policies.

Table 1: Progress as at April 2024

Directorate/Department	Policies outside review date February 2024	Policies approved February 2024 – April 2024	Policies outside review date April 2024	
			Trust	All Wales
Workforce & Organisational Development	23	0	20	3
Planning, Performance and Estates	9	5	4	0
Infection Prevention and Control	3	2	0	1
Health and Safety	4	1	3	0
Quality and Safety	5	2	2	1
Digital Services	3	0	1	2
Information Governance	2	0	0	2
Corporate Communications	2	0	0	1
TOTAL	**51**	**10**	**30**	**10**

3.3 Since February 2024, there have been **2** policies archived:
- Health and Safety QS37 - this now forms part of the policy QS35.
- Corporate Communications GC20 - the Remuneration Committee in November 2023 had agreed that this policy to be archived and updates in relation to anonymous communications will be provided to the Quality, Safety and Performance Committee for assurance.

3.4 Appendices 1-4 provide an update on Trust Wide policies outside of their review date.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Policy compliance has risen **9.09%** since February 2024, with Workforce & Organisational Development remaining the division with the largest number of policies that have passed their review date.

4.2 Unfortunately, following a meeting between Compliance and WOD, the policy lead for WOD is currently absent so a substantial update is not available. However, the Deputy Director of WOD is taking responsibility for the policies and is in the process of collating an update in order to provide a timeline to review as soon as possible. For completeness, Appendix 5 provides the list of the Trust WOD policies outside of their review date.

4.3   Table 2 highlights the number of policies within each division and the number of policies both within and outside of their review dates.

Table 2: *Policy Breakdown by Department*

Directorate/Department	Policies outside of review date (inc. All Wales)	Policies within review date (inc. All Wales)	Total policies within the division
Workforce & Organisational Development	23	25	48
Planning, Performance & Estates	4*	10	14
Infection Prevention & Control	1	11	12
Health & Safety	3	7	10
Quality & Safety	3	8	11
Digital	3	5	8
Information Governance	2	5	7
Corporate Communications	1	0	1
TOTAL	40	71	111

4.4   *One of the Planning, Performance & Estate policies that are outside of their review date are included as separate items on the agenda for this meeting of the Quality, Safety and Performance Committee for approval.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☐ for people across the globe

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance		
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply		
	Safe	☒	
	Timely	☒	
	Effective	☒	
	Equitable	☒	
	Efficient	☒	
	Patient Centred	☒	
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.		
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes		
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.		
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances		
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.		
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required		
	GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents has an associated EIA. The EIA will be refreshed when GC01 is due for review.		
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.		

6. RISKS

6.1   The appointment of a permanent FCO will ensure a continual review cycle of the policies and ensure compliance with GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents.

ARE THERE RELATED RISK(S) FOR THIS MATTER	**No**
All risks must be evidenced and consistent with those recorded in Datix	

APPENDIX 1 – PLANNING PERFORMANCE AND ESTATES UPDATE APRIL 2024

Ref	Policy Title	Accountable Executive Lead	Policy Review Date (3 year cycle)	Policy Status	Policy Risk Assessment	Comments
PP 01	Fire Safety Policy	Executive Director of Strategic Transformation, Planning & Digital	Sep-23	Policy review date passed – action underway/required	Policy review date passed with low risk	To be approved by QSPC at its meeting in May 2024
PP 02	Security Policy	Executive Director of Strategic Transformation, Planning & Digital	Jan-22	Policy review date passed – action underway/required	Policy review date passed with moderate risk	Decision to be taken as to whether the policy falls under Operations or Estates
PP 08	Waste Management Policy	Executive Director of Strategic Transformation, Planning & Digital	Mar-21	Policy review date passed – action underway/required	Policy review date passed with low risk	Currently undergoing EQIA
PP16	Cleaning Manual	Chief Operating Officer	May-10	Policy review date passed – action underway/required	Policy review date passed with moderate risk	Transfer from Infection Prevention & Control IPC 22 (previously Yellow 22) Previously Management and Control of Environment (Cleaning) - Renamed Cleaning Manual. Policy to be revised due to changing COVID measures

APPENDIX 2 – HEALTH AND SAFETY UPDATE APRIL 2024

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3 year cycle)	Policy Status	Policy Risk Assessment	Comments
QS 24	Medical Devices & Equipment Management Policy	Director of Strategic Transformation, Planning & Digital	Jan-24	Policy review date passed – action underway/required	Policy risk assessment being completed	Under review
QS 30	Lone Working Policy	Director of Strategic Transformation, Planning & Digital	Mar-23	Policy review date passed – action underway/required	Policy risk assessment being completed	Under review
QS 36	Workplace Equipment Policy	Director of Strategic Transformation, Planning & Digital	May-23	Policy review date passed – action underway/required	Policy risk assessment being completed	Under consultation

APPENDIX 3 – QUALITY AND SAFETY UPDATE APRIL 2024

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3 year cycle)	Policy Status	Policy Risk Assessment	Comments
QS 04b	Compensation Claims Procedure	Executive Director of Nursing, AHPs and Health Sciences	Sep-22	Policy review date passed – action underway/required	Policy review date passed with low risk	QS04a updated and approved – pending update for QS04b
QS 31	International Health Partnership Related Activity Policy	Executive Director of Nursing, AHPs and Health Sciences	Dec-19	Policy review date passed – action underway/required	Policy review date passed with low risk	Policy remains extant whilst review underway

APPENDIX 4 – DIGITAL UPDATE APRIL 2024

Policy Reference	Policy Title	Accountable Executive Lead	Policy Review Date (3 year cycle)	Policy Status	Policy Risk Assessment	Comments
IG 10	Staff Mobile Phone Policy	Director of Strategic Transformation, Planning & Digital	Mar-12	Policy review date passed – action underway/required	Policy review date passed with low risk	Previously GC 10 Full rewrite of policy being undertaken.

APPENDIX 5 – WORKFORCE AND ORGANISATIONAL DEVELOPMENT STATUS APRIL 2024

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3 year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF12	Study Leave Policy, Procedure & Guidelines	Executive Director of OD and Workforce	Nov-13	Policy review date passed – action underway/required	Policy review date passed with low risk	Previously Black 38. Significant review and rewrite required
WF 13	Adverse Weather Policy	Executive Director of OD and Workforce	Mar-21	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 16	Welsh Language Policy	Executive Director of OD and Workforce	May-22	Policy review date passed – action underway/required	Policy review date passed with low risk	Assigned to Welsh Language Manger for review by Q3
WF 17	Policy on Reimbursement of Removal and Associated Expenses	Executive Director of OD and Workforce	Jun-21	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 18	Alcohol, Drugs & Substance Misuse Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 19	Policy for Employing Ex-Offenders and people with a criminal record	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway/required	Policy review date passed with low risk	Previously Black 50 Policy Review Completed Need to send through governance process

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3 year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 21	Close Personal Relationships in the Work Place	Executive Director of OD and Workforce	Feb-21	Policy review date passed – action underway/required	Policy review date passed with low risk	The Policy has been subject to the Equality Impact Assessment process where potential negative impact of the policy has been recognised in relation to equality and social economic impacts and potential disclosure of sensitive personal information. Options for employees to disclose to staff other than the direct line manager has been included in the policy to mitigate this and to protect individuals' right to maintain privacy. The Policy will be reviewed after the first 6 months, to respond to any unforeseen implementation issues, if applicable
WF 22	Professional Registration Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 28	Recruitment of Locum Doctor Policy	Executive Director of OD and Workforce	Apr-17	Policy review date passed – action underway/required	Policy review date passed with low risk	Significant review and rewrite required
WF 29	Maternity, Paternity, Adoption and Parental Leave Policy	Executive Director of OD and Workforce	Aug-18	Policy review date passed – action underway/required	Policy review date passed with low risk	Policy Review completed and incorporating WF49 Shared Parental Leave Policy Need to send through governance process
WF 30	PADR Policy	Executive Director of OD and Workforce	May-20	Policy review date passed – action underway/required	Policy review date passed with low risk	

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3 year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 31	Sabbatical Leave Policy for Consultant Medical Staff	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 37	Childcare Voucher Scheme Guidance	Executive Director of OD and Workforce	Jan-23	Guidance review date passed – action underway/required	Policy review date passed with low risk	
WF 40	Supporting Staff who are Carers	Executive Director of OD and Workforce	May-22	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 43	Mental Health, Wellbeing & Stress Management Policy	Executive Director of OD and Workforce	Jan-21	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 46	Supporting Transgender Policy	Executive Director of OD and Workforce	Aug-22	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 49	Shared Parental Leave Policy	Executive Director of OD and Workforce	Dec-21	Policy review date passed – action underway/required	Policy review date passed with low risk	To be incorporated into the rewrite of WF29

Policy Reference	Policy Title	Accountable Executive Lead	Review Due (3 year cycle)	Policy Status	Policy Risk Assessment	Comments / Input from WOD
WF 54	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Executive Director of OD and Workforce	Jul-23	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 55	Interpreters Procedure	Executive Director of OD and Workforce	Sep-16	Policy review date passed – action underway/required	Policy review date passed with low risk	
WF 56	Smoke Free Policy	Executive Director of OD and Workforce	Jun-22	Policy review date passed – action underway/required	Policy review date passed with low risk	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Clinical Pharmacy Technical Services Update

DATE OF MEETING	May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	INFORMATION / NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	GARETH TYRRELL, PHARMACIST (NWSSP)
PRESENTED BY	GARETH TYRRELL, PHARMACIST (NWSSP)
APPROVED BY	GARETH TYRRELL, PHARMACIST (NWSSP)

EXECUTIVE SUMMARY	The Pharmacy Technical Services continues to provide ready-to-administer products to organisations across NHS Wales under the MHRA "Specials" licence, whilst also maximising the resource utilisation opportunities through the Wholesale Dealer License. The TrAMS programme is currently not operational however progress is reported through the NWSSP Partnership Committee

RECOMMENDATION / ACTIONS	The Committee are asked to **NOTE** the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
NWSSP Managing Director / Director of Pharmacy / Clinical Director	30/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Details within this report have been presented at the NWSSP pharmacy division service board where service performance and safety is presented. There are currently no outstanding governance issues to report.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	

1. **SITUATION**

1.1 The aim of this report is to provide assurance on the current performance of the Pharmacy Division within NHS Wales Shared Services Partnership, and report to the board any matters of exception that increase the risks of service delivery.

2. **BACKGROUND**

2.1 The Pharmacy Division provided several Pharmacy Technical Services to partners across NHS Wales under agreed Service Level and Technical agreements. These services are heavily regulated under Medicines and Healthcare products Regulatory Agency (MHRA), Home Office and General Pharmaceutical Council (GPhC) licences. These services include:

- Manufacture and supply of ready-to-administer injectable medicines under an MHRA "Specials" Licence.
- Purchase, storage, and supply of licenced and unlicenced products, including vaccines, under an MHRA Wholesale Dealer Authorisation.
- Purchase, storage, and distribution of controlled drugs under Home Office Licence.

2.2 Staff within NWSSP who are named on the licences are legally responsible for implementing the regulatory requirements under The Human Medicines Regulations 2012.

2.3 All services adhere to European and UK Good Manufacturing and Distribution practices as set out within the licences and are subject to risk-based compliance inspections by the regulator intervals determined by service risk.

2.4 The service is currently deemed "low risk" and has a 24-month inspection interval.

2.5 Monthly performance reports are presented to the NWSSP Service Board for governance.

2.6 Products supplied from the NWSSP Pharmacy Division are detailed below:

- Potassium Chloride 50mmol in 50mL syringe
- Rituximab 600mg in 250mL 0.9% Sodium Chloride
- Rituximab 700mg in 250mL 0.9% Sodium Chloride
- Rituximab 800mg in 250mL 0.9% Sodium Chloride
- Nivolumab 480mg in 100mL 0.9% Sodium Chloride

3.   ASSESSMENT

3.1 NWSSP aim to comply fully with the licencing requirements for MHRA Specials Manufacturing and Wholesaler Dealing, and the regulatory standards of Good Manufacturing Practice.

3.2 The service is currently undergoing a full gap analysis and implementation programme for compliance with the updated Annex 1 – Manufacture of Sterile Products.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

The purpose of this paper is to highlight current exceptions to service adherence of Good Manufacturing and Distribution Practice and any significant changes to service model or provision.

4.1   There have been 2 errors documented within the service Pharmaceutical Quality System (PQS) relating to incorrect assembly of ingredients. Both incidents have been documented onto the PQS, investigated via internal Failure Modes Effect Analysis (FMEA) processes and corrective actions implemented. The root cause of the errors were human error and deviation from SOP. Operators involved have undergone full training revalidation before release back to operational activities.

4.2   As of April 1st 2024, NWSSP Pharmacy are now utilising Wellsky/Careflow Pharmacy system as a location under the Velindre Software Licence. Ongoing work between NWSSP and Velindre continues to minimise impact and ensure joint use of procedures and financial reporting mechanisms. The implementation has met all information governance requirements and has been documented on the NWSSP PQS under the change control management process.

4.3   The service is currently engaging with the Home Office in relation to the controlled drugs licence inspection at Picketston and staff await updated DBS checks to renew licence at Imperial Park Building 5.

4.4   Medicines Unit are working with other NWSSP divisions and Welsh Government policy leads on the National Influenza Programme.

4.5   The Quality Assurance team within NWSSP Pharmacy Unit have completed a programme of disinfection at the Velindre NHS Trust Aseptic unit to support decontamination within the facility. In total NWSSP Medicines Unit committed 9 working days including weekends to ensure the programme was completed on time and with minimal disruption to service provision from the Velindre Pharmacy Aseptic Unit.

4.6   Medicines Value Unit continue to engage commercial suppliers to implement All Wales contracts for outsourced aseptic products. Tender submissions have been received from all commercial suppliers by NHS Wales and these are currently being assessed against quality assessments, pricing structures and service level agreements before recommendations provided to UHBs in relation to best practice when engaging with the commercial sector to ensure best value and service.

5.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: NO
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☐ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☐ for people across the globe

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Working / Stakeholder Engagement	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply	
	Safe	☐
	Timely	☐
	Effective	☒
	Equitable	☐
	Efficient	☒
	Patient Centred	☐

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The implications outlined in this report as exceptions risk the ability of the service to prepare medicines within a times and efficient manner
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**

FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	[
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

This section should indicate whether any matters addressed in the report carry a significantly increased level of risk for the Trust – and if so, the steps that will be taken to mitigate the risk - or if they will help to reduce a risk identified on a previous occasion.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

<table>
QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
</table>

<table>
Duty of Quality NWSSP Update	
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DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	DR RUTH ALCOLADO, MEDICAL DIRECTOR (NWSSP)
PRESENTED BY	DR RUTH ALCOLADO, MEDICAL DIRECTOR (NWSSP)
APPROVED BY	DR RUTH ALCOLADO, MEDICAL DIRECTOR (NWSSP)

EXECUTIVE SUMMARY	The Duty of Quality which applies to both clinical and non-clinical services came into force in April 2023. This paper outlines the steps made in NWSSP in ensuring improving quality is at the heart of the wide variety of services provided by NWSSP on behalf of NHS Wales.

RECOMMENDATION / ACTIONS	To **NOTE** the progress made in implementation of the Duty of Quality

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE N/A

APPENDICES N/A

1.   SITUATION

The Duty of Quality came into force in April 2023.

The Duty is measured against 12 Health and Care standards which should be taken into account when making decisions regarding delivery of clinical and (for the first time) non-clinical services.

The traditional 6 domains of clinical quality were supplemented with 6 enablers to produce the 12 Health and Care standards.

12 Quality Standards:

1) Safe
2) Timely
3) Effective
4) Efficient
5) Person Centred
6) Equitable
7) Leadership
8) Workforce
9) Culture
10) Information
11) Learning/Improvement
12) Whole System

Page 2 of 6

2. BACKGROUND

Quality as outlined in the Duty, comprises12 domains, these domains need to be reflected in 4 processes that make up a quality management system, namely quality planning, quality control, quality improvement and quality assurance.

Reporting was mandated in the form of a public facing annual report and 'always-on' reporting, again aimed primarily at the public in Wales.

The mechanism for reporting for NWSSP has been agreed at Partnership committee, and previously presented at this meeting.

There are 3 strands to reporting in NWSSP:
1) Annual report to be provided as agreed as a separate annex to the VUNHST Annual Duty of quality report in July 2024 for the period April 2023-March 2024.
2) Always on reporting on NWSSP quality, a monthly update is to be provided on the NWSSP intranet site.
3) Information provided to NHS bodies in Wales in support of their duty of quality where NWSSP provides services for them on behalf of NHS Wales.

3. ASSESSMENT

3.1   Update on progress:

3.1.1 A duty of quality site has been introduced to the NWSSP SharePoint site. Monthly videos are being produced by each division in turn and are uploaded to the intranet. The service submissions can be found at
https://nhswales365.sharepoint.com/sites/SSP_Intranet/SitePages/Dui.aspx

Since the last update there have been 4 further videos/presentations added to the always on reporting site. These videos provide details of the quality management systems in place in, Pharmacy Technical Services, Audit and Assurance, SMTL (Surgical Materials Testing Laboratory) and Digital Workforce Team. The videos give examples of quality improvement work as well as outlining the quality planning, quality control and quality assurance mechanisms in place.

3.1.2 NWSSP has appointed a business manager to support the Medical Director's office in the co-ordination and engagement across NWSSP with the duty of quality. The duty of quality site will now also be updated on a monthly

basis with a 'Quality-watch' blog which will include details of quality achievements and external quality assurance inspections within NWSSP.

3.1.3 The NWSSP implementation group is established and continues to meet and share best practice.

3.1.4 Quality Impact Assessments should be applied to strategic decisions. The Senior Leadership Group in NWSSP, agreed that our IMTP should undergo a quality impact assessment. The 2024/27 IMTP underwent an impact assessment to ensure that our plans outlined in the document took account of, and would have a positive impact on, the 12 health and care quality standards. This is the first time such an assessment has been undertaken, and we await feedback from the Welsh NHS Executive and will take note of this in designing the 25/28 IMTP quality impact assessment. The IMTP including Appendix F (the Quality Impact Assessment) was agreed at Partnership Board prior to submission, in line with WG planning timelines.

3.1.5 NWSSP has undergone Customer Service Excellence (CSE) Assessment for the first time as a whole organisation, previously individual divisions had sought and gained accreditation. NWSSP is the first organisation within NHS Wales to receive this prestigious accreditation. The CSE accreditation team assesses the organisation and measures customer focused areas that research has identified as a priority to customers with a particular focus on Customer Insight, Culture of the Organisation, Information and Access, Delivery and Timeliness and Quality of Service. The rigorous process took place over a week and comprised interviews and data analysis within NWSSP, as well as structured interviews and conversations with customers and partners across NHS Wales. As part of the assessment NWSSP achieved 12 Compliance Pluses - which means that the organisation exceeded the required standards. This was particularly noted, as organisations usually receive between 2-3 Compliance Pluses when assessed. Shared Services also achieved 33 Compliances where in each instance the standard required is met, with only 2 Partial Compliances / areas of Improvement which is a fantastic achievement and still gives us room for further improvement in collaboration with our customers and partners.

3.2   Annual Report

The public facing annual Duty of Quality report is in preparation detailing the progress made against the duties placed upon us to demonstrate the continuous improvement of the quality of services we provide to our partners, customers and the people of Wales.

The NWSSP report will form a separate annex or chapter, within the VUNHST report and the NWSSP Medical Director has met with the quality team in VUNHST to discuss the reporting structure.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 You are asked to note the progress made against the Duty of Quality, particularly the work focussing on non-clinical services as this is an entirely new concept for NHS Wales as a whole.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 　　　　YES - Select Relevant Goals below		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience　　　　☒ • An internationally renowned provider of exceptional clinical services　☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated　☐ areas of priority • An established 'University' Trust which provides highly valued　☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future　☒ for people across the globe		
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* This report is focused on the domains of quality and the associated enablers.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

<table>
<tr><td colspan="2" align="center">**QUALITY, SAFETY AND PERFORMANCE COMMITTEE**</td></tr>
</table>

<table>
<tr><td colspan="2" align="center">**VUNHST FIRE SAFETY POLICY PP01**</td></tr>
</table>

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	PUBLIC

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	FOR APPROVAL

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	*a)* Velindre University NHS Trust has a statutory responsibility to manage Fire Safety in each of its health premises in accordance with the *Regulatory Reform (Fire Safety) Order 2005 (the Order)* and their Mandatory duties under the Welsh Assembly Government's *NHS Wales Fire Safety Policy* (issued under cover of WHC (2006)74) and *(W)HTM 05 – Fire safety in the NHS (Firecode).* b) Currently the Trust is expected to review its fire safety annually and/or following any changes to legislation/guidance or following a significant incident and the attached policy has been subject to its annual review and no changes have been made.

RECOMMENDATION / ACTIONS	a) The Quality, Safety and Performance Committee is requested to **approve** the fire safety policy [PP01]. b) Following review and consultation, no amendments have been made to the policy.

| | c) The policy was approved by the Executive Management Board (RUN) on the 29th April 2024. |
| | d) It is recommended that the policy is formally reviewed in April 2025 as it is understood that there are proposed revisions to current NHS Wales fire safety guidance which may have an impact on the policy. |

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Executive Management Board (RUN)	29/04/2024
VCC Cenyfin group [out of committee]	12/03/2024
WBS Cenyfin group [out of committee]	12/03/2024
Trust Health and Safety Fire Management Board [out of committee]	12/03/2024
Trust Business Continuity & Emergency Preparedness [out of committee]	12/03/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

a) As there have been no changes to the policy [no changes to legislation / guidance or any significant incidents] since its last review, the policy has been submitted directly for approval by this committee.

b) No further comments/changes identified by any of the groups/individuals consulted.

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	a) The review of the fire policy and out of committee consultation has not identified any changes required to the policy.
	b) The policy was approved by Executive Management Board (RUN) on 29th April 2024.

APPENDICES

1	Fire safety policy

1.   SITUATION

1.1   The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties regarding fire safety.

1.2   This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations.

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and its hosted bodies continue to comply with their statutory and mandatory duties regarding fire safety.

2.2 This policy applies to all staff employed by or contracted to the Trust, including those within the Hosted Organisations.

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance, or best practice since the last review of the policy, there has been no changes to the policy.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 As there has been no significant changes to legislation, guidance, or best practice since the last review of the policy and the Trust have not experienced any significant incidents, there has been no changes to the policy.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☐
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☐
	Effective	☐
	Equitable	☐
	Efficient	☐
	Patient Centred	☐

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).
	a) The policy fulfils statutory and mandatory duties.
	b) The policy provides a framework for the Trust to comply with its statutory, mandatory and moral duties with regard to keeping people safety.
	c) The policy also ensure that other "goals" are achieved [protection of property, the ongoing delivery of service, protection of the environment and maintaining trust and reputation].
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all groups.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Resilient Wales - Maintaining and enhancing a biodiverse natural environment with healthy functioning ecosystems that support social, economic and ecological resilience.
	If more than one Well-being Goal applies please list below:
	The policy also supports: • A Prosperous Wales • A More Equal Wales
	If more than one wellbeing goal applies please list below: As noted above, the objects of the policy are to protect: • Life • Assets • Provision of services • The environment • Trust and Reputation
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: The ongoing provision of safe and resilient environments requires ongoing funding such as maintenance/replacement of

	outdated/damaged equipment; investment in time for training etc. Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	• Fire does not discriminate against any protected characteristic; however, the way in which the risk is addressed can be discriminatory, notably with regard to disability/impairment and age. • This policy applies to all staff patients and donors equally regardless of the social economic status and has a positive impact on all protected characteristics. PDF SIGNED EQIA Form and Action Plan_PPC
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	a) Life safety is at the core of the Trust's response to the potential risk of fire and a legal duty under the Regulatory Reform (Fire Safety) Order 2005. b) Additionally, the Trust has legal duties under other statutory instruments regarding the identification of hazards and risks and the need to eliminate or control identified hazards and risks with the primary aim of protecting life. c) The policy outlines the various statutory instruments which it addresses.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	YES
WHAT IS THE RISK?	A fire has the potential to place people at risk and cause damage to assets [buildings, equipment/systems, and information/data] relied upon to deliver safe and resilient services expected by our patients/donors and by those who commission them. Additionally, fire has the ability to cause environmental damage; especially if it involves other hazards [such as chemicals, radiological sources etc.]
WHAT IS THE CURRENT RISK SCORE	8 […but fire risk is variable as identified in site and area fire risk assessments in place across the Trust].
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	The aim of the policy is to provide a framework by which the Trust and its employees can address and mitigate the potential outcomes of a fire.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Target risk achieved through a number of measures including implementation of the Trust fire safety policy.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

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

Ref: PP01

FIRE SAFETY POLICY

Executive Sponsor & Function:	Executive Director of Strategic Transformation, Planning, and Digital
Document Author:	Trust Fire Safety Manager
Approved by:	Executive Management Board
Approval Date:	April 2024
Date of Equality Impact Assessment:	February 2024
Equality Impact Assessment Outcome:	No negative impact
Review Date:	April 2024
Version:	05

Contents

1. Policy Statement

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

2. Purpose

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

3. Scope

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

4. Aims and Objectives

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

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

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

5. Roles and Responsibilities

5.1. *All staff, contract staff and volunteers*

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

- take reasonable care for themselves and others who may be affected by their acts or omissions at work;

- comply with the Trust's fire safety protocols and fire procedures and those set by others such as landlords etc;

- participate in fire safety training and fire evacuation exercises where applicable;

- inform their manager of any work situation, defect or other failing that represents a serious or imminent danger;

  Where necessary, report deficiencies and/or shortcomings in fire safety arrangements to the appropriate person(s) such as line manager, Fire Wardens, estates/facilities etc;

- report fire incidents and false alarm signals in accordance with Trust's protocols and procedures;

- always ensure the promotion of fire safety to help reduce the occurrence of fire and unwanted fire alarm signals;

- set a high standard of fire safety by personal example so that members of the public, visitors and students when leaving Trust premises take with them an attitude of mind that accepts good fire safety practice as normal.

5.2. *Trust Board*

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

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

5.2.3. The Trust Board will:

- discharge its responsibilities as a provider of healthcare to ensure that suitable and sufficient governance arrangements are in place to manage fire-related matters;

- provide appropriate levels of investment in the estate and personnel to facilitate the implementation of suitable fire safety precautions;

- facilitate the development of partnership initiatives with stakeholders and other appropriate bodies in the provision of fire safety where reasonably practicable.

5.3. *Chief Executive*

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

5.3.2. The Chief Executive discharges the day-to-day operational responsibility for fire safety through the Board Level Director (FIRE).

5.4. *Board Level Director (FIRE) - Director of Strategic Transformation, Planning, and Digital*

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

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

- ensure that the Trust has in place a clearly defined fire safety policy and relevant supporting protocols and procedures;

- seek assurance that all work that has implications for fire precautions in new and existing Trust buildings is carried out to a satisfactory technical standard and conforms to all prevailing statutory and mandatory fire safety requirements (including Firecode);

- seek assurance that all proposals for new buildings and alterations to existing buildings are referred to the Fire Safety Manager before building control approval is sought;

- seek assurance that all passive and active fire safety measures and equipment are maintained and tested in accordance with the latest relevant legislation/standards, and that comprehensive records are kept;

- seek assurance that suitable arrangements are in place regarding cooperation between other employers where two or more share Trust premises;

- seek assurance through senior management and line management structures that full staff participation in fire training and fire evacuation drills is maintained;

- ensure that agreed programmes of investment in fire precautions are properly accounted for in the Trust's annual business plan;

- ensure that an annual audit of fire safety and fire safety management is undertaken, and the outcomes communicated to the Trust Board;

- fully support the Fire Safety Manager function.

5.4.3. In line with delegated authority, the Board Level Director (FIRE) devolves day-to-day fire safety duties to the Fire Safety Manager.

5.5. *Fire Safety Manager*

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

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

- the development, implementation, monitoring and review of the organisation's fire safety management system;

- the development, implementation and review of the organisation's fire safety policy and protocols;

- reporting of non-compliance with legislation, policies and procedures to the Board Level Director (FIRE);

- raising awareness of all fire safety features and their purpose throughout the Trust;

- providing expert advice on fire legislation;

- providing expert technical advice on the application and interpretation of fire safety guidance, including Firecode;

- the assessment of fire risks within premises owned, occupied or under the control of the Trust including the undertaking and recording and of fire risk assessments and development of action plans;

- ensuring that risks identified in the fire risk assessments are included in the Trust's risk register as appropriate;

- the operational management of fire safety risks identified by the risk assessments;

- the development, implementation and review of the organisation's fire emergency action plan including the preparation of fire prevention and emergency action plans where appropriate and integration with Major Incident Plan(s) developed by divisions;

- ensuring that requirements related to fire procedures for less-able staff, patients and visitors are in place;

- the development, delivery and audit of an effective fire safety training programme;

- the investigation and reporting of all fire-related incidents and fire alarm actuations in accordance with Trust policy and external requirements;

- monitoring, reporting and initiating measures to reduce false alarms and unwanted fire signals;

- liaison with the enforcing authorities on technical issues;

- liaison with managers and staff on fire safety issues;

- liaison with NWSSP – Specialist Estates Service – the Trust's Authorising Engineer (Fire);

- monitoring the inspection and maintenance of fire safety systems to ensure it is carried out;

- ensuring that suitable fire safety audits are undertaken, recorded and the outcomes suitably reported;

- providing a link to the relevant Trust committees;

- ensuring an appropriate level of management is always available by the establishment of Fire Response Teams for Trust sites or premises.

5.6.   *Local Management*

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

- monitoring fire safety within their respective workplaces and ensuring that contraventions of fire safety precautions do not take place;

- ensuring local fire risk assessments are undertaken and maintained up to date;

    Where necessary, ensuring that risks identified in the fire risk assessments are included in Divisional and/or Departmental risk registers as appropriate.

- notifying the Fire Safety Manager and others of any proposals for "change of use", including temporary works that may impact on the risk assessment, within their area;

- reporting any defects in the fire precautions and equipment in their area and ensuring that appropriate remedial action is taken;

- ensuring that local fire emergency action plans are developed, brought to the attention of staff and adequately rehearsed to ensure sufficient emergency preparedness;

- ensuring that local fire emergency action plan is revised in response to changes, including temporary works, which may affect response procedures;

- ensuring the availability of a sufficient number of appropriately trained staff at all times to implement the local fire emergency action plan;

- ensuring that the duties outlined in this document and relevant fire safety instructions are brought to the attention of staff through local induction and ongoing staff briefings;

- ensuring that every member of their staff attends fire safety training as set out in the Trust's fire safety training matrix;

- ensuring that all new staff, on their first day in the ward/department, are given basic familiarisation training within their workplace, to include:

  - local fire procedures and evacuation plan
  - means of escape
  - location of fire alarm manual call points
  - fire-fighting equipment
  - any fire risks identified;

- keeping a record of staff induction and attendance at fire safety training;

- ensuring staff at all levels understand the need to report all fire alarm actuations and fire incidents as detailed in the fire safety protocols;

- ensuring that the staff record is completed and returned denoting how this document has been brought to the attention of staff;

- where appropriate, ensuring that sufficient Fire Wardens are identified and appointed for their specific areas of responsibility.

5.7. *Fire Wardens*

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

5.7.2. Wardens will:

- act as the focal point on fire safety issues for the local staff;

- organise and assist in the fire safety regime within local areas;

- raise issues regarding local fire safety with their line management;

- support line managers in their fire safety issues.

6. Equality
6.1. The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against protected characteristics [age, disability, sex/gender, sexual orientation, gender reassignment, marriage/civil partnership, pregnancy/maternity, race, religion, socio-economic and Welsh language].

6.2. The Trust has undertaken an Equality Impact Assessment [EQIA] and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any protected characteristics identified within the Equality Act 2010.

6.3. The assessment found that there was **no impact** to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary

actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

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

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

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

- All new starters receive essential fire safety information as part of their local induction.

- All new starters undertake essential fire safety training within 1 month of their start date

- Staff undertake the appropriate refresher training as follows:

  - Clinical staff and WBS Blood Collection Team staff - *Annually*
  - Non-clinical staff – *3-yearly*
  - Fire Wardens and Fire Response Team members - *Annually*

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

8. Resources

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

9. Implementation

9.1. The Trust Board expects those tasked with managing aspects of fire safety to:
- diligently discharge their fire safety responsibilities as benefits their position;

- have in place a clearly defined management structure for the delivery, control and monitoring of fire safety measures;

- have in place a programme for the assessment and review of fire risks;

- develop and implement appropriate protocols, procedures, action plans and control measures to mitigate fire risks, comply with relevant legislation and, where practicable, codes of practice and guidance;

- develop and disseminate appropriate fire emergency action plans pertinent to each department/building/area to ensure the safety of occupants, protect the delivery of service and, as far as reasonably practicable, defend the property and environment;

- develop and implement a programme of appropriate fire safety training for all relevant staff; and

- develop and implement monitoring and reporting mechanisms appropriate to the management of fire safety.

10. Audit and Monitoring

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

- periodic review of fire and Unwanted Fire Signal (UwFS) reports;

- periodic reviews of fire safety training records;

- periodic review of fire service notices and communications;

- receipt of annual fire safety audit report;

- periodic independent reviews of fire safety by NWSSP – Specialist Estates Services.

11. Policy Conformance / Non-Compliance

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

12. Distribution

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

13. Review

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

14. Legislation

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

- The Regulatory Reform (Fire Safety) Order 2005

- The Health and Safety at Work etc Act 1974

- The Building Act 1984

- The Housing Act 2004

- The Equality Act 2005

- The Fire and Rescue Services Act 2004

- The Construction (Design and Management) Regulations 2015

- The Smoke-Free Premises etc. (Wales) Regulations 2007

- The Management of Health and Safety at Work Regulations 1999 (as amended)

- The Dangerous Substances and Explosive Atmospheres Regulations 2002

15. Further Information

15.1. *Contact*

Further information and support is available from the Trust Fire Safety Manager (robin.weaver@wales.nhs.uk) on 029 2061 5888 / 07976 417285.

15.2. *Key guidance*

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

- 05-01: Managing healthcare fire safety (Welsh Edition).

- 05-02: Guidance in support of functional provisions for healthcare premises

- 05-03: Operational provisions (Parts A to L)

The Trust will also implement:

- Other Health Technical Memorandums

- Relevant Department of Health and NWSSP - Facilities Services Health Building Notes

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

- Offices & Shops

- Places of Assembly (small)

- Places of Assembly (large)

- Sleeping Accommodation

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

15.3. *Supporting Documents*

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

- Fire Safety strategy

- Fire Safety and Risk Management System

- Fire prevention including the management of arson

- Fire risk assessment/audit strategy

- Emergency planning and procedures

- Fire safety training including training needs analysis and strategy for delivery

- Development of local fire safety information including fire strategies, fire manuals, fire drawings and information for attending fire crews

- Fire safety during construction and refurbishment projects

- Unnecessary fire alarm activations

- Passive fire protection

- Maintenance of fire safety systems and equipment.

16. References

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

Quality, Safety and Performance Committee

Trust Learning Framework

DATE OF MEETING	9th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science.

EXECUTIVE SUMMARY	**The Trust Learning Framework** is intended to enable Velindre University NHS Trust to become a Learning Organisation. Velindre University NHS Trust is committed to promoting a culture which values and facilitates learning, in which the lessons learned are used to improve the quality of patient and donor care, safety and experience. This Learning Framework demonstrates how learning will be identified, triangulated, disseminated and implemented in practice, in order to facilitate and embed a culture of appreciative enquiry to continually improve the Trust's health care services

RECOMMENDATION / ACTIONS	To **Approve** the Trust Learning Framework

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality and Safety Group	23/04/24
Executive Management Board	29/04/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
Endorsed for onward Approval	

7 LEVELS OF ASSURANCE

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/A

APPENDICES	
1.	**Trust Learning Framework**

IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: - Outstanding for quality, safety, and experience ☒ - An internationally renowned provider of exceptional clinical services ☒ that always meet, and routinely exceed expectations - A beacon for research, development, and innovation in our stated ☐ areas of priority - An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. - A sustainable organisation that plays its part in creating a better future ☒ for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety		
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**		
	Safe	☒	
	Timely	☒	
	Effective	☒	
	Equitable	☒	
	Efficient	☒	
	Patient centred	☒	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required		

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	No impact identified

	No issues identified through the equality impact assessment
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	This framework will support the Trust meeting the Putting Things Right, Duty of Candour and Duty of Quality Responsibilities.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	Sharing Learning is essential to prevent harm and reduce risk. The framework supports a culture of continuous learning and improvement across the Trust, identifying opportunities to draw on good practice and minimise the risk of poor practice.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	

Velindre University NHS Trust
Learning Framework

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Canolfan Ganser Felindre
Velindre Cancer Centre

Contents

1. Introduction

Velindre University NHS Trust is committed to promoting a culture which values and facilitates learning, in which the lessons learned are used to improve the quality of patient and donor care, safety and experience.

This Learning Framework demonstrates how learning will be identified, triangulated, disseminated and implemented in practice, in order to facilitate and embed a culture of appreciative enquiry to continually improve the Trust's health care services.

This Framework seeks to complement and build on these arrangements by adding a strategic approach to support the organisation to learn lessons from a range of internal and external sources, and to use this learning to share knowledge, shape change and create opportunities to develop excellence in practice.
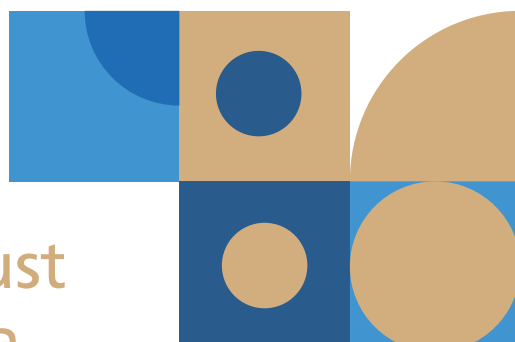
"Velindre University NHS Trust is committed to promoting a culture which values and facilitates learning."

2. Objectives

This framework is intended to enable Velindre University NHS Trust to become a Learning Organisation and fulfil the following objectives:

- Ensure that patients, donors and key stakeholders have their voice heard and that this influences service design, provision, change and improvement.
- Ensure that the Trust expectations are clear in respect of organisational learning to support continuous improvement.
- Ensure that relevant performance data is captured, analysed and reported to inform decisions and priorities.
- Ensure that the Trust workforce is suitably skilled, that they benefit from relevant training, and learning is of appropriate quantity and quality.

- Supporting a Just Culture where individuals feel safe and supported to raise concerns, with confidence that we will learn from them.
- Ensure that learning is continually captured and builds an organisational memory.
- Ensure that the Trust fulfils its statutory functions as set out in relevant Welsh Government legislation and that the Trust's Annual Plans are informed, and focused, on relevant priorities.

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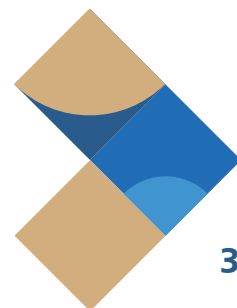
3. Principles

The principles underpinning the Learning Framework should consistently review our practice through the lens of quality and safety ensuring that:

- There is a culture of continuous learning and improvement across the Trust, identifying opportunities to draw on good practice and minimise the risk of poor practice.
- Divisions and service areas take ownership and responsibility for disseminating learning to all staff, using appropriate methodologies and evidence that this has been implemented appropriately, documenting completion through the Trust's Quality and Safety Regulatory Tracker.

- Practitioners should be fully involved in learning activities and be invited to contribute their perspectives within a positive learning environment that fosters a safe space to learning.
- Improvement is sustained through monitoring and that learning makes a real impact on quality, safety, experience and outcomes.
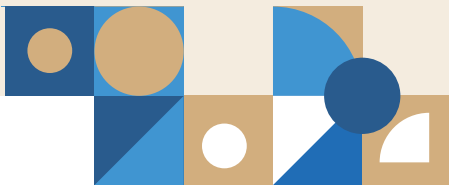
4. Continuous improvement

Continuous improvement is based on the idea that there is always room to advance the healthcare we provide, and as a Trust we should consistently seek ways to enhance the service provided to our donors and the treatment provided to our patients. Patient's and Donors who use our services should be encouraged and supported to contribute to the Trust's service improvement processes.

This Learning Framework focuses on how the Trust identifies problems, implements changes, and monitors the results in a systematic and sustainable approach. Enhancing the quality of care and outcomes for patient's and donors should involve all staff members when planning and executing ongoing improvement strategies and practices.

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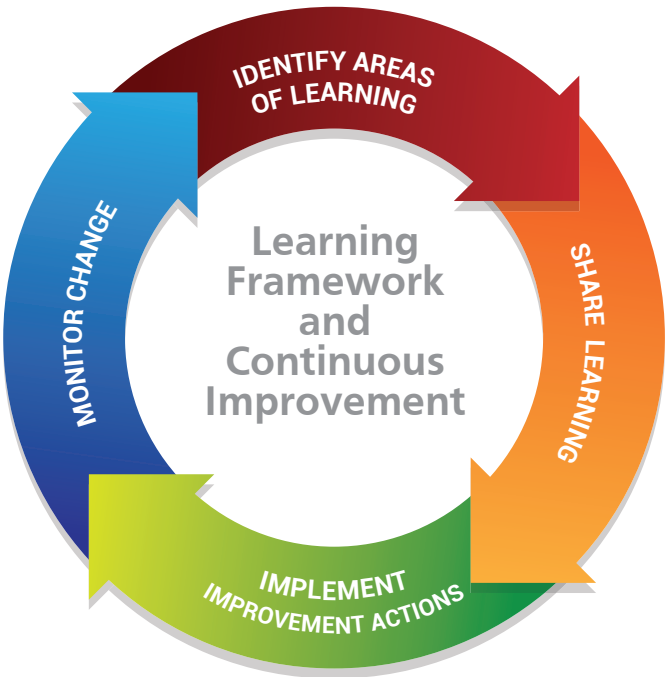
5. Roles and responsibilities

All staff are responsible for contributing and responding to areas of learning and improvement activity in a timely manner.

All employees are responsible for:	All managers are responsible for:
- Completing regulatory and refresher training requirements. - Adopting new or amended processes and procedures. - Reporting and escalating issues that need to be addressed, through the Trust reporting system. - Cooperating with Trust incident review processes. - Participating in learning initiatives and embracing outcomes from investigations. - Engaging in Quality Assurance, Patient and Donor Safety Groups.	- Supporting staff when things don't go to plan. - Encouraging a culture that provides a psychological safe space to empower individuals to raise concerns and incidents. - Ensuring staff attend and complete regulatory and new training requirements. - Ensuring staff are trained and utilise Datix Cymru and the Trust Quality and Safety Regulatory Tracker. - Ensuring that lessons learnt are widely disseminated within the organisation. - Embedding learning into practice, using systems of evaluation, audit and survey to quantify the impact of learning in practice. - Sharing findings from external inspections, internal reviews and quality assurance audit activity.

6. Implementation

This Framework supports listening and learning activities that are undertaken across the Trust that identify areas of improvement. The Learning Framework establishes how the Trust will embed various methods to widely share learning identified, implement improvement actions and support service areas whilst monitoring change.

"This Framework supports listening and learning activities that are undertaken across the Trust that identify areas of improvement."

5
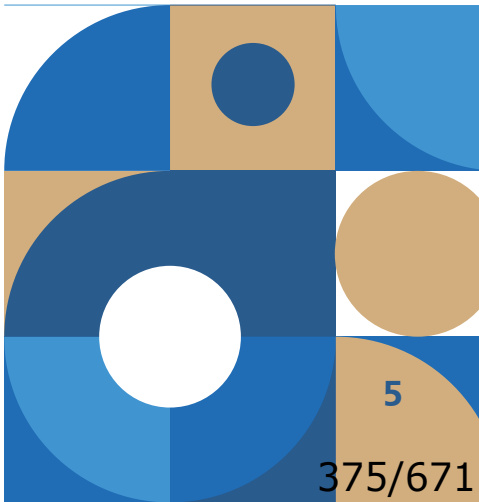
The diagrams below demonstrate and interactively* lead you to useful Trust Intranet pages, containing relevant information and examples to support the Velindre University NHS Trust Learning Framework.

6.1 Identifying areas of learning

There are many ways to improve Trust services by the ways in which we work and, by learning from experiences within our Organisation. Knowing how to identify areas of improvement help meet the needs to put effective practices in place and encourages a collaborative working environment where employees commit to the overall objectives.

Here are some of the ways the Trust identify areas of learning:

Diagram 1 — **Patient and Donor Feedback**: *Ombudsman notifications, Appointment and discussions, *CIVICA Surveys, *Concerns raised, *Patient, donor and staff incidents, *Wall of Thanks

Diagram 2 — **Methods of Feedback**: *Internal/External Audits, *Digital Patient/Donor Surveys, *Written/verbal Concerns, *Interpreter on wheels, Service Managers, *Incident reporting (Datix Cymru)

Diagram 3 — **Legislative requirements**: *Health & Social Care (Quality and Engagement Act) 2020, *Putting Things Right (PTR) Regulations, *Redress, Claims and Inquests, *Wales Safeguarding Policies, *Equality Act 2010, *Information Commissioner Office (ICO)

Diagram 4 — **Corporate/Divisional review**: *Identified themes, *"You said, we did" Displays, *Dashboards (Datix Cymru), *Gauging of a Just Culture, *Evidence of psychological safety, *SMART action planning

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6.2 Sharing learning

The Trust has adopted various ways to share recommendations and learning identified following adverse events, in order to seek an understanding throughout the organisation to prevent similar future events occurring. Equally, positive learning identified can also be shared in the same way.

Here are some of the ways the Trust shares identified learning:

Professional Learning
- Grand round
- *Professional Forums
- *Doctrina
- *Reflection Events
- *Clinical Trials
- *Audit Reports

Team Learning
- *Quality and Safety Hubs
- Team meetings
- Safety Huddles
- Listening & Learning Forums
- *Reflection Events
- *Patient Safety Solutions

Digital Learning
- *Trust Intranet
- *eNewsletter
- *Patient & Donor Digital Stories
- *National Networks
- *Datix Concerns
- *Performance Reports

Written Learning
- *Board and Performance Reports
- *Intranet Learning Repository
- *Newsletters
- *Investigation Reports
- *Audit Reports
- *Standard Operating Procedures

6.3 Implementing learning

Effective learning processes and proactive changes in working practices, following areas of learning being identified, prevent future adverse events from taking place. Engagement with the workforce is vital to reduce the risk of repeating the same adverse event or suffering incidents with similar causes.

Here are some of the ways the Trust supports implementing learning:

Systems and Trackers:
- *Quality and Safety Regulatory Tracker
- Procedure updates and planned reviews
- *Policy reviews and updates
- *Datix Cymru - thematic learning event
- *Targeted training and education
- *SMART action planning

Operational:
- *Reflection meetings - Targeted communications
- *Learning from events reports
- *Task and Finish Groups
- *Improvement projects
- *Guidance updates
- *National Learning

6.4 Monitor change and improvement

The ability to manage change effectively relies upon staff members and department managers paying close attention to the process of implementation, tracking change progress through to completion and measuring the effectiveness once fully embedded within the department. The Senior Leadership Team should have oversight of all significant action plans that are being progressed through the Division, for monitoring purposes.

Internal review:
- Trust Integrated Quality and Safety Group
- *Quality and Safety Regulatory Tracker
- *Planned Audits
- *Senior Leadership Team meetings
- *Training compliance
- *Concern/ Incident trends

Public Domain:
- *Regulatory and Guidance Documents
- *Trust Board and Committees
- *Public Services Ombudsman for Wales
- *Local Partnership Forum
- Performance reports
- *Annual reports

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7. Just Culture

*A Just Culture guide

The concepts behind a 'just culture' relates to system thinking – specifically, that mistakes are generally a product of faulty organisational cultures, rather than solely brought about by the person or people directly involved. In a 'just culture' the question asked after an incident is "What went wrong?" rather than "Who caused the problem?".

A just culture is the opposite of a blame culture.
A 'just culture' is founded on two principles, which apply simultaneously to everyone in the organisation:

1. Human error is inevitable, and the organisations' policies, processes and interfaces must be continually monitored and improved to accommodate those errors.
2. Individuals should be accountable for their actions if they knowingly violate safety procedures or policies.

NHS Improvement has produced a Just Culture guide, aimed at protecting patients by removing the tendency to treat wider patient safety issues as individual issues.

People are 'part of the system because their behaviour is shaped by systemic influences. It looks, therefore, at the interactions between people and factors in the workplace. In the systems approach, people and processes jointly create the system.'

"This guide encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way."

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8. Psychological safety at work

Psychological safety promotes learning. To ensure effective incident oversight, it is crucial to adopt an open environment that considers different perspectives, discusses opportunities for improvement, and encourages recommendations for solutions. To adopt a mindset within a psychologically safe culture, the following principles should be adopted:

Amy C. Edmondson, a professor of leadership and management, stumbled upon the concept of psychological safety while studying the relationship between teamwork and error rates in hospitals.

The outcome realised, that teams that openly discussed failure without fear of repercussions avoided potential issues before they occurred and took risks that fostered innovative solutions.

https://www.bing.com/videos/riverview/related video?q=physcolocally+safe&mid=8FC001AF979 1B1DC3B368FC001AF9791B1DC3B36&FORM= VIRE

Focus on Improvement: Prioritise improving the safety of care in incident management, rather than solely monitoring the quality of investigations.

Avoid Blame: Instead of assigning blame to individuals, focus on identifying system factors contributing to patient safety incidents.

Proactive Learning: Treating incidents as opportunities for learning is a proactive step toward continuous improvement, not an indication of wrongdoing.

Emphasise Collaboration: Effective oversight requires collaboration; it cannot be achieved by individuals or organisations working in isolation.

Harness Curiosity: Leaders play a vital role in oversight by using curiosity to understand and improve, rather than judging. Asking questions for understanding is a powerful tool.

Compassionate Leadership: Quality improvement and learning, demand a just culture and compassionate leadership. Leaders should actively listen to understand the perspectives of staff, service users, and their families.

9. Learning Repository and Action Tracking

Velindre University NHS Trust has developed a Learning Repository which can be accessed through the Trust Intranet site (*Tile/link to be added once developed in the next week). Within the repository you will find useful information and tools in support of this Framework.

To support the management of recommendations and improvement actions, the Trust has adopted the use of a Regulatory Quality and Safety Tracker which will help drive improvements within service areas and assist in monitoring change, for both short- and long-term action planning.

Trust Intranet – Trust Learning Repository

https://nhswales365.sharepoint.com/sites/vel_intranet

Audit Management and Tracking (AMaT)

https://velindre.amat.co.uk/trust/

Quality, Safety and Performance Committee

Trust Incident Management Framework

DATE OF MEETING	9th May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science.

EXECUTIVE SUMMARY	The Trust Incident Framework was developed through collaboration with staff in both divisions and provides a structured overview of incident management at Velindre University NHS Trust. The framework is designed to achieve the following: • Implement standardised reporting mechanisms for incidents, • Support robust and proportionate investigations, • Grow a culture of psychological safety, openness, and transparency, • Foster a robust learning culture, • Enhance staff understanding of a system-based approach to preventing, analysing and learning from incidents, • Ensure compliance with legal and internal and external reporting requirements.

RECOMMENDATION / ACTIONS	To **APPROVE** the Trust Incident Management Framework

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	23/04/24
Executive Management Board	29/04/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *Integrated Quality & Safety Group* - Endorsed for onward Approval.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/A

APPENDICES	
1.	**Trust Incident Framework**

3. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 　　　　YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety, and experience　　　　☒ • An internationally renowned provider of exceptional clinical services　☒ 　that always meet, and routinely exceed expectations • A beacon for research, development, and innovation in our stated　☐ 　areas of priority • An established 'University' Trust which provides highly valued　☐ 　knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future　☒ 　for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result Click or tap here to enter text.

	No issues identified through the equality impact assessment
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	This framework if implemented facilitates the Trust meeting its Putting Things Right and Duty of Quality responsibilities.

4.   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*Not complying with the framework would create a risk. As effective incident management is essential to learning and improvement.*
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	

Velindre University NHS Trust
Incident Management Framework

Contents

1. Purpose

This Incident Management Framework, collaboratively developed with Velindre University NHS Trust (VUNHST) staff, provides a structured overview of incident management at Velindre University NHS Trust. It aims to guide decision-making, establish a standardised approach, and highlight how we can learn from incidents rather than assign blame. The framework is designed to achieve the following:

- Implement standardised reporting mechanisms for incidents.
- Support robust and proportionate investigations are key.
- Grow a culture of psychological safety, openness, and transparency.
- Foster a robust learning culture.
- Enhance staff understanding of a system-based approach to preventing, analysing, and learning from incidents.
- Ensure compliance with legal and internal and external reporting requirements.

The framework outlines the expectations for reporting, recording, and appropriate investigations of all incidents and near misses. This promotes continuous improvement, while aligning with relevant legislative and regulatory requirements.
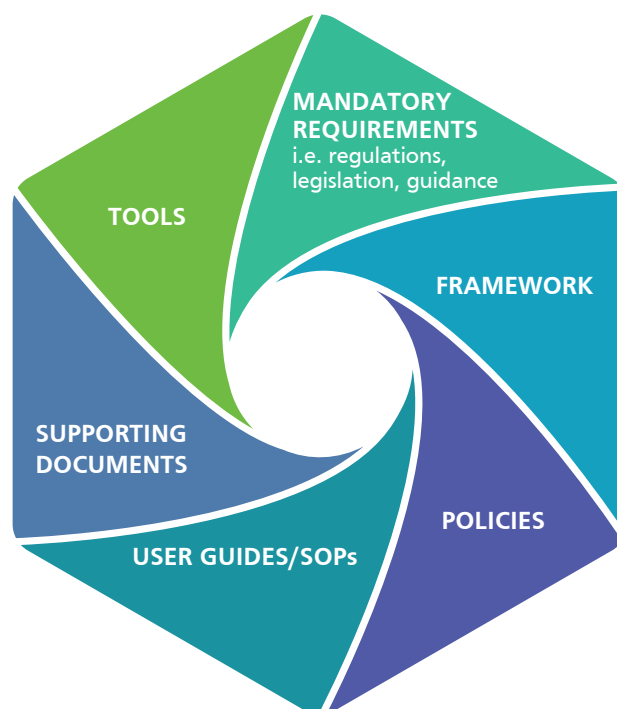
All staff are responsible for:

- Reporting and escalating incidents in accordance with this framework and collaborating as needed in any investigations.
- Participating in learning initiatives and embracing outcomes from investigations.
- Raising concerns to their line manager through the incident reporting system or as outlined within 'Speaking Up Safely' regarding the delivery of care/services to service users.
- Raising concerns about the safety of their environment or work activities, in line with the Trust Health & Safety policy.

2. What is an incident?

An incident is described as an event or circumstance that resulted in or could have resulted in unintended harm, complaints, loss, or damage to one or more patients/donors or service users. This includes adverse events, misses and omissions where potential benefits from medical interventions were not provided. It is essential to report these incidents into the DATIX Cymru system (also known as DATIX Once for Wales).

For quality/process deviations or errors, which are deviations from written procedures that did not cause harm to service users, these may be recorded outside of DATIX Cymru, in a chosen electronic quality management system, for monitoring and improvement purposes.

Why do we report and manage incidents?

Effective incident management can improve safety, processes, and raise awareness of good practice. A well-designed incident management system will assist service users and the workforce to identify, report, manage and learn from incidents. Incident management helps identify and address issues in processes relating to care, promptly ensuring timely resolution and preventing future occurrences.

Incident reporting reflects the dedication of staff members to prioritise person-centered care over simply adhering to protocols. Staff who voice concerns about unsafe conditions or practices contribute to creating better conditions for individuals, colleagues, and service users. The intention behind reporting and reviewing incidents should not be to assign blame to individuals but to evaluate if there are opportunities to improve any fault in a process. All personnel should feel empowered to report anything impacting patient/donor/staff safety. This encouragement will be promoted by:

Lower reporting threshold
Encourage reporting of low-risk incidents, near misses and process deviations.

Investigation will look at all of the factors involved
Incident reporting and investigation must not attribute blame to individuals but seek to find the causes and identify contributory factors to an event. Incidents are almost always multifactorial and should be considered.

Analyse results and create action plan
Identify the cause of the incident, focussing on all of the contributory factors and not on the individual. Look for all underlying causes, not just the 'final error' which led to the incident. Seek a long-term result, not a short-term fix.

Feedback the results of the process
Those who reported the incident should be informed of the results of the investigation and action taken. Key actions points should be shared with all relevant members of staff and foster a team-based approach. Failure to communicate could jeopardise the reporting culture.

Take action to prevent future incidents
This places emphasis on person-centred care as outcomes will improve safety, experiences and outcomes. When visible changes are seen, commitment to reporting increases.

Foster a team approach
Everyone has a vital role to play. Ensure staff feel valued, and support those who are involved in incidents.
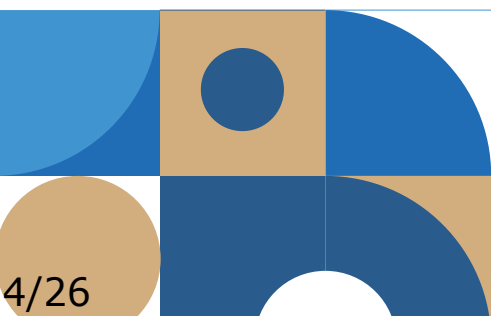
Putting Things Right

'Putting Things Right' regulations and Duty of Candour drive the need for thorough, transparent investigations. These aim to ensure that there is proper investigation when a concern, incident, or complaint is raised, and that lessons are learned. Information about the causes identified should be shared with those involved, and where possible, there should be an immediate correction of what has gone wrong.

Duty of Candour

The Duty of Candour is a legal requirement for all NHS organisations in Wales to be open and transparent with service users when they experience harm whilst receiving health care and builds on the Putting Things Right Regulations (2011). The duty comes into effect in if both of the following conditions are met:

1. A person (the "service user") to whom health care is being or has been provided by the body has suffered an adverse outcome.
2. The provision of the health care was or may have been a factor in the service user suffering that outcome.

For further information and explanation about Duty of Candour, please visit The Duty of Candour Statutory Guidance 2023.

Putting Things Right

Putting things right provides NHS bodies in Wales guidance on raising, investigating, and learning from concerns, and provides guidance on how to interpret and incorporate the requirements of National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011.

Anyone can raise a concern and this practice should be encouraged to help drive improvement, improve patient safety, care and outcomes.

Being open and honest are at the heart of the Putting Things Right guidance, and also the Duty of Candour regulations, which both work hand in hand and both support improvements in the management of concerns. The concerns managed under Putting Things Right may also trigger the Duty of Candour.

Putting Thing Right and The Duty of Candour drive how we mange concerns within NHS Wales. For further information, please visit Putting Things Right Guidance.

3. Incident Management Process

A robust incident management process ensures that incidents are investigated thoroughly, actions are taken to correct the initial incident and prevent further recurrence, learning outcomes are identified and shared, and the best outcome is realised. The process is driven by regulatory and legislative requirements and the notion that person-centred care is at the heart of what we do.

Through listening, acting, investigating, reporting, learning, and improving we, as a Trust can demonstrate a positive incident management culture that is supportive, and person centred.

LISTEN

IMPROVE

ACT

PERSON-CENTRED CARE

LEARN

INVESTIGATE

REPORT

Stages of Incident Management

The stages of incident management are detailed as follows. There shall be documented policies and procedures in place incorporating each stage to ensure effective recording, management and outcomes from incidents.

Identification
What types of incidents do we report?

Immediate Action
How do we minimise the immediate risk?

Incident Reporting
How/where do we report the incident?

Initial Assessment and Proportionate Investigation
What is the risk/harm? Do we have all the information?

Action Plans
Implementation of recommendations and action plan – How do we improve? How will we know we have improved?

Closure and Feedback
How do we tell people what happened and what we did to improve safety?

Learning
How can we learn from events? How can we improve and learn from good practice?

3.1 Identification

As a Trust, we have a commitment to report and manage incidents to continuously develop services to improve care, experience and outcomes to service users. There are several 'types' of incidents that are reported either into DATIX Cymru or an electronic management system, each requiring various levels of investigation and action. The types of incidents categories include:

1. Concerns and complaints

Safety incidents or expressions of dissatisfaction from patients, donors, or users, where harm may or may not have occurred.

May follow Putting Things Right guidelines; based on NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011, Duty of Candour, or redress, depending on harm implications.

The Trust must make reasonable adjustments to ensure the concerns process is accessible to all service users.

2. Process/Quality Deviations/Errors

Deviations/non-conformances from procedures causing no harm, typically identified internally through processes and quality checks. Reported into DATIX or chosen electronic Quality Management System.

3. GMP complaint

Complaints, received by the Welsh Blood Service, from customer hospitals about product/component issues. These are managed in the chosen electronic Quality Management system.

4. Donor adverse events and reactions (DAERs)

DAERs are adverse reactions that can occur in blood donors as a result of the blood collection process.

5. Serious patient safety incidents

A Serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services and care resulting in:

- the unexpected or avoidable death of one or more patients, staff, visitors or members of the public.
- A scenario that prevents or threatens to prevent the ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment.

These incidents include those that are of sufficient nature to be reported externally. See **externally reportable incidents** for more information.

6. Information governance incidents

Where there is a breach or non-compliance with Records Management requirements as stated within statutory provision and good practice guidance. It is the duty of all staff to record and report any incidents or 'near misses' involving records or personal data (including the unavailability and loss).

7. Health and safety incidents

RIDDOR is the law that requires employers, and other people in control of work premises, to report and keep records of:

- work-related accidents which cause death
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosed cases of certain industrial diseases and
- certain 'dangerous occurrences' (incidents with the potential to cause harm).

See **externally reportable incidents** for more information.

3.2 Immediate Action

Immediate actions in incident response refer to the swift and initial steps taken to address and mitigate the impact of an incident as soon as it is identified or reported. These actions are crucial to contain the situation, protect individuals, and minimize further harm. Immediate actions typically include:

- **Assessment:** Quickly assess the nature and severity of the incident to determine the immediate risks and potential impact.
- **Notification:** Notify relevant stakeholders. Prompt communication is essential to coordinate an effective response.
- **Isolation:** Isolate the affected area or system to prevent the incident from spreading or causing additional harm.
- **Containment:** Take measures to contain the incident and prevent it from escalating. This may involve shutting down systems, isolating affected equipment, or implementing emergency procedures.

- **Communication:** Maintain clear and continuous communication with all relevant parties, including internal teams, external authorities, and affected individuals.
- **Documentation:** Begin documenting details of the incident, including the initial assessment, actions taken, and any observations. This documentation is crucial for later analysis and investigation.
- **Preservation of Evidence:** If applicable, preserve any evidence related to the incident for later analysis or investigation.
- **Activation of Emergency Response Plans:** Activate plans to ensure a coordinated and systematic response.
- **Coordination:** Coordinate the response efforts among various teams, departments, or external agencies involved in incident management.
- **Debriefing:** Conduct initial debriefing sessions to gather information, identify lessons learned, and make immediate adjustments to the response plan if necessary.

3.3 Incident Reporting

The NHS in Wales uses a system called "DATIX Cymru" or "DATIX Once for Wales" to log and manage incident data. All staff can log an incident by opening the DATIX Cymru system from the intranet pages. For quality/process deviations/errors an alternative system may be utilised. User guides are available to instruct on how to report into the relevant systems.

Incidents/errors must be reported within 48 hours of knowledge of the event occurring, with the exception of incidents that me be reported remotely, using paper-based systems, before being inputted into the relevant platform.

In some cases, it may be necessary to report incidents to external regulatory or legislative bodies. If such a requirement exists, the reporting timeline may be sooner than 48 hours. The specific requirements and obligations regarding reporting will be outlined in the guidelines provided by these bodies.

All staff identifiable information should remain anonymous throughout all reporting documentation and subsequent reports, whether this is internally to the Trust or external.

DATIX Cymru (Once for Wales)

- Safety incidents, concerns and complaints
- Service user feedback
- Donor Adverse Event Reactions
- Health and safety incidents
- Information governance incidents Process errors (with the exception of WBS)
- Operational incidents or events that pose a risk/prevent core service delivery

Electronic Quality Management System (Welsh Blood Service only)

- GMP complaints
- Process/quality deviations
- Unclassified incidents - unsure of the platform to record

Externally Reportable Incidents

There is a requirement for certain incidents to be reported externally, and where these requirements exist, they must be followed. Each incident should be evaluated individually to determine if it meets the criteria for reporting to the relevant external body. In some cases, reporting to multiple bodies may be necessary if the criteria are met. Where incidents meet the criteria to be externally reportable, a 'make safe' approach must be adopted to ensure immediate actions and response take place.

3.4 Initial Assessment and Proportionate Investigation

What is meant by proportionate investigation?

A proportionate investigation means looking into an incident in a way that matches its seriousness and impact. It ensures that the level of inquiry is suitable for the nature and consequences of the event, avoiding excessive scrutiny for minor issues and ensuring a thorough examination for more serious incidents.

For specific types of incidents, Datix Cymru has embedded focused review tools, promoting a consistent national approach. These tools are applicable to safety incidents involving falls, pressure damage, sharps, and manual handling.

It is important that incident investigations are proportionate to the event, ensuring appropriate investigation and resource identification. Regardless of the level of harm, a comprehensive understanding of the incident's cause is vital for implementing appropriate corrective and preventive actions, which promotes continuous improvement. The stages outlined within here should be followed but applied proportionally based on the severity of the incident.

Proportionality in investigations can be guided by the level of harm caused, as detailed in the Levels of Harm Framework detailed in the Duty of Candour Regulations. Whenever possible, the incident investigator should be objective, and of sufficient expertise and knowledge to lead the investigation. For more serious incidents, formal investigations should be led by trained personnel, and if necessary, consideration given to appointing external professionals in the process.

Before initiating an investigation, ensure systems are in place to protect service user from harm, protect those raising the concern, support employees, protect the organisation, and keeping service users informed.

Where the initial assessment of harm has been assessed as moderate or above, a make it safe approach must be adopted through means of a 'make it safe/rapid review meeting involving multi-disciplinary team members 24 hours from the incident being reported and assessed. This approach will confirm initial learning and actions, actual harm caused, whether the incident is externally reportable, or Duty of Candour has been triggered, the level of investigation required, and agreed timescales. Terms of reference for this approach can be found here.

The following table recommends the investigation method required based on the level of harm identified. The levels of harm detailed are based on the Putting Things right Regulations. For incidents such as Radiotherapy incidents, these are classified according to the terminology stated in the Towards Safer Radiotherapy Document, so must be consulted when determining the level of harm caused.

Level of Harm	Investigation Method
LEVEL 1 – NO HARM Had the potential to cause harm but impact resulted in no harm having arisen but could be considered 'correctable' events. **LEVEL OF INVESTIGATION - DATIX INVESTIGATION**	A proportionate investigation of non-complex, straightforward incidents, errors, or deviations, that resulted in no harm, which can be investigated and documented within the Datix incident record or electronic Quality Management System (eQMS). As a minimum, the following should be considered: • Description – what happened? • Process - what should have happened? • Risk – what is the potential risk to service user? • Remedial/corrective actions – what actions have/need to be implemented to correct? • Contributory factors – Why did this event occur? • Preventive/learning actions
LEVEL 2 – LOW/MINIMAL HARM Incident that resulted in minimal harm to one or more persons receiving NHS-funded care. May have led to a minor increase in treatment, needing first aid/intervention, or requiring additional observation. Consideration should be given to determine if the incident is externally reportable. **LEVEL OF INVESTIGATION - PROPORTIONATE, INTERNAL INVESTIGATION**	Less complex incidents managed at local level, within Datix. Requirement to complete Yorkshire Contributory Factors Framework Incidents involving falls, pressure damage, sharps, and manual handling - complete relevant All Wales Toolkit on Datix. Recommended investigation tools (if investigation is deemed necessary): • 5 whys • Timeline • Discussions • Fishbone analysis

Level of Harm	Investigation Method
LEVEL 3 – UNINTENDED OR UNEXPECTED MODERATE HARM An incident that resulted in unintended/unexpected moderate harm to a service user. Could have resulted in a moderate increase in treatment (longer hospital stay, requires emergency treatment, significant delay in necessary treatment, experience psychological harm) Level 3 incidents may trigger Duty of Candour which should be reviewed and completed within the Datix module, and Duty of Candour/Putting Things right process followed. Consideration should be given to determine if the incident is externally reportable. **LEVEL OF INVESTIGATION - COMPREHENSIVE, INTERNAL INVESTIGATION**	Perform proportionate investigation – level of which to be determined in make safe meeting. More complex, comprehensive investigation required, and root cause must be determined. Identify necessary engagement – service user, staff, family. Recommended investigation tools: ● Detailed timeline ● 5 Whys ● "Fishbone" and cause and effect analysis ● RCA template ● Discussions with staff/family/service users ● Bowtie analysis
LEVEL 4 – UNINTENDED/UNEXPECTED SEVERE HARM OR DEATH A Serious incident that occurred in relation to NHS funded services and care resulting in: ● The unexpected or avoidable death of one or more patients, staff, visitors or members of the public. ● Unexpected harm that results in avoidable, permanent harm or impairment of health. ● A scenario that prevents or threatens to prevent the ability to continue to deliver health care services, for example, actual or potential loss or damage to property, reputation or the environment. Incidents requiring this level of investigation are usually Nationally Reportable Incidents (NRIs) and trigger Duty of Candour. Consideration must be given to report to any external organisation/regulatory body. **LEVEL OF INVESTIGATION - COMPREHENSIVE, INDEPENDENT INVESTIGATION – INTERNAL OR EXTERNAL**	Complex issues/incidents to be managed by multidisciplinary teams, involving experts and/or specialist investigators. The Investigating Officer must have completed Root Cause Analysis (RCA) training and be off sufficient experience and knowledge to perform the investigation. Independent investigation may be commissioned for serious incidents where the integrity and objectivity of an internal investigation would be difficult to maintain. Recommended investigation tools to support investigation: ● Root Cause Analysis template ● Detailed timeline ● "Fishbone" and cause and effect analysis ● Systems Engineering Initiative for Patient Safety (SEIPS) ● Discussions with staff/family/service users ● Bowtie analysis

A comprehensive and accurate incident record is crucial for a timely learning response as it provides essential details about the incident. This information helps analyse factors, identify root causes, and plan preventive measures. A complete record enables prompt and targeted actions to be taken, promoting a culture of continuous learning.

The accuracy of the incident record plays a direct role in the effectiveness of the learning response and, subsequently, overall safety and performance.

15 important elements to consider during the investigation process:

1. **Reporting Platform Template:** Accurate details: description, date, type, effect on those impacted, severity.
2. **Background and Context:** Incident location, details, identification time, and similar/same previous incidents.
3. **Information and Evidence:** Methodology for collecting relevant information.
4. **Engagement and Involvement:** Transparent involvement of patients/donors/families.
5. **Terms of Reference:** Purpose of investigation and team members.
6. **Root Cause Analysis:** Approach and tools used.
7. **Staff Involvement and Support:** Details of staff debriefing and support.
8. **Good Care Aspects:** Highlight positive care/service aspects.
9. **Relevant Issues:** Identify contributory factors.
10. **Lessons Learned:** Outline areas for change.
11. **Recommendations:** Propose corrective actions.
12. **Action Plan:** Define SMART actions, responsibilities, timelines, and risk mitigation.
13. **Reporting and sharing:** Specify recipients and ensure timely distribution.
14. **Monitoring:** Assign oversight responsibility and monitoring measures.
15. **Dynamic Risk Assessment:** Ongoing risk assessment

Root Cause Analysis tools to support investigation

In our effort to understand incidents better and continuously improve, the use of root cause analysis (RCA) tools become crucial. These tools help us delve deeper into the events, identify their origins, and understand the underlying causes. The selection of root cause analysis tools is done thoughtfully, ensuring they are appropriate and proportional to the incident at hand. It's important to note that the choice of tools is case-specific to ensure effectiveness.

To carry out root cause analysis effectively, a systematic approach is adopted during investigations. Performing a root cause analysis without assigning blame is crucial for promoting a positive and constructive approach to learning from incidents. Some steps to help this are:

- Promote a non-blame culture
- Focus on systems, not individuals
- Involve a diverse team
- Encourage open dialogue
- Emphasise continuous improvement
- Use root cause analsysis tools and techniques

Root causes and conclusions are supported by documented evidence, and the process follows four key steps:

Initiation
Determine the need to carry out root cause analysis, defining purpose and scope

Establishing facts
Collect data and establish facts of what happened, where, when and by whom

Analysis
Use root cause analysis tools and techniques to establish how and why the event occurred

Validation
Identify and correct the different possibilities as to how and why the incident was caused from the analysis step

The investigation tool kit provides recommendations on tools to use to support an investigation, which includes root cause analysis tools.
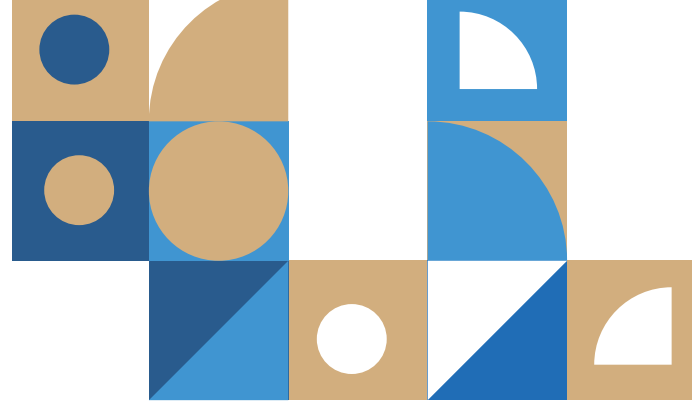
Human Factors and Psychological Safety

Human factors are the factors that impact how individuals perform. When considering safety with a human-factors approach, it involves understanding what helps or hinders people in their work. Having this understanding prioritises the well-being of individuals at work and promotes psychological safety. Ensuring people are comfortable, healthy, and motivated not only meets societal and ethical needs but also holds economic value. Human factors to be considered is as follows:
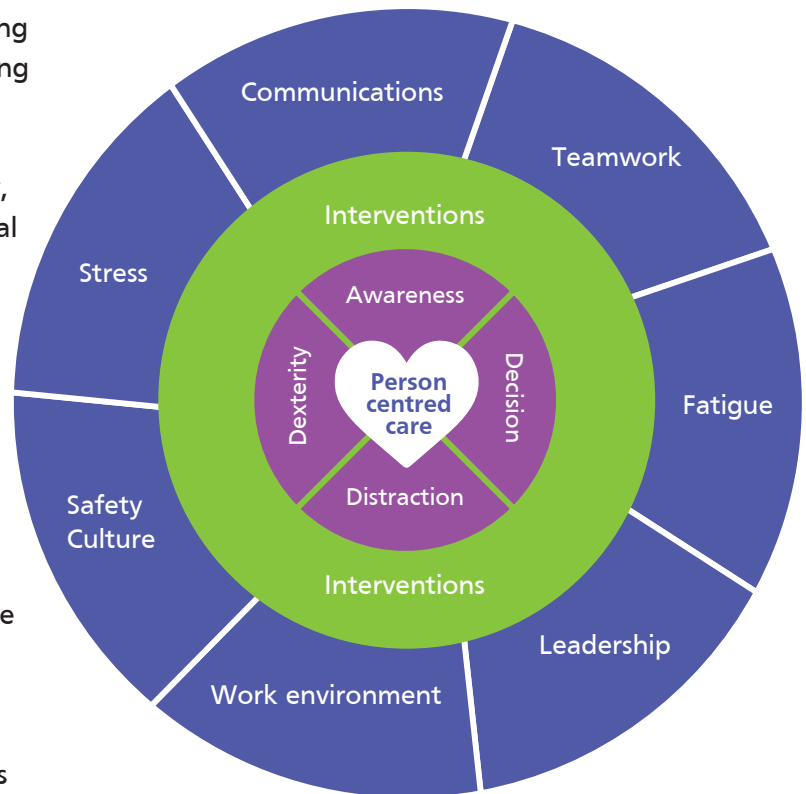
Psychological safety promotes learning. To ensure effective incident oversight, it is crucial to adopt an open environment that considers different perspectives, discusses opportunities for improvement, and encourages recommendations for solutions. To adopt a mindset within a psychologically safe culture, the follow principles should be adopted:

1. **Focus on Improvement:** Prioritise improving the safety of care in incident management, rather than solely monitoring the quality of investigations.

2. **Avoid Blame:** Instead of assigning blame to individuals, focus on identifying system factors contributing to patient safety incidents.

3. **Proactive Learning:** Treating incidents as opportunities for learning is a proactive step toward continuous improvement, not an indication of wrongdoing.

4. **Emphasise Collaboration:** Effective oversight requires collaboration; it cannot be achieved by individuals or organisations working in isolation.

5. **Harness Curiosity:** Leaders play a vital role in oversight by using curiosity to understand and improve, rather than judging. Asking questions for understanding is a powerful tool.

6. **Compassionate Leadership:** Quality improvement and learning demand a just culture and compassionate leadership. Leaders should actively listen to understand the perspectives of staff, service users, and their families.

3.5 Action Plans

A SMART action plan, aligned with the investigation, should outline the steps required in response to an investigation report to provide assurance. These steps should be drawn from the understandings and recommendations identified during the investigation. SMART actions should follow the principles of:

Specific	Measurable	Achievable	Relevant	Time-bound
• Clear, specific goals • Avoid ambiguity • Provide clear defintion on what to accomplish	• Quantifiable goals that allow progress to be measured • Determine criteria for success • Specify how progress will be tracked	• Realistic and attainable goals • Goal should be feasible taking into account resource, time and constraints	• Goals should align with the broader objective • Goal must be meaningful and contributes to the overall purpose	• Apply a specific time-frame for completion • Set deadlines and prioritise actions

When setting SMART actions, individuals or organisations are more likely to achieve success and avoid vague or unrealistic goals and should be encouraged.

The action plan must be agreed by the investigation team, and progress monitored by the divisional quality teams.

3.6 Completing (Closing) an incident investigation

The accountability for completing (closing) an incident investigation sits with the division who undertook the investigation. Incidents must be completed in a timely manner, in line with this framework, and incorporate patient/service user/staff involvement, quality assurance, and Executive sign off (where deemed necessary).

Although there will be expected timeframes of closure depending on the severity and level of investigation required for an incident, it is imperative that a robust investigation is undertaken with meaningful, SMART actions that ensure the best outcomes and experience for patients/donors, staff and families. Incident records can only be considered closed when the actions have been completed and, where required, effectiveness checks have been undertaken.

To allow The Executive Board to be assured that incidents have been dealt with appropriately, there must be robust processes in place to inform and assure The Board that:

- the quality of their investigation processes is of a high standard.
- investigations are being undertaken and completed in a timely manner.
- patients or service users or anyone acting on their behalf are being engaged and supported during the investigation process and the findings and outcomes of the investigation are shared with them; and
- appropriate actions are being taken and learning is being shared across the organisation.

3.7 Learning from incidents

Learning from incidents is essential for preventing harm, improving safety, fostering continuous improvement, and developing a resilient and proactive organisational culture. It contributes to the overall growth and effectiveness of individuals and organisations in various fields. It is important to note that learning from incidents doesn't just come from the identification of improvements of practice, but also good practice that has been observed.

Sharing good practices can be a proactive approach to preventing future events.

Please refer to the Learning Framework for tools, tips and templates on how to learn from events. These are valuable tools for personal and professional development, promoting self-awareness, continuous learning, and improved critical thinking.

3.8 Summary of Incident Management Process

Key Steps	Level 1 & 2	Level 3	Level 4
Immediate Action	Identify and Implement Immediate Corrective Actions		
	within 48 hours of identification		*within 48 hours of identification*
Report	Report into DATIX/eQMS	Report into DATIX	
	within 30 days of assigning investigator		
Assess and Investigate	Internal investigation completed in reporting platform	If Duty of Candour has been triggered - follow Putting Things Right guidance	Rapid review/make safe meeting held to confirm risk and level of investigation required	Determine if externally reportable - refer to regulations/ legislation
Action Plan	Identify any further preventive actions	Undertake comprehensive investigation - determine root cause(s)	Undertake comprehensive independent investigation
		Create Action Plan	
Review and Close	Revire and close identify learning	Review and close identify learning	

Timeframe to be determined in make/safe MDT meeting 30/60/90 days

4. Key timescales

48 hours from identification/knowledge of incident/error:

- Report any incident/error/deviation into relevant platform.
- Instigate make safe/MDT meeting for incidents that have caused moderate harm or more.

*Be mindful that if the incident is externally reportable, the required timeframe to report may be sooner than 48 hours.

72 hours from incident identification:

- Initial manager review takes place in Datix.
- Make safe meeting has taken place and actions are identified and recorded.
- Investigator assigned in Datix, if necessary

30 days from assignment of investigator:

- Undertake investigation.
- Identify and assign actions.
- Complete actions (where possible within 30 days) and final review undertaken by manager to allow closure of incident record.

* Investigation timeframes and response may be stipulated by external bodies
**Where the 30 days target is not possible due to the complexity of the incident or ability to complete actions, a rationale must be provided
** 60 or 90 days may be assigned in cases where the incident spans multiple departments, disciplines, and is complex in nature, or as stipulated by an external body. This must be identified and agreed on a case-by-case basis.

12 months from completion of actions:

- In cases where a significant incident has occurred, effectiveness checks will be performed at defined intervals following the incident, to ensure corrective and preventive actions have been effective.
- Identify any further learning.
- Audits should review the specific part of the pathway where an error may have occurred that could have contributed to a patient being seriously or moderately harmed.

5. Incident Trending

It is crucial to establish effective mechanisms for incident trending. Incident trending serves as a proactive approach to risk management, facilitates continuous improvement, optimises resource allocation, and ensures compliance with regulatory standards. Additionally, it plays a pivotal role in nurturing a safety-oriented culture and enhancing overall organisational resilience. Implementing a mechanism for incident trending involves several key steps:

1. **Define metrics:** Outline key parameters (incident types, severity, locations, etc.).
2. **Data collection:** Gather comprehensive data on incidents.
3. **Use incident management systems:** Utilise dedicated systems or software for streamlined data handling.
4. **Establish time frame:** Decide on a consistent time frame for trending (monthly, quarterly, annually).
5. **Categorise incidents:** Organise incidents based on predefined criteria.
6. **Assess severity and factors:** Evaluate incident severity and identify contributing factors.
7. **Create visual representations:** Use charts and graphs for visual trend analysis.
8. **Continuous monitoring:** Regularly review and update trending data for relevance.
9. **Feedback and improvement:** Provide feedback to stakeholders and implement corrective actions based on trends.
10. **Documentation:** Thoroughly document trending methodologies, findings, and actions taken.
11. **Training and communication:** Train staff on incident reporting and communicate the importance of trending.
12. **Review and adjust:** Regularly review and adapt trending methodologies based on organisational changes and emerging trends.

6. Engagement and support

Engagement and level of involvement must be in keeping with the wishes of those affected as far as possible. When a family or staff member informs the organisation that something has gone wrong, they must be taken seriously from the outset, and treated with compassion and understanding. Following the detection of an incident/error, it may be a distressing time for all concerned especially if the incident is of clinical significance. The welfare of the individuals involved, including staff, investigators, families, and the patient/donor must be considered, particularly in relation to psychological trauma or stress. There are four key steps to consider when engaging with families:

1. Before contact
- Identify the family contact
- Assess inclusivity needs
- Assess potential support needs
- Ensure familiarity with the incident
- Assess potential for parallel responses and prepare guidance

2. Initial contact
- Provide a clear introduction
- Offer a meaningful apology
- Identify key point of contact
- Explore support needs
- Discuss the incident
- Explain what happens next
- Address questions
- Schedule or discuss next contact (if required)
- Confirm involvement preferences if investigation will be initiated

3. Continued contact
- Agree timeframe for responding to questions
- Revisit support needs
- Check for additional questions
- Share experience of the incident

FOR INVESTIGATION:
- Define/discuss terms of reference
- Agree timeframe for completion
- Revisit involvement preferences
- Discuss report preferences
- Share draft report

3. Closing contact
- Address questions
- Reiterate meaningful apology
- Final contact (formal end)
- Ongoing support

FOR INVESTIGATION:
- Final report
- Discuss any further investigations
- Opportunities for further involvement

Staff involved in an incident should be reassured that they will not be blamed and receive full support, help and advice where required. They should be kept fully informed of the investigation and outcome and advised to seek further advice and support from their respective professional bodies.

A debrief session should be arranged following an incident that has caused moderate harm or more, to help staff engage in true reflective practice to explore good practice, areas for improvement, and identify opportunities for learning. It can be a mechanism whereby leaders can actively support staff experiencing difficult situations. It is important that everyone has an opportunity to speak openly and honestly, without feeling judged. There should be no apportioning of blame.

Due to the range of incidents that can occur, and the different needs of individuals affected, the following principles should be flexibly applied when engaging with or involving those affected by safety incidents:

1. **Apologies are meaningful** – Apologies are crucial and should communicate understanding of the incident's impact, a commitment to address concerns, and a sense of accountability without assuming responsibility before investigation. Proper apologies set the tone and align with the Duty of Candour.

2. **Approach is individualised** – The approach to engagement must be individualised, adapting to practical, physical, and emotional needs. Recognising the diversity of responses based on individuals' circumstances is essential.

3. **Timing is sensitive** – Some people can feel they are being engaged and involved too slowly or too quickly, or at insensitive times. Consideration for significant dates, such as birthdays or anniversaries, is crucial, particularly when someone has experienced a loss.

4. **Treat with respect and compassion** – Those affected must be treated with respect and compassion, fostering trust and open communication. A lack of trust and compassion risks damaging relationships between individuals and the organisation.

5. **Guidance and clarity are provided** – Guidance and clarity are essential to help service users understand the post-incident processes, reducing confusion. Communications should be clear, avoiding assumptions about prior understanding.

6. **Those affected are 'heard'** – Everyone affected should have the opportunity to be 'heard,' which helps contribute to comprehensive understanding that supports learning and positive outcomes. This is important to maintaining and restoring relationships.

7. **Approach is collaborative and open** – A collaborative and open investigation process, providing answers, can reduce the likelihood of litigation. However, litigation isn't always about establishing blame – some feel it is the only way to get answers to their questions.

8. **Subjectivity is accepted** – Subjectivity should be accepted, acknowledging that individuals experience incidents differently. All perspectives, from patients to healthcare staff, should be considered credible sources of information in response to an incident.

9. **Strive for equity** – Striving for equity is essential, weighing the opportunity for learning against the needs of those affected. Engagement leads must understand the impact of response types on individuals and guard against introducing inequity into the safety response process.

7. Assurance/Governance

Governance in incident management involves creating processes to guide the effective management of incidents. This includes, but not limited to, developing clear policies with defined roles and responsibilities, establishing leadership and oversight, fostering a culture of continuous improvement, ensuring legal and regulatory compliance, measuring performance with key indicators, facilitating external reporting when required, and conducting periodic audits and reviews for verification and improvement.

As a Trust, there should be necessary structures and processes in place to detect, respond to, and recover from incidents efficiently and effectively while minimising their impact on operations and service users.

Monitoring the completion and effectiveness of actions resulting from incidents will be through organisational governance processes. For incidents graded moderate or above, monitoring and assurance will take place at the divisional quality Hubs, Integrated Quality and Safety Group and Senior Leadership Teams.

Data in relation to incidents, near misses, emerging themes and associated learning and improvements will be shared and discussed regularly at various forums including but not limited to divisional governance meetings, safety and risk forums, Management Board meetings and Divisional and Trust level Quality and Safety meetings. These forums will receive regular highlight reports for assurance purposes.

Level of Incident	Level of Governance
Level 1 & 2	Manager acknowledgement and review Oversight at Operational Group meetings
Level 3	Divisional quality meetings Clinical Governance groups Senior Leadership Quality, Safety and Performance Committee
Level 4	Divisional quality meetings Clinical Governance groups Senior Leadership Quality, Safety and Performance Committee
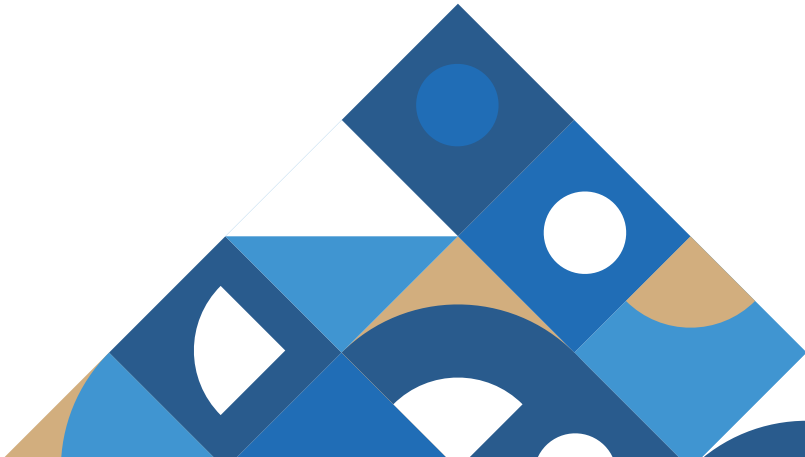
8. Supporting information
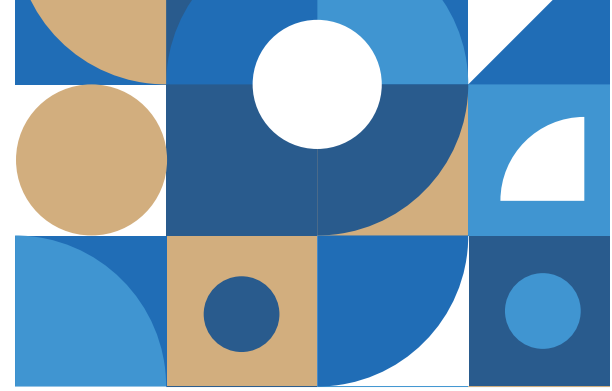
Staff support and wellbeing:

Mental health first aiders:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Mental-Health-First-Aiders-(MHFAs).aspx

Speaking up safely:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Speaking-up-Safely.aspx

Wellbeing and engagement:

https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/Wellbeing-and-Engagement.aspx

Duty of Candour, Putting Things right and complaints:

https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour

https://www.gov.wales/nhs-wales-complaints-and-concerns-putting-things-right

https://www.gov.wales/nhs-duty-candour#:~:text=From%20April%202023%20The%20duty,incidents%20that%20have%20caused%20harm

https://www.cqc.org.uk/guidance-providers/all-services/regulation-20-duty-candour

https://www.legislation.gov.uk/wsi/2011/704/madehttps://law.gov.wales/public-services/health-and-health-services/nhs-complaints

Duty of Quality:

https://www.gov.wales/sites/default/files/publications/2023-04/duty-of-quality-statutory-guidance-2023_0.pdf

National Policy on Patient Safety Incident Reporting and Management:

https://du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/

NHS England publications:

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/#new-approach#

https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework/engaging-and-involving-patients-families-and-staff-following-a-patient-safety-incident/

Appendix A

National Reportable Incidents - reportable to NHS Executive

- **Never Events** - serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. All Never Events are reportable regardless of harm caused.
- **Suspected suicide or self-inflicted death** - in any clinical setting; or during authorised/agreed leave, following recent planned discharge, or following unplanned leave/discharge.
- **Level of harm** - if it is assessed or suspected an action or inaction has or could have caused or contributed to their severe harm/death.

- **Healthcare Acquired Infections (HCAIs)**
- **Avoidable pressure damage**
- **Incidents where the number of patients affected is significant**
- **Learning opportunities** - Where incidents present new learning opportunities (even in cases of low or no harm), particularly where similar risk may be present in other NHS organisations (includes near misses or unusual, unexpected or surprising circumstances).

Visit **https://du.nhs.wales/files/incidents/national-policy-on-patient-safety-incident-reporting-2-0-pdf/** for more information

MHRA - SHOT (Serious Hazards of Transfusion), SABRE (Serious Adverse Blood Reactions and Event)

- **Adverse reactions or events** - An adverse reaction or event is an undesirable response or effect In a patient, associated with the administration of blood or blood component.
- **Near misses** - Blood Establishments are encouraged to report to the Serious Hazards of Transfusion (SHOT) scheme.
- The information supplied to SHOT contributes to improving the safety of the transfusion process, informing policies within the transfusion services, improving standards of hospital transfusion practice, and aiding production of clinical guidelines for the use of blood components.

Visit **https://www.gov.uk/guidance/blood-authorisations-and-safety-reporting** for more information.

Appendix A

Welsh Government

- **Incidents that resulted in the unexpected or avoidable death** - of one or more patients, staff, visitors or members of the public; or a threat to prevent the ability to continue to deliver health care services.
- **Never Events** - Serious incidents that are wholly preventable because guidance or safety recommendations are available at a national level and should have been implemented by all healthcare providers. All Never Events are reportable regardless of harm caused.

- **No surprise** - Incidents that impact on service provision, e.g. flu, norovirus, infections. These are reportable to Welsh Government as a "No Surprise" (early warning).
- **Avoidable Healthcare Acquired Pressure Ulcers** - Grade 3 and 4 Avoidable Healthcare Acquired Pressure Ulcers are reported upon completion of a full investigation.
- All incidents **MUST** be reported to Welsh Government within 24 hours of identification.

Visit **https://www.gov.wales/sites/default/files/publications/2023-05/putting-things-right-guidance.pdf** for more information.

Human Tissue Authority (HTA)

- **Serious Adverse Events (SAE)** - Any untoward occurrence which may be associated with the procurement, testing, processing, storage or distribution of tissue or cells intended for human application and which, in relation to a donor of tissue or cells intended for human application or a recipient of tissue or cells –

  (a) might lead to the transmission of a communicable disease, to death, or life-threatening, disabling or incapacitating conditions; or

  (b) might result in, or prolong, hospitalisation or morbidity.

- been implemented by all healthcare providers. All Never Events are reportable regardless of harm caused.

- **Serious Adverse Reaction (SAR)** - An unintended response, including a communicable disease, in a donor of tissue or cells intended for human application or a recipient of tissue or cells, which may be associated with the procurement or human application of tissue or cells, and which is fatal, life-threatening, disabling, incapacitating or which results in, or prolongs, hospitalisation or morbidity.
- **MUST** report within 24 hours of discovery.

Visit **https://www.hta.gov.uk/guidance-professionals/licences-roles-and-fees/useful-information-dis-and-named-contacts/faqs** for more information

Appendix A
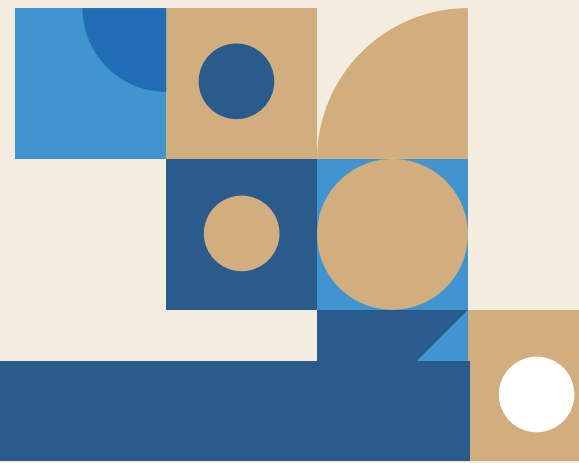
Healthcare Inspectorate Wales (HIW)

- **Ionising Radiation (Medical Exposure) Regulation Significant** - Accidental or unintended exposure (SAUE) - Must report to Health Inspectorate Wales where there is any exposure to ionising radiation that is deemed to be 'significant' or 'clinically significant' or meets criteria set out in SAUE guidance document.
- Notification to HIW must be sent within 2 days of knowledge of the incident.
- Investigation and report must be submitted no later than 12 weeks following discovery of the ??

Visit **https://www.hiw.org.uk/sites/default/files/202-09/20200826%20SAUE%20guidance%20updated%20August%202020_0.pdf** for more information

United Kingdom Accreditation Service (UKAS)

- **Significant nonconformity** - Must be reported as soon as practicable following identification of a significant nonconformity. An incident is considered a significant nonconformity if it meets one or more of 6 criteria defined by UKAS as detailed in UKAS Customer Agreement.

Health and Safety Executive (HSE) - incidents including Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

Report to HSE for incidents, including:
- accidents resulting in the death of any person.
- accidents resulting in specified injuries to workers.
- non-fatal accidents requiring hospital treatment to non-workers.
- dangerous occurrences.

Designated individuals are able to report under RIDDOR and a report must be submitted within 10 days of knowledge of the incident.

For accidents resulting in the over-seven-day incapacitation of a worker, notification must be submitted to the enforcing authority within 15 days of the incident, using the appropriate online form.

Cases of occupational disease, including those associated with exposure to carcinogens, mutagens or biological agents, must be reported as soon as the responsible person receives a diagnosis, using the appropriate online form.

Visit **https://www.hse.gov.uk/riddor/reportable-incidents.htm** for more information.

Appendix A

World Bone Marrow Association (WBMA)

Serious (Product) Events and Adverse Reactions (S(P)EAR) must be reported to the World Marrow Donor Association (WMDA) via the online reporting tool https://wmda.knack.com/spear

If an event/reaction is deemed to be one of the following it should be reported:

- Serious/unexpected/medically relevant/previously unknown.
- Hospitalisation in an event that is life threatening or fatal or unexpected.
- Expected events (e.g., nausea/pain) where they are life-threatening or fatal.
- Cell counts less than requested or expected where a clinical consequence occurred, or an error was responsible for the low count.

Visit **https://wmda.info/wp-content/uploads/2020/07/User-guide-SPEAR-2020-v1.pdf** for more information.

Information Commissioner's Office

Personal data breaches must be reported to the Information Commissioner's office within 72 hours giving as much detail as possible, including:

- what has happened.
- when and how you found out about the breach.
- the people that have been or may be affected by the breach.
- what you are doing as a result of the breach; and
- who we should contact if we need more information and who else you have told.

Visit **https://ico.org.uk/for-organisations/report-a-breach/** for more information.

Quality, Safety and Performance Committee	

Trust Updated Inquest Guidance and Protocol	

DATE OF MEETING	9th May 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience.
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science.

EXECUTIVE SUMMARY	The Trust Inquest Guidance has been updated strengthen how the Trust needs to manage Schedule 5 requests, following an increase in Schedule 5 requests from Coroners.
	Schedule 5 of the coroners and Justice Act 2009 allows a coroner to require by notice a person to provide evidence in a witness statement, or produce a document if it is in that person's custody or control.

RECOMMENDATION / ACTIONS	To **Approve** the Trust Updated Inquest Guidance

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	23/04/24
Executive Management Board	29/04/24

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
Endorsed for onward Approval.

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES	
1.	**Trust Inquest Guidance**

IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals:	

• Outstanding for quality, safety, and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development, and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐
• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Click or tap here to enter text.

	This is not required as this is a guidance document.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Fines can be issued up to £1000 if the individual/organisation fails to do what is required by the notice.

4.   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	The document has been updated to include the schedule 5 information to ensure that staff are aware of the legislative requirement and reduce the risk of legal sanction.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	

Inquest Guidance & Protocol
"*Getting it Right First Time*"
Author: Jayne Rabaiotti, Claims, Inquests & Redress Manager

Date: 12th April 2024	**Version:** V3 – draft for approval at Integrated Quality and Safety Group
	Date: 23rd April 2024

Publication/ Distribution:

- Velindre University NHS Trust (Intranet)

Review Date: February 2025

Purpose and Summary of Document:

A guide for Velindre University NHS Trust staff on Coroner's Inquests.

This protocol aims to ensure that any requests from the Coroner are monitored and witnesses are supported.

Work Plan reference: N/A

Contents

1   INTRODUCTION

This protocol details the process for dealing with requests made by His Majesty's Coroner for witness statements and attendances at inquest hearings.   It aims to ensure staff are supported when any requests are made by His Majesty's Coroners to attend Inquests or if staff are required to provide Witness Statements.

An Inquest produces a conclusion (previously referred to as a verdict although it is not a trial). It is a fact-finding inquiry conducted by a Coroner, with or without a jury, into the circumstances surrounding a death.

The inquest does not set out who is responsible for a death. It is not the Coroner's role to determine whether any civil or criminal liability attaches to any named person or to apportion blame. It is however quite possible that the findings of an inquest may be influential in subsequent legal action as part of the prosecution or defence.

2   INQUESTS - WHAT YOU NEED TO KNOW

2.1   What is the Coroner's role?

Coroners are independent judicial officers i.e. members of the judiciary (similar to that of a judge), appointed by the local authority, to investigate certain deaths within their geographical area. When a person dies, the responsibility is to hold an inquest in the area where the person died, not where the person resides.

The majority of Coroners usually have a legal background and, in some cases, a small percentage are doctors. Coroners are responsible for investigating the cause of deaths in accordance with the Coroners and Justice Act 2009. Under section 5 of the Act, a Coroner's purpose is to determine:

- who the deceased was;
- how, when and where the deceased came by his or her death; and,
- the particulars (if any) required by the Births Deaths and Registrations Act 1953 to be registered concerning the death.

A coroner is obliged to investigate deaths where there is a reasonable suspicion that the deceased has:-

- died a violent, sudden, unexpected or unnatural death,
- where the cause of death is unknown or

- if the deceased died whilst in police custody or state detention, as defined by section 1(2) of the Coroners and Justice Act 2009.

Full guidance on reporting of deaths to the Coroner can be found on the Chief Coroner's website.

[Chief Coroner's Office Guidance](#)

In addition, the Coroner will also investigate where the deceased has not been seen by the doctor issuing the medical certificate, or during the 14 days before the death.

2.2   What happens after a death has occurred?

The Coroner will consider the information given when the death was referred and decide what action to take. This could include:

- Ordering a post mortem examination. The coroner has the legal power to require a post mortem, even if this is against the family's wishes.
- Obtaining further evidence, such as statements from staff or copies of medical records.

Depending on the post mortem report and/or any additional evidence, the Coroner will decide whether to continue with an inquest. If the individual died as a consequence of a natural cause of death and there is no other reason to open an Inquest, the Coroner will discontinue its involvement. However, in certain circumstances, the Coroner must legally hold a full inquest. *Please see Appendix 4 for examples.*

2.3.   What is an inquest?

The Coroner has a duty to hold an inquest as outlined in section 6 of the Coroners and Justice Act 2009.

Inquests are legal inquiries into the cause and circumstances of a death. The inquest proceeds on a fact finding basis and gives an opportunity to understand the factual truth surrounding the circumstances of death. Therefore, in the event elements of care that were provided to the deceased are found to be below the standard expected, the Coroner may attribute some element of possible fault on a party, if satisfied that is linked to the death. It is therefore important to bear in mind that although the aim of the inquest is not to apportion blame, if the factual circumstances establish that there have been shortcomings in the care provided, the Coroner may refer to this when reaching his conclusion. In circumstances where concerns are raised that a repeat of a similar incident or event may happen again, he may issue what is known as a Prevention of Future Deaths Report (please see section 6 for further details).

A Coroner will consider both oral and written evidence during the course of an inquest.

Inquests are public hearings and can be held with or without a jury - both are considered equally valid. Under Rule 8 of the Coroners (Inquest) Rules 2013, Coroners are required to complete an inquest within 6 months of the date on which the Coroner is made aware of the death, or as soon as is reasonably practicable.

2.4.   What is a Pre-Inquest?

Once an inquest is opened to record the death, the Coroner is required to consider if the body can be released for burial or cremation, and will need to be satisfied as to the identity of the body before agreeing to its release. The Coroner may hold a pre-inquest hearing where the scope of the inquest will be considered, including the setting of timeframes and directions leading up to the inquest hearing.

Pre-inquest hearings are usually held in public, except where it is in the 'interests of justice or national security', under Rule 11(5) of the Coroners (Inquests) Rules 2013.

The Coroner will invite 'properly interested parties' and/or legal representatives to a pre-inquest hearing for the opportunity to make representations to the Coroner, where required.

2.5.   Inquest proceedings

Once the Coroner has notification that an individual has died in circumstances that led him to open an inquest, he will begin his investigation, depending on the circumstances, and will seek evidence in a variety of ways, for example, he may request:

- Witness statements from those involved with the person prior to their demise. This can include witness statements from healthcare professionals who provided care / treatment to the individual prior to the death, and witness statements from family members and carers involved with the individual.
- Witness statements may also be requested from individuals who witnessed an event, accident or incident.
- Reports from medical experts
- Reports from the Health and Safety Executive, if a person has died at work
- Criminal investigations
- Police reports after a car accident

When a clinician is called to give evidence at an inquest hearing, they are classed as "witnesses". Relatives can ask witnesses' questions at the inquest and can also instruct a lawyer to represent them at the hearing. Lawyers may also represent witnesses at the hearing and are allowed to cross examine witnesses when giving evidence.

2.6.   What an Inquest means to families

In most cases a Coroner's inquest will be the only public and independent investigation into the circumstances of a particular death. For the family of the deceased it can:

• Help with the bereavement process.

• Provide factual and explanatory information to assist the family's understanding.

• Provide a setting in which their questions can be answered.

• Demonstrate changes in practice or procedures which may save future lives.

2.7.   Inquests held with a jury

Usually, an inquest is held before a Coroner alone. However, the Coroner also has the power to call a jury, if the following circumstances apply:-

- if a person has died in prison or police custody
- Any death involving the Health and Safety Executive e.g. if a person is fatally injured at work
- Any death on a railway line
- Where it would be in the public interest
- if a person dies in suspicious circumstances e.g. in a hospital or care home
- if a person dies due to a notifiable disease
- If a person dies as a result from the act or omission of a police officer
- If a person dies following detention under the Mental Health Act
- If a person dies from poisoning or exposure to a toxic substance
- If a person dies as a result of a medicinal product, controlled drug or psychoactive substance
- If a person dies a violent, trauma or injury
- If a person dies as a result of self-harm
- If a person dies as a result of neglect or self-neglect
- If a person dies as a result of a treatment or procedure of a medical nature
- If a person dies as a result of a disease attributable to any employment within the deceased's lifetime

Where an inquest is held with a jury, it is the jury that decide on the conclusion under direction from the Coroner. The jury may put questions to witnesses via the Coroner. Other than on these two points, there is little difference between inquests held with or without a jury.

During a jury inquest, you must not speak to any member of the jury. If you know any member of the jury in a personal or professional capacity, you must inform your claims manager or the coroner's officer immediately. You must not do anything that could identify a member of the jury to the public or media. You must not photograph any member of the jury either inside or outside the court building.

2.8. Coroner's Conclusions (previously known as Verdicts)

At the conclusion of the evidence the Coroner will sum up the facts. If there is a jury the Coroner will direct them on the law. No one else is entitled to address the Coroner on the facts (including any legal representatives present). It is only permissible to address the Coroner on matters of law. All conclusions are dealt with to the civil standard of proof, or on "the balance of probabilities" (i.e. more likely than not), except for conclusions of unlawful killing and suicide where the criminal standard of 'beyond all reasonable doubt' applies.

The Coroner does not decide if someone is responsible for the death but he does give a conclusion relating to the death. There is no definitive list of conclusions available to a Coroner, however the following are the most commonly found:

- accident or misadventure;
- industrial disease;
- dependence on drugs/non-dependent abuse of drugs;
- attempted/self-induced abortion;
- disasters subject to public inquiry;
- lawful killing (such as deaths caused during acts of war, or self-defence);
- unlawful killing;
- suicide;
- open verdict (where there is insufficient evidence for any other verdict).
- natural causes (including fatal medical conditions);
- alcohol/drug related death, and
- road traffic collision.

Following an inquest, the Coroner, or a jury, can reach one of the above conclusions (formerly known as a verdict), once satisfied of the necessary facts that meet the required standard of proof.

2.8.1. Narrative conclusions

The use of narrative conclusion(s) is increasingly common. The Coroner will often choose this form of conclusion to make the sequence of events clearer for the family, and can also use the narrative where shortcomings of care have occurred. This conclusion sets out the facts surrounding the death and includes an explanation in relation to the conclusion reached relating to the death.

Clarifications: Accident implies something over which there is no human control (e.g. a fall) whereas misadventure suggests a lawful human act (e.g. an operation) which takes an unexpected turn and leads to death. If the deceased had a life threatening condition which was either exacerbated by medical treatment or allowed to progress, then the death may be considered to be by accident or misadventure. If, however the death was caused by the underlying disease that proved fatal then natural causes would be the conclusion.

Whilst the list of conclusions above, are helpful, the Coroner is not bound by the list. This means that provided the Coroner can form a conclusion which is concise and indicates how the deceased came by their death, a narrative verdict is acceptable. In more serious narrative conclusions, the Coroner may find the following:-

Gross Failure

A gross failure is a failure which is more than a basic failure.

Neglect

The Coroner does not imply negligence. It has a narrow, specific meaning – much narrower than the duty of care in the law of negligence. It is not to be equated with negligence or gross negligence.

The Coroner can add a rider of "neglect" to the conclusion where it is felt that there was a missed opportunity or gross failure to provide medical attention. There must be a clear connection between the neglect and the cause of death on "the balance of probabilities". Neglect often occurs from a breakdown in communications rather than a deliberate act, e.g., neglect is concerned with the consequences of, for example failing to make simple ("basic") checks or do something the patient very obviously needed. It can mean a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration). Failure to provide medical attention for a dependent person whose physical condition is such as to show that he/she obviously needs it may amount to neglect.

The critical point is "the opportunity of rendering care…which would have prevented death".

It is not enough to show that there was a missed opportunity to render care which might have been made a difference; it must be showed that care should have been rendered and that it would have made a difference and saved or prolonged life.

The Coroner is, however, unable to apportion any blame or civil or criminal liability of another individual (as defined by section 10(2) of the Coroners and Justice Act 2009).

Unlawful killing: is extremely rare, but the consequences are very serious. It is very unlikely but you should be aware of this potential conclusion. In this situation the Coroner, or your legal representative, will inform you when you do not need to answer a question due to the risk of self-incrimination.

The Coroner cannot apportion blame to a named person of criminal liability, but will state that the deceased was unlawfully killed, without making reference to an individual. The Coroner will refer the case to the Crown Prosecution Service (CPS).

2.8.2. Schedule 5

Recently the Coroner is serving more Schedule 5 notices on NHS organisations, this has included Schedule 5 Notices served on the Trust. Please do not under-estimate the seriousness which a Coroner will take in respect of any lack of co-operation and the loss of liberty staff potentially face if they decide to disregard a Coroner's Order.

Schedule 5 of the Coroners and Justice Act 2009 gives Coroners the power to require evidence to be given or produced as follows:

- At the inquest by giving evidence and producing any document in the person's custody or under their control relating to a matter relevant to the inquest.
- Providing a written statement during the investigation (previously provision of statements was a voluntary matter)
- Producing any documents or other items relevant to the investigation
- The exemption of privileged material that would not be required to be disclosed in civil proceedings.

When issuing a Schedule 5 Notice, the Coroner will:-

- (a) explain the possible consequences, under paragraphs 6 and 7 of Schedule 6, of not complying with the notice;

- (b) indicate what the recipient of the notice should do if he or she wishes to make a claim under sub-paragraph (4).

- A claim by a person that—

- (a)he or she is unable to comply with a notice under this paragraph, or

- (b)it is not reasonable in all the circumstances to require him or her to comply with such a notice, will be determined by the Coroner, who may revoke or vary the notice on that ground.

The Coroner may decide whether to revoke or vary a notice on the ground mentioned in sub-paragraph (4)(b), but must consider the public interest in the information in question being obtained for the purposes of the inquest or investigation, having regard to the likely importance of the information.

For the purposes of Schedule 5, a document or thing is under a person's control if it is in the person's possession or if he or she has a right to possession of it.

To be effective, these powers require the Coroner to serve a formal notice on the Trust that also sets out the consequences of not complying. There is an opportunity to respond and explain that compliance is not possible or is unreasonable, following which the Coroner then makes a decision after considering the importance of the information and

the public interest. A document is in a person's custody whether they are in possession of it or merely have a right to possession of it.

Intentional suppression or concealment of a document believed to be relevant, or its alteration or destruction, can result in criminal sections, including a fine or imprisonment.

The Coroner has wide ranging powers and clearly take great care and consideration when dealing with disclosure issues. It is important that early legal advice and intervention is sought in cases which are likely to result in an inquest and subsequent civil claims.

Article 23 of the General Data Protection Rules provides information on what restrictions apply when providing information in relation to disclosure. In inquests where a Schedule 5 notice has been served, individual rights are suspended insofar as the provisions correspond to the rights and obligations highlighted in Articles 12 to 22. A Schedule 5 notice therefore allows for the usual rights and obligations to be suspended in the interests of public security, for the prevention, investigation, detection or prosecution of criminal offences or the execution of criminal penalties, including the safeguarding against and the prevention of threats to public security, including other important objectives of general public interest, including the protection of judicial independence and judicial proceedings; the prevention, investigation, detection and prosecution of breaches of ethics for regulated professions;

3 WITNESS STATEMENTS

3.1. Role as a Witness

The Coroners and Justice Act 2009 conferred on Coroners the power to require a witness e.g. a clinician, nurse, police officer etc. to provide a written statement and to call a witness to appear at an inquest to give evidence.

The Coroner may, however, require a statement to be provided by any person he/she feels may have information relevant to the investigation. If a person does not provide a statement when requested by the Coroner without good reason, they could be issued with a fine of up to £1000.

The Coroner may write directly to a person instructing them to give a statement, or they may ask the police or the Trust to collect statements from staff.

Once a Witness Statement has been produced, the Coroner will consider the content to consider if the witness is required to attend the hearing.

A Witness Statement is a legal document and is disclosable in law. It is important to remember that what is stated in a statement is also disclosable to the public, as inquests are in the public domain and may be relied upon by third parties in any future public or media interest and in relation to any prospective claim or criminal investigation.

It is therefore important that time is taken to prepare a statement. The Coroner is generally seeking factual evidence of the witness' involvement and it is worth remembering that a statement will be a reflection of professional duty and standing. Statements are also an important source of information for others to understand what has happened. If they are drafted shortly after an incident, while events are still fresh, a statement can be seen as critical evidence concerning an incident.

A witness should refer to the relevant documents and records before starting the preparation of the statement. This is to refresh the memory or acquaint oneself with the deceased's history. A witness may be called to give first hand evidence of the involvement or care of the deceased. Alternatively, a witness may be asked to comment as the "leader of the team". If so, this should be made clear that this is the purpose of the statement that is being provided with the knowledge and understanding e.g. via colleague comments and review of case notes.

When preparing your witness statement, please bear in mind the following points:

☐ Assume no medical or specialist knowledge on the part of the reader or the Coroner. A witness should explain all business, medical or industry terms and abbreviations.

☐ Focus on the factual issues and prepare the statement on the basis of a chronological (numbered) outline of the facts.

☐ It is vital that a witness statement has a logical order with a start, middle and ending must not be influenced by others. The statement should be easy to read and a reflection of the professional standing and the capacity in which it is being written.

☐ The statement should use numbered paragraphs, be typed and prepared on 1.5 line spacing. There are certain formalities in respect of a proper heading and a statement of truth at the end is required, attesting to the truth of your witness statement. (*Appendix 1).*

All witness statements will need to be verified by a statement of truth. By signing the statement, the witness attests to its truth. If it transpires that there is any information included by the witness which is not truthful, the witness may be found to be in contempt of Court. There are new rules regarding this. Any false misrepresentation is now a criminal offence and may lead to prosecution and imprisonment.

3.2.   Internal investigations

It is important to be aware that statements given for any other purpose are potentially disclosable to the Coroner. For example, a statement given as part of a root cause analysis investigation could be required as evidence by the Coroner. If you are writing a statement for any purpose regarding a person's death, you should bear in mind that it could be used as part of the inquest process.

3.3.   Concerns regarding the submission of evidence

A witness must not leave any concerns to the last minute or until the day of the inquest hearing. If a witness has any concerns regarding evidence, or have concerns regarding any of the following points, please escalate to the senior manager and inform the Claims Manager immediately:-

- The care provided
- The quality of care provided
- The treatment or lack of treatment provided
- The conduct of others
- Systems in place

A witness has a professional obligation to bring these to the attention of the relevant managers who will be responsible for invoking internal governance procedures.

The Trust has a responsibility to investigate any concerns or issues in line with its Quality and Safety arrangements outside of the inquest process. The outcomes of such may be of relevance to the Coroner and, if so, will be made available to the Coroner.

If a witness is unable to recall or remember something, this must be stated. A witness must not leave a gap in the evidence, e.g. "*I don't remember this specific patient as I see around 40 patients each day, but my normal practice is to check the patient's previous medical history before the examination*"

3.4.   Changing a Witness Statement

We are all human and a witness may remember something later and want to make a change to the statement. Normally these will be factual inaccuracies. This is acceptable.

A witness may revise a statement, informing the Coroner where the amendments have been made. A witness must not cross out whole chunks of the statement and scribble over the original. Information that is crossed out or illegible invite further challenge.

When altering a statement, the witness must make sure of the following:-

1) make it clear what is being altered and why
2) strike through in red what is being amending or added in red.

3) Ensure any alterations made are clear, initialled and signed, to show where the amendment or addition has been made.

Alternatively, the witness may produce an addendum or supplementary statement explaining the changes made.

3.5. What happens to your statement?

Although a Witness Statement is prepared for the Coroner, it must be assumed that others outside the organisation will see it, as it is a public document. This is likely to include the family and other interested persons, who may be present at the inquest. It is good practice to write a statement knowing that family, lawyers, press and other interested parties may see it. In rare circumstances, it is possible the statement will help to inform civil or criminal proceedings and therefore, it is always advisable that a witness retains a copy of the signed statement for future reference.

3.6. Witness Summons

A witness may either be required to give a statement which will be read out at the inquest or may be called to give evidence in person. Every effort is made to request that witness evidence is read out orally at court by the Coroner, however, this is very much in the Coroner's direction and cannot be guaranteed.

The Coroner has the legal power to require you to give evidence at an inquest. If you are summoned and you do not attend without good reason, you may be subject to a fine of up to £1000.

The Coroner also has the power to instruct police to find and bring a witness to court if necessary.

Notification to appear as a witness will generally be informal, but a Coroner will usually serve a Witness Summons. Summonses are issued under the Coroner's common law powers and are governed by the directions set out in the Civil Procedure Rules.

Coroners have the ability to issue two types of summonses:

➢ requiring attendance to give oral evidence and
➢ requiring attendance to produce documents

A witness cannot refuse to be a witness or attend court unless in exceptional circumstances, with the permission of the Coroner. Once sworn in, a witness may refuse to answer any questions put to them on the grounds of self-incrimination (Rule 22 - Coroners (Inquests) Rules 2013.

The Coroner may consider receiving witness evidence in another way, such as via video link, or rearranging the inquest. Ultimately, the Coroner has the legal power to compel a witness to attend. If you receive a witness summons, you should let your line manager and Claims Manager know as soon as possible so they can provide you with support and ensure that you are released from your normal duties to attend court.

3.7. Order of witnesses

In multi-witness inquests, the coroner may issue a provisional running order which sets out on what days he/she expects to hear from each witness. This is subject to change as the inquest progresses and a witness may be told to attend earlier or later than indicated in the running order. A witness must be available to attend on any of the days indicated in the summons letter. For example, you may receive a summons letter for a 5 day inquest but be told that you are provisionally required on day 3. You should plan to attend court on day 3, but you may be told to attend on day 2, if the inquest is progressing more quickly than expected.

4   PREPARATION FOR INQUESTS

Giving evidence at a Coroner's court can be a daunting prospect, but there are some simple steps to help with your preparations. Make sure you read through your statement ahead of the inquest so you are familiar with the content. Sometimes cases can take months or even years to come to inquest, so it may have been a long time since you wrote your statement.

Make sure you have a copy of your statement to have with you while giving evidence. If there has been an internal investigation, make sure you have read this and are aware of any actions taken. If the Trust is being legally represented at the inquest, the solicitor or barrister will normally arrange to speak with you in the week or two before the inquest. You will be given access to a copy of the medical records to refer to while you are giving evidence. The Coroner will not expect you to have memorised every detail of blood tests or observations, but you should ensure that you are familiar with your involvement with the patient.

4.1. Legal Representation and Interested Parties

In a Coroner's inquest, there is no prosecution or defence as you would see in a criminal trial and nobody wins or loses as you would see in a civil trial.

Legal representation depends on the circumstances of each case. The Trust will usually be aware as to whether the family are legally supported or not and will guide you throughout the process.

It is sometimes assumed that any contact with inquests or litigation needs the involvement of your medical defence union. Unless you are employed as a contractor, you do not need to inform your medical defence union, unless you wish to do so. However, if you wish to contact your medical defence union for additional legal support or are uncertain what to expect and desire further guidance, medical defence unions will often liaise with the Trust to give you further support should you require it.

The inquest will involve a number of people/organisations that are known as 'properly interested persons'.

The Coroner will decide ahead of the inquest who is a properly interested person. Examples of properly interested persons include:

- The deceased's next of kin
- The Trust, if the deceased was in hospital or received treatment around the time of the death
- The Ministry of Justice, if the death occurred in prison.

Each of the properly interested persons can choose to instruct legal representation at the inquest if they wish. This could be a solicitor and/or a barrister (sometimes referred to as 'counsel'). The Trust does not have legal representation for every inquest and this is decided on a case by case basis. Factors involved in the decision include:

• The number of Trust witnesses who are called to give evidence

• Whether the deceased's family are being legally represented

• The findings of any internal investigation

• Whether the inquest is being held with a jury

• The likelihood of issues of law arising during the inquest.

The Trust does not have its own solicitor. Legal representation is provided by NHS Wales Shared Services Partnership if required.

In very rare situations, if a legal conflict arises between an individual staff member and the Trust that means they cannot be represented by the solicitor/barrister acting for the Trust. This would only occur in circumstances such as a serious breach of policy, a

criminal act or a conflict regarding key facts. The staff member would be advised to arrange their own legal representation for the inquest.

What is more common however, is for the family and friends of the deceased to attend and to be present throughout the inquest. This may be distressing for those who have been called to an inquest to give evidence as, understandably, the family or friends may be grieving the loss of their loved one and may be emotional.

As an inquest is a public hearing, anyone has the right to attend the inquest; therefore, if those who are called to an inquest feel they may benefit from support, they are able to bring a family member, friend, work colleague or work manager with them. Additionally, the inquest may attract members of the press and media coverage, which may also be distressing for some. However, the press and media do have a code of conduct and ethics to follow when reporting on an inquest.

4.2. Giving Evidence at the Hearing

➢ Arrive promptly and dress smartly
➢ If you have provided a statement/report to the Coroner, read it carefully before the Inquest and take a copy with you.
➢ Familiarise yourself with the medical records and ensure that you are able to refer to relevant points at the Inquest – use tabs if necessary.
➢ When it is your turn to give evidence, the Coroner will call you to the witness box. The Coroner's officer will ask you whether you want to take an oath or affirmation, if they have not already checked beforehand. The officer will hand you the relevant holy text if applicable and ask you to read the oath or affirmation from a card.

➢ Once the oath or affirmation has been given, the Coroner will invite you to sit down. In the witness box will be folders which contain copies of any relevant documents. It is a good idea to take a copy of your witness statement into the witness box as it is easier to have it to hand. The Coroner will normally begin by asking you to confirm your name, professional qualifications and how long you have been in your current role. The Coroner may ask you to confirm that your written statement is true to the best of your knowledge. There is no set way in which the Coroner has to take your evidence, but normally the Coroner will ask you to explain your involvement with the deceased. The Coroner may also ask you to read sections of your written statement and ask questions specifically regarding your involvement.

➢ Speak clearly when giving your evidence.

➢ Listen and answer the question asked.

➢ If you do not understand a question, ask for it to be repeated or clarified.

➢ Do not be afraid to tell the Coroner that you do not know the answer to a question, or refer to the medical records to refresh your memory.

➢ Do not answer a question outside your area of expertise/knowledge; or about an event which you are unable to recall, or were not directly involved.

➢ Try to avoid using medical jargon. If you do refer to medical terms, provide an explanation so that a lay person can understand.

➢ Be prepared for possible media interest. Journalists often attend inquests and take notes.

You may also be asked questions by legal representatives of Interested Parties or by the Interested Parties themselves and also by members of the jury. The Coroner usually asks questions first. Once you have provided your evidence, the Coroner may then permit you to leave the stand and also, the inquest, if permissible.

Be mindful of the use of medical language during the inquest and ensure that every attempt is made to answer questions using plain English.

The length an inquest may last may vary, depending on the circumstances of a death. If the circumstances are less complicated, an inquest can last a couple of hours or even less. If however the circumstances of death are more complicated then the inquest could last days or even weeks. The length of inquest may also depend upon the Coroner.

Once all evidence has been heard and questions asked, the Coroner will sum up what has been found. After this, the Coroner or jury will give their conclusion/verdict. The inquest is not a criminal trial; therefore the conclusion will not place any civil or criminal liability on a person or organisation.

4.3. Remote hearings

Due to current Covid-19 guidance, many inquests and associated hearings are being held remotely. Witnesses, solicitors and families attend virtually using videoconference services such as Microsoft Teams or Skype.

If you are required to attend an inquest remotely, detailed guidance will be provided by the Coroner's Office. The following key points apply regardless of the videoconference service used:

• Make sure you are in a quiet place where you will not be interrupted.
• Ensure that you have all relevant documents available, such as copies of notes and your witness statement.
• You will need to use a device with both a camera and microphone. Use headphones to avoid feedback/echo which can disrupt proceedings.
• You must only speak if invited to do so by the Coroner. Do not interrupt or interject during the hearing; wait to be invited to speak.
• If you have questions during the proceedings, please make a note of these and ask the Coroner when asked. He, or she will let you know when the right time arises to ask questions.
• Only one person may speak at a time. If another person is speaking, please do not interrupt. The Coroner will let you know when it is the right time to speak. Under no circumstances should you, or anyone with you record or otherwise re-broadcast the inquest. This is illegal and will be treated as a contempt of court.

4.4. Testifying/Affirming
If you are giving evidence remotely at the inquest you need to swear on a book of faith or affirm. If you wish to swear on a book of faith, you need to ensure that you have the book with you at the start of giving evidence.

4.4.1. Testifying by Holy Text:
"*I swear by Almighty God that the evidence I shall give shall be the truth, the whole truth and nothing but the truth*".

If you are not swearing on a book of faith, you will need to testify as follows:-

4.4.2. Affirming
"*I solemnly and sincerely declare and affirm that the evidence I shall give shall be the truth, the whole truth and nothing but the truth*".

4.5. Court Day Checklist

• Ensure in advance that your clinical duties will be covered by a colleague. This may need discussion with the consultant, Medical/Clinical Director and/or your Educational/Clinical Supervisor.

- Travel arrangements: Allow plenty of time for delays and have change for parking if you are travelling by car.
- If travelling with a colleague have a contingency plan for getting home in case you are giving evidence at different times.
- It is important to ensure that you have a copy of your statement to which you can refer.

4.6. Post Evidence

You are normally free to leave after you have completed giving evidence. However, you may wish to stay to hear the conclusion as you may find this helpful.

If the Coroner makes recommendations in relation to their findings, you may wish to reflect on how this may influence your practice. After court you may feel tired and emotionally drained. A debriefing after the hearing may be arranged to discuss the outcome and your input at the hearing. You may also wish to discuss the outcome with your Educational/Clinical Supervisor and/or Clinical Mentor and record this in your portfolio as learning point(s), if required.

5   MEDIA INTEREST

5.1. Reporters are aware that they are often dealing with people at a deeply distressing time and that finding a balance between sensitivity and accurate reporting is essential. There is also a public interest in making clear the circumstance surrounding a person's death.

There are three main reasons why there can sometimes be media interest:-

1. For justice to be done, it must be seen to be done – in this regard a coroner's court is no different to any other court of law.
2. Reporters have a duty to ensure that hearings are a matter of public interest and that all cases are treated fairly and with respect.
3. It is in the public interest in reporting inquests to ensure that lessons can be learned and that others avoid the same situation.

5.2. Independent Press Standards Organisation

The independent press standards organisation (IPSO) gives advice for journalists reporting on inquests, it says: "*Newspapers might report on inquests for a number of reasons – to make sure that the public understands how and why a person has died; to draw attention to the circumstances of a death, in the hope that this will prevent other such deaths in the future; or to clear up any suspicions about a person's death.*"

5.3. Photography

Photography is not allowed inside the court room or court building. The media may photograph or film you entering/leaving the building or on any public land such as the surrounding streets. The media do not need your permission to do this.

5.4. Contact from the Media

If you are contacted by the media, do not enter into conversation or discussion but politely decline e.g. state "no comment" and inform the communication team who will handle sensitive and legal issues appropriately.

6   CORONER'S PREVENTION OF FUTURE DEATHS REPORT

Occasionally there will be serious findings in a conclusion which contain future implications for the Trust. The Coroner can issue a Prevention of Future Deaths Report, previously known as a Rule 43 report, to a Trust or another body, indicating a need for corrective action to prevent a future death. The Coroner *must* make a report to the relevant person in the belief that they have the power to take action.

6.1.   Regulations 28 and 29 Coroners (Investigations) Regulations 2013, sets out the procedure that apply to reports and responses.

6.2.   Following a section 28 Prevention of Future Deaths (PFD) report, the Trust must investigate and report any resultant changes in practice /procedure, which would help to prevent a future recurrence. An organisation has 56 days from receipt of the notification of a future deaths report to respond with a written response and provide the remedial action taken to prevent a future death.

6.3. Prevention of Future Deaths reports and responses are recorded by the Coroner and published in the annual Chief Coroner's Report.

6.4. There is no automatic right of appeal of the conclusion of a Coroner's court. It is inevitable that some parties maybe aggrieved by the conclusion and seek to have this overturned. This is effected by way of a judicial review or by application to the high court. This would only be done in exceptional circumstances if there has been a serious error of law. This is not a re-hearing of the facts; the review hears the specific application that the matter was dealt with in a manner that was unlawful, procedurally unfair and/or irrational. A successful review may result in a re-hearing but would not substitute a conclusion.

7 Trust Support and Clinical Mentoring

7.1. Being involved in an inquest creates understandable anxiety. It may be an unpleasant experience, for both witness and family. The Trust's claims and inquest manager will help to co-ordinate statements and will be familiar with the process and give appropriate advice. It will be normal practice to have a Trust pre-inquest preparatory meeting to review statements and give advice on giving evidence and the inquisitorial process, including post inquest debriefing.

7.2. Clinical staff giving evidence will also be able to seek additional support from a clinical mentor, who will be assigned to you, should you require this. The clinical mentor may have given evidence before and will understand your concerns and anxieties and will be available to support you throughout the process, in addition to the Claims and Inquests Manager.

7.3. If anxiety is turning into overt stress then support is available from your Occupational Health department, your clinical mentor, educational supervisor, Medical and/or Clinical Director/Head of Nursing, who will also provide additional support and assistance.

Flowchart 1 – Witness Statement request   *Appendix 1*

Velindre University NHS Trust	Inquest Guidance & Protocol – Getting it Right First Time

Notification from HMC requesting statement

Claims Manager acknowledges HMC request and opens Datix ID

Claims Manager identifies witness and request statement. Offer meeting

Claims Manager notifies directorate

Directorate to offer additional clinical mentoring to support clinical staff

Claims Manager will request patient/donor records

Claims Manger will meet with witness/relevant staff to discuss process, and address any queries

Claims Manager to liaise with HMC re inquest details/jury service requirement and consider instructing L&R

Claims Manager submits copy records and relevant documentations to HM Coroner

Clinicians to produce draft statement within specified timeframe for review by Claims Manager

Claims manager review and iterate statement, working with clinician

Claims Manager identifies any issues and escalate to senior staff for review/discussion and next steps – consider instruction of L&R if necessary

Witness statement to be signed and returned to Claims Manager

Learning Assurance

Any learning identified to be addressed by directorate leads prior to inquest hearing

Claims Manager to seek directorate approval prior to submission of Witness Statement

Claims Manager to submit Witness Statement to HMC within specified time frame

Flowchart 2 – Witness Summons issued   *Appendix 2*
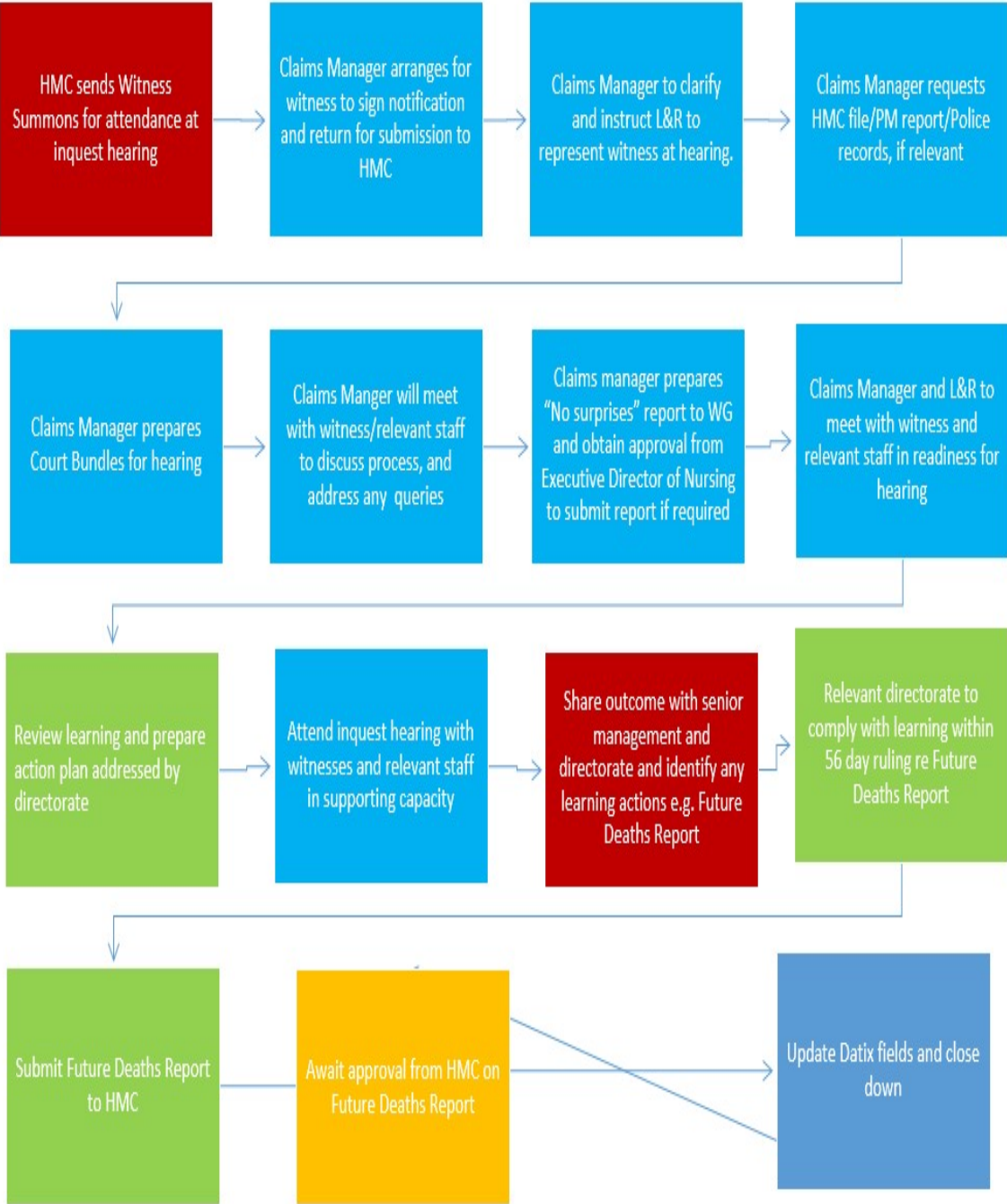
Appendix 3

CORONER'S STATEMENT

TEMPLATE STATEMENT GUIDE

Ref:

Date:

Report for: e.g. Statement for Her Majesty's Coroner in the Inquest Touching the Death of [Joe Blogs]

Dear Sir,

RE: Patient's Name: (dob:) Patient's Address:

1) Write your statement in first person.
2) Set out your full name, your work address, your current post, your post and level at the time of the incident in question, and details of your qualifications.

2) Set out details of where you worked, either unit or team, and explain the nature of the ward/team and the patient group that you worked with. If it is a ward please set out its size and the type of patients on the ward – including whether under Section or not and whether any specialist services are provided.

3) If appropriate please set out details of your role on the ward/team, e.g. do you have primary nurse responsibility, are you a manager, do you participate in multidisciplinary team planning and so on. If you were under supervision, you should say by whom.

4) Please set out details of your earliest contact with the patient. Ensure you refer to the medical records – if this is not possible you should state this. If you use an abbreviation, this should be explained fully and a translation provided. Set out dates and times in full using the 24hr clock, e.g. 1300hrs on 27.06.11 – not 1 on 27/6.

5) Then set out the story - in chronological order, and in first person (I did this …). Say what your involvement was – what you did, what you heard, what you saw (other

witnesses can explain their own involvement), include details of your subsequent contact with the patient, your interaction with them, and/or relevant others. If you made a decision jointly, set this out e.g. "…… and I agreed that I should do this ……"

6) A statement should be factual, and you should avoid providing an opinion.

7) When referring to others use their name and job title. If protocols or standard procedures are relevant, you can refer to these in your statement – and attach a copy if you have one. Any attachments should be marked as an exhibit (e.g. with your initials and a number) and referred to in the statement.

8) As far as possible be clear when you have witnessed events, or if you have been given information, and set out the source of it.

9) If you refer to specific information in the records and/or a report of some kind then please identify this by date. Sometimes it is helpful to have a transcript of those notes incorporated into your statement. Sometimes a diagram/illustration will help you explain - these can also be incorporated into your statement.

10) Insert a 'Statement of Truth' – i.e. attestation clause

I believe that the facts stated in this statement are true. I understand that proceedings for contempt of court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth

SIGNATURE

DATE

Appendix 4

Example: Attestation Clause

At the end of your statement you must sign and date your witness statement by hand or by electronic signature. Typing your signature is not sufficient.

Signature: *Joe Bloggs* Full Name: Joe Bloggs Date of Signing: 28/12/2022	Signature: *Joe Bloggs* Full Name: *JOE BLOGGS* Date of Signing: 28/12/22

✓ **Hand signed and scanned**   ✓ **Electronic signature**

Signature: Full Name: Date of Signing:	*Joe Bloggs* Joe Bloggs 2812/2022

✗ **Typed signature**

By signing your statement, you are confirming that it is true to the best of your knowledge. If you knowingly make a false statement, you could be liable to prosecution and potentially imprisonment

Velindre University NHS Trust	Inquest Guidance & Protocol – Getting it Right First Time

Appendix 5

Witness Summons

If you have been asked to give a statement by the coroner, or if you have been involved in the care of a patient whose death is being investigated by the coroner you may be called to give evidence at inquest. If you are called to give evidence in person, it does not mean that you have done anything wrong. The coroner alone decides who he/she needs to hear evidence from in person at the inquest.

If you are called to give evidence at inquest you should receive a summons letter either in the post or more commonly, via email. You must complete and return the reply slip to the coroner's office as soon as possible. There is no minimum notice that the coroner has to give to summon you to give evidence, however most witnesses are notified at least a few weeks ahead of the inquest. The summons letter will explain when and where the inquest will take place, and for how long you must be available. Some inquests may only last a few hours other more complex inquests may last a week or longer

GRAEME HUGHES

HER MAJESTY'S
SENIOR CORONER

SOUTH WALES CENTRAL CORONER
AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

Telephone: 01443 281100
Facsimile: 01443 485862
Email: Coroneradmin@rctcbc.gov.uk
www.southwalescentralcoroner.co.uk

To: Dr

Date: x

Ref: x

NOTICE REQUIRING EVIDENCE TO BE GIVEN

Paragraph 1 of Schedule 5 to the Coroners and Justice Act 2009

Inquest touching the death of xx.

I hereby give notice that you are required to attend to give evidence at an inquest on **xx 2022 at xx hours** at Merthyr Coroner Court, xx

If you consider that you are unable to comply with the terms of this notice or consider that it would be unreasonable to require or compel you to do so, you must make representations to the Coroner. Any claim made will be considered by the Coroner, who may revoke or vary the notice.

If you fail to comply with the terms of this notice, without reasonable excuse you may be liable to a fine not exceeding £1000. (Paragraph 6 of Schedule 6 to the Coroners and Justice Act 2009).

If there are any documents relevant to your evidence e.g. the medical records or Police PNB, please ensure that you bring these to the hearing even if you have already provided a statement.

Inquests are formal judicial proceedings, which are held in a court room before a Coroner. Please be mindful of this at all times.

When attending an inquest:

- **PLEASE DO NOT ATTEND IF YOU ARE UNWELL.** If you or anyone you live with have had any symptoms, particularly fever or a new, continuous cough, in the last 14 days, please remain at home as per government advice.

- On arrival you will be directed to a form of declaration that you will be required to complete before accessing the building. Access will not be permitted unless, & until the declaration has been completed by ALL attendees.

- Please ensure that you arrive on time. Due to the restrictions in place we will only be able to let people into the building at certain specific times so you **must** be there in time to be admitted. If you are running late, please call the designated number:

- Once inside the building, please follow the signage to the court room. Please sit in the designated areas. There will be signs to indicate this.

- No food or drink is permitted in the court room.

Signature:

Sharon Pugh

pp Graeme Hughes
Senior Coroner
South Wales Central

WITNESS RESPONSE TO NOTICE

To: Pontypridd Coroner's Court
       Courthouse Street, Pontypridd
       CF37 1JW

Ref: 23219

In response to your witness notice,

I xx will attend on xxx **2022 at xxx** to give evidence at the Inquest touching the death of xx

Should the Coroner be happy for you to give your evidence remotely, you will be advised by the Coroner's Officer managing the hearing. Should this be an option, please advise whether you would be happy to use Teams to video link to the Courtroom

I am happy to join the inquest hearing by Teams and am aware of the videolink protocol   (please tick)

Witness signature...

Witness telephone number...

Witness email address for Microsoft Teams link to be shared...

Date...

9. Contact Details:

9.1. If you wish to discuss, or have any queries regarding the protocol, please contact:-

Jayne Rabaiotti
Claims, Inquests and Redress Manager
Quality and Safety Department
Velindre University NHS Trust
2 Charnwood Court
Parc Nantgarw
Cardiff CF15 7QZ
Jayne.Rabaiotti@wales.nhs.uk and

HandlingConcernsVelindre@wales.nhs.uk

9.2. For further information:

South Wales Central Coroner South Wales Central Coroner

INQUEST—a charity supporting bereaved people following a death in state care or custody https://www.inquest.org.uk/

Office of the Chief Coroner Office of the Chief Coroner

Ministry of Justice—Guide to coroner services Ministry of Justice Guide

Preparing for an Inquest and giving evidence

https://resolution.nhs.uk/resources/how-to-prepare-for-an-inquest/

Quality Safety and Performance Committee

TRUST QUALITY & SAFETY FRAMEWORK & QUALITY PRIORITIES UPDATE

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ENDORSEMENT

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience
PRESENTED BY	Tina Jenkins, Interim Deputy Director of Nursing and Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Trust Board approved the Quality & Safety Framework in July 2022. The plan was to review the framework by March 2024 to reflect the requirements of the Duty of Quality and that this would be informed by an external peer review. A peer review was undertaken by the Quality and Safety Lead at Hywel Dda University Health Board and the review completed by 31st March 2024. Key changes made to the framework are: • Inclusion of the approved Quality Management System • Inclusion of the Duty of Quality and Duty of Candour

Page **1** of **4**

	• Feedback from the peer review included defining your reader (employees), so wording amended to us and we, in the framework to reflect the audience • Enhanced alignment with other newly developed Learning and Incident Management Frameworks. • Inclusion of revised governance reporting structures

RECOMMENDATION / ACTIONS	To **ENDORSE** the revised Trust Quality and Safety Framework for onward Board approval.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
Integrated Quality and Safety Committee	25/03/24
Request to send to both divisional leadership teams for comment.	
Executive Management Board (Endorsed for Approval)	2/04/24

7 LEVELS OF ASSURANCE

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	N/A

APPENDICES

Appendix 1	Quality and Safety Framework

1. **BACKGROUND**

   The Trust Board approved the Quality & Safety Framework in July 2022. The Quality Framework was refreshed in March 2024, to reflect the requirements of the Duty of Quality and the outcome of the Quality & Safety Lead at Hywel Dda University Health Board.

2. **FEEDBACK FROM THE PEER REVIEW**

   The feedback from the external review quality and safety framework peer review is summarized below:

   • Be clear on your intended reader,

- Reorder some sections for easier reading.
- Improve the document flow.

3. **QUALITY & SAFETY FRAMEWORK REFRESH**

Changes made to the Trust Quality & Safety Framework during this review include:

- Inclusion of the approved Quality Management System
- Inclusion of the Duty of Quality and Duty of Candour
- Feedback from the peer review included defining your reader (employees), so wording amended to us and we, in the framework to reflect the audience
- Enhanced alignment with other newly developed Learning and Incident Management Frameworks.
- Inclusion of revised governance reporting structures
- Reordering framework in line with peer review feedback to improve readability and flow.

Following approval of the refreshed Quality and Safety Framework, it will be sent to the publisher for visual enhancement of the document.

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe		☒ ☒ ☒ ☐ ☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information:* *STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
QUALITY AND SAFETY	Select all relevant domains below	

IMPLICATIONS / IMPACT	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	The Quality Framework is an enabler for the delivery of the 6 domains of quality and the 6 enablers
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Update report
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There are significant financial implications on the Trust if this framework is not implemented as it will increase the likelihood of patient harm which has associated costs
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	An equality impact assessment not required on the framework refresh and no changes would have any impact on protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	The Duty of Quality is a legislative requirements implementation of which will be enhanced through this revised framework

Quality, Safety and Performance Committee

Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act (2016) – for National Reporting

DATE OF MEETING	9th May 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Anna Harries, Head of Nursing, Professional Standards and Digital
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science
EXECUTIVE SUMMARY	This paper is to provide the Quality, Safety and Performance Committee with the assurance that all statutory requirements of the Nurse Staffing Levels (Wales) Act 2016 are being met. This report provides the position from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly reports that go to Boards in May 2024 will only include data relating to serious incidents closed by 31st January 2024. This report also provides the 2023/24 annual information that, due to timelines has not been reported separately. The report highlights that: • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for the one Velindre Cancer Service 25B area: First Floor Ward. There are no financial concerns in relation to the staffing of this area. There has been no change in the planned roster

	since 2022. • The First Floor Ward establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse coordinator also remains surplus to the planned roster on each day shift. • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 (2022/23) to 88.2% in Year 3 (2023/24). • ***There has been no reportable harm in relation to the quality indicators during the 3-year period in respect of nurse staffing levels on the First Floor Ward.*** • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act. • The October 2023 establishment review process highlighted three 25A areas where it was deemed the establishment was insufficient to provide sensitive care to patients: SACT, Clinical Nurse Specialist Team and Assessment Unit. A detailed financial oversight meeting in respect of these areas took place on the 16th April 2024 where detailed financial information was considered. It was concluded that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist (CNS) Team. A CNS review has been undertaken and a development plan instigated. Due to the work plan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **DISCUSS** the 3 yearly assurance report 2021 - 2024 and **ENDORSE** the report prior to submission for onward approval to the Trust Board prior to submission to Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nurse Forum	07/03/2024
EMB	02/04/2024
EMB	29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Executive level consideration in respect of headroom in the identified 25A areas. Endorsed for onward approval	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full *In respect of 25B area*

1. **BACKGROUND**

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:
- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and;
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

Section 25B of the Nurse Staffing Levels (Wales) Act 2016 requires organisations to have sufficient staff to provide appropriate patient centred care. Section 25A places a duty on Health Boards/Trusts to take due regard to have sufficient nurses to allow nurses time to care sensitively for patients wherever nursing services are provided or commissioned.

Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and paediatric inpatient wards.

This report provides the position from the 6th April 2021 to the 5th April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly reports that go to Boards in May 2024 will only include data relating to serious incidents closed by 31st January 2024. A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September

2024 and then Welsh Government in October 2024.

There is only one area of the Trust that sits under the requirements of 25B of the Act, First Floor Ward at Velindre Cancer Service. This was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act (2016).

Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out 6-monthly utilising a triangulated approach.

2. **ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION**

2.1 *Nurse Staffing Levels Act Reporting*

Section 25E of the Act states that for each three-year reporting period, Health Boards/Trusts with wards where section 25B of the Act is applicable must submit a report outlining the extent to which nurse staffing levels have been maintained.

The three-yearly report is attached. This report highlights:

- During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022.
- Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for first floor ward (25B area) have taken place using a triangulated approach.
- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor.
- Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.
- There has been no change in the planned roster since 2022.
- The first-floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator

also remains surplus to the planned roster on each day shift.

- The HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023.
- There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 (2022/23) to 88.2% in Year 3 (2023/24).
- There has been no reportable harm in relation to the quality indicators during the last 3-year period.
- There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor.
- All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act.
- Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been undertaken and the nurses have commenced employment (between November 2023 and March 2024).
- The October 2023 establishment review process highlighted three 25A areas where it was deemed the establishment was insufficient to provide sensitive care to patients: SACT, Clinical Nurse Specialist Team and Assessment Unit. A detailed financial review took place on the 16th April 2024. The deficits within SACT are negatively impacting on morale in the 25B area due to the frequent requirement for risk based staff reallocation.

Following the October 2023 establishment reviews a comprehensive review of financial establishment verses required approved rosters was undertaken across all Nursing areas of Velindre Cancer Services by Nurse Leaders and finance colleagues and detailed spreadsheets developed. A meeting was held on the 16th April 2024 where these were scrutinised in detail attended by: Executive Director Nursing, AHP & Health Science; Executive Finance Director, Head of Nursing & Deputy Head of Nursing VCC, Senior Nurse SACT VCC, Deputy Head of Finance Business Partnering and Head of Professional Standards and Digital. The outcome of the meeting was:

- Overall there is sufficient budget currently to cover the establishment requirements and headroom across all nursing areas at VCC with the exception of the Clinical Nurse Specialist (CNS) Team.
- Budgets do require realignment across a number of departments to achieve this and a plan agreed to deliver this.

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- Additional HCSW resource required in some SACT Units to ensure 2 per shift in all units apart from Neville Hall. Only one required there due to unit size. This is now being enacted.
- The CNS review is complete, and a development plan being worked through following discussion with each SST. Significant role review is required as the review identified that, at the time, 40% of time was being spent on non-CNS related work. It is anticipated that it will be Autumn 2024 before the full workforce requirement is known after the job planning and role modernisation work is completed. In the interim, plans are being enacted to two generic CNS roles to the team to increase resilience and provide headroom cover to enhance the service cover pending this work being completed.

2.2   Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that employs registered nurses.   The establishment reviews include all front-line care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and relevant Head of Nursing. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

2.2.1   Current funded establishments
2.2.2   Vacancies and staff in post
2.2.3   Datix Incidents – related to service delivery and staffing
2.2.4   Complaints relevant to establishment or staffing
2.2.5   Training compliance
2.2.6   PADR compliance
2.2.7   Review of Roster
2.2.8   Patient Feedback (CIVICA)
2.2.9   Audits (Tendable)
2.2.10 Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
2.2.11 KPI review
2.2.12 Quality Indicators (25B)
2.2.13 Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents of harm relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the 3-year reporting period.

2.3 Electronic Rostering

Health roster is fully utilised in six nursing areas and for the nurse bank. Rostering Key Performance Indicators (KPI's) are produced electronically which are scrutinised locally to assess rostering efficiency and effectiveness. An overview of these KPI's is also undertaken as part of establishment reviews. Health Roster also facilitates rapid and robust assurance that staffing levels are safe across all nursing areas. These rosters are legible, auditable and viewed in one centralised location for visibility of responsible staff.

3. FUTURE REPORTING

Based on a national review of the Health Boards/Trusts first 3-yearly reports and feedback from operational leads on their experience of completing the reports; a report was presented to the Executive Directors of Nursing & Midwifery and the Chief Nursing Officer for Wales in 2021 requesting a review of the current reporting process. A sub-group of the All-Wales Nurse Staffing Group was set up to improve and refine the reporting process; standardise reporting in line with the Duty of Candour set out in the Health and Social Care (Quality & Engagement Act) (Wales) Act 2020 and broaden the reporting scope of incidences of harm to provide more meaningful data. The findings and recommendations of the Reporting Sub-Group were presented to the Executive Nurse Directors in August 2023 who approved the recommendations to take effect from the next reporting period i.e. 6th April 2024 – 5th April 2025. The agreed quality indicators for the adult acute medical and surgical inpatient wards from 6th April 2024 will be as follows:

- *Avoidable hospital acquired pressure damage (grade 3, 4 and unstageable).*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above from 6th April 2024 will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/complaints not closed and to be reported on/during the next year*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**		
If yes - please select all relevant goals:		
• Outstanding for quality, safety and experience		☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		☒
• A beacon for research, development and innovation in our stated areas of priority		☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.		☐
• A sustainable organisation that plays its part in creating a better future for people across the globe		☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	
	Select all relevant domains below	

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☒
	Timely ☒
	Effective ☒
	Equitable ☒
	Efficient ☒
	Patient Centred ☒
	The Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centered delivery. **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There is a cost implication if additional headroom resources are required for he Clinical Nurse Specialist Team.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for this type of report
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Risk that we cannot deliver timely and sensitive care to our patients if there is insufficient headroom within the Clinical Nurse Specialist Team to provide cover during periods of absenteeism.
WHAT IS THE CURRENT RISK SCORE	9
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Detailed Clinical Nurse Specialist team development work is required to determine the long term required staffing model and headroom requirements
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	March 2025
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Traditional ways of working
All risks must be evidenced and consistent with those recorded in Datix	

`	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Velindre University NHS Trust		
Reporting period	The reporting period is from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly report that go to Board in May 2024 will only include data relating to serious incidents closed by 31st January 2024 (A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024).		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	28/7/2022 P:\board papers\Annual Assurance Report May NSA 2021-2022.docx	25/5/2023 Annual Assurance Report NSL 2023 NT Final.docx	Caveated report to be presented in March 2024 with full report to be submitted in May 2024 Annual assurance report 23-24 ver1.docx
Number of adult acute medical inpatient wards where section 25B applies	1	1	1
Number of adult acute surgical / Paediatric inpatient wards where section 25B applies	0	0	0
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**

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Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	• During the COVID pandemic in 2020 bed capacity was reduced from 32 to 20 beds (to meet required bed spacing standards given patient vulnerability). There was no change in the primary purpose of the ward during this time. Due to the fact that there is only one inpatient ward there was no specific COVID ward. Suspected COVID patients were nursed in cubicles or cohorted to help reduce any spread of infection. • The ward was reinstated to full capacity of 32 beds in September 2022. • Nurse staffing was not a significant problem on the ward during this period due to the reduction in bed capacity.			
Informing patients	• Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period, and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQ's for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. • Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.			

Section 25E (2a) Extent to which the nurse staffing level is maintained				
As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.				

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	Number of wards: 1		
		RN: 23.68		
		HCSW: 23.68		
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards		**2021/2022**	**2022/2023**	**2023/2024**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May)	Number of wards: 1	Number of wards:1	Number of wards:1
		RN: 23.68	RN: 23.68	RN: 28.42
		HCSW: 23.68	HCSW: 23.68	HCSW: 14.21
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle	Number of wards: 1	Number of wards: 1	Number of wards: 1
		RN: 23.68	RN: 23.68	RN: 28.42
		HCSW: 23.68	HCSW: 23.68	HCSW: 14.21

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Required establishment (WTE) of adult acute medical and surgical inpatients wards **calculated** during second cycle (Nov)	Number of wards: 1	Number of wards: 1	Number of wards: 1
	RN: 23.68	RN: 28.42	RN:28.42
	HCSW: 23.68	HCSW: 14.21	HCSW: 14.21
WTE of required establishment of adult acute medical and surgical inpatients wards **funded** following second (Nov) calculation cycle	Number of wards: 1	Number of wards: 1	Number of wards: 1
	RN: 23.68	RN: 28.42	RN: 28.42
	HCSW: 23.68	HCSW: 14.21	HCSW: 14.21

		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	WTE: 1	WTE: 1	WTE: 1

The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor Ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.

The first floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave.
The ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients.

- The planned roster was reduced during the pandemic to reflect reduced bed capacity.
- There has been no change in the planned roster since 2022.
- The band 7 ward manager is supernumerary and not included in the required establishment figures. First floor has a nurse co-ordinator role that is also additional to the planned roster.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

	Total number of shifts	Shifts where planned roster **met** and **appropriate**	Shifts where planned roster **met** but **not appropriate**	Shifts where planned roster **not met** but **appropriate**	Shifts where planned roster **not met** and **not appropriate**	Data completeness
2021/2022	4745	3773 80%	0	972 20%	0	100%
2022/2023	652	414 64%	36 5%	72 11%	130 20%	89%
2023/2024	562	496 88.2 %	18 3.2%	10 1.8%	38 6.8%	93.4%

Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards

Year 1 and 2 data was extracted from the Health Care Monitoring System (HCMS). Year three data has been extracted from SafeCare. SafeCare was fully implemented and has been utilised to record nurse staffing and acuity data since March 2023.

The data highlights a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 88.2% in Year 3. There has also been an improvement in the number of shifts where the planned roster was not met and not appropriate reducing from 20% in Year 2 to 6.8% in Year 3.

Process for maintaining the nurse staffing level for Section 25B wards

There are established risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include:

- Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills.

- Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care.

- Utilising bank and agency.

During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, Velindre University NHS Trust has had to rethink the workforce planning strategy and has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala in India who are currently undergoing their OSCE training in Swansea. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	0	0	0	5
	Year 2	0	0	0	1
	Year 3	0	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	1	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0

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There has been no reportable harm in relation to the quality indicators during the last 3-year period. There have been no complaints or harm caused where nurse staffing levels were considered to be a contributing factor. There were 7 complaints about nursing care which were managed through the putting things right framework: 5 in year one, one in year 2 and one in year 3.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was</u> <u>not</u> maintained in section 25B wards	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g. the utilisation of temporary workforce and using a risk-based approach to redeploy staff. On occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care on the ward. Staff can raise a red flag in SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: - All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. - The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. - Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
Conclusion & Recommendations	- During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022 - Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for first floor ward (25B) have taken place using the triangulated approach - Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor - Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas - There has been no change in the planned roster since 2022. - The first floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift - HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023 - There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 88.2% in Year 3. - There has been no reportable harm in relation to the quality indicators during the last 3-year period - There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor - All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act

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| | • Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated. |
| | • In relation to 25A areas it was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined. |

Velindre Trust NSA 3 yearly report – 2021-2024

![GIG CYMRU NHS WALES / Ymddiriedolaeth GIG Prifysgol Felindre / Velindre University NHS Trust]

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

CHAIR'S URGENT ACTION MATTER REPORT

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	TO CONSIDER AND ENDORSE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Liane Webber, Business Support Officer
PRESENTED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff
APPROVED BY	Lauren Fear, Director of Corporate Governance & Chief of Staff

EXECUTIVE SUMMARY	This report details Chair's Urgent Action taken between the 14/03/2024-02/05/2024. There was one (1) urgent item of business for the Quality, Safety & Performance Committee that was considered via Chairs Urgent Action during this period: 1. Flexible Working Policy No objections to approval were received in respect of the items of business considered.

RECOMMENDATION / ACTIONS	To **CONSIDER** and **ENDORSE** the Chairs Urgent Action taken between the **14/03/2024-02/05/2024.**

GOVERNANCE ROUTE	
QSP Committee Members - via email	27/03/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS
The Quality, Safety & Performance Committee **ENDORSED** the item of business considered via Chair's Urgent Action for approval by Trust Board.

7 LEVELS OF ASSURANCE – N/A

APPENDICES – N/A

1. SITUATION

This paper provides the Quality, Safety & Performance Committee with an overview of key decisions and outcomes considered via Chair's Urgent Action between **14/03/2024-02/05/2024.**

2. BACKGROUND

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

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

3. ASSESSMENT/SUMMARY OF MATTERS FOR CONSIDERATION

The following is a summary of the key outcomes from the item of business considered by the Quality, Safety & Performance Committee via Chairs Urgent Action since the last formal meeting of the Committee held on 14th March 2024:

3.1 Flexible Working Policy

The Quality, Safety & Performance Committee were sent an email and Chair's Urgent Action Report on the **27th March 2024** in relation to the **Flexible Working Policy** that required urgent approval and were asked to:

- **ENDORSE THE ADOPTION** of the All-Wales Flexible Working Policy for implementation in the Trust.

The following approvals were received:

Recommendation Approved by:
- Vicky Morris, Chair of the Quality, Safety & Performance Committee and Independent Member
- Stephen Harries, Independent Member
- Hilary Jones, Independent Member

4.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☐ ☐ ☐ ☐	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	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.	

3

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com /sites/VEL_Intranet/SitePages/E.asp x*	Not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

4

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Medicines Management Group
Update Report October 2023 to March 2024

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Bethan Tranter – Chief Pharmacist Anthony Cadogan – Deputy Chief Pharmacist Usman Malik - Principal Pharmacist, Clinical Services
PRESENTED BY	Bethan Tranter, Chief Pharmacist
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The purpose of this report is to provide assurance that the roles and responsibilities of the Medicines Management Group are being executed in line with accepted current best practices. This report focusses primarily on the work between October 2023 and March 2024.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the **ASSURANCE** this report provides in relation to the ongoing work of the Medicines Management Group in line with its main functions.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC SLT	17/04/24
Medicines Management Group	24/04/24
EMB RUN	29/04/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS VCC SLT received paper. Approved subject to comments back to Chief Pharmacist by 22/04/24. Approved at EMB RUN 29/04/24	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be completed.**	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended

APPENDICES	

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1.   SITUATION/BACKGROUND

The function of the Velindre Cancer Centre (VCC) Medicines Management Group (MMG) is to hold strategic, operational and clinical governance oversight of all medicines management practices within VCC to ensure that medicines are used safely, effectively and in line with accepted current best practices.

In line with the cycle of business for the MMG and Trust Quality Safety and Performance (QPS) Committee, the below assurance report outlines the work of the MMG in the period October 2023 to March 2024.

2.   ASSESSMENT/SUMMARY OF MATTERS

2.1   Strategy, Leadership and Governance

2.1.1   Strategic Context

In Autumn 2023 the WG/RPS Independent Review of Clinical Pharmacy Services at NHS Hospital in Wales was published, the purpose of which was to review the current provision of clinical pharmacy services in hospitals and how they align to priorities and changing needs of the NHS Wales. This review, alongside other key Trust, NHS Wales and Pharmacy strategies will be utilised as to the basis to develop the next iteration of the VCC Pharmacy, Medicines Management and Prescribing Strategy during 2024/2025. Underpinning this strategy will be the Health and Care Quality Standards, upon which the key outputs of the pharmacy and medicines management directorate, and the workplan of the Medicines Management Group can be mapped.

Diagram 1: Health and Care Quality Standards.

Demand for SACT (parenteral and oral) services has increased considerably since Autumn 2023, when growth exceeding previously projected forecast demand for the full year effect. Currently, provision of SACT services is subject to business continuity measures with pharmacy capacity being the key challenge. Investment to secure additional pharmacy resource has been secured which will support recovery and on-going maintenance and compliance of regulatory, professional and good practice standards as outlined below in addition to increasing SACT capacity.

2.1.2   Regulatory and legislative compliance and good practice standards
In line with the principles outlined above, the following standards are maintained by the Pharmacy department:

1. Clinically verification of Systemic Anti-Cancer Therapy (SACT) prescriptions in line with the national British Oncology Pharmacy Association (BOPA) Verification Standards. This standard is being further supported by implementation of the BOPA 'SACT Verification Passport' to standardise and assure the training and competency of Pharmacy staff in this activity.

2. Update of SST treatment algorithms to include newly-approved treatments, which supports the planned implementation of SACT treatment options.

The remaining remedial actions to address recommendations identified within the external Quality Assurance Audit for Pharmacy Technical Services May 2023 are near completion with their closure expected in June 2024 on successful recruitment and on-boarding of new staff members. The service will next be audited in May 2024.

Additional work that is planned for the following 12 months includes:
1. Implementation of Electronic Prescribing and Medicines Administration (ePMA) e-Prescribing for general medicines at VCC over the next 2 years enables maintenance or achievement of many of these standards, namely safety, efficiency and better access to information. This work is being managed as a VCC wide project and will be reported via Velindre Futures Board.
2. Development of treatment protocols for SACT regimens.
    As well as providing a basis for consistent and equitable care, this will support new ways of working within SACT pre-assessment clinics and to even out demand for daycase services across the week and thus improve service efficiencies.
3. Implementation of pharmacy technician SACT verification
    This promotes prudent utilisation of workforce that is again in line with the Health and Care Quality Standards.

2.2 Working Groups

Responsibilities of the MMG are discharged via the use of sub-groups and reports which each oversee dedicated aspects of medicines management across VCC. MMG is chaired by Dr Amy Quinton with professional secretariat provided by the pharmacy team. The groups report to the MMG and their outputs are summarised as below:

2.2.1 Medicines at Home (MaH) service
MMG Lead: Anthony Cadogan, Deputy Chief Pharmacist

The MaH team within pharmacy oversee and manage the delivery of specified oral SACT direct to a patient's home, and of the MaH Nantgarw Support Unit service, which is delivered on a mobile unit based near Trust Headquarters.

Service delivery performance is monitored via nationally agreed Key Performance Indicators (KPIs), which are reported to MMG three times per year. The KPIs capture third party provider performance, such as treatment deliveries within agreed timeslots and patient safety incidents. VCC finance team maintain close oversight of the financial savings generated by the MaH team to both VCC and its Health Board partners, with VCC over-achieving against the savings targets.

As of the end of March 2024, there are approximately 1450 patients currently registered with VCC's MaH service, of which over 1100 patients receive their oral SACT delivered to their homes.

The MaH team are currently leading on the re-tender of the compounding, nursing and facilities contract for the MaH Nantgarw Support Unit, a £5million contract designed to provide flexibility of capacity up to 5 days a week (from the current 2). This contract is due to be awarded in May 2024 with additional capacity coming on line from August 2024.

2.2.2 VCC Controlled Drugs (CD) Oversight Group
MMG Lead: Bethan Tranter, Chief Pharmacist

The VCC Controlled Drugs Oversight Group meets twice per year to ensure the safe use of CDs across VCC. It ensures compliance with Controlled Drugs Regulations and NICE Guidance NG46.

It undertakes point prevalence review, (2 x 1 month of data per year) of the prescribing of CDs on WP10(HP)s to ensure triangulation between patient, their need for the prescription, and contact with a VCC clinician at the time of the WP10(HP) being written. This is to ensure that CDs are being appropriately prescribed for dispensing in the community. The group also maintains oversight of ward stock checks undertaken by the Pharmacy Team.

As an example, a review of all WP10(HP) prescriptions written by VCC clinicians in January 2024 (1242 prescription items reviewed) identified 14 prescriptions for controlled drugs for 13 different patients. All prescriptions were triangulated with the annotations written within the patients notes (on Welsh Clinical Portal), with no concerns identified.

The CD Oversight Group also ensures that there is VCC representation and formal report submission at all of VCC's neighbouring health board Local Intelligence Network (LIN) meetings. LIN meetings are a useful source for information gathering and sharing and VCC's attendance ensures that we remain informed of local issues related to controlled drugs which may impact VCC. Reports were submitted by VCC to the Gwent LINS meeting in October 2023, and to both the Cwm Taf Morgannwg and Cardiff and Vale LINS meetings in January 2024. All learning generated from attending these meetings has been shared with the VCC Controlled Drugs Accountable Officer and where appropriate, with the Palliative Care team.

The group is currently seeking oncologist representation to comply with it's ToR.

The VCC CD Oversight Group receives all incidents which involve Controlled Drugs. In this reporting period (October 2023 to April 2024), there were 8 controlled drug related incidents recorded, of which:

      5 have been investigated and closed
      3 await closure
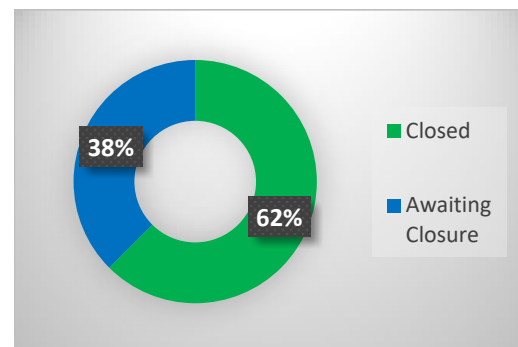
All 8 incidents have resulted in no injury or harm,

In September 2023, the Care Quality Commission (CQC) published an update to its 'The Safer Management of Controlled Drugs' document. Although CQC publications are not applicable to Wales, it is good practice to review all relevant UK wide standards as appropriate/ Thus, the CD Oversight Group have reviewed this updated publication, and an action plan to address the new recommendations was agreed at VCC CD Oversight Group meeting in April 2024.

2.2.3 Medical Gases Group
MMG Lead: Bethan Tranter, Chief Pharmacist

As medicinal products, the safe use of medical gases is the responsibility of the Chief Pharmacist.

The Medical Gases Group meets twice per year to oversee the safe use of medical gases at VCC, and is chaired by the Chief Pharmacist. The group comprises of clinical, estates

and facilities and operational services colleagues. The focus of the group is on the safe use of medical gases and medical gas cylinders with the oversight of the medical gas pipeline systems being undertaken through Estates and Facilities colleagues.

The group has approved a revision to it's ToR to re-align it's reporting to MMG. It has also acted as the expert group to provide advice to the nVCC Estates and Facilities team as to the medical gas (and pipeline systems) requirements of the new hospital. In addition, a SLA has been agreed between VCC and National Wales Shared Services Partnership to provide a Quality Control Pharmacist for medical gases pipeline services as a contingency resource in case of emergency.

The group monitors the use of medical gas cylinders across VCC and consequently has removed nitrous oxide cylinders as they are no longer required, can be harmful to the environment if they leak and have resale attraction for non-medicinal purposes.

2.2.4   Medication Safety Group
MMG Lead: Ruth Hull (Medicines Management Nurse) for Rebecca Dent (Maternity Leave, Medication Safety and Governance Pharmacist)

The Medication Safety Group (MSG) is a key multidisciplinary subgroup of MMG, which maintains oversight of medication safety related work-streams and supporting procedures. The group also link in with the all-Wales medication safety group for learning and sharing of good practices.

The group, chaired by the Medication Safety and Governance Pharmacist, who along with the Medicines Management Nurse maintains oversight of all medicines related incidents and consider themes and learning opportunities. These key staff members link with nursing and pharmacy colleagues on a regular basis with the group reporting to MMG twice per year. Medical colleagues are consulted with as required.

- From October 2023 to March 2024, the total number of medication-related DATIX incidents submitted was 59, of which:

- 43 are closed
- 3 are awaiting closure
- 2 are under investigation
- 9 are in the initial 'Management review / Make it safe' phase and are awaiting investigation
- 2 were rejected

These figures appear to reflect a reduction in dedicated medications safety resource due to the maternity

Chart legend:
- Closed — 73%
- Awaiting Closure — 5%
- Under investigation — 3%
- Awaiting investigation — 15%
- Rejected — 3%
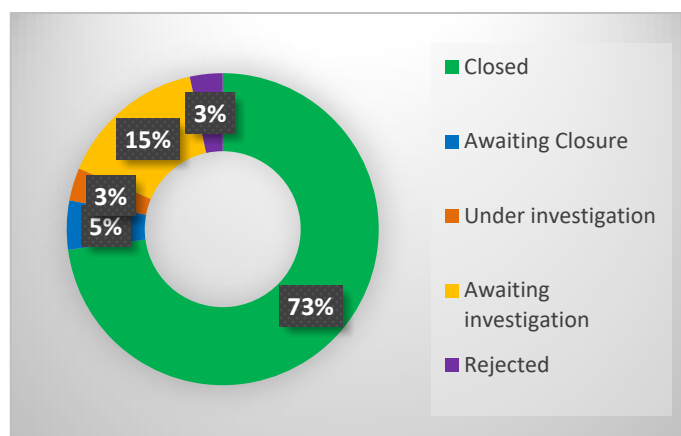
leave, and whilst some of these roles have been reallocated on an interim basis the level of input available to monitor and support investigations and timely closure is substantially reduced.

There appears also to be a reduction in reporting rate which coincides with the change to reporting of Hypersensitivity reactions to SACT (which has been transferred to a separate, non-DATIX process). No other themes have been identified.

2.2.5 Cancer and Hospital Acquired Thrombosis (CHAT) Group
MMG Lead: Usman Malik, Principal Pharmacist Clinical Services

In accordance with the Welsh Risk Pool (WRP) 'National Review into the Prevention of Venous Thromboembolisms (VTE) in NHS Wales', VCC established its Cancer and Hospital Acquired Thrombosis (CHAT) group.

The group has continued to meet on a regular basis throughout 2023, and has achieved all the main recommendations within the WRP national report. There is ongoing work to ensure that all clinical staffs receive formal training, awareness and understanding of 'Venous Thromboembolisms' as part of their statutory and mandatory training, and the CHAT group will continue to review compliance against this training and feedback to specific clinical groups as appropriate.

One of the main quality measures undertaken by all NHS organisations relates to the number of 'Potentially Avoidable Hospital-Acquired Thrombosis (HAT)' events that occur. Within VCC, this audit is undertaken each month on every patient diagnosed with a thrombosis This data is included on the Trust's Performance Management Framework. Between October 2023 and March 2024, there have been no cases of Potentially Avoidable HATs identified at VCC.

In April / May 2024, there will be a national Venous Thromboembolism (VTE) Board established in Wales. The aim of the board is to follow up on the progress that has been made by NHS organisations against the recommendations within the WRP report. VCC will have representation on this national board.

0

Potentially avoidable
Hospital-acquired
Thrombosis (HAT) events
at VCC

October 2023 to March 2024

2.3 Access to Medicines

2.3.1 VCC Individual Patient Funding Request (IPFR) Advisory Group
MMG Lead: Bethan Tranter, Chief Pharmacist

VCC IPFR Advisory Group continue to meet on a weekly basis to review all IPFR applications for clinical appropriateness prior to submission to the health boards, and to consider whether VCC are able to fund applications through it's discretionary "High Cost Drugs" budget, which it also monitors expenditure.

Importantly the group also provides advice to consultant colleagues in terms of the IPFR process and systems, and liaises with HB teams clinically and operationally when required.

Number of IPFR applications Received

2021/22	2022/23	2023/24
37	55	86
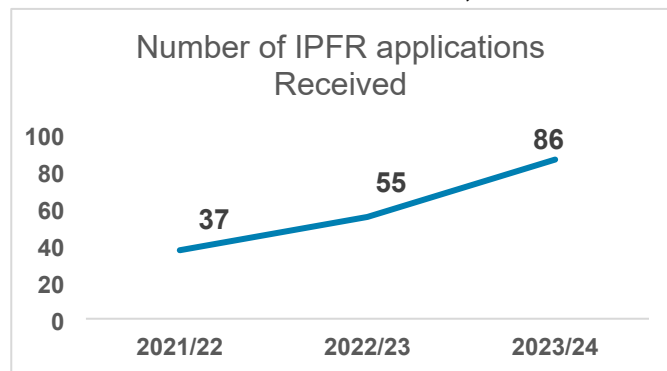
Between October 2023 and March 2024, there have been 46 IPFR requests reviewed by the VCC IPFR Advisory Group, of which VCC have funded 9 applications via the discretionary budget.

Of note, there has been a steady increase in the number of IPFR applications over recent years. This may be reflective of the increasing number of external IPFRs submitted to WHSCC for routine, non-standard procedures/investigations (e.g. Gamma Knife, PET-CT) for which the IPFR panel provides an oversight & tracking function.

2.3.2 Early Access of Medicines Schemes and Compassionate Use Programs
MMG Lead: Rhys Craig, Procurement and Medicines@Home Pharmacy Lead

Early Access of Medicines Scheme (EAMS) and Compassionate Use Programs (CUPs) allow access to medicines that are either not license or not funded, but evidence shows a clinical benefit. These medicines are typically utilised when there are no other treatment options available or when the agent is innovative.

Between October 2023 and March 2024, VCC pharmacy had set up 4 new access schemes, which makes a total of 17 access schemes currently open. As of April 2024, there are 24 patients receiving SACT via one of these access schemes.

CUPs are resource-intense and complex to deliver from a pharmacy administrative perspective. MMG has previously discussed BOPA's position statement supporting the prioritisation of SACT approved by commissioning bodies (NICE, AWMSG etc) over SACT available through pharmaceutical companies as free of charge (FOC) schemes due to pharmacy resources.. Whilst there was some support for this position being

adopted at VCC, our consultant body values the clinical options that access to these schemes allows. Thus in practice Pharmacy will support schemes on an individual basis wherever possible, however there are occasions when this is challenging to deliver, particularly where eligible patient numbers are significant.

In 2024-25 Pharmacy will consider ways to enable consistent access to FOC schemes.

2.3.3 Horizon Scanning
MMG Leads: Anthony Cadogan Deputy Chief Pharmacist, Jaimie Davies (Maternity Leave, Advanced Oncology Pharmacist)

Following the departure of key individuals from VCC in 2023, the monthly horizon scanning group meeting will be re-established from 17th April 2024, with a revised terms of reference.
In the interim, regular updates have been submitted to the MMG and the process of implementation of new medicines via the Managed Implementation form (MIF) process continues.
In 2024/25 and as part of the ToR revision, the group will consider the remit of the horizon scanning group in light of the work being undertaken at a national level by All Wales Therapeutics and Toxicology Centre (AWTTC), and of the need to inform (in real time) the planning process within VCC to enable access to new treatments.

2.3.4 Medication alerts, shortages and discontinuations
MMG Leads: Usman Malik Principal Pharmacist Clinical Services , Rhys Craig, Procurement Pharmacy Lead

Pharmacy manages the response to WG and Pharma initiated medication alerts, shortages and discontinuation notices, playing an active role in both the All Wales Medicines Shortage Group and All Wales Medicines Procurement and Logistics Group. Each notice is assessed for its potential impact on patient care at VCC with the pharmacy team ensuring that corrective actions are undertaken including sourcing alternative clinical options when necessary.

Between Oct 2023 and March 2024, there have been 16 national drug recall alerts and 49 drug shortage alerts, all of which were action within required timeframes without any detriment to patient safety.

2.3.5 Patient Safety Notice (PSN)
MMG Lead: Usman Malik, Principal Pharmacist, Clinical Services

Patient Safety Notices (PSN) and Patient Safety Alerts (PSA) are guidance documents issued by Welsh Government, which identify significant safety risks along with a series of recommendations which NHS organisations are mandated to implement.

Between October 2023 and March 2024, there have been three medication related alerts and notices that are applicable to VCC practices, namely:

- Risk of underdosing for the use of IV calcium gluconate in the treatment of severe hyperkalaemia
- New regulatory measures associated with the prescribing of valproate-based drugs and its association with congenital malformations, and
- Potential for inappropriate dosing of insulin when switching from insulin degludec products.

All required actions of the above alerts have been completed.

2.4 Medicines Expenditure

Expenditure against t VCC drug budgets is monitored by the MMG. All expenditures are within approved budgetary limits. VCC purchases all pharmaceuticals according to best practice through All Wales Drug Contracts and supports national best practice guidance in it's proactive adoption of biosimilar and generic medicines at the earliest opportunity.

VCC Pharmacy Procurement Team ensure that all drugs which are available as part of a simple patient access scheme (discount at point of invoicing) are sourced appropriately at point of ordering and that those with a complex patient access scheme (retrospective discount or require additional administration paperwork) are managed according to each scheme's requirements. VCC Finance Team capture this information and are considering how to better ensure that HB partners are sighted on this in order to help demonstrate that VCC is managing these budgets effectively.

2.4.1 Value and Sustainability / Low value for prescribing
Pharmacy Lead: Rhys Craig, Procurement Pharmacy Lead

The 'National Prescribing Indicators 2022 – 2025' highlights medications that have a 'Low Value for Prescribing' across NHS Wales. In response to this, MMG have produced and agreed an action plan for those medications prescribed at VCC that complies with the principles of the document and promote value and sustainability.

Examples of this approach within VCC include:
- acquisition of biosimilar medications with the lowest cost, e.g. trastuzumab, infliximab and more recently pegylated-GCSF (pegfilgrastim) managed switches have been delivered in VCC

Pelmeg
Annual Spend
£290,642

Pelgraz®
Annual Spend
£184,636

Pegfilgrastim Annual Saving: £106,000
from 24/25
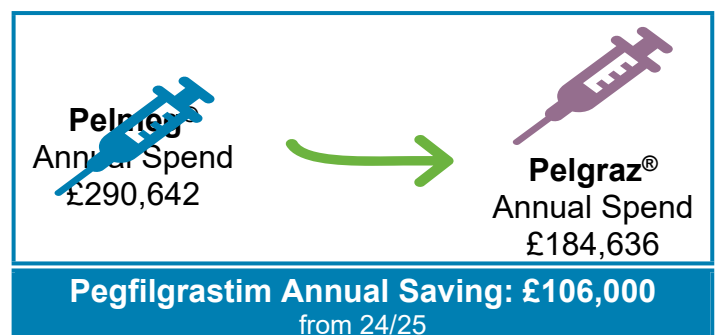
- quick uptake of generic medication products such as abiraterone and apixaban
- purchasing outsourcing pre-made SACT from NHS Wales Shared Services Partnership (NWSSP) instead of commercial companies. Both Nivolumab and atezolizumab have been ordered via NWSSP since October 2023
- rationalisation of specific medications to ensure 'specialist initiation' only, e.g. lidocaine patches and Targinact ® for palliative care team use only

2.5   Clinical Effectiveness

2.5.1   Unlicensed and Off-label use of medicines
MMG Leads: Usman Malik Principal Pharmacist Clinical Services, Rhys Craig Procurement Pharmacy Lead

MMG continue to review, approve and have clinical governance oversight of all unlicensed and 'off-label' medications. Between October 2023 – March 2024, there have been 13 requests that have fall under this category, all of which were clinically appropriate, and approved by MMG.

2.5.2   Antimicrobial Stewardship
MMG Leads: Usman Malik Principal Pharmacist, Clinical Services, Gemma Saxty Anti-microbial Pharmacist (training)

Assurances of good Antimicrobial Stewardship (AMS) involves pharmacy undertaking a monthly audit against the national 'Start Smart Then Focus' (SSTF) measures; these measures form part of the Welsh Government Improvement Goals for 2021/22 (and remain to be the measures for 2022/23 2023/24).

Of the four main SSTF measures, over the 2023/24 year, VCC have performed above the all-Wales average for all measures. Performance of these measures is regularly fed back to the Trust Infection Prevention and Control Management Group (IPCMG) along with the junior medical staff (SHOs). The importance of undertaking these measures is also covered in the new medical staffing pharmacy led induction.

As of Q4 2023/24, VCC has now appointed an 'Antimicrobial Lead Pharmacist' who can further embed quality and safe prescribing practices in line with the principles of Antimicrobial Stewardship.

2.6 Communication
MMG Lead: Usman Malik

MMG produces a quarterly newsletter to communicate activities of the group, draw attention to safety issues or to influence practice.

Medicines Management Group (MMG) Newsletter
November 2023

The role of the Medicines Management Group (MMG) is to ensure medicines are used safely, cost effectively and in accordance with accepted best practice.

Safety Issues

Herbal medicines & Complimentary theraipes and chemotherapy treatment

A recent case whereby a cancer patient who took a herbal remedy died after a rare reaction has highlighted the dangers of taking alternative agents whilst on SACT treatment – (LINK – BBC Wales).

As alternative agents are unlicensed and therefore have not undergone the rigorus testing required for licensed medications, the only information available on their adverse affects are those that are reported on a case by case basis. A lack of information, e.g. whether there is an interaction between a alternative agent and a licensed SACT, does not mean that the agent is safe to take. Therefore, it is best to advise against using any alternative agent whilst on SACT.

Tyrosine Kinase Inhibitor (TKI) Patient Education Video

Policies Procedures and Guidelines update

Antimicrobial Stewardship

In response to the 2023/24 Anti-Microbial Resistance (AMR) improvement goals (LINK.pdf), all health care professionals MUST follow the principles of 'Start Smart Then Focus' when prescribing antimicrobial agents on inpatient wards. These include (at the point of prescribing):

- Documentation of Indication for treatment on medication chart
- Document the duration or specify a review date on medication chart
- Choice of agent to comply with guidelines, cultures & sensitivities or be based on microbiology advice
- Review the continuing need for antimicrobials at 48 – 72 hours

3. RECOMMENDATION

The Quality, Safety and Performance Committee is asked to **NOTE** the **ASSURANCE** this report provides in relation to the ongoing work of the Medicines Management Group in line with its main functions.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 　　　　　YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☒ ☐ ☐ ☐ ☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety

Page 13 of 15

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
	The report summarises the work of MMG over the previous 6 months (October 2023 – March 2024) and provides assurances that MMG continue to perform its duties as outlines in the Terms of Reference to ensure safe and effective use of medicines across Velindre Cancer Centre.	
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health	
	If more than one Well-being Goal applies please list below:	
	The report gives several examples whereby patients health and wellbeing are maximised from the work undertaken by pharmacy and medicines management, e.g., providing treatment closer to home, ensuring access to medications through the use of early access schemes and individual funding requests, to ensuring safe prescribing through good antimicrobial stewardship.	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.	

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	No areas of inequality identified within report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Highlight Report from the Radiation Protection and Medical Exposures Strategic Committee

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Kathy Ikin, Head of Radiation Services
PRESENTED BY	Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director

1. PURPOSE

This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues and items considered by the Radiation Protection and Medical Exposures Strategic Committee (RPMSC) on the 21/03/2024. Key highlights from the meeting are reported in Section 2.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There are no items for escalation.
ADVISE	***HSE Consent and Registration Processes*** The HSE have started a new registration process (10/23) and will be starting a new consent process (4/24 on a five-year rolling programme). This will require the completion of an online safety assessment and site visits across VCC and WBS. Dependent upon timing, this may also need to reflect foreseeable changes with regard nVCC and the Satellite Centre. The Trust has successfully applied for the Registration for delivering services with Ionising Radiation, and the relevant approval certificates have been received. The new consent process will require the Trust to apply for five individual consents. Each consent are expected to cost between £6000and £10,000, although final costs have not been published by the Health & Safety Executive (HSE). The HSE bulletins are being shared through the Institute of Physics and Medical Engineering and guidance and developments are being monitored and actioned thorough the Radiation Protection and Medical Exposure Management Group. A Compliance Working Group, and associated specific Task and Finish Group, has been established to pre-emptively coordinate actions to raise compliance in readiness and collate necessary submission evidence, through the consent process. ***Leadership for Ionising Radiation – Head of Medical Physics and Clinical Engineering Role and Medical Leadership*** There has been a recommendation to strengthen the ionising radiation leadership; through the introduction of a Director of Medical Physics and Clinical Engineering role to lead the increased regulatory requirements. Employer responsibilities for leadership in policies and procedures have highlighted areas where employees are assuming the role of the authorised radiation employer in lieu of formal entitled roles.

The recommendation to introduce this role has been considered by Executive Management Board 29th April with a view to progressing implementation imminently.

HASS Disposal
A project team has been convened to manage the disposal of the research HASS sources, led by Matthew Ager. Initial meetings conducted to scope the project and identify with procurement colleagues an appropriate route of disposal. NWSSP Procurement are actively approaching potential suppliers on the NHS Framework to determine feasibility of use.

Senior colleagues in Velindre Cancer Centre have recently be re-engaged with Operation Fieldfare which may still be an option for source disposal prior to the decommissioning of VCC.

National Resources Wales and the Counter Terrorism Advised have been informed of our actions to date, and recommend pursuing both commercial and Home Office disposal options. If Operation Fieldfare becomes an option to proceed this will be the Trust preferred option and is recommended by the regulators.

HIW Inspection Radiotherapy
The HIW inspection report has been issued and a formal Trust response to the action plan has been provided. The actions are currently ongoing and being managed by Claire Davies.

HSE Inspection WBS
The HSE inspection resulted in notices of contravention and an improvement plan concerning training and contingency plans was required. The Trust response has been accepted by HSE and a short-term extension was requested and accepted to implement the actions. All actions have been completed with formal response from HSE confirming closure.

Pregnancy and Breastfeeding Trust Policy
New guidance has been issued by the SOR regarding inclusive pregnancy enquiries for those undergoing ionising radiation procedures. A project group has been convened to review and update the policy for Trust ratification and adoption. To note, the policy does not have a nominated radiation employer Trust representative (see Alert / escalate).

	Entitlement and Appointment Under IRMER17, IRR17 and EPR VCC Departments have begun using the RPMESC-ratified procedure for entitlement and appointment of personnel (RPA/RPS/MPE/RWA etc). Co-signed letters of appointment have been submitted for final authorisation and are awaiting response.
ASSURE	***Radon Monitoring*** Radon Monitoring in the Trust identified the mechanical workshop as requiring remedial work to reduce the levels of radon in the working environment. Remediation has been completed, follow up monitoring is being undertaken to assure that remedial works are effective in reducing radon concentrations. ***NRW Regulatory Inspection*** An inspection of VCC HASS sources by NRW, accompanied by Counter Terrorism, was conducted on 28/2/24. On-the-day feedback indicated satisfactory inspection outcomes across Brachytherapy, Radiation Protection and Research areas. We are awaiting formal written feedback.

3. RECOMMENDATION

The Quality, Safety & Performance Committee are asked to **NOTE** the key deliberations and highlights from the Radiation Protection and Medical Exposures Strategic Committee on the 21/03/2024.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Standards for Competency Assurance of Non-Medical prescribers in Wales 2024

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Bethan Tranter, Chief Pharmacist
PRESENTED BY	Bethan Tranter, Chief Pharmacist
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	HEIW has developed national standards for competency assurance of independent and supplementary prescribers in Wales, which all providers of NHS services in Wales are expected to comply with as per WHC/2024/02. VCC will work with HEIW to develop an implementation plan by 30th September 2024 for approval by Executive Management Board thereafter.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the content of this report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VCC SLT EMB RUN	04/042024 29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Approved by VCC SLT Approved by EMB RUN	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance *N/A - Purpose of report is Information / noting*

APPENDICES	
1	Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales Oct 2023

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1. SITUATION

1.1 In 2019, Health Education and Improvement Wales (HEIW) conducted scoping work which Identified a need to produce guidance to more consistently support non-medical prescribers in appropriately evidencing their continued competence to prescribe.

1.2 The Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales were developed by HEIW following a review of the non-medical prescribing policies currently in place within NHS organisations in collaboration with key internal and external stakeholders.

1.3 The standards support a "once for Wales" approach to the quality assurance of the non-medical prescriber workforce in Wales. They set the minimum requirements for evidencing and review of ongoing competence to prescribe for non-medical prescribers and employers of non-medical prescribers in four key areas:
- Annual self-assessment of prescribing competence;
- Annual declaration of scope of prescribing practice and of continued competence to prescribe;
- Regular prescribing appraisal with a suitably qualified individual; and
- Use of portfolios to evidence competence.

1.4 The standards are aimed at all non-medical prescribers who provide NHS services to patients in Wales, and their employers in all sectors of practice and apply to all independent prescribers and supplementary prescribers at VCC.

1.5 These standards complement and do not replace or supersede standards set by professional regulatory or leadership bodies either relating to prescribing or revalidation more generally.

2 BACKGROUND

2.1 Velindre Cancer Centre has utilised non-medical prescribers to support clinical services since 2003 when approval was given for supplementary prescribing to pharmacists and nurses.

2.2 Since then, there has been a conscious and consistent approach to train pharmacists, nurses and therapeutic radiographers as independent prescribers.

2.3 Physiotherapists and dieticians are also able to prescribe medicines as non-medical prescribers; at present there are none practising at VCC as there is not an identified need.

2.4 Non-medical prescribers are accountable for all their prescribing decisions and any consequences arising from them. They should therefore only prescribe medicines they know are safe and effective for the patient and the condition being treated. They must be able to recognise and deal with pressures and conflicts of interest that could lead to inappropriate prescribing.

2.5 All non-medical prescribers are individually professionally accountable to their respective professional regulatory bodies and must act in accordance with the relevant professional standards and code of ethics and conduct.

2.6 Where an appropriately trained and qualified non-medical prescriber prescribes as part of their professional duties with the consent of their employer, the employer is vicariously liable for the actions of the prescriber. Employers must therefore have in place robust arrangements for ensuring the initial and continued competence of non-medical prescribers working within their organisations.

2.7 Velindre Cancer Centre has a policy regarding the employment, supervision and review of non-medical prescribers.

3 ASSESSMENT

3.1 There are four standards for employees and four standards for employers outlined within the recommendations.

3.2 Initial assessment of the VCC position for the employee standards is that two are met and that the remaining two are recommended within the VCC policy but are not mandatory.

3.3 Initial assessment of the employer standard is that all are partially met but that further work is required to fully comply with the standard.

3.4 In order to achieve the standards, there will need to be considerable engagement with VCC's non-medical prescribing workforce, it's consultant body (who currently act as the Designated Supervising Practitioner for most new trainees and subsequently throughout their practice) and departmental managers.

3.5 There is the potential that the non-medical prescriber workforce may consider that the additional effort to, for example, self-assess prescribing competence annually and to gather portfolio evidence may dissuade staff members from continuing to maintain their prescribing competency, where their roles and job descriptions allow.

3.6 To mitigate against this risk, enactment of job plans which support CPD will be essential. This will be considered further as part of the VCC implementation plan.

3.7 As an employer, as an example, VCC will need to formalise agreement to support CPD opportunities related to NMP practice and consider changes to the way in which appraisal of prescribing practice will occur.

3.8 As the non-medical prescribing workforce grows, it is possible that administrative resource will be required to comply with these standards in a similar way as support is available to ensure re-validation of other staffing groups. This will become clearer on development of the implementation plan.

4 SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Welsh Government require that:
- All health boards, Velindre UNHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust are required to implement the

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standards for competency assurance of non-medical prescribers within their organisation by 31 March 2026 at the latest.
- To support implementation, these organisations are required to develop an implementation plan with the support of HEIW by 30 September 2024.
- All health boards, Velindre UNHS Trust, the Welsh Ambulance Services NHS Trust, and Public Health Wales NHS Trust should identify an appropriate senior manager within their organisation to be responsible for developing the implementation plan and whose details should be shared with HEIW by 28 March 2024.

4.2   To achieve these requirements
- The Chief Pharmacist will be the VCC senior manager to link with HEIW to develop an implementation plan
- The implementation plan will be presented to the Executive Management Board for approval in October 2024.

4.3   The Quality, Safety and Performance Committee is asked to **NOTE** the content of this report.

5   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**		
If yes - please select all relevant goals:		
• Outstanding for quality, safety and experience		☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations		☒
• A beacon for research, development and innovation in our stated areas of priority		
• An established 'University' Trust which provides highly valued knowledge for learning for all.		☐
• A sustainable organisation that plays its part in creating a better future for people across the globe		☐
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety	

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below	
	Safe	☒
	Timely	☒
	Effective	☒
	Equitable	☒
	Efficient	☒
	Patient Centred	☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not required	
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health	
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.	
EQUALITY IMPACT ASSESSMENT *For more information:* https://nhswales365.sharepoint.com/sites/VEL_Int net/SitePages/E.aspx	Not required - please outline why this is not required	
ADDITIONAL LEGAL IMPLICATION / IMPACT	There are no specific legal implications related to the activity outlined in this report.	

6   RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

GIG CYMRU NHS WALES | Addysg a Gwella Iechyd Cymru (AaGIC)
Health Education and Improvement Wales (HEIW)

Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales

October 2023

Contents

500/671

1. Introduction

The Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales have been developed by Health Education and Improvement Wales (HEIW) in partnership with our stakeholders. The standards support a "Once for Wales" approach to the quality assurance of the non-medical independent and supplementary prescriber (NMP) workforce in Wales. They set the minimum requirements for evidencing and review of ongoing competence to prescribe for non-medical prescribers and employers of non-medical prescribers.

HEIW conducted scoping work in 2019 which identified a need to produce guidance to support non-medical prescribers to appropriately evidence ongoing competence to prescribe. The Standards for Competency Assurance of Independent and Supplementary Prescribers in Wales were developed by HEIW following a review of NMP Policies currently in place across Wales and in collaboration with key internal and external stakeholders.

Application of these standards is a multidisciplinary responsibility. All non-medical prescribers are responsible for prescribing within their own scope and competence, using their acquired knowledge, judgement, and skills, and must be able to provide evidence of their competence to prescribe.

2. Scope of Standards

In Scope:

The standards are aimed at registered non-medical prescribers who provide NHS services to patients in Wales, and employers of non-medical prescribers, in all sectors of practice within Wales. The standards apply to non-medical independent prescribers, community practitioner nurse prescribers and supplementary prescribers.

Out of scope:

 The competence assurance of doctor and dentist prescribers.

Evidencing requirements for individuals new to prescribing practice, expanding or changing scope of practice, and those returning to practice after periods of absence.

These standards do not preclude professionals from meeting their own professional regulatory requirements nor have they been developed to create duplication of revalidation requirements; any activities undertaken, or evidence collated as part of professional revalidation can be utilised as evidence of ongoing competence to prescribe.

For information and advice on good practice and for guidance on the administrative and procedural steps needed to enable nurses, midwives, pharmacists, optometrists and allied health professionals to act as independent and/or supplementary prescribers see Independent and Supplementary Prescribing in Wales – Guidance Document, published by Welsh Government.

For guidance on expanding scope of practice see the Royal Pharmaceutical Society (RPS) Professional Guidance: Expanding Scope of Practice.

3. Standards for competency assurance of Independent and Supplementary Prescribers

Maintaining confidence and competence to prescribe is a competency within the RPS Competency Framework for All Prescribers which indicates the importance of an ability to evidence ongoing prescribing competence.

The following standards outline the minimum requirements for non-medical prescribers to evidence their ongoing competence to prescribe.

Standard 1: All NMPs will self-assess prescribing competence annually using the RPS Competency Framework for All Prescribers

- Utilise the RPS Competency Framework to undertake a self-assessment of prescribing practice and ongoing competence to prescribe, at least annually, to identify any areas in which to focus learning[1].
- Where it is identified that the competencies are met, evidence recorded within the portfolio should reflect this.
- The framework does not specify how competence should be assured but does provide a framework against which ongoing competence can be assessed and can be utilised to support development of a portfolio to demonstrate continued prescribing competence.
- If a need to expand prescribing scope of practice is identified, refer to the RPS Guidance for Expanding Prescribing Scope of Practice. *Note – evidencing requirements for expanding or changing scope of practice are beyond the scope of this guidance*.

[1]While differences may exist against the RPS competency framework for some professions, it is advised that a self-assessment of prescribing practice and ongoing competence to prescribe is undertaken against the current competency framework used as part of non-medical prescriber training for that profession.

Standard 2: All NMPs will complete an annual declaration of continued competence to prescribe AND a declaration of their scope of prescribing practice at least annually

- Annual declaration of continue competence to prescribe:
  - Professional declaration that the NMP has undertaken a self-assessment of their prescribing practice (as per Standard 1), has maintained their competence to prescribe, and can provide evidence of this in line with these standards.
- Declaration of scope of prescribing practice:
  - In accordance with the RPS Competency Framework, prescribers are responsible for prescribing within their own scope of practice and referring or seeking support where appropriate.
  - Scope of prescribing practice must be declared annually as a minimum and more frequently if there are any changes (for example as prescribing scope is expanded or if a change in sector of practice requires a change to scope of prescribing practice).
  - Scope of prescribing practice must state clinical area (and/or disease state(s)) in which NMP intends to prescribe.

Declarations of ongoing competence to prescribe and scope of prescribing practice to be made and retained on a centralised platform, for example the Electronic Staff Record (ESR) or NHS Wales Shared Services Partnership (NWSSP).

Standard 3: All NMPs will undergo a prescribing appraisal with a suitably qualified individual every three years

- Constructive appraisal of prescribing practice to include:
  - review of a portfolio of evidence (details of minimum evidence to include provided in Standard 4.1)
  - discussion of any developmental or learning needs
  - discussion of any challenges (including errors) identified
- Prescribing appraisal to be undertaken by a suitably qualified individual (e.g. line manager (if also a prescriber), designated prescribing practitioner, mentor, consultant, GP) who has undertaken appropriate training, as outlined in Section 4, Standard 2.
- The prescribing appraisal may form part of the individual's overall performance appraisal and development review.

Standard 4: All NMPs will evidence their ongoing competence to prescribe in a portfolio

- The RPS Competency Framework for All Prescribers recommends utilising a portfolio to demonstrate continued competence in prescribing and as a method to improving prescribing practice. It is recommended that a combination of methods is used to assess and assure competence to prescribe, as outlined in the table below (4.1).
- A combination of evidence should be collated to form a portfolio of evidence to demonstrate ongoing prescribing competence.
- Evidence collated must relate to scope of prescribing practice.
- The table below (4.1) outlines the amount of evidence that should be incorporated as a minimum within a prescribing portfolio.
- Evidence may be utilised in more than one way, for example:
    - continuing professional development (CPD) activities undertaken as part of professional revalidation may be utilised as evidence within a prescribing portfolio
    - a clinical log may take the format of CPD
- Where possible, evidence collated should cover examples of prescribing events where the decision was taken 'to prescribe' but also where the decision was made 'not to prescribe'.
- The evidence collated should also include reflection on any prescribing errors which may have occurred.
- The examples of activities that could be undertaken to achieve each evidence type are not exhaustive. Consideration should be given to how these can be achieved within your own sector of practice.

Standard 4.1: Minimum evidence to be produced annually and incorporated within a prescribing portfolio

Evidence Type	Minimum Quantity	Rationale	Examples of Evidence
Peer Review	1	Clinical peer review is a method used by healthcare professionals to evaluate each other's clinical performance. The primary purpose is to improve the quality and safety of patient care. Peer reviews can be utilised to assess competence to prescribe and should be *undertaken by someone working in the same scope of practice as the person being reviewed* in order that feedback can be provided on both generic skills and on condition specific issues.	• **Case-based reviews** – discussions with mentor, designated prescribing practitioner (DPP), or peers • **NMP peer groups** – opportunity for training, discussion of learning, and peer feedback. Inter-professional sources of evidence (e.g. peer support with NMPs from other professions) should be considered where possible and appropriate to enable shared learning across professions. • **Clinical supervision** – e.g. – observation of clinical practice, clinical assessment skills, and consultation skills undertaken by peer prescriber, DPP, mentor, or a medical prescriber. • **Discussion of prescribing practice**, including discussion of prescribing errors and instances where the decision was made NOT to prescribe, with mentor or DPP • **Random case analysis** – review of a proportion of cases the NMP has managed, undertaken by a mentor/peer/DPP followed by feedback of analysis to the NMP. Any learning needs identified should be discussed and a plan for ongoing development agreed.
Clinical Log	2	Clinical logs are a structured record of a learning event. They support critical reflection of practice and learning.	• **CPD** – see below • **Case review** – e.g. reflecting on a case following shadowing, peer discussion, or supervision, reflection on prescribing errors
Continuing Professional Development (CPD)	2	CPD is the way in which healthcare professionals continue to learn and develop throughout their careers to ensure that their skills and knowledge are up to date and that they can practice safely and effectively. CPD provides evidence of ongoing learning. It is a key component of revalidation requirements for all prescribing professions and underpins several competencies within the RPS Competency Framework for All Prescribers.	• **Planned CPD** – e.g. attendance at a training event • **Unplanned CPD** – e.g. learning in response to a prescribing error, or patient unmet needs (PUNs) when an NMP was not sure about the prescribing so sought out additional training/learning/guidance/discussion with colleague to answer clinical question • **Audit** – e.g. review of personal prescribing data. CPD entry could be produced consolidating learning identified during the audit process • Patient experience or service user feedback can be included as evidence of continued learning and development

4. Standards for competency assurance requirements for employers

The following standards outline the minimum requirements for employers to enable NMPs to maintain their competence to prescribe.

Standard 1: Where there is a service need to prescribe, NMPs must be supported to maintain their competence to prescribe.

- Service provision should be such that prescribers are supported to utilise their prescribing skills in practice. Employers must ensure prescribers have adequate opportunity to undertake prescribing within their practice in order to maintain their competence to prescribe.
- Employers must provide opportunities for NMPs to undertake the required development opportunities, including CPD, to meet the standards outlined above.
    - A shared approach to planning CPD between NMPs and employers is encouraged to ensure NMPs are provided with opportunities that best suit their learning style and the support that they require. NMPs should be able to subsequently demonstrate their learning and how they have incorporated it into daily practice.
    - Examples include: supporting a minimum of annual attendance at NMP Peer Group Meetings or CPD events.

Standard 2: Employers must provide/assign a suitably qualified individual to undertake appraisal of prescribing practice and prescribing portfolios for NMPs every 3 years

- Individual to be determined/defined by employer. This could be, for example, a line manager (if also a prescriber), mentor, consultant, or DPP.
- Individuals undertaking reviews of prescribing practice must have received appropriate training to be able to determine the quality of evidence provided, provide appropriate and supportive feedback, and implement appropriate support systems where required.
- Reviews of prescribing portfolios should be undertaken at least once every three years at a time that is convenient for the NMP and employer, for example during a performance appraisal and development review.

Standard 3: Employers can only expect prescribers to take on roles within the NMPs scope of prescribing practice

- The scope of prescribing practice of NMPs should be discussed at least annually. NMPs and employers should work in partnership to ensure that the NMPs prescribing skills are in line with service and patient requirements. If a need to expand scope of prescribing practice to meet service need is identified, refer to the RPS Guidance: Expanding Prescribing Scope of Practice.
- NMPs will complete a declaration of their scope of prescribing practice to their employer on at least an annual basis, or more frequently if there are any changes to prescribing scope of practice (for example, as prescribing scope is expanded or if a change in sector of practice requires a change to scope of prescribing practice).
- Prescribers can only be expected to take on prescribing roles within the declared scope of practice. Where a person's condition or the medication prescribed are outside the NMPs scope of prescribing practice, the NMP must consider the best interests of the person and decide whether they have the competence to prescribe. If the NMP is not competent to prescribe, the person must be referred to another appropriate prescriber.

Standard 4: Employers must maintain an accurate electronic record of their prescribers, including an up to date scope of practice

- Employers to maintain an electronic database of prescribers, alongside the annual declaration of scope of prescribing practice and declaration of continued competence to prescribe, which can be shared with other organisations where appropriate.

5.Glossary

Independent prescriber – defined by the RPS as: "A prescribing healthcare professional who is responsible and accountable for the assessment of patients with undiagnosed or diagnosed conditions and for decisions about the clinical management required, including prescribing."

Non-medical prescriber (NMP) – defined by the RPS as: "This term encompasses healthcare professionals (excluding doctors and dentists) working within their clinical competence as an independent and/ or supplementary prescribers or community practitioner nurse prescribers. Further information on the types of non-medical prescriber and what they can prescribe can be found in the British National Formulary (BNF)."

Scope of prescribing practice – defined by the RPS as: "The activities a healthcare professional carries out within their professional role. The healthcare professional must have the required training, knowledge, skills and experience to deliver these activities lawfully, safely and effectively. They must also have appropriate indemnity cover for their prescribing role. Scope of practice may be informed by regulatory standards, the professional body's position, employer guidance, guidance from other relevant organisations and the individual's professional judgement."

Supplementary prescribing – defined by the RPS as: "A voluntary partnership between a doctor or dentist and supplementary prescriber, to prescribe within an agreed patient-specific clinical management plan (CMP) with the patient's agreement. At the time of publication, nurses, midwives, optometrists, pharmacists, physiotherapists, podiatrists, radiographers, paramedics and dietitians may become supplementary prescribers. Once qualified, they may prescribe any medicine (including controlled drugs) within their clinical competence, according to the CMP."

6.Acknowledgements

Competency Framework Short-Life Working Group

NMP Policy Leads – 7 Health Boards, Velindre, Welsh Ambulance Service NHS Trust

HEIW Deans and Deputies Group

Chief Pharmacists Group

All Wales Quality and Patient Safety Group

Education and Training Primary Care Pharmacist Forum

Royal College of General Practitioners

Chartered Society of Physiotherapy – Pip White

College of Paramedics – David Rovardi, Helen Beaumont-Waters

Royal College of Podiatry – Debbie Sharman

General Optical Council – Samara Morgan, Ben Pearson

College of Optometrists – Paramdeep Bilkhu

Society of Radiographers – Dianne Hogg, Sue Johnson

Royal Pharmaceutical Society – Elen Jones, Karen Hodson

Clinical Services Community Pharmacy Contractual Framework Implementation Group

Community Pharmacy Wales

Welsh Government – Policy Leads – Andrew Evans, David O'Sullivan, Ruth Crowder, Sue Tranka, Paul Labourne, Rob Orford

HEIW Primary Care Leads – Esther Lomas and Rachel Brace

HEIW Profession Directorate Leads

Sophie Harding

Lloyd Hambridge

HEIW Pharmacy - Rebecca Hunter, Karen Brambles

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Pharmacy Review

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	RACHEL HENNESSY, INTERIM DIRECTOR
PRESENTED BY	RACHEL HENNESSY, INTERIM DIRECTOR
APPROVED BY	Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	The purpose of this report is for Quality, Safety and Performance Committee (QSPC) to receive Welsh Government's response to the Royal Pharmaceutical Society's review of clinical pharmacy services in Wales published in September 2023 and the external review of VCS pharmacy service conducted by Andrew Davies, received in September 2023. The QSPC are asked to note both reports and the intention to establish a Pharmacy transformation workstream under Velindre Futures programme to

	take forward the recommendations of both reports.

RECOMMENDATION / ACTIONS	The QSPC are asked to: • **NOTE** this report • **RECEIVE** the Welsh Government document and external pharmacy review document • **NOTE** the establishment of pharmacy transformation workstream as part of Velindre Futures

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
EMB	
VCS Senior Leadership Team	21/02/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE

If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 1 - Actions for symptomatic issues, no defined outcomes *Please refer to the Detailed Definitions of 7 Levels of Evaluation to Determine RAG Rating / Operational Assurance and Summary Statements of the 7 Levels in Appendix 3 in the **"How to Guide for Reporting to Trust Board and Committees"***

APPENDICES

1	VUNHS Trust Pharmacy Review
2	Independent Review of Clinical Pharmacy Services at NHS Hospitals

1. SITUATION

The paper provides QSPC with details of the review commissioned by Welsh Government in relation to clinical pharmacy services provision across Wales. In addition, the recommendations from an external review commissioned by VUNHST of pharmacy services.

The QSPC asked to note the reports, recommendations and process proposed for supporting and monitoring implementation.

2. BACKGROUND

In September 2023, Welsh Government published their response to an independent review they had commissioned from the Royal Pharmaceutical Society into hospital pharmacy services which provided a prioritised action plan as to the significant changes expected in the provision of hospital pharmacy services across NHS Wales.

There were 36 recommendations made by the RPS reviewers. The Welsh Government simultaneously published their response setting out 60 strategic actions to progress alongside those to be taken forward by health boards, Velindre University NHS Trust, and partner organisations.

In July 2023, prior to the publication of the Welsh Government review, an external review of the VUNHST pharmacy department was commissioned by COO, Director and Chief Pharmacist to identify a baseline for the services and assess assurance of leadership, quality, safety and performance of medicine supplies and clinical services linked to medicine. The external review also took into consideration the anticipated recommendations coming from the RPS review.

3. ASSESSMENT

The external review of pharmacy at VUNHST had five aims:
- Provide a baseline assessment of VUNHST pharmacy services – including statutory role of the chief pharmacist and provision of unlicensed (section 10 exempted) aseptic medicines supply
- Identify the most efficient 5-year delivery model for the services
- Assess assurance of quality, efficiency, safety and performance of medicines supply and clinical services linked to medicines
- Evaluate at a macro level the financial sustainability and value for money of currently provided services
- Identify a range of potential next steps within 6 key themes:
  - Doing things differently

- o Improved clinical outcomes
- o Supporting our workforce
- o Innovation data and technology
- o Productivity and efficiency
- o Clinical trials and research

The WG review noted the significant variation between different hospitals across Wales including between pharmacists and clinical activities and also recognised that VCC was an early adopter of some significant service enhancements such as non-medical prescribing.

Key recommendations of the NHS Wales wide WG review included:
- Enabling pharmacist and technician to prioritise their time on clinical activities
- The need for a review of leadership and development needs of the pharmacy team
- Potential restructuring to optimise clinical outcomes
- Improved efficiency of hospital medicines supply and logistics arrangements, digitisation and automation.

4.   **SUMMARY OF MATTERS FOR CONSIDERATION**

SLT formally received both documents in February 2024. In response to both reviews, SLT have formally asked for tenders to develop and write a 5-year strategy for pharmacy and medicines management services.

In addition to this a formal project will be established under the Velindre Futures structure. This will provide clear and transparent response and action to the delivery of the report, enable risks to be captured and will formally report through the exiting VF governance structure through to Executive Management Board via a monthly highlight report, identifying by exception any areas of concern.

On establishment the workstream will be required to review the recommendations in both documents, aligning deliverables against existing key programmes/project and timelines. An overall delivery plan will be created. It is recommended that the SRO for this project is the Medical Director as the executive clinical lead for Pharmacy and Medicines Management services.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☒
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☒
• A sustainable organisation that plays its part in creating a better future for people across the globe	☐

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	[In this section, explain in no more than 3 succinct points why an assessment is not considered applicable or has not been completed]. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	This section should outline the financial resource requirements in terms of revenue and/or capital implications that will result from the Matters for Consideration and any associated Business Case. Narrative in this section should be clear on the following: **As yet unknown** **Source of Funding**: **Choose an item** Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Choose an item** **Scale of Change**

	Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	There are no specific equality impact implications related to the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*[Please insert detail here in 3 succinct points].*
WHAT IS THE CURRENT RISK SCORE	Insert Datix current risk score
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
	[In this section, explain in no more than 3 succinct points what the barriers to implementation are].
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University Hospital NHS Trust

Pharmacy Review (Phase I)

Andrew Davies, September 2023

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Executive summary

The prescription of a medicine is the most common healthcare intervention undertaken within the NHS. Across the UK Hospital pharmacy practice has become increasingly patient orientated with clinical pharmacy skills being in high demand. Wales, like England and the other home nations is looking to the transformation of hospital pharmacy services as the use, complexity and expenditure of medicines has increased.

In September 2023, the Welsh Government published their response to an independent review they had commissioned into hospital pharmacy services which provides a prioritised action plan as to the significant changes being expected in the provision of hospital pharmacy services across NHS Wales.

There is considerable variation between different hospitals across Wales, including between pharmacists' clinical activities, the services offered to different specialties, the way in which the pharmacy workforce is structured, management arrangements and the culture of leadership. This review was commissioned to identify a baseline for the pharmacy service at Velindre University Hospital NHS Trust and to assess assurance of the leadership, quality, safety and performance of medicines supply and clinical services linked to Medicines.

The pharmacy at the Velindre Cancer Centre was an early adopter of some significant service enhancements – such as non-medical prescribing however, as with the wider NHS, there are multiple demands for change driven by policy, professional and public expectations. To ensure that medicines are used to deliver the best clinical outcomes for patients it is essential that a comprehensive Pharmacy, Prescribing and Medicines strategic vision for the organisation is developed, updated and effectively communicated to Executives, healthcare professions and the pharmacy team as to the future of the pharmacy service and how it best aligns with the organisations plans to transform cancer services and changing patient needs and expectations.

As with all healthcare professions the pharmacy workforce across Wales is under significant pressure to deliver more for patients. Enabling pharmacists and pharmacy technicians to prioritise their time on clinical activities is critical to integration and to the consistent delivery of outstanding pharmaceutical care. The leadership of, skill-mix and development needs of the VCC pharmacy team needs review and, potentially, restructuring to optimise clinical outcomes.

Potential efficiencies can be achieved through improved efficiency of hospital medicines supply and logistics arrangements, digitisation and automation. However, it is essential that significant developments, issues and risks are effectively communicated within the organisation through briefings and, where appropriate, through the risk register.

This external review of the Velindre Cancer Centre pharmacy service forms the start point for transforming the Pharmacy, Prescribing and Medicines service and provides a draft strategic model and recommended next steps to meet future challenges.

Introduction and Background

In July 2023, an external review of the Velindre University NHS Trusts Velindre Cancer Centre's pharmacy department was commissioned by the organisation's Chief Operating Officer, Cancer Service Director and Chief Pharmacist to identify a baseline for the Service and assess assurance of the leadership, quality, safety and performance of medicines supply and clinical services linked to Medicines.

This review intends to Identify the potential optimal 5-year delivery model for the pharmacy services into the New Velindre Cancer Centre and assess, at a macro level, the financial sustainability and Value For Money of currently provided services.

Areas considered within scope of the review include
  Core services delivered - clinical, non-medical prescribing, procurement and supply of medicines.
  Governance and assurance - considering the statutory, professional and leadership role of the Chief Pharmacist aligned to organisational priorities to deliver safe and effective clinical care.
  Additionally, the preparation and supply of Systemic Anti-Cancer Therapies (SACT) in-house and via commercial out-sourced arrangements (in preparation for future Welsh TrAMs supply) were reviewed.

The review process utilised a range of documents provided by the pharmacy department (Appendix E) and then face-to-face and Microsoft Teams based interviews with senior leaders across pharmacy, Velindre Cancer Centre, the wider Velindre University Hospital NHS Trust and national pharmacy leads across Wales (see Appendix B for interviewees).
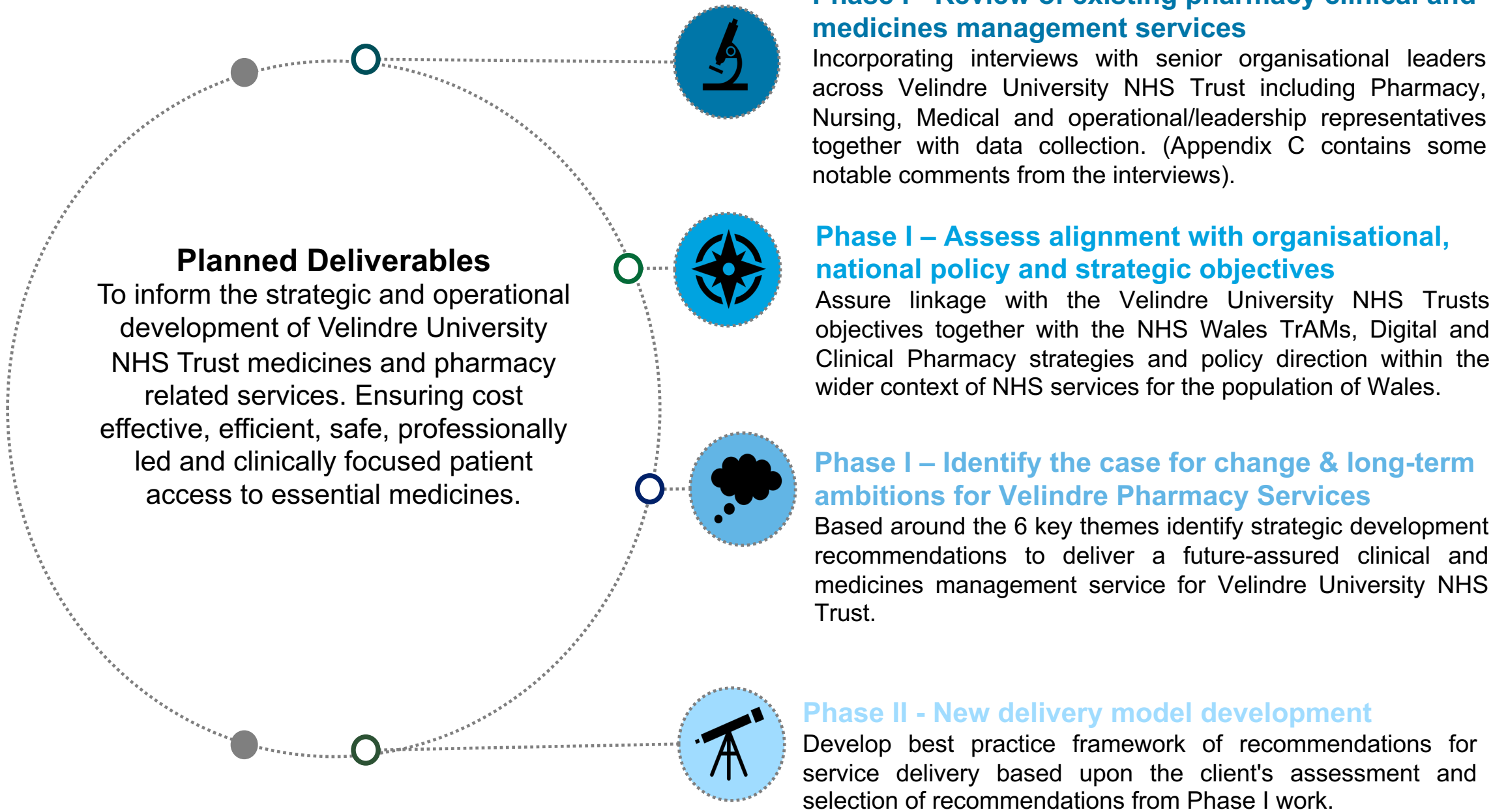
The review has been undertaken based on the professional experience of the reviewer who has worked across the NHS for 33 years with extensive experience as an NHS Chief Pharmacist in multiple NHS Trusts in England and, most recently, for 5 years as the national Director of Hospital Pharmacy for NHS England leading on pharmacy productivity and efficiency, modernisation of NHS Hospital Pharmacy Aseptic Services and NHS Medicines Manufacturing.

Strategic plans for the implementation of Welsh Government intentions around the future of clinical pharmacy, electronic prescribing, digital interoperability and uptake of technology and the subsequent use of data to improve patient clinical outcomes were explored.

The review then identifies a range of potential next steps (Phase II) within 6 key themes:

Doing things differently	Improved clinical outcomes	Supporting our workforce	Innovation data & technology	Productivity and efficiency	Clinical Trials & Research

Review outline

Planned Deliverables

To inform the strategic and operational development of Velindre University NHS Trust medicines and pharmacy related services. Ensuring cost effective, efficient, safe, professionally led and clinically focused patient access to essential medicines.

Phase I - Review of existing pharmacy clinical and medicines management services

Incorporating interviews with senior organisational leaders across Velindre University NHS Trust including Pharmacy, Nursing, Medical and operational/leadership representatives together with data collection. (Appendix C contains some notable comments from the interviews).

Phase I – Assess alignment with organisational, national policy and strategic objectives

Assure linkage with the Velindre University NHS Trusts objectives together with the NHS Wales TrAMs, Digital and Clinical Pharmacy strategies and policy direction within the wider context of NHS services for the population of Wales.

Phase I – Identify the case for change & long-term ambitions for Velindre Pharmacy Services

Based around the 6 key themes identify strategic development recommendations to deliver a future-assured clinical and medicines management service for Velindre University NHS Trust.

Phase II - New delivery model development

Develop best practice framework of recommendations for service delivery based upon the client's assessment and selection of recommendations from Phase I work.

Pharmacy Review September 2023

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BASELINE ASSESSMENT (1)

Review of existing pharmacy clinical and medicines management services
Through interviews with senior organisational leaders across Velindre University NHS Trust including Pharmacy, Nursing, Medical and operational/leadership representatives together with data collection.

The Velindre Cancer Centre (VCC) is a small tertiary, non-surgical solid tumour, cancer service based in Cardiff delivering in-patient, out-patient and homecare Systemic Anti-Cancer Therapy (SACT) based treatments across multiple Health Boards in the South of Wales. There is a very clear focus on patient care across the organisation.

The pharmacy service is delivered under the leadership of a long-standing Chief Pharmacist supported by a team of Senior Pharmacists and a wider team of pharmacists, pharmacy technicians and support staff.

At the current time 9 of the organisations 23 pharmacists are non-medical prescribers supporting a range of Site-Specific Teams. A further 4 pharmacists are undergoing prescribing training. Of the remaining pharmacists 5 are "non-patient facing".

The Chief Pharmacists role was expanded to include leadership for SACT delivery in 2020. During the review, feedback received questioned the appropriateness of this with the significant agendas and challenges in both areas. This is subject of separate discussions at VCC.

As with other NHS organisations pharmacy teams, the VCC Pharmacy service is increasingly experiencing significant pressure to expand their contribution in newer areas and in different working models but are at risk of withdrawing from others in favour of traditional task-based pharmacy roles including medicines supply and logistics, technical services (SACT preparation) and medicines information services.

The VCC pharmacy service currently provides all routine medicines supply and logistics facilities as would be provided by a larger organisation including:
- Medicines procurement
- Stock storage and supply,
- Dispensing
- Aseptic activity preparing and supplying Systemic Anti-Cancer Therapies.

For technical services good progress has been made outsourcing aseptic compounding with the team estimating 50% of product volume being outsourced as of May 2023. During the review it has been established that a further 40% of the total VCC compounded activity could be outsourced. There has however been a significant challenge with the rate at which the national Transforming Access to Medicines (TrAMs) programme is progressing. The impact of the pandemic has delayed the availability of large scale, standardised compounded product availability.

BASELINE ASSESSMENT (2)

Review of existing pharmacy clinical and medicines management services
Through interviews with senior organisational leaders across Velindre University NHS Trust including Pharmacy, Nursing, Medical and operational/leadership representatives together with data collection.

At the current time, the planned TrAMs delivery model would appear to be several years from full realisation and product delivery.

A recent "Rough-cut Capacity and Improvement Plan" (Tyrone review) looked, using Lean methodologies, at the workflows within the VCC aseptic unit identifying some options to increase capacities. However, it did not align with Welsh Government policy direction around moving away from in-house aseptic compounding activity, where possible, and the review did not recommend greater use of commercial outsourced aseptic compounding (indeed it recommended repatriation of some activity) and made no effort to understand full service costs vs. external acquisition.

There is an urgent need to increase the supply of ready to administer SACT doses for VCC patients. This issue has been an organisation concern for a significant time and the optimal next steps do not appear to have been effectively considered.

Excellent progress has been made moving VCC pharmacists to having job plans which incorporate many of the recognised elements from the guidance document "E-job planning the clinical workforce". However, this process would appear to have started from the individual pharmacist's perspective rather than the demand profile for pharmacy services in all clinical areas (including working requirements to support optimal patient need) and the need to

strategically define the nature and extent of the service and hence the specific role(s) of the pharmacy team.

Pharmacy services provided have evolved over many years and there would appear to have been no review or value assessment and reprioritisation to meet the VCC strategic vision.

There is no Chief Pharmacy technician role identified within the VCC pharmacy structure. This diminishes the professional leadership of this workforce group that forms 38% of the hospital pharmacy workforce in Wales. Additionally, VCC does not utilise the potential for pharmacy technicians undertaking additional appropriate clinical roles, a gap that is exacerbated by the lack of access being made to HEIW funding in place to support formal Clinical pharmacy Technician training.

There is aspiration for the VCC pharmacy team to provide some leadership around development of accredited SACT training to support the wider NHS in Wales. At the current time there is no strategic plan to support this wish.

From discussions with the VCC team there is limited pharmacy input into multidisciplinary education and training structures at VCC beyond 'ad hoc', small scale input when requested.

Finally, there would appear to be limited strategic planning within the pharmacy making the departments vision and direction of travel somewhat 'opaque' to the wider organisation.

Alignment

National alignment:
Pharmacy is a profession that has a wide range of legislative, regulatory and professional requirements. Several recent Welsh Government reports clearly identify the priorities for the NHS in Wales including the importance of quality in all health services (Duty of Quality Statutory Guidance 2023) and the future based around services provided outside hospital and closer to home.

Pharmacy specifically has its future state described within Pharmacy Delivering a Healthier Wales with the focus of hospital pharmacy teams shifting to delivery of care and transformation of access to medicines.

The most recent *(September 2023)* publication is the Welsh Government response to their commissioned Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales, undertaken by the Royal Pharmaceutical Society. This confirms the clinical focus for future pharmacy services and the strategic intent to review the efficiency of traditional medicines supply and logistic processes in hospital to support workforce capacity through release of pharmacist and pharmacy technician time for clinical care.

This report includes a priorities action list that directly tasks health boards and, in the majority of cases, Velindre University Hospital NHS Trust. Many of the identified priorities link directly to the findings of this review.

Transforming Access to Medicines (TrAMs) is an NHS Wales programme establishing a shared Pharmacy Technical Service for Wales supported with an initial investment of £67m. The new service sits within NWSSP, under the governance of the Shared Services Partnership Committee.

The Digital Medicines Transformation Portfolio (DMTP) brings together the programmes and projects that will deliver the benefits of a fully digital prescribing approach in all care settings in Wales. For VCC this includes Electronic Prescribing and Medicines Administration which will support the small in-patient population but also the transmission of out-patient prescriptions to patients' pharmacy of choice.

Organisational alignment:
The key objectives for Velindre University Hospital NHS Trust come from the Transforming Cancer Services in South-East Wales Programme which includes the provision of a new Velindre Cancer Centre and safe delivery of locality-based care closer to patients' home. All VCC services require a trajectory to meet the planning assumptions within the programme of change including care closer to home.

Case for change (1)

Identify the case for change & long-term ambitions for Velindre Pharmacy Services
Based around the 6 key themes identify strategic development recommendations to deliver a future-assured clinical and medicines management service for Velindre University NHS Trust.

The pharmacy service at Velindre Cancer Centre has been delivered on a historical evolutionary basis with limited transformative development. There are good examples of high quality, valued services especially linked to aspects of non-medical prescribing, individual clinical support for medical staff and reacting to patient needs.

However, there would appear to be a lack of formal strategic planning within the pharmacy service which makes the service very reactive rather than planned. When requested it was identified that there was no overarching pharmacy strategy in place. A Medicines Management strategy developed in 2018 by the Medicines Management Group ran up to 2023 and development of a future strategy was on hold awaiting the proposed external pharmacy review to be undertaken.

In September 2023 the Welsh Government, via the Chief Pharmaceutical Officer, published their strategic recommendations for the NHS in Wales to deliver Clinical Pharmacy services at NHS Hospitals in Wales. Many of the recommendations within the review of the pharmacy service at Velindre Cancer Centre mirror those found in the national review as they are based on professional principles contained within existing Key UK wide and Wales specific references listed in Appendix D.

Several fundamental changes should be considered as a result of this pharmacy review:

Move from Medicines Management:
The term "medicines management" has been popular since the 1990's and was used, mainly, for primary care, non-clinical activities that were often at a distance from patients. The terminology also suggests management rather than leadership. With the focus on patients, clinical and prescribing roles there is a strong case to move to a more suitable naming such as Pharmacy, Prescribing and Medicines.

The pharmacy team, through the Chief Pharmacist, their own skills and their wider senior team, should take the leadership role for all prescribing activities undertaken within the organisation to ensure improvement in the effectiveness and safety of all medicines used across Velindre University Hospital NHS Trust.

It would be necessary to review and update the naming conventions used for posts and groups previously described as "medicines management".

Strategic leadership for Pharmacy, Prescribing and Medicines:
Whilst the naming and scope of the activities previously described as Medicines Management are being changed there should also be the development of a small, "executive leadership' group for the former Medicines Management Group (MMG).

Case for change (2)

Identify the case for change & long-term ambitions for Velindre Pharmacy Services
Based around the 6 key themes identify strategic development recommendations to deliver a future-assured clinical and medicines management service for Velindre University NHS Trust.

During the interviews there were a number of comments about the large size of the MMG and the need to assure its workplans strategic link into the wider organisation and that agendas align with organisational objectives. A small group including the MMG Chair, Chief Pharmacist, the Medical Director and a nursing lead should be overlaid onto the wider MMG to bring focus, a strategic perspective and to support and enhance the future Pharmacy, Prescribing and Medicines groups impact patient care, safety and clinical outcomes from the use of medicines.

Strategy, strategy, strategy:
With the multiplicity of national, organisational, educational and professional agendas it is essential that a formal, comprehensive, organisationally visible and evolving Pharmacy, Prescribing and Medicines strategic model is developed as a matter of urgency. A draft starting model is included within the review to demonstrate the complexity and potential structure. This needs further development and can then be operationalised by the former Medicines Management Group.

Transforming Access to Medicines (TrAMs)
Rather than wait for full TrAMs service implementation VCC (and other Welsh NHS organisations) should utilise, on an interim basis, available commercial providers to maximise supply of standardised routine aseptic products to meet increasing patient needs and to release local

aseptic capacity for preparation of products that cannot be sourced from a commercial compounder. The operational changes required to co-ordinate standardised product specifications within VCC and across Wales will support the eventual TrAMs model and will also facilitate moves to the proposed All Wales SACT IT system.

Organisational clarity around the TrAMs programme and how it fits with the VCC pharmacy business model does appear to be limited. There could also be wider opportunities to further transform medicines supply processes at VCC and influence the design of the new Velindre Cancer Centre pharmacy facility. During the review it was confirmed that the Technical Services, as designed, does not effectively support the future external supply route for the majority of aseptically prepared products in terms of workflow, room adjacencies and storage requirements. This is due to the internal VCC pharmacy view that the TrAMs service model has not been agreed therefore the design of the facility needs to allow for more in-house compounding. This position must be updated.

Whilst TrAMs is, currently, focussed on aseptic preparative facilities the original business case included wider medicines supply arrangements (including stock and Homecare medicines) VCC could look to more collaborative working with neighbouring health boards to obtain the more traditional pharmacy functions such as Medicines stock supply.

Case for change (3)

Identify the case for change & long-term ambitions for Velindre Pharmacy Services
Based around the 6 key themes identify strategic development recommendations to deliver a future-assured clinical and medicines management service for Velindre University NHS Trust.

Digital development:

As a small organisation Velindre is unlikely to be attractive to a commercial software provider to provide Electronic Prescribing and Medicines Administration systems to. It will therefore be highly likely that VCC will need to partner with a larger, local, NHS organisation to progress with EPMA. This will bring economies of scale for the supplier and efficiencies for Velindre however will require strong leadership to deliver and will, in all likelihood, drive changes in existing practice.

VCC has a longstanding implementation of the ChemoCare SACT prescribing and supply system. However, from discussions with pharmacy and clinical interviewees a "root and branch' reset of the system is required. Historic development of regimens and reliance on IT naming conventions (use of a numbering convention in regimens & having multiple for the same drug) has led to an overly complex and inflexible ChemoCare system that does not best support clinical practice.

The VCC team has no strategic leadership or operational resourcing to deliver the ChemoCare system which is the key, mission critical, tool for prescribing, preparation and administration of systemic anti cancer medication - the fundamental purpose of a cancer centre.

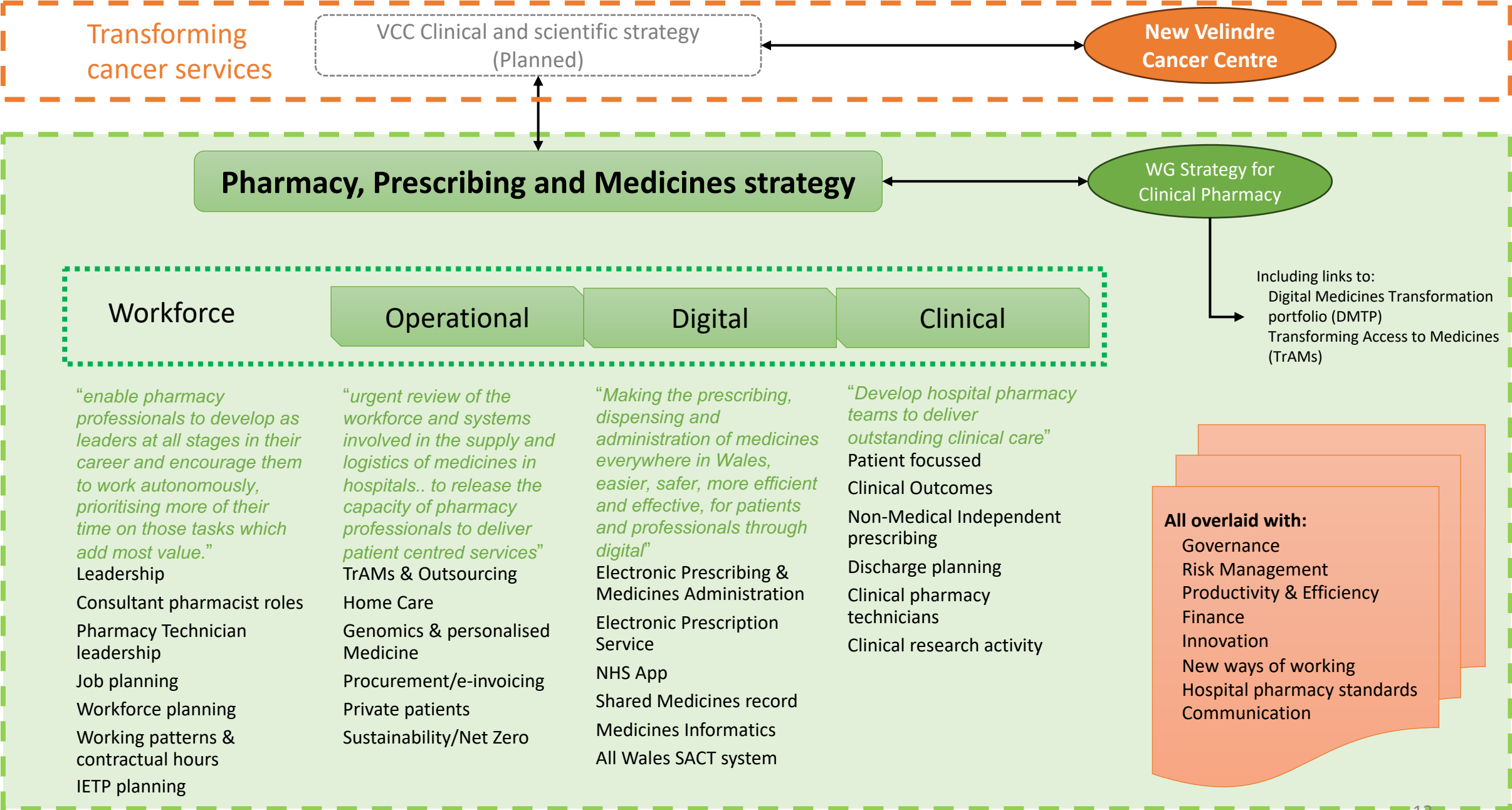During the clinical interviews it was clear that there is a strong need for better clinical intelligence to be produced from current and future IT systems including those relating to medicines. Being able to access information on regimens given and available and the clinical outcomes from such treatments will further improve patient care.

VCC, until recently, had a Pharmacy IT lead in post 0.6wte funded through Welsh Government Digital infrastructure resources however the post did not cover the principles of Pharmacy informatics which leverage pharmacist's clinical expertise and knowledge about information technology to improve medication management processes and shape drug distribution systems to assure drug administration safety. The importance of future informatics needs must be included within the pharmacy strategic vision.

Communication:

Whilst there is evidence of good clinical communication there are examples of poor leadership and organisational communication The pharmacy service needs to ensure that significant issues such as the development of the TrAMs programme, significant risk issues such as fungal contamination, critical failings in assurance of aseptic preparation of medicines and reports from Welsh Government requiring organisational actions are all effectively briefed on, where relevant captured in risk registers and understood in a timely manner by the wider Velindre University Hospitals Trust leadership.

Pharmacy, Prescribing and Medicines draft strategic model

Transforming cancer services

VCC Clinical and scientific strategy (Planned)

New Velindre Cancer Centre

Pharmacy, Prescribing and Medicines strategy

WG Strategy for Clinical Pharmacy

Including links to:
Digital Medicines Transformation portfolio (DMTP)
Transforming Access to Medicines (TrAMs)

Workforce | Operational | Digital | Clinical

Workforce

"enable pharmacy professionals to develop as leaders at all stages in their career and encourage them to work autonomously, prioritising more of their time on those tasks which add most value."

Leadership

Consultant pharmacist roles

Pharmacy Technician leadership

Job planning

Workforce planning

Working patterns & contractual hours

IETP planning

Operational

"urgent review of the workforce and systems involved in the supply and logistics of medicines in hospitals.. to release the capacity of pharmacy professionals to deliver patient centred services"

TrAMs & Outsourcing

Home Care

Genomics & personalised Medicine

Procurement/e-invoicing

Private patients

Sustainability/Net Zero

Digital

"Making the prescribing, dispensing and administration of medicines everywhere in Wales, easier, safer, more efficient and effective, for patients and professionals through digital"

Electronic Prescribing & Medicines Administration

Electronic Prescription Service

NHS App

Shared Medicines record

Medicines Informatics

All Wales SACT system

Clinical

"Develop hospital pharmacy teams to deliver outstanding clinical care"

Patient focussed

Clinical Outcomes

Non-Medical Independent prescribing

Discharge planning

Clinical pharmacy technicians

Clinical research activity

All overlaid with:
Governance
Risk Management
Productivity & Efficiency
Finance
Innovation
New ways of working
Hospital pharmacy standards
Communication

New delivery model development

Develop best practice framework of recommendations for service delivery based upon the client's assessment and selection of recommendations from Phase I work.

Doing things differently

- Develop a formal, comprehensive and evolving Pharmacy, prescribing and medicines strategic vision. This should link into the wider planned Velindre Clinical and Scientific strategy.
- Develop a comprehensive pharmacy service demand profile for clinical areas and ensure pharmacy team working patterns align to patient and service needs.
- Focus on moving, as rapidly as possible to an outsourced Chemotherapy model where possible. This will, eventually, be through the TrAMs service however much of the change process required for TrAMs could be implemented using existing commercial compounders.
- Review existing new Velindre Cancer Centre pharmacy department plans to ensure technical services design supports maximised external ready to administer chemotherapy supply.
- VCC has recognised an unmet need for private cancer SACT therapy and, over recent years, has increased the number of Private patients being treated. Pharmacy should work closely with the Private Patients Improvement Group to assure appropriate funded medicines supply.

Improved Clinical outcomes

- Develop formal Service Level Agreements (SLA's) for pharmacy services to clinical areas including Non-Medical prescribing and any advance practice (and potential future consultant) level roles.
- Link Pharmacy team job plans to Pharmacy demand profile and SLA's.
- Further progress the integration of pharmacy teams into the organisations Multi-Disciplinary Teams
- Support VCC pharmacy technicians to access additional clinical training to improve clinical outcomes. This will support the development of the existing VAPP service and the pharmacy input to SACT telephone helpline.
- Maximise availability of TTO packs to support discharge of patients – broader range needed to support patients.

Next steps (2) – Phase II

New delivery model development
Develop best practice framework of recommendations for service delivery based upon the client's assessment and selection of recommendations from Phase I work.

Supporting our workforce

- As a key pillar of the Pharmacy strategy develop a comprehensive VCC Pharmacy workforce plan to meet the strategic vision for the service. This must include the actions included in the Welsh Government future hospital clinical pharmacy document including:
  - ➢ Working patterns & contractual hours   ➢ Integration into MDT's   ➢ Expand/develop advance/consultant pharmacist practice
  - ➢ Standardised post-reg career frameworks ➢ Updated standard job titles   ➢ Job planning linked with care closer to home
  - ➢ Pharmacy Technicians access to Clinical training.
- To recognise the professional leadership for the Pharmacy Technician workforce VCC should developing funding for and the role of Chief Pharmacy Technician.
- Aligned with the VCC pharmacy strategic vision develop the business case and job plan for a future, initial, Consultant pharmacist role.

Innovation data & technology

- Review, in line with wider VCC Pharmacy strategic vision, the prioritisation and role of pharmacy informatics lead role to deliver the Digital Medicines Transformation Portfolio (DMTP) aspirations.
- Develop partnership approach with a local Health board to share the Velindre approach to implementation of a suitable Electronic Prescribing and Medicines Administration for the VCC non-SACT medicines for in-patients and out-patients.
- Identify the approach required to support medicines related Informatics (Pharmacy Informatics) to facilitate clinical care and improved patient clinical outcomes. This will need to take the data collected by systems such as ChemoCare/EPMA and the wider patient heath record and convert it to information & wisdom
- Close involvement with the development and implementation of the all Wales SACT IT system to replace ChemoCare.
- Fully realise the benefits of wider use of innovation to guide therapeutic decision making.

New delivery model development
Develop best practice framework of recommendations for service delivery based upon the client's assessment and selection of recommendations from Phase I work.

Productivity and efficiency

- Work with other specialist cancer centres across the UK to ensure pharmacy services are benchmarked and optimised to deliver best patient care and innovation and learning/innovation is shared.
- Whist waiting for full TrAMs facility development work with NWSSP's Assistant Director of Medicines Procurement and Optimisation to develop Commercial compounding service contracts with KPI's and monitoring to assure continuity of supply
- 'Root and branch' review of the VCC ChemoCare system including disease tree, protocols/cycles and regimens to support product standardisation and outsourcing, improve clinical useability and prepare for planned all-Wales SACT IT system.
- As with all NHS Wales organisations optimal efficient use of medicines is a priority, including those medicines recharged to other organisations. All stock, SACT and WP10 medicines usage must be subject to regular, structured review to assure best value for taxpayers.

Clinical trials & research

- Have a clear VCC strategy to deliver pharmacy and medicines related technological advances, such as expanding access to pharmacogenomic testing, fundamentally transforming decisions about individual patient's treatment.
- Closer working with clinical research leads to support opportunities to provide medicines data to support health research with digital systems that more fully support data analysis.
- Ensure close involvement in the Pharmacy Research Strategy in Wales refresh including participation in proposed network of pharmacy research mentors.
- Participation and supervision of research to be built into relevant Job Plans.

Next steps Summary

New delivery model development

Doing things differently	Improved clinical outcomes	Supporting our workforce	Innovation data & technology	Productivity and efficiency	Clinical Trials & Research
Pharmacy, prescribing and medicines strategy.

Pharmacy service demand profile including working hours.

Maximise outsourced chemotherapy.

Review nVCC pharmacy plans and design principles.

Pharmacy input to developing VCC Private Patient service. | Formal pharmacy Service Level Agreements.

Link job plans to demand profile and SLA's.

Fuller MDT integration of pharmacy teams.

Clinical development of VCC Pharmacy Technicians.

VAPP and SACT helpline development.

Maximise TTO packs. | Comprehensive VCC pharmacy workforce plan.

Develop Chief Pharmacy Technician role.

Consultant Pharmacist role development and approval. | Pharmacy informatics lead post.

EPMA implementation partnership approach.

Pharmacy informatics strategy – systems to support clinical outcomes.

All Wales SACT system implementation.

Innovation to support therapeutic decision making. | Benchmarking with other Cancer Centres.

Commercial compounding contracts with KPI's.

ChemoCare system review and optimisation.

Structured review of medicines usage. | Strategy for pharmacy and medicines related technological advances.

Medicines data systems.

Pharmacy research strategy in Wales.

Incorporate Research remit into job plans. |

Pharmacy review – Velindre University NHS Trust

Background information:

Following discussion between Cath O'Brien (Chief Operating Officer, Velindre University NHS Trust) who shared previous objectives scoped for a review, Andrew Davies was asked to develop a proposal for a Pharmacy Review for Velindre University NHS Trust.

Andrew Davies has extensive experience as an NHS Chief Pharmacist across NHS Trusts in England and, in the 5 years up to his early retirement in 2022, substantial experience as national Director of Hospital Pharmacy for NHS England. In this role leading on the pharmacy elements of Lord Carter's review of NHS Productivity and Efficiency plus modernisation of NHS Hospital Pharmacy Services developing specific, detailed reports and national strategies, on Aseptic Services and NHS Medicines Manufacturing. In addition, leading on NHS England secondary care medicines data analysis and funding for Electronic Prescribing & Medicines Administration roll out nationally. These experiences give him an in-depth knowledge of the NHS, current policy and the political issues affecting it.

After an initial discussion between Cath and Andrew Davies this set of slides outlines a proposed review process in two phases:

1. **Phase I** – baseline assessment and review of existing pharmacy and medicines management services in Velindre University NHS Trust. Together with identification of potential next steps in transforming pharmacy services within the organisation in line with organisational and national strategic aspirations.

2. **Phase II** – development of a 'menu' of key transformation recommendations identified in phase I with timeframes to then be onboarded by the Velindre team to effectively and efficiently deliver optimal care for patients within the organisation.

These 2 phases are distinct and Phase II can be progressed, as appropriate, with externally commissioned support or within internal resourcing.

This slide deck identifies the context, objectives for and scope of the work together with the proposed deliverables all with a focus on Phase I **NB Phase II will require the completion of Phase I to be fully developed in terms of timescales and costings.*

In addition a draft indicative Phase I timeline is included. Actual timescales would depend on the Velindre University NHS Trusts needs and budget for the work. The review's progress will be monitored with the Velindre University NHS Trust leadership team every 2 weeks throughout Phase I. Any time or capacity pressures would be discussed through these monitoring meetings.

Pharmacy review – Velindre University NHS Trust

Project context, objectives and scope

Context

- Small tertiary, non-surgical solid tumour, cancer service based in Cardiff delivering in-patient, out-patient and homecare SACT based treatments across multiple Health Boards.
- Service delivered on historical evolutionary basis with limited transformative development.
- New hospital (nVCC) build and changing Welsh Government strategic direction around complex injectable medicines supply and governance concerns linked to the assurance of unlicensed aseptic preparation of medicines.
- NHS challenges linked to COVID-19, workforce, productivity and efficiency together with evolving professional remit/scope of practice & patient needs and expectations.

Objectives

This review will:

- Provide a baseline assessment of Velindre University NHS Trust Pharmacy services - including the statutory role of the Chief Pharmacist and provision of unlicensed (Section 10 exempted) aseptic medicines supply.
- Identify the most efficient 5-year delivery model for the services (e.g. direct local, shared service or partnership working).
- Assess assurance of quality, efficiency, safety and performance of medicines supply and clinical services linked to medicines.
- Evaluate at a macro level the financial sustainability and Value For Money of currently provided services.
- Identify a range potential next steps (Phase II) within 6 key themes:

Doing things differently	Improved clinical outcomes	Supporting our workforce	Innovation data & technology	Productivity and efficiency	Clinical Trials & Research

Scope

Medicines Management Services: Core services delivered including clinical, Non-medical prescribing, procurement & supply.

Governance & assurance: Statutory role of Chief Pharmacist, organisational alignment, patient safety and care quality.

Aseptic (Section 10 exempt) preparation: Including chemotherapy, dose banding and standardisation together with links to NHS Wales Transforming Access to Medicines (TrAMs) programme and supply of aseptic products (not limited to chemotherapy) from licensed facilities.

Financial aspects of service: To include funding flows, productivity & efficiency (such as biosimilar uptake), skill mix and workforce.

Digital and technological developments: Strategic plans for EPMA, digital interoperability and uptake of technology.

Interviewees

Velindre University Hospitals NHS Trust – Internal:

    Cath O'Brien - Chief Operating Officer (*& Review sponsor*)

    Bethan Tranter – Chief Pharmacist

    Martin Rees-Milton – Principal Pharmacist Technical Services

    Usman Malik – Principal Pharmacist Clinical Services

    Kerry Crompton – Senior Digital Lead Pharmacist

    Paul Wilkins – Director Velindre Cancer Centre

    Nicola Williams – Director of Nursing

    Amy Quinton – Consultant in Medical Oncology, Chair of Medicines Management Group

    David Osbourne – Finance lead (with colleagues James Coliandris & Helen Lock)

    Andrea Hague – Director new Velindre Cancer Centre

    Eve Gallop-Evans - Clinical Director and Consultant in Clinical Oncology

    Jacinta Abrahams – Medical Director

    Viv Cooper – Head of Nursing

    Carl James – Director of planning and strategy

External:

    Colin Powell - Director All-Wales Pharmacy Technical Services

    Laura-Jayne Keating – All Wales Specialist Pharmacist QA and QC

    Mark Francis – Assistant Director of Medicines Procurement and Optimisation Wales

    Andrew Evans – Chief Pharmaceutical Officer, Welsh Government

Notable interview comments

VCC has no strategic leadership for the ChemoCare SACT system – this is at significant variance with all other NHS Wales organisations.

ChemoCare disease trees are not built in a helpful way.

Chemotherapy regimens are over complicated due to naming using numbering.

Pharmacy is amazing – we (doctors) work with them on an equal footing.

So many opportunities for pharmacy to support research.

Pharmacy needs to take ownership of medicines related challenges and be an enabler rather than a blocker.

Digital systems must support analysis of patient outcomes.

There are opportunities for medicines efficiencies.

Key strength of the pharmacy is its patient focus.

Pharmacy has not been given or taken the opportunity to 'grow'.

Pharmacy is a huge opportunity for the organisation.

Pharmacy do not appear to see communicating with the Exec's as helpful.

Day to day pharmacy and nursing work well together.

We need a clearer strategy for Non-Medical Prescribers linked to the workforce planning process.

Services have tended to develop by accident rather than design.

Pharmacy service feels very different from other organisations I have worked at – feels much more 'passive'.

Core reference sources

This review has been undertaken based on the professional experience of the reviewer who has worked across the NHS for 33 years with extensive experience as an NHS Chief Pharmacist in multiple NHS Trusts in England and, most recently, as national Director of Hospital Pharmacy for NHS England leading on pharmacy productivity and efficiency, modernisation of NHS Hospital Pharmacy Services and NHS Medicines Manufacturing.

Key UK wide and Wales specific references:

Pharmacy Delivering a Healthier Wales LINK

Professional Standards for Hospital Pharmacy services – Royal Pharmaceutical Society LINK

Independent review of Clinical Pharmacy Services at NHS Hospitals in Wales – Welsh Government response September 2023 LINK

Prescribing Progress: Transforming Clinical Hospital Pharmacy in Wales for Enhanced Patient Care – Royal Pharmaceutical Society September 2023 LINK

NHS Wales Transforming Access to Medicines (TrAMs) programme LINK

Operational Productivity and performance in English NHS acute hospitals: Unwarranted variations 2015 LINK

Transforming NHS Pharmacy Aseptic Services in England – NHS England LINK

Assurance of aseptic preparation of medicines in NHS Wales (formerly 1997 NHS DGM(97)5)

NHS Quality and Safety Framework Learning and Improving LINK

A Healthier Wales: our Plan for Health and Social Care LINK

Digital Health and Care Wales - Digital Medicines Transformation LINK

E-Job planning the clinical workforce LINK

Velindre specific:

Transforming Cancer Services in South-East Wales Programme.

Documents requested

Document	Available
Organisational structure (including pharmacy's place in it)	No
Pharmacy service outline including service hours and restrictions	Yes
Leadership structure	Yes
Medicines management strategy	Yes – 2018-2023 version
Medicine procurement strategy	Draft
Governance structures (committees including formulary, medical gases, patient safety/risk management)	Yes
Pharmacy staffing structure	Yes
Workforce plan including education and development.	No departmental plan available – only draft for Tech Services
Finance information including budgets, income streams, productivity & efficiency information and savings plans	Yes
Risk and issues register including external assessments e.g. Unlicensed Aseptic dispensing in NHS hospitals	Yes
Digital strategy including Electronic Prescribing & Medicines Administration, Chemotherapy prescribing/preparation & automation	None available
Existing New Hospital (nVCC) plans specifically pharmacy service provision and facility design that informed the FBC	Yes
Pharmacy research and clinical trial strategies	None available

Independent Review of Clinical Pharmacy Services at NHS Hospitals in Wales
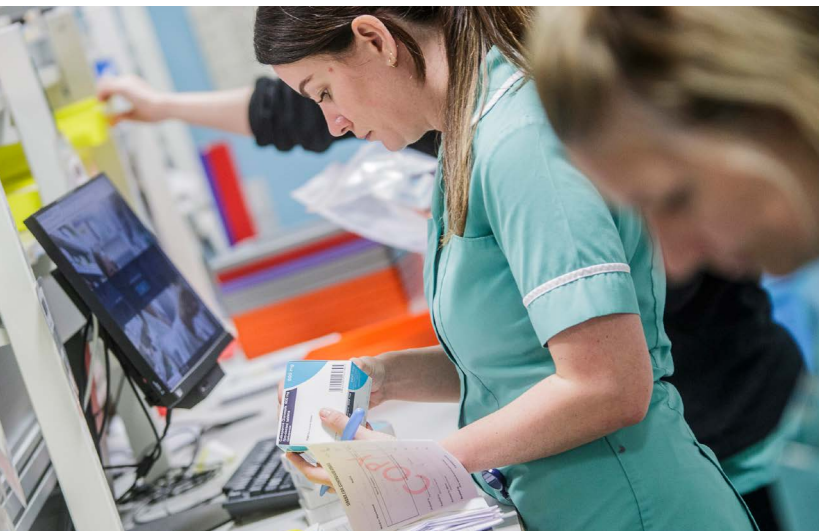
Response by the Welsh Government

September 2023

Contents

1. Background

Hospital pharmacy services

The prescription of a medicine is the most common healthcare intervention undertaken within the NHS. Medicine supply remains a major part of the hospital pharmacy service and pharmacists and pharmacy technicians play a vital role in the procurement and manufacturing of medicines. In addition, pharmacy teams have a broader role in healthcare teams through their involvement in monitoring and improving the effectiveness and safety of medicines used in hospitals.

Hospital pharmacy practice has become increasingly patient orientated and has been described as the "engine of innovation" for pharmacy services.[1] As the use, complexity and expenditure of medicines has increased, hospital pharmacy practice has been at the forefront of expanding the clinical role of pharmacists and more recently pharmacy technicians.

What is clinical pharmacy?

Clinical pharmacy is one element of medicines management and pharmacy services delivered by integrated pharmacy teams. It comprises a set of functions that promote the safe, effective, and economic use of medicines for individual patients.[2]

Clinical pharmacy skills are in high demand in the NHS where the expertise of pharmacy professionals plays a key role in addressing suboptimal medicines use, polypharmacy, high levels of preventable medication related admissions, increasing antimicrobial resistance, rising therapeutic costs and supporting the wider healthcare team with the increasing complexity of medicines.

Hospital pharmacy has been at the forefront in demonstrating how the clinical expertise of pharmacists and pharmacy technicians can be best used to maximise patient outcomes. Many hospital pharmacists are now prescribers and pharmacy technicians in hospitals are taking on more clinical roles. However, there is considerable variation between different hospitals, including between pharmacists' clinical activities, the services offered to different specialties, the way in which the pharmacy workforce is structured, management arrangements and the culture of leadership, and whether pharmacists are organised as part of the clinical services or are aligned to the pharmacy department. There are opportunities to ensure the benefits of clinical pharmacy practice are prioritised and available more consistently to those with the greatest need including in less-traditional areas and outside hospitals as more care is provided in the community closer to people's homes.

1   Farrar K. Hospital pharmacy: thinking the unthinkable. The Pharmaceutical Journal, PJ, January 2000;():DOI:10.1211/
     PJ.2000.20000004
2   Whittlesea C and Hodson K. Clinical Pharmacy and Therapeutics. 6th edition. Elsevier 2019

NHS Wales' priorities

The Welsh Government's long term plan for health and social care A Healthier Wales describes how in future more services will be provided outside hospitals, closer to or at home, and how people will only go into hospital for treatment that cannot be provided safely elsewhere.

To help achieve its long term vision for health services, the Welsh Government has recently published statutory guidance on implementing the duty of quality to ensure that Welsh Ministers and NHS bodies secure continuous improvements in the quality of the services they provide, and guidance to support transformation of urgent and emergency and planned care through its Six Goals for Urgent and Emergency Care programme and programme for transforming and modernising planned care and reducing waiting lists in Wales. Alongside these transformative plans there are opportunities presented by the imminent deployment of electronic prescribing in every hospital in Wales, and the reforms to the initial training of pharmacists, which mean all registering from 2026 will be prescribers.

The need for a review: The future clinical role of pharmacy professionals in hospitals

Pharmacy: Delivering a Healthier Wales (PDaHW) describes the long-term professional goals and principles for the pharmacy profession in Wales and includes a key goal that by 2030 the focus of hospital pharmacy teams will have shifted to respond to changes in the delivery of care and to transform access to medicines.

In the future, only those patients who require urgent, intensive or highly specialist care will require access to advanced practice pharmacists and their teams within the hospital setting and more pharmacists and pharmacy technicians need to be enabled to input into patients' care in the community. Not every patient admitted to hospital will need pharmacy input, and in some cases, a short hospital stay may not be an appropriate time to make an intervention to someone's prescribed medicines. Equally, in the future, unless the current hospital pharmacist workforce substantially increases or there is divestment in some traditional activities, it will not be possible, or necessary, for a pharmacist to see every patient. In this context the way in which clinical pharmacy services in hospitals have traditionally been organised needs to change to meet the changing expectations of the NHS.

2. The Review

In 2022, the Welsh Government commissioned the pharmacy professional leadership body the Royal Pharmaceutical Society (RPS), to undertake an independent review of the provision of hospital clinical pharmacy services in Wales. The purpose of the review was to consider the current provision of clinical pharmacy services in hospitals and how they aligned to the priorities and changing needs of NHS Wales.

The fieldwork for the review was completed in the early part of 2023 and is described in detail with its findings in a report published by the RPS in September 2023.

3. The Review's findings

There are just under 2,000 people working as part of hospital pharmacy teams across Wales of which 44% (866) are pharmacists (748) or foundation pharmacists (118),[3] 38% (748) are pharmacy technicians (669) or pre-registration pharmacy technicians (79),[4] and 18% (350) are non-registrant pharmacy assistants. In contrast to other parts of the workforce, the number of full time equivalent (FTE) pharmacists has fallen in the last five years.

The review concluded that pharmacy teams are increasingly experiencing significant pressures, meaning despite evidence demonstrating their value, they are unable to expand their contribution in newer areas and are at risk of withdrawing from others, in favour of traditional task-based pharmacy roles which add less value. Review participants highlighted the need to address growing pressure on pharmacy professionals in non-clinical roles outside the scope of the review, in order to achieve its objectives.

These included medicines supply and logistics, technical services, and medicines information services.

Despite challenges, the review found clear opportunities for service redesign to benefit patients, the pharmacy workforce, and the wider NHS, and that across Wales there are many good examples of pharmacy professionals making the types of contribution the NHS needs. These included examples of pharmacy professionals supporting urgent and emergency care, planned care, and quality improvement however these are inconsistently delivered not just between health boards but often between hospitals within the same health board.

To address these concerns the review makes 36 recommendations in a range of areas covering patient centred care, integration, pharmacist prescribing, digital and technology, workforce development, leadership, and quality and governance (Annex A).

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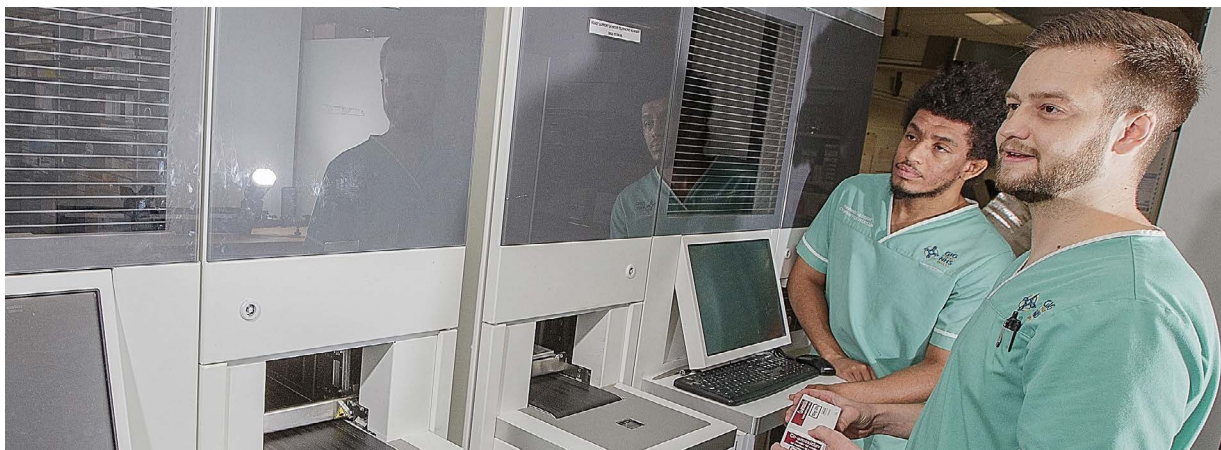
3   Foundation pharmacists are trainees undertaking the required 52 week period of foundation training required alongside passing the registration examination, to register as a pharmacist with the General Pharmaceutical Council (GPhC)
4   Pre-registration pharmacy technicians are trainees undertaking a two-year vocational training programme to gain the required experience and qualification(s) needed to register as a pharmacy technician with the GPhC

4. Responding to the review's findings

Many thousands of medicines are prescribed, dispensed, and administered every day in hospitals across Wales. Not only are people taking more medicines than they have before, but often medicines are increasingly complex in the way they are prepared and in their pharmacological action. Technological advances such as expanding access to pharmacogenomic testing also have the potential to fundamentally transform how we make decisions about individuals' treatment. The provision of high quality, readily accessible clinical pharmacy services is therefore critical to realising the potential of advances in medicine.

The Welsh Government is already progressing its plans to transform how some medicines are prepared and used, and to fully digitise how medicines are prescribed and administered in hospitals through the Transforming Access to Medicines (TrAMs) programme, reconfiguration of local medicines information (MI) services into a single Welsh Medicines Advice Service (WMAS) and the Digital Medicines Transformation Portfolio (DMTP) led by the NHS Wales Shared Service Partnership, MI teams in every health board, and Digital Health and Care Wales (DHCW) respectively. The findings of the RPS independent review build on this work and help describe how hospital pharmacists and pharmacy technicians can be supported to better use the unique skills and expertise to contribute

to addressing the challenges faced by the NHS, throughout their careers, and in new settings reflecting changes to the way care has traditionally been provided.

The review's findings reinforce that clinical pharmacy services are an essential component of high-quality hospital care, helping to improve health outcomes and prevent avoidable harm but as the nature of hospital care changes, so too must the provision of clinical pharmacy services. There must be clearer career pathways for pharmacists and pharmacy technicians, greater integration of pharmacists within multidisciplinary teams, defined roles for pharmacist prescribers at all stages in their clinical career, consistent access to the knowledge and expertise of pharmacy professionals whenever they are needed including in those clinical areas where evidence demonstrates significant benefits aligned to NHS priorities, and stronger leadership and lines of accountability.

Implementing the review's recommendations will lead to benefits for pharmacy teams, other healthcare professionals, the NHS, and most importantly patients receiving hospital care whether in hospital or in the community. To support implementation an initial list of 60 strategic actions (Annex B) has been developed under four themes and 16 sub-themes (Figure one).

Figure one:
Themes describing the priority actions for implementing the recommendations of the review

1

Enabling pharmacy professionals to practise in areas where they add most value

Reducing time spent by pharmacy professionals on non-clinical activities

Prioritising clinical pharmacy service provision to better meet the needs of the NHS

Scope of clinical pharmacy services and the relationship with multidisciplinary teams

Realising the potential of pharmacist prescribing

Improving pharmacy support to meet the NHS's stated priorities

Pharmacy's role in optimising patient flow

2

Developing hospital pharmacy teams to deliver outstanding clinical care

Improving pharmacy workforce planning

Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care

Supporting professional development at all stages in careers

Understanding and continually improving the quality of pharmaceutical care

3

Strengthening quality, pharmacy leadership, and governance at all levels

Improving organisational scrutiny of the quality and effectiveness of pharmacy services

Pharmacy system leadership

Talent management and developing future leaders within pharmacy

Clinical leadership

4

Realising the potential of digital, automation and other technological advances to transform how pharmaceutical care is provided

Better use of data and technology to prioritise pharmaceutical care

Realising the benefits of wider use of innovation to guide theraputic decision making

Enabling pharmacy professionals to practise in areas where they add most value

(Review recommendations 1-12, 16 and 23)

There are good examples across Wales where pharmacy teams are integrated within wider multidisciplinary teams, but practice is inconsistent between health boards, hospitals and clinical specialities. There must be greater integration to improve access to pharmacy expertise for the other healthcare professionals in those teams wherever and whenever it is needed. Integration will also ensure patients' medication needs are addressed prior to planned admissions, at an early stage for unplanned care, and before discharge, removing obstacles to hospital flow. In urgent and emergency care, use of pharmacist prescribers will release clinician time to provide care and improve a range of quality indicators.

Enabling pharmacists and pharmacy technicians to prioritise their time on clinical activities is critical to integration and to the delivery of outstanding pharmaceutical care consistently across organisations. To do this will require health boards to review how they work currently, to consider where deploying pharmacists and pharmacy technician skills offer the greatest benefit, and the potential efficiencies which could be achieved through digitalisation and automation. This will require organisations to ensure they optimise the skill mix between traditional members of the pharmacy team (pharmacists, pharmacy technicians and pharmacy support staff) particularly to realise the opportunities presented by pharmacist prescribing, and to diversify

pharmacy teams both to develop new skills amongst the current workforce and to include other non-pharmacy professionals in their teams.

Developing hospital pharmacy teams to deliver outstanding clinical care

(Review recommendations 15 and 17-22)

Pharmacists working in NHS hospitals have unique experience and expertise gained through practising alongside and supporting other healthcare professionals with therapeutic decision making, prescribing and administration of medicines, taking account of the needs of individual patients. They are the experts in all aspects of medicines use in hospitals. Many hospital pharmacists in Wales have already undertaken additional training to be able to prescribe medicines within their clinical specialities and from 2026 all new registrants will be prescribers. Ensuring plans are in place to utilise the skills of prescribing pharmacists at all stages of their career is important if the NHS is to realise the benefits of pharmacist prescribers and for recruitment and retention of the pharmacist workforce. There is now an urgent need to prepare for the changes resulting from the General Pharmaceutical Council's updated Initial Education and Training standards for Pharmacists (IETP).

Alongside the changes to the ITEP, it will also be necessary to support the continuing professional development of both pharmacists and pharmacy technicians at every stage of their career in order to maximise their contribution to care. Building on the work Health Education and Improvement Wales (HEIW) has undertaken to develop novel foundation and post-registration foundation training programmes,

a formalised career framework will be required to develop to advanced and consultant level pharmacy practice. This will include supporting pharmacists to participate in and supervise education and training, and research, at a level commensurate to their career stage.

As the clinical roles of pharmacy technicians expand to take on new roles previously undertaken by pharmacists, a similar career framework underpinned by curricula for each stage of pharmacy technicians' careers will also be required. The Welsh Government is already working with other UK governments to secure legislative changes which will support enhanced roles for pharmacy technicians, which when enacted will further contribute to the opportunities identified in the review.

Strengthening quality, pharmacy leadership, and governance at all levels

(Review recommendations 13, 14 and 24-31)

To support current and future clinical pharmacy practice, in particular the role of pharmacists as prescribers, governance arrangements will need to be strengthened. However, changes must enable pharmacy professionals to develop as leaders at all stages in their career and encourage them to work autonomously, prioritising more of their time on those tasks which add most value. This must be supported by clearer and more appropriate lines of managerial, professional and clinical accountability both within pharmacy teams and of pharmacy within organisations.

Supported by the introduction of career frameworks, succession planning needs to be improved to develop future generations of clinical leaders

in advanced and consultant level practice and system leaders up to and including Directors of Pharmacy.

Realising the potential of digital, automation and other technological advances to transform how pharmaceutical care is provided

(Review recommendations 32-36)

Technological advances are transforming the way in which healthcare is provided. Hospital pharmacies in Wales have been benefiting from the transformative effect of automation on traditional pharmacy roles like dispensing for over 20 years and within the next three years the deployment of electronic prescribing and medicines administration systems and the shared medicines record in every hospital, will transform how clinical pharmacy is provided in a similar way. Therapeutic developments including the wider use of pharmacogenomic testing to guide treatment choice, and the growing number of approved advanced therapy medicinal products available in the NHS, are also changing the way in which some, and in the future many more, pharmacy professionals work. Realising the potential of digital, automated and other technological advances will require the NHS not only to implement new technologies but also to ensure the way in which organisations and individuals work changes and adapts to maximise these opportunities. This will include ensuring more pharmacy professionals have the right skills to lead deployment of digital and therapeutic innovations.

What happens next?

The comprehensive nature of the review provides a blueprint for the development of clinical pharmacy within hospitals over the long term. Whilst some recommendations can be implemented in the short term, others will require more time. Ultimately, the majority of the recommendations identified in the review will be for health boards and Velindre University NHS Trust to act on, however support will be needed from partners including HEIW and DHCW. The Welsh Government will work with the NHS Executive, health boards and other NHS organisations to ensure the 60 system wide strategic actions are progressed alongside those recommendations made in the review which are specifically for health boards and Velindre University NHS Trust to consider. The Welsh Government will consider what arrangements are needed to oversee and drive change and will continue to work closely with the General Pharmaceutical Council as regulator, and the RPS and the Association of Pharmacy Technicians UK as the professional leadership bodies for pharmacy professionals, to maximise the contribution pharmacists and pharmacy technicians make to improving the quality of care for people in Wales.

Annex A: Recommendations made in the Royal Pharmaceutical Society's independent review

	Recommendation
1	Pharmacy teams must be routinely integrated within every multidisciplinary team.
2	For patients receiving planned hospital care, pharmacy teams must optimise their medication in pre-admission or pre-habilitation services.
3	Pharmacy teams, including advanced emergency department practitioners, must be available in every emergency department and integrated into the patient assessment process, to ensure good medicines decisions and management at the first opportunity.
4	On admission, patients must be triaged to identify and prioritise their pharmaceutical needs. This must be documented as part of their overall treatment plan.
5	Patients must be empowered to take responsibility for their medicines and, wherever possible, must be actively involved in decisions about their medicines and care during an inpatient stay. Pharmacy teams must play an active role in preventing the functional deconditioning of patients.
6	Pharmacy teams must be involved in planning for discharge, starting on admission, with the default position being to refer patients for post-discharge medicines support/care unless it is clearly not needed.
7	The specialist knowledge and skills of advanced practice and consultant pharmacists must be made available to benefit patients and practitioners in community settings.
8	An urgent review of the workforce and systems involved in the supply and logistics of medicines in hospitals is needed in order to release the capacity of pharmacy professionals to deliver patient centred services.
9	Dedicated pharmacy resource should be integrated into MDTs in clinical priority areas with an ambition to embed pharmacy professionals in every MDT over time.

	Recommendation
10	The working patterns of pharmacy teams must be more aligned to the needs of patients and the MDT that they support.
11	New service developments or service redesign within hospitals must consider the clinical and technical pharmacy service requirements from the outset, and regularly evaluate and review those requirements.
12	Pharmacists working within MDTs should be prescribers and be actively prescribing to meet the needs of their MDT and the patients they care for.
13	Pharmacists must embrace and promote their role as prescribers, and accept the associated autonomy, responsibility and accountability.
14	Appropriate governance frameworks and organisational structures are in place for pharmacist (and other non-medical) prescribers to maintain and expand their scope of practice.
15	Clinical placements must be available for undergraduate pharmacy students both in sufficient numbers and at the appropriate level to prepare students for practice as prescribing pharmacists. MDT experiences should be core to this approach.
16	The skill mix of pharmacy teams must reflect The Prudent Healthcare Principle of "only do what only you can do" to maximise the opportunities that all roles can deliver.
17	Pharmacists must demonstrate their competency, through credentialing, in order to progress their careers including through to advanced and consultant roles, across all settings.
18	Pharmacy technician roles must have a post-registration development structure that supports their progression and defines and assures their advancing levels of practice.
19	A culture of continual professional development, quality improvement, service evaluation and research must be further embedded within the pharmacy team. Education providers must design flexible training around the workforce needs.
20	The education and training of pharmacy teams, including undergraduate placements, must be further integrated in wider healthcare training, to allow multi-professional training and embedding pharmacy as an essential component of the MDT.

	Recommendation
21	All registered pharmacy professionals must have a job plan which integrates the four-pillars of professional practice: clinical practice, leadership and management, education, and research in a way which is appropriate to each stage of their career.
22	Pharmacy workforce plans should be developed at both local and national levels, developed collaboratively with the MDT and aligned to Welsh Government and NHS priorities.
23	The pharmacy and medicine management service must diversify their structures to include more non-pharmacy expertise for example clinical informaticists, project managers, and data analysts.
24	Pharmacy must consistently embrace the four pillars of advanced practice i.e. clinical practice, leadership and management, education and research to drive models of excellence.
25	Leadership and management knowledge and skills must be developed and supported for all pharmacy professionals throughout their career.
26	A strategy must be developed in Wales for Advanced and Consultant pharmacist roles at a local, regional and national level. Talent management and succession planning must be in place for advanced practice and consultant roles.
27	Pharmacy must be better represented within the health board and trust senior leadership teams and improving the quality of medicines use should figure more prominently in discussions at Board and Board Committee levels.
28	Strategic leadership for pharmacy in Wales must be collaborative across pharmacy and the wider healthcare system. It must also be more cohesive, outward facing and ambitious.
29	A pharmacy professional assurance and governance framework must be in place in all NHS Wales organisations that employ pharmacy professionals.
30	Boards must have systems to provide assurance that their hospital pharmacy services are operating to a high quality and at standards consistent with best practice and hold pharmacy services to account.
31	The quality systems and governance of medicines management and optimising medicines use must be better established and incorporated within health board/trust governance structures and processes.
32	Hospital pharmacy services must support innovation and lead the implementation of new therapeutic technologies relating to their specialism, for example in pharmacogenomics.

	Recommendation
33	There must be adequate investment in hardware, software and the pharmacy informatics workforce to fully realise the benefits of digital advancements. Systems must be accessible, user friendly, inter-operable and their benefits evaluated.
34	Pharmacy professionals must develop and maintain competence in the technological advancements that will transform their roles over the next ten years.
35	Health boards and Velindre University NHS Trust must have clinical informatics pharmacy professional(s) to lead and support safe digital developments to improve patient care, workforce efficiencies and prudent healthcare. These will work closely with Digital Health and Care Wales to implement national strategy.
36	Electronic medicines management systems must ensure an All Wales consistent approach across all settings with interoperability fundamental to any plans for safe and effective patient care.

Annex B: Strategic Action Plan

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
1. Enabling pharmacy professionals to practise in areas where they add most value		
1.1 Reducing time spent by pharmacy professionals on non-clinical activities		
The Welsh Government will commission a review of opportunities to improve the efficiency of hospital medicines supply and logistics arrangements and release pharmacist and pharmacy technician time for clinical care	Immediate	• Welsh Government • Health boards • Velindre University NHS Trust • NWSSP
Health boards and Velindre University NHS Trust should continue to prioritise and contribute to the work already underway to reconfigure pharmacy technical services and medicines information services on a national basis through the TrAMs programme and WMAS project	Immediate	• Health boards • Velindre University NHS Trust • NWSSP • Cardiff and Vale University Health Board

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
1.2 Prioritising clinical pharmacy service provision to better meet the needs of the NHS		
Health boards and Velindre University NHS Trust should undertake a stocktake to map how pharmacy resource is currently deployed on clinical activities across the organisation and to identify the nature and extent of the clinical pharmacy activity provided in hospitals by speciality and division/directorate(s) for inpatient, outpatient and any other services within their organisation	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive • HEIW
Health boards and Velindre University NHS Trust should identify specialities or clinical areas that currently do not receive or only have a limited clinical pharmacy service; determine which if any should be prioritised for pharmacy input; and develop plans to enable more appropriate deployment of pharmacy professionals in those specialities/areas. This could include reprioritisation or disinvestment and redeployment, from lower priority and lower value activities	Short	• Health boards • Velindre University NHS Trust • NHS Executive
Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists are designated to support clinical divisions/directorates based on the results of the resource mapping exercise	Short	• Health boards • Velindre University NHS Trust • NHS Executive
Health boards should ensure that systems are in place for triage and prioritisation of patients for the provision of pharmaceutical care on admission. Prioritisation should be based on the use of clinical prioritisation tools validated and used in NHS hospitals in the UK	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
1.3 Scope of clinical pharmacy services and the relationship with multidisciplinary teams		
Where a clinical pharmacy service is provided to a clinical division(s)/ directorate(s) or clinical area, health boards and Velindre University NHS Trust should establish: i) a formal agreement defining the nature and extent of the service and the specific role(s) of any advanced practice and consultant pharmacists involved in the provision of the service, as set out in their job plan(s) ii) the agreement should set out clearly the arrangements for managerial, clinical, and professional accountability	Short	• Health boards • Velindre University NHS Trust
Health boards and Velindre University NHS Trust should determine the demand profile for pharmacy services in all clinical areas and ensure working patterns of pharmacy teams are aligned to patient and service needs. This should include times when pharmacy services may not currently be being provided and should ensure provision wherever it is needed, seven days a week	Medium	• Health boards • Velindre University NHS Trust • NHS Executive
Health boards and Velindre University NHS Trust should ensure the requirements for clinical and non-clinical pharmacy services are considered in all new service developments and in any clinical service redesign	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
1.4 Realising the potential of pharmacist prescribing		
Health boards and Velindre University NHS Trust should ensure all advanced practice and consultant pharmacists in clinical roles are or are training to be, prescribers	Medium	• Health boards • Velindre University NHS Trust • HEIW
The Chief Pharmacists' Peer Group should establish a multidisciplinary short life working group to agree how recommendations 12 and 13 of the RPS's review relating to pharmacist prescribing should be implemented	Short	• Chief pharmacists • Health boards • Velindre University NHS Trust • Higher Education Institutes (HEIs) • NHS Executive
1.5 Improving pharmacy support to meet the NHS stated priorities		
Health boards should ensure all Urgent and Emergency Care settings receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams within all Emergency Departments and Same Day Emergency Care units as a priority	Immediate (before winter 2023)	• Health boards • Velindre University NHS Trust • NHS Executive
HEIW will prioritise funding opportunities to develop pharmacists' skills to work in Urgent and Emergency Care settings. Funding will include the development of skills in independent prescribing, clinical examination and clinical health assessment, diagnostics and triage	Short	• Health boards • Velindre University NHS Trust • HEIW

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
Health boards should review and where necessary amend, the working patterns and contractual hours of pharmacy teams to ensure they are aligned with service demand in Emergency Departments and Same Day Emergency Care units	Short	• Health boards • Velindre University NHS Trust • NHS Executive
Health boards should ensure planned care services receive a clinical pharmacy service and that appropriately trained pharmacist prescribers are incorporated into multidisciplinary teams, prioritising pharmacist prescriber roles in pre-admission and pre-habilitation services	Short	• Health boards • Velindre University NHS Trust • NHS Executive
1.6 Pharmacy's role in optimising patient flow		
Health boards and Velindre University NHS Trust should implement all actions included in the guidance Optimising pharmacy services at hospital discharge to improve patient flow published by the Welsh Government in December 2022	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive
Health boards and Velindre University NHS Trust should establish and fully implement their patient medicines self-administration policies to enable patients to manage their own medicines whilst they are in hospital	Medium	• Health boards • Velindre University NHS Trust • NHS Executive
The Welsh Government will commission updated messaging encouraging patients to bring their regular medicines to hospital, supported by national communications activities	Short	• Health boards • Velindre University NHS Trust • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
Health boards and Velindre University NHS Trust should ensure that pharmacy teams, as routine practice, record every patient's nominated community pharmacy in their online record (e.g. in the Welsh Clinical Portal) to facilitate a Discharge Medication Review (DMR) after discharge from hospital. The Welsh Government will commission updated patient and carer communication materials to support this action	Immediate	• Health boards • Velindre University NHS Trust • Community pharmacies • NHS Executive
Pharmacy teams should ensure that all patients requiring post-discharge support with their medicines are referred to the most appropriate community services (e.g. a medicines review by GP or GP practice pharmacist, or a community-based/domiciliary medicines service)	Short	• Health boards • Velindre University NHS Trust • Community pharmacies • GP practices • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
2. Developing hospital pharmacy teams to deliver outstanding clinical care		
2.1 Improving pharmacy workforce planning		
Health boards and Velindre University NHS Trust should ensure their organisational workforce plans take account of the benefits of integration of pharmacy professionals in multi-disciplinary teams	Immediate	• Health boards • Velindre University NHS Trust
Health boards and Velindre University NHS Trust chief pharmacists should ensure the organisation has a pharmacy workforce plan to support and expand advanced and consultant pharmacist practice and to identify more clinical roles for pharmacy technicians	Short	• Chief pharmacists • Health boards • Velindre University NHS Trust
HEIW and health boards should continue to prioritise funding for opportunities for hospital pharmacists to access advanced practice training and for pharmacy technicians to access additional clinical training and put in place arrangements to ensure such training is aligned to NHS priorities	Short	• Health boards • Velindre University NHS Trust • HEIW • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
2.2 Introducing pharmacy career frameworks and job planning to support workforce retention and delivery of pharmaceutical care		
HEIW will work with health boards and Velindre University NHS Trust to develop standardised post registration career frameworks aligned to post-registration curricula, for all pharmacists and pharmacy technicians employed by the NHS in Wales	Medium	• Health boards • Velindre University NHS Trust • HEIW • NHS Executive
As part of the career frameworks, NHS organisations will develop standardised national nomenclature for job titles for NHS employed clinical pharmacists aligned to the RPS curricula for post registration practice	Medium	• Health boards • Velindre University NHS Trust • NHS Employers • HEIW • RPS • NHS Executive
Once agreed, health boards and Velindre University NHS Trust should adopt the standardised national nomenclature for pharmacist job titles	Medium	• Health boards • Velindre University NHS Trust
Health boards and Velindre University NHS Trust should ensure the career progression of all NHS employed pharmacists and pharmacy technicians requires individuals to demonstrate they meet the required minimum standard for practising at the level of practise required by the job description (and the standardised nomenclature for job titles) including through credentialling by a professional body where available	Medium	• Health boards • Velindre University NHS Trust • HEIW • RPS • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
National template job descriptions, updated Agenda for Change job profiles, and national template job plans (encompassing the four pillars of advanced practice) should be developed for all pharmacists	Short	• Health boards • Velindre University NHS Trust • NHS Employers • NHS Executive • Welsh Government
Health boards and Velindre University NHS Trust should ensure all NHS employed pharmacists have a job plan appropriate for each stage of an individual pharmacist's career	Medium	• Health boards • Velindre University NHS Trust
Job plans for advanced practice and consultant pharmacists should include time for providing outreach services and integrated working across sectors to support community-based practitioners and patients in the community	Medium	• Health boards • Velindre University NHS Trust • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
HEIW, working with the Association of Pharmacy Technicians UK (APTUK), will develop comprehensive post-registration curricula for pharmacy technicians employed by the NHS in Wales Once such curricula have been developed, further work should be undertaken to develop a standardised national nomenclature for job titles for NHS employed pharmacy technicians. The nomenclature for job titles should be aligned to those curricula; and national template job descriptions, updated Agenda for Change job profiles, and national template job plans for pharmacy technicians. Health boards and Velindre University NHS Trust should then adopt the standardised national nomenclature for pharmacy technician job titles; and ensure all NHS employed pharmacy technicians have a job plan which is appropriate for each stage of an individual pharmacy technician's career	Medium Long	• Health boards • Velindre University NHS Trust • NHS Employers • HEIW • APTUK • NHS Executive
2.3 Supporting professional development at all stages in careers		
HEIW should work with the Schools of Pharmacy at Cardiff and Swansea Universities to describe examples of pharmacy undergraduate placements within hospital multidisciplinary teams which meet their educational requirements. This should include maintaining and publishing a list of entrustable professional activities for pharmacy undergraduates including appropriate clinical pharmacy activities in hospitals	Immediate	• Health boards • Velindre University NHS Trust • HEIW • Cardiff University • Swansea University

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
Health boards and Velindre University NHS Trust should develop plans to ensure adequate numbers of pharmacy undergraduate, foundation and post-registration foundation placements are available aligned to the planned number of trainees in Wales including placements with pharmacist prescribers and within multidisciplinary teams	Short	• Health boards • Velindre University NHS Trust • HEIW • Cardiff University • Swansea University
Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising education commensurate with the stage of individuals' careers	Medium	• Health boards • Velindre University NHS Trust • HEIW
HEIW should undertake a review of the continuing professional development offer for hospital pharmacy teams to ensure it is meeting their development needs and provides a sufficiently flexible approach for participants	Short	• Health boards • Velindre University NHS Trust • HEIW
Health boards and Velindre University NHS Trust should ensure there is appropriate pharmacy input into multidisciplinary education and training structures	Long	• Health boards • Velindre University NHS Trust • HEIW • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
2.4 Understanding and continually improving the quality of pharmaceutical care		
The Chief Pharmacists' Peer Group should commission a refresh and refocus of the Pharmacy Research Strategy in Wales aligned to the recommendations of the independent review	Short	• Chief pharmacists • Health boards • Velindre University NHS Trust • Health and Care Research Wales • HEIs
The Welsh Government working with health boards, HEIs, and Health and Care Research Wales (HCRW) should develop a network of research mentors for pharmacy professionals	Medium	• Welsh Government • Health boards • Velindre University NHS Trust • HEIs • Health and Care Research Wales
Standardised job plans for pharmacists and pharmacy technicians should include protected time for participating and supervising research and development commensurate with the stage of individuals' careers	Medium	• Health boards • Velindre University NHS Trust • HEIW
The Chief Pharmacists' Peer Group should establish a programme of work with HEIW to establish a continuous rolling programme for formally appraising pharmacy and medicines management workforce needs aligned to new technologies and NHS priorities	Short	• Chief pharmacists • Health boards • Velindre University NHS Trust • HEIW • NHS Executive • Welsh Government

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
3. Strengthening quality, pharmacy leadership, and governance at all levels		
3.1 Improving organisational scrutiny of the quality and effectiveness of pharmacy services		
Health boards should ensure they employ a Director of Pharmacy accountable for the quality of clinical and technical pharmacy services provided within the organisation	Immediate	• Welsh Government • Health boards • NHS Executive • Welsh Government
The Director of Pharmacy should be a member of the health board's senior management team, must report to a health board executive director, and be able to raise matters relating to the quality or provision of pharmacy services and medicines within the organisation, directly to the board	Short	• Health boards • NHS Executive • Welsh Government
Health boards and Velindre University NHS Trust should agree arrangements for routinely reporting on assurance of medicines and pharmacy quality and safety issues to the organisation's board or relevant sub-committee of the board	Short	• Health boards • Velindre University NHS Trust • NHS Executive • Welsh Government
Health boards and Velindre University NHS Trust should ensure pharmacy services are included within their strategic planning cycle	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
The Welsh Government will work with the NHS Executive, health boards and Velindre University NHS Trust to develop and implement key performance indicators including those derived from digital systems, which demonstrate the effectiveness of pharmacy services, on improving the quality of care	Medium	• Health boards • Velindre University NHS Trust • NHS Executive • DHCW
3.2 Pharmacy system leadership		
Each health board's Director of Pharmacy should be responsible for producing a plan for pharmacy and medicines management within the health board setting out how pharmacy teams are responding to relevant Welsh Government and NHS Executive priorities	Short	• Health boards • NHS Executive • Welsh Government
Health boards and Velindre University NHS Trust should review pharmacy senior leadership and management arrangements including job titles to ensure they meet the new GPhC regulatory requirements and the needs of increasing clinical roles	Medium	• Health boards • Velindre University NHS Trust • NHS Executive
3.3 Talent management and developing future leaders within pharmacy		
Working with HEIW and Academi Wales, the Welsh Government will ensure aspiring leaders in pharmacy have access to a range of multidisciplinary and public sector wide opportunities for leadership development such as HEIW's Executive Talent Pool and Academi Wales' Leadership Development Programmes	Short	• Health boards • Velindre University NHS Trust • Welsh Government • HEIW • Academi Wales

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
Health boards and Velindre University NHS Trust must implement the actions identified in the HEIW "Senior Leadership Development in Pharmacy" report	Medium	• Health boards • Velindre University NHS Trust • HEIW • NHS Executive • Welsh Government
HEIW should work with Health boards and Velindre University NHS Trust to promote awareness of the tools in the "Gwella" leadership platform to promote leadership development at all stages of pharmacy professionals' careers and personal development	Short	• Health boards • Velindre University NHS Trust • HEIW
HEIW will review the outcomes of participation in the Centre for Pharmacy Postgraduate Education's (CPPE's) programme, "The Chief Pharmaceutical Officer's Pharmacy leaders' development", with a view to establishing a rolling programme to develop future NHS Wales Directors of Pharmacy	Short	• HEIW

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
3.4 Clinical leadership		
HEIW will lead the development of a consultant pharmacist strategy and implementation plan, and health boards and Velindre University NHS Trust should establish a succession plan for advanced practice and consultant pharmacist roles within their respective workforce plans	Medium	• Health boards • Velindre University NHS Trust • HEIW
The Welsh Government will work with health boards, Velindre University NHS Trust and HEIW to establish clinical governance arrangements for all pharmacist and other non-medical prescribers, which will include the implementation of the agreed NHS Wales Non-Medical Prescribing (NMP) standards, signposting to guidance and facilitating prescribers to expand their scope of practice	Medium	• Health boards • Velindre University NHS Trust • HEIW • Welsh Government
The Chief Pharmacists' Peer Group should review the arrangements for sharing and adopting examples of best practice between health boards. There should a specific focus on standardising clinical pharmacy services in urgent and emergency care and pre-admission/ pre-habilitation care, within the first 12 months of this plan being published	Short	• Chief Pharmacists

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
4. Realising the potential of digital, automation and other technological advances to transform how pharmaceutical care is provided		
4.1 Better use of data and technology to prioritise pharmaceutical care		
Health boards and Velindre University NHS Trust should continue to work with the DMTP to progress implementation of electronic prescribing and medicines administration (ePMA) systems for every hospital in Wales in line with the agreed timescales including ensuring pharmacy professionals have access to IT hardware needed to realise the benefits of digital systems	Immediate	• Health boards • Velindre University NHS Trust • NHS Executive • DHCW • Welsh Government
Health boards and Velindre University NHS Trust should prioritise the development of digital and technological skills within pharmacy workforce training and establish clinical informatics pharmacy professional roles within their organisations	Short	• Health boards • Velindre University NHS Trust • DHCW • HEIW
Working with the DMTP, the Chief Pharmacists' Peer Group should establish a short life working group to agree how ePMA systems and the development of the Shared Medicines Record can be used to provide optimal support for prioritisation and pharmaceutical care planning including outreach services in enhanced community care (virtual wards)	Immediate	• Chief pharmacists • DHCW

Proposed Action	Priority (Immediate, Short, Medium, Long term)	Stakeholders
4.2 Realising the benefits of wider use of innovation to guide therapeutic decision making		
Health boards and Velindre University NHS Trust should have plans in place to support the wider use of pharmacogenomic testing including the role of pharmacy professionals in advance of the development of a Wales-wide pharmacogenomic panel	Medium	• Health boards • Velindre University NHS Trust • Genomics Partnership Wales • All Wales Medical Genetics Service • HEIW • NHS Executive
Health boards and Velindre University NHS Trust should work with HEIW to provide opportunities to develop awareness of innovative technologies (e.g. Artificial Intelligence and pharmacogenomics) which impact on therapeutic decision making amongst pharmacy teams. This should include but not be limited to, encouraging more pharmacy professionals to access the Swansea and Bangor University postgraduate programmes in genomic medicine	Medium	• Health boards • Velindre University NHS Trust • HEIW • Swansea University • Bangor University • Genomics Partnership Wales
Health boards and Velindre University NHS Trust should develop advanced practice and consultant pharmacist roles for pharmacogenomics to lead the development and implementation of pharmacogenomics plans across the NHS	Long	• Health boards • Velindre University NHS Trust • HEIW • Genomics Partnership Wales • All Wales Medical Genetics Service

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

INFECTED BLOOD INQUIRY

DATE OF MEETING	09/05/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Suzanne Jones, Project Support Officer WBS
PRESENTED BY	Alan Prosser, Director WBS; Non Gwilym, Communications and Engagement Director
APPROVED BY	Steve Ham, Chief Executive

EXECUTIVE SUMMARY	The Final Report of the Infected Blood Inquiry is due to be published on 20th May 2024. Key issues: 1. Chief Executive, Director and Medical Director at WBS are attending the publication event in person 2. Internal and External Communication Plans drafted and plans implemented in anticipation of the final report 3. Working closely with UK Blood Services, NHS Wales and Welsh Government in planning for the final report

	This report is intended to provide an update on the IBI and the action being taken. Preparations for the publication of the report are underway to ensure a number of issues are addressed. These include: • Regular meetings with the other UK Blood Services and NHS Wales • Identifying the key risks to the Trust and Wales specific issues • Identifying the potential criticisms of the Blood Services and the WBS in particular • Development of an internal and external communications plan with key stakeholders prior to and post the publication date • Task and Finish Group to be established by Welsh Government to review and implement recommendations where appropriate

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/04/2024

7 LEVELS OF ASSURANCE
The purpose of the report is for information/noting

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	

APPENDICES – N/A

1. SITUATION

1.1 The Infected Blood Inquiry is the independent public statutory inquiry into the use of infected blood particularly since the 1970's.

1.2 The Inquiry has been established to examine why men, women and children in the United Kingdom were given infected blood and / or infected blood products; the impact on their families; how the authorities (including government) responded; the nature of any support provided following infection; question of consent; and whether there was a cover-up.

1.3 The Welsh Blood Service (WBS), VUNHST has core participant status in the Inquiry.

1.4 The Inquiry has been in operation for over 5 years and has been taking evidence from those affected and infected together with a number of individuals representing relevant organisations.

1.5 During the majority of the period under review, WBS was legally an entity within a number of Welsh NHS organisations and operated in effect as a regional center under a collaborative working arrangement across England and Wales. As such, the evidence given by NHSBT has in the main covered England and Wales.

This report provides an update on the work of the Inquiry and the response of the Trust.

2. BACKGROUND

2.1 The hearings were completed in 2023 and the Chair has retired to consider the conclusions and recommendations he may wish to consider. This has now been confirmed for 20th May 2024.

3. ASSESSMENT

3.1 The Inquiry's final report is due to be published on 20th May 2024. An event to coincide with publication has been organised in London and will be attended in person by the Director and Medical Director at WBS and the VUHST Chief Executive, together with the legal representative. An embargoed version of the report will be available to Core Participants 1 hour prior to the publication of the report. The publication event will be broadcast live via the Infected Blood Inquiry website.

3.2 Internal preparations with regards to the publication of the report are underway. These include:

- Regular meetings with the other UK Blood Services and NHS Wales.

- Identifying the key risks to the Trust and Wales specific issues

- Identifying the potential criticisms of the Blood Services and the WBS in particular

- Development of an internal and external communications plan with key stakeholders prior to and post the publication date.

- Task and Finish Group to be established by Welsh Government to review and implement recommendations where appropriate.

3.3. Weekly meetings with the Chief Executive and Director of Corporate Governance and Chief of Staff are being held to provide updates on the progress to date. Meetings with the UK Blood Services are being held on a fortnightly basis. An additional meeting has been scheduled the week prior to the publication date.

4. SUMMARY OF MATTERS FOR CONSIDERATION

Members of the Quality, Safety and Performance Committee are asked to note the report.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals:	
• Outstanding for quality, safety and experience	☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations	☒
• A beacon for research, development and innovation in our stated areas of priority	☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.	☐

• A sustainable organisation that plays its part in creating a better future for people across the globe	☒

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item**
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outlined in this report - The Inquiry relates to historic timelines. Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Historical issues being examined by the Inquiry
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	Historical issues being examined by the Inquiry
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Historical issues being examined by the Inquiry
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Inquiry will identify in relation to its' Terms of Reference, any individual responsibilities as well as organisational and systematic failures.

6. RISKS

The risks are recorded on Datix and monitored as further information is made available by the Inquiry. Coordinated planning with the UK Blood Services, Welsh Government and NHS Wales is intended to mitigate the risks associated with the increased media attention leading up to the publication of the report.

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	Increased publicity with potential criticisms of WBS
WHAT IS THE CURRENT RISK SCORE	4
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Working with the UK Blood Services, Welsh Government, NHS Wales and Communications Teams to anticipate criticisms and recommendations and prepare a statement prior to the publication of the Final report
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	May 2024
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

EDUCATION STRATEGY AUDIT REPORT

DATE OF MEETING	9 May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Victoria Davies, People and Organisational Development Manager
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	Between November 2023 and February 2024 a review of the Trust Education Strategy was completed by the NHS Wales Audit and Assurance Services, in line with the 2023/24 Velindre NHS University Trust Internal Audit Plan. This paper sets out the key findings and recommendations of the report and outlines the Trust response and plans to address.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the contents of the report

1

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
People Development and Education Steering Group	26/03/2024
Executive Management Board	29/04/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Discussed and endorsed the report for submission to the Quality, Safety and Performance Committee.	

7 LEVELS OF ASSURANCE N/A

APPENDICES	
Appendix 1	Education Strategy Action Plan

1. SITUATION

Between November 2023 and February 2024 a review of the Trust Education Strategy was completed by the NHS Wales Audit and Assurance Services, in line with the 2023/24 Velindre NHS University Trust Internal Audit Plan. The purpose was to 'provide assurance over the implementation of the Trust's Education Strategy.' The audit concluded a 'reasonable' level of assurance.

This paper sets out the key findings and recommendations of the report and outlines the Trust response and plans in appendix 1 to address areas for improvement.

2. BACKGROUND

The Trust Education Strategy was published in 2019 and set out the organisation's direction to creating and maintaining an agile workforce through the development of skills and competencies required to deliver excellence. The strategy was developed just prior to the COVID pandemic, subsequently its implementation was impacted.

Since the Education Strategy was introduced, the organisation has developed and implemented a Trust People Strategy. The Strategy sets the vision for achieving a skilled and developed, healthy and engaged, and planned and sustained workforce. The People strategy is reflective of the ambitions contained in the Education Strategy.

An audit of the Education Strategy provided an opportunity to review its implementation and identify areas for improvement that will also support the implementation of the Trust People Strategy.

Key risks considered in the review were:

- the Trust is not focusing on the right things to support the delivery of the Education Strategy;
- insufficient focus to deliver the strategy appropriately; and
- processes, systems, and procedures do not enable staff to achieve their set roles and the implementation of the strategy.

3.   ASSESSMENT

The audit identified the following matters requiring management attention and a re-audit in 6 months' time (May 2024):
1. A lack of robust workplans setting out timescales and responsible officers. Whilst work is underway, this is still required for the remaining actions.

2. There has been no evaluation exercise completed by the People Development and Education Steering Group to evaluate where the Trust's Strategy implementation is at or whether the objectives have been achieved.

3. There is partial reporting taking place, but there is a limited escalation of the position of the deliverables.

4.   SUMMARY OF MATTERS FOR CONSIDERATION

Management response to each recommendation is set out below:

1. An Implementation Plan for the Education Strategy to be developed to reflect actions, timescales and responsible officers. Monitoring of the plan will be managed by the People Development and Education Steering Group.

2. An evaluation framework noting key performance indicators (KPI) to assess and monitor the successful implementation of the Education Strategy Plan will be presented to the People and Development Steering group in June 2024. On agreement, the plan will be monitored by the group. Following each Steering group a highlight report is presented to Executive Management Board, any issues to escalate will be noted there.

3. An evaluation exercise, using the agreed evaluation framework, will be undertaken from June to September 2024 and presented to the People and Development Steering group in September for discussion and next steps. This will be reported back to EMB via the Steering group highlight report.

5.   IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)		
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below		
If yes - please select all relevant goals: • Outstanding for quality, safety and experience • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated areas of priority • An established 'University' Trust which provides highly valued knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future for people across the globe	☐ ☐ ☒ ☒ ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	Choose an item TAF 04	
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply	
	Safe Timely Effective Equitable Efficient Patient Centred	☐ ☐ ☒ ☐ ☒ ☐

	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Effective and Efficient – Education, development and training is planned, appropriate, timely, and affordable.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	The socio - economic duty is not required as this is a report in response to an audit
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The Equality Impact Assessment is not required as this is a report in response to an audit
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

Audit report identified the following potential risks:
- The Strategy is not embedded in a timely manner.
- Staff are not developed or trained within their roles.
- The Strategy is not implemented in a timely manner.

- Progress is not being tracked and results in delayed action.
- A lack of visibility / oversight of current progress.

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	
All risks must be evidenced and consistent with those recorded in Datix	

Strategic Driver	Activity/Task	Taf Ref	Governance Mechanism	Timelines
Healthy and Engaged Workforce	Implement the actions within the Health and Wellbeing Action plan	TAF 04	Healthy and Engaged Steering group/EMB Run/Quality Safety and Performance (QSP)	Mar-24
	Deliver the Trust action plan for Speaking up Safely		EMB Run/QSP	Mar-24
	Deliver project to revise Trust Values - BOFT project		EMB Shape/Strategic Development Committee	Mar-24
	Review the Staff Survey results and triangulate outputs and themes with the engagement exercises ongoing		EMB Run/QSP	Mar-24
	Update the EQIA process for the Trust		EMB Shape/Strategic Development Committee	Sep-23
	Deliver an action plan 23/24 commitment in the Trust Anti- Racist Action plan		EMB Shape/Strategic Development Committee	Mar-24
	Monitor Welsh Language Standards, working with Divisions on improvement plans		EMB Shape/Strategic Development Committee	Mar-24
	Update an improved Corporate Induction process		EMB Shape/Strategic Development Committee	Sep-23
	Update all WOD related policies and procedures		EMB Run/QSP	Mar-24
	Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA		EMB Run/QSP	Summer 2023/December 2023
	Review performance indicators for a Healthy and Engaged workforce including EQIA measures		EMB Run/QSP	Oct-23
Planned and Sustained Workforce	Education Strategy review	TAF 03	EMB Run/QSP	Mar-23
	Agree a plan for the Widening Access programme		EMB Run/QSP	Mar-24
	Recruitment Marketing Campaigns for hard to fill roles		EMB Run/QSP	**Dec-23**
	Developing the HCSW role (using the delegation framework)		EMB Run/QSP	Mar-24
	Enhances Welsh Language Translation resources to support development		EMB Run/QSP	Dec-23
	Deliver the International nurse Recruitment Programme		EMB Run/QSP	Mar-24
	Develop a Nurse retention plan		EMB Run/QSP	Mar-24
	Following the service model agreement develop the Trust Strategic Workforce Plan		EMB Shape/Strategic Development Committee	Mar-24
Skilled and Developed Workforce	Deliver and Evaluate the Inspire management and leadership development Programme	TAF 03	EMB Shape	Mar-24
	Develop the BOFT leadership development programme		EMB Shape	Mar-24
	Deliver a programme of workforce planning training		EMB Run	Sep-23
	Deliver the Welsh language training plan		EMB Run	Mar-24

# Education Strategy Implementation Plan - Year 1 2024/25

POD Ref No.	Quadrant of Education Strategy	TAF reference	Objective	Action	Owner/Lead	Interdependences (POD Ref No.)	Measures — Year 1 24/25	Year 2 25/26	Year 3 26/27	How will we know we have met our objectives?	Status
ES1.1	ES1 - Ensure the development of a competent, caring and capable workforce	TAF04	Develop the infrastructure and systems to enable the effective development of a competent, caring and capable workforce	Develop processes to capture and report on people development activity	POD		✔				
ES1.2				Colleagues developed in line with appropraite funding frameworks	POD		✔			Bi-annual report provided to PDESG on attrition rates of learners	
ES1.3			Essential training available to all colleagues to meet statutory and mandatory training requirements	Support the provision of statutory and mandatory training by working with subject matter experts and systems (ESR) to enable all staff to access training.	POD		✔	✔	✔	85% completion rate for Statutory and Mandatory training maintained	
ES1.4				Deliver the Welsh language training plan	POD			✔		100% of colleagues have completed the Awareness course. Year-on-year increase in the levels of Welsh competency across the Trust reported via ESR	
ES1.5			Support all colleagues to receive a meaningful PADR with user friendly templates and processes allowing for a constructive and meaningful conversation, whilst enabling a personal development and career plan.	Review current Policy and Procedures engage with stakeholders and external benchmarking	POD		✔			85% compliant PADR. Motivated and engaged workforce (measured via Annual Staff Engagement Index). Improovedment seen PDR Appraisal results via Staff Survey	Closed
ES1.6				Design new processes and paperwork templates following scoping exercise outcomes	POD		✔				
ES1.7				Pilot to ensure process and paperwork meet the objective criteria, update management training and toolkits	POD			✔			
ES1.8				Update all management training, toolkits and launch new process	POD			✔			
ES1.9				Evaluation of new process and paperwork template	POD			✔	✔		
ES1.10			Provide a fair and eqitable approach to development opportunities	Implement the new People Development Policy and Application Process	POD		✔			Motivated and engaged workforce (measured via Annual Staff Engagement Index). Training, Education and Development opportunities are accessed by colleagues - KPI needed here can be taken from the insight gained from the People Development Application process. WRES measurements of access to development	
ES1.11				Pilot to ensure process and paperwork meet the objective criteria, update management toolkits	POD		✔				
ES1.12				Update all management toolkits and launch new process	POD		✔				
ES1.13				Evaluation of new process and paperwork template	POD			✔			
ES1.14			Provide management and leadership development opportunities required for Destination 2033, as set out in Building Our Future Together and utilising the 'Just in time, Just for me' approach	Development of a leadership and management development action plan in place	POD		✔			Evaluation of leadership and management interventions and benefit through impact assessments (link with People Relationship team as part of evaluation). Agreed leadership and management development action plan in place	
ES1.15				Deliver and Evaluate the Fundamentals of Management Programme	POD		✔	✔	✔		
ES1.17				Deliver and Evaluate the Inspire management and leadership development Programme	POD		✔	✔	✔		
ES2.1	Support development of new training pathways	TAF04	Enable people from all backgrounds to find a role within the NHS that meets their potential and aspiration.	Development of a widening access and participation action plan	POD		✔			Agreed widening access and participation action plan in place. Relative liklihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues (Data gathered as part of WRES reporting accessed from the People Development Application process and ESR)	
ES2.2				Contacts made with local community groups/schools/colleages sharing information on opportunities and careers within the NHS	POD		✔				
ES2.3				Development of Apprenticeships to grow our own workforce to support succession planning	POD		✔	✔	✔		
ES2.4				Health Care Support Worker and Advanced Practice Frameworks are embedded, making best use of funding by working in partnership with HEIW, Welsh Government and Training Providers.	Clinical Education Leads		✔	✔	✔		
ES2.5				Development of career pathways for all job family groups	POD			✔			
ES2.6				Working with divisions, training and development is planned annually to enable effective workforce planning	POD		✔	✔	✔		
ES3.1	Leading Educational Role with Academic and National Partners	TAF04	Enable and support VHNST Academic Profile	Support Velindre Oncology Academy and establish a range of training opportunities for internal and external clinicians and academics.	VOA		✔	✔	✔	Progress report from Velindre Oncology Academy	
ES3.2				Include representatives from HEIW and Academic partners on the Trust Education Steering Group	POD		✔	✔	✔	HEIW and academic partners regular members of group	
ES4.1	High quality enabled learning environments	TAF04	Identify digital options that innovate learning methods	Develop digital solutions to enable colleague learning i.e. implementation of a LMS system, greater utilisation of ESR			✔	✔	✔		

Evaluation Framework

Evaluation Framework to be presented to Steering Group in June
Evaluation to be undertaken from June to September 2024, to be presented to the Steering Group in September

Measures
How will we know we have met our objectives? Evaluatoin
Bi-annual report provided to PDESG on attrition rates of learners
85% completion rate for Statutory and Mandatory training maintained
100% of colleagues have completed the Awareness course.
Year-on-year increase in the levels of Welsh competency across the Trust reported via ESR
85% compliant PADR Motivated and engaged workforce (measured via Annual Staff Engagement Index) Improovedment seen PDR Appraisal results via Staff Survey
Motivated and engaged workforce (measured via Annual Staff Engagement Index) Training, Education and Development opportunities are accessed by colleagues
Evaluation of leadership and management interventions and benefit through impact assessments (link with People Relationship team as part of evaluation) Agreed leadership and management development action plan in place
Agreed widening access and participation action plan in place Relative liklihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues (Data gathered as part of WRES reporting accessed from the People Development Application process and ESR)
Progress report from Velindre Oncology Academy
HEIW and academic partners regular members of group

How will we measure our success? How do we know if we have made an impact?

Kirkpatricks's level of learining evaluation	Methods
Level 1: Reaction	
The degree to which participants find the training favourable, engaging and relevant to their jobs	Real time polls
Level 2: Learning	
The degreeto which participants acquire the intended knowledge, skills, attitude, confidence and commitment based on their participation in the training	Real time polls and experience
Level 3: Behaviour	
The degree to which participants apply what they learned during training when they are back on the job	Impact
Level 4:	
The degree to which targeted outcomes occur as a result of the training	Engagement
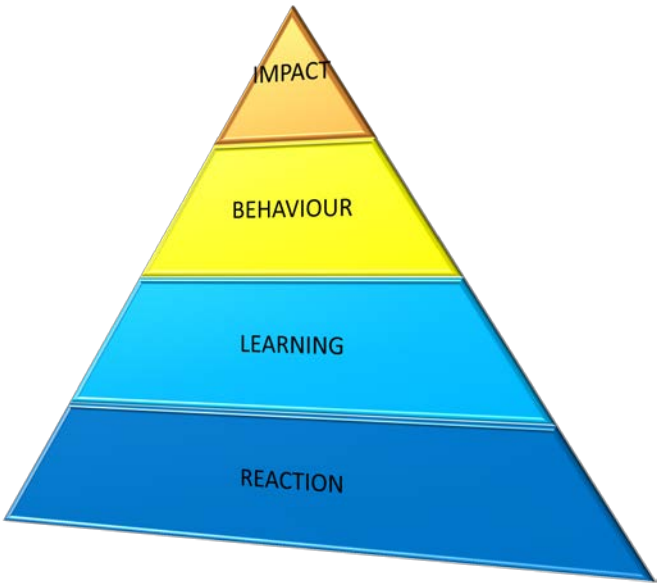
QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Strategic Equality Plan 2024 – 2028
Action Plan

DATE OF MEETING	9 May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The Strategic Equality Plan 2024 - 28 was approved by the Trust Board on 26 March 2024. This paper presents an action plan describing the activity during the first year of implementing the four-year plan.

RECOMMENDATION / ACTIONS	To NOTE the action plan 2024-25.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	Date
EMB Run	29.4.24
	(DD/MM/YYYY)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

7 LEVELS OF ASSURANCE	
Not for assurance	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES	
1	Strategic Equality Plan 2024 – 28
2	Strategic Equality Plan action plan 2024-25

1. SITUATION

1.1 The Trust approved the Strategic Equality Plan for 2024 - 28 in March 2024 (Appendix 1). This fulfils our specific duties under the Equality Act 2010 and sets out our strategic priorities, focusing on how the Trust can contribute to a fairer society, advancing equality and good relations.

1.2 This paper presents an action plan for 2024-25 showing what will be done over the next 12 months to progress with the strategic objectives.

2. BACKGROUND

2.1 The Trust has four objectives within the Strategic Equality Plan 2024 – 28:

    1. Increase workforce diversity and inclusion and eliminate pay gaps.

2. Engage with the community.
3. Communicate with people in ways that meet their requirements.
4. Ensure service delivery reflects individual requirements.

These objectives are Trust-wide and span workforce issues and service delivery.

2.2 During the second half of 2023-24, a programme of engagement was undertaken to develop the Strategic Equality Plan. The feedback has been instrumental in defining the strategic objectives of the plan and in shaping the annual action plan underpinning it.

2.3 Further work was undertaken in March 2024 to define specific actions in support of the objectives, leading to the action plan for 2024-25 (Appendix 2)

2.4 The Equality Impact Assessment for the Strategic Equality Plan covers this secondary document. Additional points relating to equality that were raised during March 2024 have been reflected in the action plan.

2.5 The implementation of the action plan will be monitored and reviewed through the Healthy and Engaged Steering Group.

3. **ASSESSMENT**

3.1 The actions have been chosen as meaningful steps towards achieving the strategic objectives. They are proportionate and achievable within the current context of the service.

3.2 The success of this plan depends on the actions being delivered by stakeholders from all areas of the Trust. The People and OD team will lead on delivering the workforce aspects and the Divisional leadership teams will lead on delivering service aspects. The People and OD team will collate feedback on progress for the Healthy and Engaged Steering Group.

4. **SUMMARY OF MATTERS FOR CONSIDERATION**

4.1 The action plan 2024-25 should be APPROVED by the Executive Management Board.

5. **IMPACT ASSESSMENT**

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: **Choose an item**	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services ☐ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ☐ areas of priority • An established 'University' Trust which provides highly valued ☐ knowledge for learning for all. • A sustainable organisation that plays its part in creating a better future ☒ for people across the globe	

RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	02 - Partnership Working / Stakeholder Engagement 04 – Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☐ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
	The Strategic Equality Plan guides our work with our staff and those we serve. The relevance and impact of the objectives and actions that we choose will be shaped by the quality of feedback that we access from our stakeholder community.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Yes

For more information: *https://www.gov.wales/socio-economic-duty-overview*	Click or tap here to enter text. Completed as part of the EQIA for the Strategic Equality Plan. No specific issues arose during consultation.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Funding requirements will be identified as part of individual actions
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The EQIA was conducted during the consultation on the Strategic Equality Plan. The feedback has directly influenced the actions outlined in Appendix 2.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	S149 of the Equalities Act 2010 sets out the Public Sector Equality Duty. This was supplemented in Wales in 2012 with a regulation requiring the publication of Strategic Equality Objectives.

3. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	.

WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

Strategic Equality Plan 2024 - 2028

Introduction

As a public body we are required to publish a Strategic Equality Plan which sets out our equality objectives and explains how we will achieve these objectives. We are guided by the Equality Act 2010 and the Public Sector Equality Duty, which call on us to think ahead so we can better meet the needs of the people we work with. The Trust publishes an annual report with information about our progress, together with equality information about our workforce each Spring.

There are three overall aims of the Public Sector Equality Duty:

1. Eliminate unlawful discrimination, harassment and victimisation (and other conduct prohibited by the Act).
2. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

Under the Equality Act, there are **9 protected characteristics**, they are:

Age	Disability	Gender Reassignment
Religion & Belief	Sex (Gender)	Race
Sexual Orientation	Pregnancy & Maternity	Marriage / Civil Partnership

Developing our Objectives for 2024 – 2028

We consulted and engaged with patients, staff, partners, equality organisations and other stakeholders in partnership with Wales Public Body Equality Partnership. We asked these stakeholders what they thought the equality priorities should be for the Trust and what they thought should be done to improve equality. We also identified what research and information was already available to help in the development of the objectives. We surveyed patients, staff, partners, equality and third sector organisations and other people as to whether our previously set objectives should be kept as they are, changed or whether we needed to add new ones.

In light of the understanding of our legal obligations, our strategic intentions and stakeholder feedback, we have established our Vision for Equality and four Strategic Equality Objectives for 2024 – 2028. We have also described the broad areas of work that will enable us to achieve our vision.

Our Vision for Equality

Our vision for equality is that our values of Caring, Respectful and Accountable are evident in **everything** we do, thereby improving the lives of all our stakeholders, irrespective of their background. We will use this Strategic Equality Plan to put patients, donors and staff at the heart of everything we do. The lens of equality will allow us to challenge the status quo and ask questions so that we can design our organisation and systems around people, taking heed of individuals' views, requirements and aspirations.

Our overarching ambition is to ensure that there is enhanced collaboration between the members of the Leadership and management teams and the people we employ. There will be an improved relationship between staff and patients and we will strive to eliminate barriers to care. Teams throughout Velindre Cancer Service, the Welsh Blood Service and Trustwide Services will reduce working in silos and will have an improved knowledge of other departments' working strategies and aims. There will be increased engagement throughout the Trust which will in turn develop relationships and knowledge sharing. Patients and Donors will be invited to networks to listen to their feedback which will then improve services delivered in Cancer and Blood services and we will develop strategies to reduce barriers to care and service delivery. A positive working environment will be fostered with clear channels of staff feedback, tackling each equality issue raised.

Bringing the objectives to life

We have four clear objectives and have outlined the key areas of work over the next four years that will enable us to achieve our vision for equality.

1 **Increase workforce diversity and inclusion and eliminate Pay Gaps**
We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disability.

Actions
- Check that our approaches to recruitment and selection are open and fair.
- Acknowledge that our workforce profile is changing and our teams need to develop to meet this change, for example our teams are becoming more diverse as a result of successful recruitment of Doctors and Nurses from India and Hong Kong.
- Build on our links with schools, colleges and the community to introduce people from across the whole community into roles and careers in healthcare.
- Support women to thrive in STEM professions.
- Create a positive working environment in all areas so that the Trust is regarded as an employer of choice where people want to stay.

- Utilise reasonable adjustments from first contact with applicants throughout their employment with the Trust.
- Prioritise professional development for all.
- Embed staff engagement and diversity forums in day-to-day life, including consideration of the impact of intersectionality.
- Implement the Trust Anti-racist Action Plan and the Workforce Race Equality Standard.
- Build on our status as a Disability Confident employer, achieving Leader Level.
- Develop our reporting of pay gaps and feed the recommendations into annual work plans.

2 **Engage with the community**

In order to ensure that we are providing services that our patients and donors want and need, it is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways.

Actions
- Create opportunities for staff, patients and donors to engage with communities, for example Pride, Sign Language Week, Disability Equality Week, Black History Month to allow everyone to learn, experience and connect with different communities and cultures.
- Establish a regular system of capturing feedback from stakeholders to understand how people feel about our services and organisation.
- Further develop our stakeholder engagement for Cancer and Blood services by engaging with diverse groups and communities.

3. **Communicate with people in ways that meet their requirements.**

We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.

Actions
- To continue to improve collection of language information and communicate effectively with patients, donors, their carers and families, in the language of their choice.
- Improve access to our services for BSL users to allow Deaf people to be able to communicate with, access, engage and provide feedback/ concerns to the system in a way that fully meets their needs.
- Truly implement the Active Offer for Welsh speakers and comply with the Welsh Language Standards Framework

4. **Ensure service delivery reflects individual requirements.**

We provide specialist cancer services to the population of south east Wales at a time when people are particularly vulnerable. We are also indebted to our donors who volunteer to give blood or tissue for the benefit of others. We

want all these individuals to be able to access what they require as simply as possible.

Actions

- Apply the Equality Impact Assessment methodology to any projects on redesigning patient pathways, including a consideration of the impact of age.
- Improve the accessibility of our services by innovating, in light of patient and donor feedback, including a regular review of disability or adjustments.
- Improve the recording and transfer of patient data so that patients identified by other services as being disadvantaged receive the appropriate support when they come to us.
- Support the development of a single, unified approach towards Equality Impact Assessments across all NHS Wales.
- Support managers in undertaking Equality Impact Assessments to create positive change
- Educate staff on the needs of other people across all protected characteristics.

Checking our progress

Progress with the Strategic Equality Plan will be monitored within the Healthy and Engaged Steering Group. A full progress report is presented with the Annual Equality Report, in line with the Trust's reporting cycle.

The measures that demonstrate progress will be:

1. Workforce data showing a broadening of the employee profile over time, both in relation to year-on-year change and in relation to comparison with the 2021 Census figures.

2. Improved scores shown in the NHS Staff Survey for equality and diversity measures.

3. Improved scores shown in the Workforce Race Equality Standard report.

4. Increase in numbers of staff involved in engagement events, training and Diversity Forums.

5. Increase in numbers of patients and donors offering feedback and participating in engagement events.

6. Comprehensive use of Equality Impact Assessments where required and improvements in the quality of recommendations and actions resulting from the analysis.

Vision for Equality	TAF reference	Objective	Ref	Action	How will we know we have delivered our actions?	SMART Action	Lead	Date
Our vision for equality is that our values of Caring, Respectful and Accountable are evident in **everything** we do, thereby improving the lives of all our stakeholders, irrespective of their background. We will use this Strategic Equality Plan to put patients, donors and staff at the heart of everything we do. The lens of equality will allow us to challenge the status quo and ask questions so that we can design our organisation and systems around people, taking heed of individuals' views, requirements and aspirations. Our overarching ambition is to ensure that there is enhanced collaboration between the members of the Leadership and management teams and the people we employ. There will be an improved relationship between staff and patients and we will strive to eliminate barriers to care. Teams throughout Velindre Cancer Service, the Welsh Blood Service and Trustwide Services will reduce working in silos and will have an improved knowledge of other departments' working strategies and aims. There will be increased engagement throughout the Trust which will in turn develop relationships and knowledge sharing. Patients and Donors will be invited to networks to listen to their feedback which will then improve services delivered in Cancer and Blood services and we will develop strategies to reduce barriers to care and service delivery. A positive working environment will be fostered with clear channels of staff feedback, tackling each equality issue raised.		**Increase workforce diversity and inclusion and eliminate Pay Gaps** We would like the workforce to better reflect the diverse nature of the communities that we serve and also to ensure that there is no systemic pay disparity between people of different genders, races or disability.	1,1	Check that our approaches to recruitment and selection are open and fair.	TRAC data shows equal progression through application, shortlisting and offer for Race, Gender and Disability	A report is produced for 2024-25 showing progression of job applicants through application, shortlisting and offer correlated with Race, Gender and Disability.	CB	31.3.25
			1,2	Acknowledge that our workforce profile is changing and our teams need to develop to meet this change, for example our teams are becoming more diverse as a result of successful recruitment of Doctors and Nurses from India and Hong Kong.	The changing workforce profile is quantified and described within the Annual Equality Report.	The Annual Equalities report for 2023-24 describes the changes in the workforce profile over the past three years and the implications this has for the Trust.	CB	31.5.24
			1,3	Build on our links with schools, colleges and the community to introduce people from across the whole community into roles and careers in healthcare.	People decide to enter employment in the NHS or start training in one of the health professions.	A Widening Access engagement programme is agreed and put into practice and a report produced summarising and enumerating all contacts with schools, colleges and the wider community.	AG	31.3.25
			1,4	Support women to thrive in STEM professions.	Women in STEM roles report receiving appropriate support to develop within their profession.	A pilot programme is developed with one STEM department to identify what support will help women within their profession.	MF	31.12.24
			1,5	Create a positive working environment in all areas so that the Trust is regarded as an employer of choice where people want to stay.	NHS Staff Survey reflects annual decrease in desire to leave and annual increase in the Employee Engagement Index.	The Values and Behaviour project is concluded. Relevant policies are updated to refect new values. Training is offered to staff to understand how to use values in tehir work.	CB	30.9.24
			1,6	Utilise reasonable adjustments from first contact with applicants throughout their employment with the Trust.	Evidence from staff that reasonable adjustments are utilised throughout their employment journey.	Five case studies are collated from people who offer to share their experiences of needing adjustments in order to thrive at work.	MF	30.9.24
			1,7	Prioritise professional development for all.	People Development Policy in place making this statement. NHS Staff Survey Development Theme shows improvement year on year.	The People Development Policy is approved and application process is in place. The change in the 2023 and 2024 Development Theme is reported to the Education Steering Group in March 2025.	VD	31.3.25
			1,8	Embed staff engagement and diversity forums in day-to-day life, including consideration of the impact of intersectionality.	Terms of Reference for for Race, Gender, LGBTQ+ and Disablity Forums are in place. Forums able to meet at least twice a year and submit ideas to the POD team.	Terms of Reference for for Race, Gender, LGBTQ+ and Disablity Forums are in place. Documented feedback is sent from each Forum to the People and OD team.	MF	31.3.25
			1,9	Implement the Trust Anti-racist Action Plan and the Workforce Race Equality Standard.	Year on year improvement in WRES indicators.	WRES data reported by 30.4.24. Task and Finish Group established to implement changes coming from the Trust Anti-racist action plan in light of WRES data.	MF	31.3.25
			1,10	Build on our status as a Disability Confident employer, achieving Leader Level.	Disability Confident Level 3 in place.	Self assessment completed and actions taken to enable Trust to apply for Disablity Confident Level 3.	MF	30.6.24
			1,11	Develop our reporting of pay gaps and feed the recommendations into annual work plans.	Pay Gap data is visible in annual equalities workplans.	Gender Pay Gap for 31.3.24 reported in May 2024 and reflected in Annual Equalities report.	CB	31.7.24
		Engage with the community In order to ensure that we are providing services that our patients and donors want and need, it is important that we understand them and ask them about what things they want from us and how we might be able to do to that in better ways.	2,1	Create opportunities for staff, patients and donors to engage with communities, for example Pride, Sign Language Week, Disability Equality Week, Black History Month to allow everyone to learn, experience and connect with different communities and cultures.	Evidence of connection and liaison regarding equalities communication campaigns.	Communications plan agreed for 2024-25 including themes, dates and target audiences.	MF	31.5.24
			2,2	Establish a regular system of capturing feedback from stakeholders to understand how people feel about our services and organisation.	Patient Engagement and Donor Engagement functions agree engagement approach. Working relationship with Llais further developed and embeded in service development projects.	Patient Engagement and Donor Engagement leads agree stakeholder engagment strategy that links into the Healthy and Engaged Steering Group.	Divisional Directors	30.6.24
			2,3	Further develop our stakeholder engagement for Cancer and Blood services by engaging with diverse groups and communities.	Target of 800 Black and Minority Ethnic Donors on stem cell register is achieved.	Leads can demonstrate that feedback from stakeholders has been used to improve a range of projects.	Divisional Director WBS	31.3.25
		Communicate with people in ways that meet their requirements. We have a variety of ways that we stay in contact with the people of Wales; letters, phone calls, social media; it is important that we are doing this in way that people can easily understand and in their first, or preferred, language.	3,1	To continue to improve collection of language information and communicate effectively with patients, donors, their carers and families, in the language of their choice.	Positive feedback from patients and donors regarding use of preferred language. Use of easy read materials for people who need that format.	Review of stakeholder satisfaction with written documentation is completed and recommendations made to relevant Divisional SLT.	Divisional Directors	31.3.25
			3,2	Improve access to our services for BSL users to allow Deaf people to be able to communicate with, access, engage and provide feedback/ concerns to the system in a way that fully meets their needs.	Positive feedback from patients and donors regarding use of BSL.	To be conducted as part of 4.2 below.	Divisional Directors	31.3.25
			3,3	Truly implement the Active Offer for Welsh speakers and comply with the Welsh Language Standards Framework	No failures in complying with the Welsh Language Standards identified.	Divisional Welsh Language Groups renew their action plans in light of any further feedback from the Commissioner's office in order to deliver the Active Offer.	Divisional Directors	31.3.25
		Ensure service delivery reflects individual requirements. We provide specialist cancer services to the population of south east Wales at a time when people are particularly vulnerable. We are also indebted to our donors who volunteer to give blood or tissue for the benefit of others. We want all these individuals to be able to access what they require as simply as possible.	4,1	Apply the Equality Impact Assessment methodology to any projects on redesigning patient pathways, including a consideration of the impact of age.	Every project has an EQIA on file with timed actions and closure loop in place.	Every project has an EQIA on file with timed actions and closure loop in place.	Divisional Directors	31.3.25
			4,2	Improve the accessibility of our services by innovating, in light of patient and donor feedback, including a regular review of disability or adjustments.	Evidence of improvements to accessiblity in response to feedback. Data set in place which correlates patient experience with protected characteristics. Specific review of accessiblity for blood donors with disabilities is completed.	Undertake comprehensive EQIAs for access to cancer treatment and participation in blood donation with a particular focus on Disability. Report findings to Divisional SLT for action.	Divisional Directors	31.3.25
			4,3	Improve the recording and transfer of patient data so that patients identified by other services as being disadvantaged receive the appropriate support when they come to us.	Trust processes capture demographic information including disablities and langauge requirements in particular where this is documented by the Health Board referring a patient.	Identify patient systems and records that would need to be used to measure this improvement.	Divisional Directors	31.3.25
			4,4	Support the development of a single, unified approach towards Equality Impact Assessments across all NHS Wales.	VUNHST present at all Wales discussions and supporting the improvement.	VUNHST can demonstrate our inputs into the project and applies any changes within three months of them being finalised.	MF	31.3.25
			4,5	Support managers in undertaking Equality Impact Assessments to create positive change	Training and resources offered to managers leading to better quality EQIAs being completed for all policies and projects as shown in annual review of EQIAs received.	Six training sessions for managers on EQIAs are delivered between May and December 2024 and the evaluation of impact is reported to the Healthy and Engaged Steering Group.	MF	31.3.25

| | | | | 4,6 | Educate staff on the needs of other people across all protected characteristics. | Improvement in the NHS Staff Survey measures on equality and diversity 2023 compared with 2024. | Learning materials used in Croeso and Inspire are adapted and made available to all staff. Two teams undertake a pilot of the Culutre Competence Audit. | MF | 31.12.24 |

Quality, Safety and Performance Committee

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY ACTIONS FOR 2023 / 2024 (Q4 YEAREND)

Date of meeting	9/05/24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

Prepared by	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Phil Hodson, Deputy Director of Planning and Performance
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2023/24** 1.1 This report provides an update (position as of 31st March 2024) of progress against the actions (January – March 2024) which were included within the IMTP for 2023/24 as at Quarter 4. 1.2 These updates are provided in the form of the monitoring templates for WBS, VCS and Trust-wide (See Appendix 1, Appendix 2 and Appendix 3). 1.3 Good progress has been made again against IMTP actions as at Quarter 4.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committees is asked to: • **NOTE** the progress made in the delivery of the agreed IMTP (2023 – 2026) actions as at Quarter 4 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide initiatives.

GOVERNANCE ROUTE

List the Name(s) of Committee / Group who have previously received and considered this report:	Date
VCS SLT / Performance Review	20 April 2024
Executive Management Board	29 April 2024
Summary and outcome of previous governance discussions: The report has been considered and endorsed at the VCS Performance Review and Executive Management Board and is presented to the QSP for information and noting.	

7 LEVELS OF ASSURANCE

ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Select Current Level of Assurance

APPENDICES

1	Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 at 31/3/24.
2	Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 at 31/3/24.
3	Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 4 at 31/3/24.

ACRONYMS and INITIALISM

IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

2. SITUATION/BACKGROUND

2.1   The Integrated Medium Term Plan (IMTP) 2023/24-2025/26 was submitted to the Welsh Government on 31st March 2023. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1   The timing of the end of Quarter 4 (January to March 2024), has given only a short time for a detailed assessment of progress against IMTP actions during early April for EMB consideration.

3.2   The table below gives a high-level overview of progress made in the delivery of actions at Q4 for WBS, VCS and Trust-wide.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2023/24 Actions	Velindre Cancer Services IMTP 2023/24 Actions	Trust-wide Initiatives IMTP 2023/24 Actions
BLUE	Action successfully completed with benefits being realized		3 Q Actions	
GREEN	Satisfactory progress being made against action in line with agreed timescale	11 Q actions	9 Q actions	26 Q actions (Finance, Digital Estates & Sustainability)
YELLOW	Issues with delivery identified and being resolved with remedial actions in place	4 Q actions	9 Q actions	6 Q actions (Workforce)
AMBER	Delays in implementation / action paused due to external issues beyond our control		1 Q actions (TrAMs)	
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2023/23 Quarterly Actions		**15 Q actions**	**22 Q actions**	**32 Full Year Actions**

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3.3 WBS are making satisfactory progress, categorized as '*green or yellow*', against all 15 of their actions as at Q4, **see Appendix 1.**

3.4 VCS are making satisfactory progress, categorised as 'blue, *green or yellow*', against 21 of their 22 actions, **see Appendix 2.**

3.5 However, one action remains assessed as 'amber'. This is defined as *'Delays in implementation / action paused due to external issues beyond our control'*. These two actions are:
- Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Service (pg.23)

3.6 There are 32 Trust-wide actions or 'themes' (Digital 6; workforce 6; Estates 4; Sustainability 10 and finance 6). Good progress is again being made against these actions, **see Appendix 3.**

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ⊠ • An internationally renowned provider of exceptional clinical services ⊠ that always meet, and routinely exceed expectations • A beacon for research, development and innovation in our stated ⊠ areas of priority • An established 'University' Trust which provides highly valued ⊠ knowledge for learning for all. • A sustainable organization that plays its part in creating a better future ⊠ for people across the globe	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.

	Safe ☐
	Timely ☐
	Effective ☐
	Equitable ☐
	Efficient ☐
	Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarized here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021).

Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives |
| **SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:**
For more information: *https://www.gov.wales/socio-economic-duty-overview* | Not required |
| | Click or tap here to enter text |

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below:
Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding:
Choose an item
Please explain if 'other' source of funding selected:
Click or tap here to enter text
Type of Funding:
Choose an item
Please explain if 'other' source of funding selected:

	Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text **Type of Change** Choose an item Please explain if 'other' source of funding selected: Click or tap here to enter text
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/* *SitePages/E.aspx*	Not required - please outline why this is not required
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 as at 31/3/2024.

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2032 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2025/26.	• Personalised donor experience • Wider communication choice for donors • Increased donor retention • Improved information (for sharing/decision-making) • Increased levels of efficiency/ productivity	Prepare donor data recovery map for incorrect donor details.	Begin implementation of donor data recovery plan.	Finalise implementation of donor data recovery plan. Re-platform appointment system portal for booking blood donations.	Scope requirements of integrated communication platform for Donor Contact Centre.	The donor data recovery plan is complete. The appointment system portal launch is planned for Summer 2024. Scoping completed for the integrated communication platform for Donor Contact Centre.	🟩
	Develop and implement strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2023/24.	• Increased stem cell donor panel • Increase in stem cells supply. • Improved resilience in stem cell supplies • Improved clinical	Develop strategy. Engagement with key stakeholders.	Formal sign off of strategy. Communication plan developed and approved. Develop implementation plan.	Launch and implement strategy.	Post implementation review.	Development of strategy has been transferred to WBS Futures portfolio and work is underway. Timelines are being reappraised. Stem cell donor recruitment has been	🟨

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
		outcomes in Wales/globally • Increased income levels					incorporated within the new donor strategy.	
SP2: To provide a world class donor experience **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Implement our new donor strategy by 2025/26.	• Right size/shape donor panel • Increased resilience for supply of blood/products across Wales • Improved levels of efficiency/productivity Reduced importation and costs • Increased brand awareness and reach • Wider population/donor education • Development of rich data to improved insights and	Sign off strategy.	Review existing systems and processes in line with strategy.	Identify opportunities for further improvement.	Commence implementation. Review and identify opportunities. Review current establishment.	Final draft strategy developed, awaiting sign off in Qtr. 1 2024/25 prior to initiating a review of systems and processes	

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Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
		focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively • Reduced length of stay post-surgery • Prudent use of (reduced demand for blood). • Increased equity of care and outcomes • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance. • Improved efficiency • Cost efficiencies.	Advertise and recruit Anaemia Team Review baseline Digital Health Care Wales (DHCW) data.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Develop bespoke Health Board Anaemia Plan with key stakeholders.	Implement relevant plan as agreed. Recruit Health Board nurses to manage Anaemia clinics. Raise profile with primary care leads, and the internal review of the Pathway with users (January 2024).	Revised All-Wales Pre-Operative Anaemia Pathway out for consultation. Gap analysis of Local Health Boards against the pathway complete. Patient Blood Management (PBM) education delivered to all F1/F2 doctors across Wales. Anaemia presentations delivered at BHNOG Conference. £20k cost saving identified at one Local Health Board (LHB) using test set developed for programme. Scoping further roll-out across LHBs.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 4 and 5)**	Revised blood collection clinic portfolio by 2024/25.	• Increased /Sustainable collection model • Improved access for service users • Improved collection efficiency • Reduction in costs. • Improved access to donors for recruitment to the Welsh Bone Marrow Donor Registry	Continue reintroduction of Mobile Donation Collections.	Introduce 'tours' to remote areas of North West Wales.	Establish project group to progress identified fixed site options.	Continue to progress fixed site model.	Business case for North Wales 'Tours' drafted, with staff engagement commencing in April 2024. Fixed site for plasma collection in north Wales scoped and included as part of WBS futures portfolio.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
	Introduce clinically led collection team model by 2023/24.	• Improved leadership capability. • Standardisation of terms and	Continue phased implementation of OCP (2019) outcomes.	Continue phased implementation of OCP (2019) outcomes.	Complete implementation of OCP (2019) outcomes.	Prepare OCP 2 process in relation to clinically led service model.	The Organisational Change Process (OCP) implementation completed.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24					Progress Rating
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q4	
		conditions across collection teams. • Improved quality • Improved safety • Reduction in staff turnover. • Improved collection efficiency.	Complete new job descriptions.	Complete review of existing service model.	Develop workforce plan. Provide and promote leadership learning opportunities.	Complete OCP2 consultation. Implement new clinically led collection team model.	Impact review upon collection teams continues. OCP2 will form part of the WBS Futures portfolio. Timelines are being reappraised.	
	Develop and implement a platelet strategy by 2024/25.	• Improved levels of efficiency • Improved alignment between capacity and demand • Reduction in avoidable waste • Reduce wastage.	Establish a platelet strategy group under the Laboratory Modernisation Programme to coordinate the work. Complete development of platelet planning tool.	Planning tool developed and in routine use. Review the clinic collection plan for Apheresis to ensure the clinic times are optimised.	Clinical and Scientific roadmap established to predict future trends e.g., cold platelets. Begin development of platelet strategy.	Continue development of the platelet strategy.	The Platelet Strategy development transferred to WBS Futures portfolio and work is underway. Phase 1 (Demand Planning Tool) to be completed by Qtr. 1 2024/25 and Phase 2 (Human Leukocyte (HLA) Selected Platelets) to be completed by Qtr. 4 2024/25. .	

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
	Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	• Improved availability of information • Increased efficiency /productivity through Improved patient experience • Reduced turnaround times. • Reduction in avoidable waste	Secure funding from Welsh Government.	Commence procurement process.	Complete procurement process.	Develop implementation plan.	Contract awarded in March 2024. System licences issued in March 2024 enabling implementation in April 2024. Implementation plan included in WBS Futures portfolio.	(green)
	Procure new Blood Establishment Computer System (BECS) contract.	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	Commence Supplier engagement for new BECS contract.	Supplier Engagement.	Contract award.	Confirm supplier & commence implementation	Schedule for procurement approved. User Requirements Specification undergoing final review. Outline Business Case to be presented to Trust Board in May 2024. Funding position remains unconfirmed but both commissioners and Welsh Government	(yellow)

IMTP Strategic Priorities Welsh Blood Services for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
							have been alerted to this system requirement.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25.	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales • Compliance with SaBTO recommendations.	Implemented testing strategy in 2022/23. Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	Ongoing look back exercises as required. Input data into SaBTO review.	The project has run to plan, in compliance with SaBTO recommendations. Data has been submitted for a planned SaBTO review. The review report date to be confirmed.	
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of	• Maintain compliance with regulatory standards • Improved quality • Improved safety • Improved donor experience.	Complete reconfiguration of the Regulatory Assurance and Governance Group to create the Divisional Quality Hub.	Validation and deployment of eQMS. Review document hierarchy structure. Adapt change management process to	6 month review of Quality Hub delivery. Implementation of eQMS. Review amended Change Management process.	Review pilot of electronic signatures and implement learnings. Review eQMS implementation and	The digital signature system procurement is complete. Updated system due by the end of Q1 2024-25. High level project plan for eQMS agreed with supplier and change project underway. System configuration to commence by mid-April	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	
	regulatory compliance and maximises digital technology by 2023/24.		Launch the pilot of electronic signatures. Commence formal procurement of an electronic quality Management system (eQMS). Review feedback from Change Management workshops and update processes.	support Continuous Improvement culture.		functionality.	with support from the supplier.	■
	Implementation of Foetal DNA typing by 2023/24.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women • Improved safety	Procure commercial kit	Undertake digital developments to support new test. Validate test.	Complete validation and implementation of new test.	Implement all-Wales service for cell free Foetal DNA testing.	Validation of test and development of software in progress. National integration requirements have been moved to phase 2. 'Go live' planned for May 2024.	■

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved patient experience • Reduction in avoidable waste/costs						
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales.	• Secure the supply chain for Immunoglobulins in Wales • Reduces need for importation. • Cost avoidance/reduction • Avoids patient rationing.	Develop project plan for supply of recovered plasma for fractionation (estimated start date April 2025). Develop high level business case for investment to support the plasma programme.	Renegotiate / renew supply contracts for diagnostic plasma to align with fractionation plan and maximise income. Develop detailed business case for plasma programme (subject to WG policy decision).	Commence validation of leucocyte filtration (NQT) blood packs. Commence validation of Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG pathway and governance arrangements are clear. Consider options for BC preparation for Welsh Government for source and recovered plasma.	Financial modeling review completed & updated business case submitted to Welsh Government (WG) and WHSCC in March 2024. The Business Case is awaiting Ministerial approval. WG advice on program governance at Wales level to be agreed, subject to approval of the business case.	
SP6 Sustainable services that deliver the greatest value	Develop and implement an energy efficient, sustainable, SMART estate	• Improved donor satisfaction • Improved staff well-being	Refresh of Programme Business Case (PBC).	Further development of Outline Business Case (OBC) to	Internal scrutiny of Outline Business Case (OBC).	Submission to Welsh Government.	Following a proposal from Specialist Estate Services (SES), Welsh Government have been	

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
to our communities **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2 and 5)**	at Talbot Green site that will facilitate a future service delivery model	• Increased service resilience • Reduction in energy consumption and utilisation • Reduction in carbon emissions • Compliance with statutory requirements • Improved efficiency, reduction in waste and carbon emissions.	Further development of Outline Business Case (OBC) to incorporate Laboratory Services Modernisation.	incorporate Laboratory Services Modernisation (following outcome of Feasibility Study).			approached to consider combined OBC/FBC. Initial support received from Welsh Government with a request to share preferred option with SES and submit a bid for funding.	
SP7 **Develop great people and a great place to work** **(Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	• Enhanced workforce capacity & capability to meet need. • Enhanced Leadership capacity & capability • Improved staff satisfaction	Consult on new Senior Leadership Team (SLT) workforce model and recruit to roles where there are substantive job holders.	Permanently recruit to remaining SLT roles where there are currently only seconded post holders. Scope out new WBS workforce model for	Permanently recruit to remaining SLT roles where there are currently only seconded post holders. Plan and deliver training / team development	Review of newly implemented SLT workforce model. Phased implementation of new Clinical Services workforce model.	Senior Leadership Team (SLT) recruitment complete. The Clinical Services delivery model scoping has concluded, and a new model recommended. Existing roles are being reviewed/introduced via a phased approach.	

IMTP Strategic Priorities Welsh Blood Services for 2023/24								
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved staff well-being • Improved service quality, safety and donor satisfaction.		Clinical Services. Laboratory Services Modernisation Programme determine requirements for future workforce in Laboratory Services.	sessions with new SLT. Phased implementation of new (Clinical Services workforce model. Scope out new WBS workforce model for Laboratory Services.	Phased implementation of new Laboratory Services workforce model.	The Laboratory Services Modernisation Programme is on schedule, and will be delivered via the WBS Futures portfolio.	

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 4 as at 31/3/2023

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**					**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q4**	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction	Complete recruitment to any additional posts identified in workforce plan. Review SLAs. Review operational model	Undertake staff training. Deploy communications plan. Review SLAs	Development of a transition and implementation plan to support the move to the Satellite Centre in 2024/25 Installation of 2 standard linear accelerators and a CT Sim at the centre.	Complete recruitment to any additional posts identified in workforce plan Develop stakeholder communication plan .	• Build programme on track. • Workforce recruitment progressing well with several appointments offered. • Working on service specification and SLA progressing. Joint workshops held in January, February and March.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Integrated Radiotherapy Solution**	• Improved patient outcomes	Clinical commissioning of first replacement	Realise initial pathway improvements. Initiate digital	Decommissioning and removal of second linear accelerator.	Installation and commissioning of second	• All aspects of phase 1 (year 1) delivered on-	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
	Programme by 2026/27	• Improved quality of care • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	linear accelerator at the existing VCS First patient treatment (June 2023)	implementation and develop benefits realisation plan.	Bunker refurbishment commenced in advance of installation of second replacement linear accelerator.	replacement linear accelerator at VCS	time and on-budget. • Linear accelerator 3 bunker refurbishment on track for completion in quarter 1 2024-25. • Planning for phase 1 (year 2) in development.	(green)
Trust Strategic Goals 1 and 2	**Implementation of findings of Clatterbridge peer review within brachytherapy**	• Improved patient outcomes • Improved quality of care	Establish Brachy therapy service improvement group. Identify actions	Optional appraisal to be completed to identify and agree service model required to address	Business case to be completed (if required) to address additional resource requirement.	Continue to implement local actions.	• Work on the peer review action plan has been paused following the resignation of a Brachytherapy	(yellow)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
	services by Q1 2024/25	• Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction	requiring divisional/Trust support. Gather and review baseline data set for theatre utilisation and determine capacity gap Work with Cardiff and Vale University Health Board to review anaesthetic provision and associated SLA	capacity gap. Continue to implement local actions. In conjunction with CAV review processes and flows aligned to Brachy theatre utilisation	Continue to implement local actions		MPE. Now single handed MPE focused activity on Clinical Commissioning and training additional MPE to maintain operational service.	🟨
Trust Strategic Goals 1, 2 3 and 4	**Implement Radiology Informatics System (RISP) and participate in RISP - Radiology Informatics**	• Improved diagnostics information • Better information sharing and enhanced	Continue to engage with DHCW facilitated project board		Development of a local implementation plan to support National implementation	Development of a local implementation plan to support National implementation	Velindre Cancer Services 'go-live' scheduled for quarter 2 2024-25 by national implementation programme.	🟩

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
	System Procurement.	clinical decision-making • Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Improved productivity and efficiency levels • Improved patient satisfaction						
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety		Complete phase 2 of SDEC programme Develop business case to secure ongoing funding			• Year 3 work plan complete. • All year 2 objectives complete.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
		• Improved productivity and efficiency levels • Reduction in avoidable admissions • Improved patient satisfaction						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Quality Management System (Hub) within Velindre Cancer Services by Q2 2023/24**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety	Establish Task and Finish group. Agree scope of Quality Management System.	Identify resource within VCS to support delivery of functions of QMS Develop and implement revised governance structure	Fully implement QMS	Establish patient engagement hub	• Hub at VCS fully implemented.	
Trust Strategic Goals 1 and 2	**Implementation of Cancer Nurse Specialist**	• Improved patient outcomes • Improved quality of care	Identify possible funding requirements and develop business case to support	Align work to wider scope/review of CNS as part of charity funding expectations	Engage with commissioners on matter of funding of CNS posts	Review and evaluate impact of implementation	• CNS competency framework formally approved.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
	Review by Q3 2023/24	• Improved patient safety • Improved patient • Satisfaction • Reduction in avoidable admissions	change of service model / finance		Completion of review		• Capacity and demand review complete in the case of all tumour sites. • Feedback to CNS teams and wider SSTs complete.	
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of the national Transforming Access to Medicines (TrAMS) Model across Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Progress Pilot 3 - BOPA Centralised (Separated) Clinical Verification Process	Clinical and technical elements of Clinical Verification separated Undertake local compounding of materials	Define local financial impact of model. Further review / Development of SACT processes to ensure service sustainability	Confirm Pay Tech Service resource that must remain @nVCC	• Agreed model for VCC dispensary. • Secured capital funding to support expansion of VCC dispensary capacity. • Continued engagement with national programme.	

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
Trust Strategic Goals 1, 2 and 5	**Expansion of VAP services by Q4 2023/24**	• Provision of care at home/close to home • Reduced patient needs to travel • Increased patient experience / satisfaction		Develop service model for expansion of service (to include opportunities for service transformation).	Develop workforce plan. Develop financial plan and supporting business case.	Realise service expansion subject to any resource requirement being secured. Evaluation of service change.	• Business case to support VAP expansion completed and submitted to VCS Senior Leadership Team for scrutiny and approval.	(green)
Trust Strategic Goals 1, 2 and 5	**E-prescribing implementation of phases 1 and 2 for E-prescribing for general medicines in line with national timeframes**	• Improved quality • Improved patient safety • Improved information (access to and sharing of) • Improved levels of efficiency and productivity • Reduction in carbon emissions	Establish engagement with ePMA suppliers, arrange demonstrations and identify preferred supplier Map business processes and consider the effects ePMA will have on ways of working	Develop local procurement specification Identify resource required for implementation team Develop business case to support recruitment of implementation team Develop project	Recruit VCS system implementation team	Recruit to VCS System Implementation Team (if staff additional to Pre-implementation Team required)	• National business case in development. Anticipated that case will be submitted to Welsh Government in early quarter 2 2024-25. Velindre Cancer Services Senior Leadership Team have confirmed a preferred implementation timetable.	(yellow)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
				plan for implementation				
Trust Strategic Goals 1, 2, 4 and 5	**Implementation of SACT improvement programme by Q1 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved levels of efficiency and productivity • Reduced costs • Improved patient experience	Commence implementation of changes in response to findings of capacity reviews in nursing, treatment booking and pharmacy Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs	Commence implementation of changes in response to findings of capacity reviews in nursing and treatment booking Monitor delivery against KPIs.	Implementation of findings from capacity reviews in nursing and booking NHH interim service model in place Best practice service model in place ready to transition to nVCC	Progress continues: • Nursing – all recommendatiosn complete. • Bookings – 4 of 6 recommendations complete. • Pharmacy – all recommendations complete.	
Trust Strategic Goals 1 and 2	**Enhance the Velindre Cancer Services SACT telephone helpline to provide 24hr advice, triage service and**	• Improved quality • Improved patient safety • Improved access • Improved clinical outcomes	Establish working group as part of the Safe Care Collaborative Technical capability to record all telephone calls	Develop guidelines for audit. Conduct audit process	SACT treatment helpline fully implemented	Respond to audit findings Ensure the SACT triage line is achieving agreed VCS standards in accordance	• Improvements to processes implemented supported by the Safe Care Collaborative. • Further digital telephony	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
	achieve required standards by Q3 2023/24	• Reduced waiting times • Improved patient experience	is in place Digitalise UKONS tool and upload to clinical system Revise guidelines for escalation of calls.			with the VCS Generic Patient Enquiry implementatio n action plan	improvement work identified.	(yellow)
Trust Strategic Goals 1, 2 and 4	**Implementation of pathway programme to support optimisation of cancer pathway and transition to nVCC by Q4 2024/25**	• Improved quality • Improved patient safety • Reduced waiting times • Improved access • Improved clinical outcomes • Reduced waiting times • Improved patient experience	Establish governance structure, develop work plan and define timelines (programme to encompass a number of work streams which will include a focus on supporting improved system-wide Suspected Cancer Pathway compliance. Improving compliance	Establish work streams to support the delivery of the pathway programme to include RRTT Develop action plan in response to support work with Improvement Cymru and Toyota to address area for improvement Establish project teams to take forward Safe	Develop supporting business case(s) where required to support new delivery models, identifying funding stream. Implementation of pathway improvements where possible Review ways of working and identify opportunities for workforce reconfiguration	Develop and implement revised processes / pathways. Implementatio n of service delivery model for Attend Anywhere Continued engagement in Safe Care Collaborative Programme Identify new ways of working and	• Scoping work on development of interim process to rationalize referral processes ahead of introduction of Hospital 2 Hospital referral solution undertaken. New referral proforma developed and trial initiated with Cardiff and	(green)

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
			against new radiotherapy time-to-treatment (previously COSC) targets and improved flow and performance in Outpatients) Identify two tumour sites to commence pathway work. Set up workshop to map sessions and agree key processes and treatment specific pathways for focus Identify service improvements / opportunities for change aligned to best practice / national	care Collaborative project and ensure clear scope of work Develop and Implement new service and delivery model for Attend Anywhere.	Continued engagement in Safe Care Collaborative programme, including review of existing pathways for MSSC and SACT telephone helpline Implementation of services delivery model for Attend Anywhere	opportunities for workforce reconfiguration	Vale UHB lung team. ● Safe Care Collaborative project teams have identified and implemented various pathway improvements and areas for further focused improvement work.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			standards Gather and review baseline data sets Establish Task and Finish Group to identify service improvement opportunities within outpatients department and medical records/medical secretaries Initiate service improvement projects in conjunction with the Safe Care Collaborative within MSSC pathway and SACT telephone helpline					

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			Review lessons learned/benefits from previous Attend Anywhere pilot, identify tumour site group to initiate work, secure approval to proceed Establish project group					
Trust Strategic Goals 1, 2 and 5	**Digitisation of Medical Records programme by Q4 2024/25**	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity	Establish Project group	Identify service improvements / opportunities for change	Identify additional resource requirements Undertake options appraisal Explore off-site storage options as part of a	Develop supporting business case(s) Initiate phased delivery of the Project	Project group yet to be established.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Reduced carbon emissions			phased transition			(yellow)
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of national prehabilitation to rehabilitation deliverables by 2025/26**	• Improved quality • Improved patient safety • Reduction in cancelled treatments • Improved patient health and well-being • Improved clinical outcomes • Improved patient experience	Continue engagement with Prehab to Rehab south-east Wales collaborative and WCN national prehabilitation group Establish local governance structure, develop work plan and define timelines Review funding streams and commissioning models to facilitate prehabilitation service development.	Establish task and finish group to develop prehabilitation website for VCS patients	Introduce prehabilitation (self-management) website for VCS patients Introduce physical activity prehabilitation group sessions.	Introduce virtual physical activity programme Develop local service improvement plan	• Local working group fully operational. • Continued engagement with national prehabilitation meetings. • Staff engagement and awareness survey in development. • First project communication newsletter developed.	(green)

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) by 2025/26 (December 2025)**	• Improved quality • Improved patient safety • Improved patient dignity and experience • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Reduction in carbon emissions • Reduced staff sickness	Secure FBC approval from the Welsh Government Secure full planning permission Complete clinical design Ground clearance works Continued engagement between nVCC project team and VCS.	Achieve financial close Ground clearance works Continued engagement between nVCC project team and VCS.	Commence nVCC construction Continued engagement between nVCC project team and VCS.	nVCC construction Revise/refine delivery plans Develop plans to support the transition of services from VCS to the nVCC Finalise clinical models to be implemented to support nVCC.	• Full Business Case submitted to Welsh Government for approval.	
Link to Trust Destination 2032 – Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Outreach Programme by 2025/26**	• Increase care close to home • Improved access • Improved equity	Project board re-established in conjunction with HBs	Service model developed and agreed in partnership with ABUHB Development of service model in	Identify and agree additional workforce requirements and funding streams	Service model developed and agreed with both CTMUHB and C&VUHB	• Strategic planning assumptions and baseline data reviewed.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
		• Improved patient experience • Reduction in carbon emissions		partnership with CTMUHB	Development of service model in partnership with CTMUHB Development of service model in partnership with CTMUHB Ongoing discussions with CTMUHB to determine model and next steps.		• Engagement with Aneurin Bevan UHB, in the first instance, on delivery model undertaken. Further joint workshops scheduled for quarter 1 2024-25.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Phase 1 of the regional Acute Oncology Service by 2023/24**	• Improved quality • Improved patient safety • Improved clinical outcomes • Reduction in avoidable admissions • Improved patient experience	Establish an acute care programme board Agree scope and develop a statement of intent	Undertake review of service model at VCS and identification of required next steps	Develop communication strategy Develop AOS framework for VCS and service model	Undertake engagement on service model for nVCC	• New operational manager recruited to support regional work. • Velindre specific acute oncology project progressing	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
		• Reduction in carbon footprint					with particular focus on pathways, processes and patient transport issues. • Regional workshop scheduled for May 2024.	
Trust Strategic Goals 1, 2 and 4	**Implementation of national programme for palliative care and end of life in line with national timeframes**	• Improved quality of care • Reduction in avoidable admissions • Improved patient experience	Review baseline data and outcome from pilot work to date. Identify scope of palliative radiotherapy within VCS and as part of a regional model.	Develop agreed costed model for palliative radiotherapy Identify opportunities for workforce redesign and develop associated workforce plan Identify possible funding options	Collaborate with Cardiff and Vale University Health Board to explore options for regionalised chronic pain service Review and develop agreed costed model for palliative radiotherapy Identify opportunities for workforce	Develop business case to support palliative radiotherapy model if required	• Initial meetings focusing on the development of an agreed, sustainable model for palliative radiotherapy undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	**Q2**	**Q3**	**Q4**		
					redesign and develop associated workforce plan			
Trust Strategic Goals 1, 2, and 4	**Implementation of new services / delivery models by 2025/26.**	• Improved quality • Improved patient safety • Increased levels of efficiency and productivity • Reduced waiting times • Improved staff attraction and retention • Improved staff well-being • Enhanced organisational reputation for quality of service	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments Establish working group to develop service model to support delivery of internal mammary lymph node (IMN) radiotherapy for eligible patients	Finalise the priority of implementation of key treatments where external funding is required and agree timescales Determine requirement for additional funding and where appropriate commence business case developments for agreed treatments in phased approach according to priority and	Identify preferred service model and any additional resource requirement. To support delivery of partial breast and axillary radiotherapy for eligible patients with breast cancer Develop strategy and service model to support adoption of motion management	Identify additional resource required to implement partial breast and axillary radiotherapy and develop business case for consideration by commissioners Expand SRS service to support the routine treatment of patients with more than 3 metastases Identify additional	• Working group established to plan introduction of IMN and other novel breast cancer treatments. Group will identify treatment solution and any resource implications which will inform the development of a business case to support introduction of new techniques.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			with breast cancer Continue to engage with WHSSC service appraisal process in relation to proposed PRRT service Develop service model to support implementation of PRRT service for eligible patients with neuroendocrine tumours Identify additional resource required to expand HDR brachytherapy boost treatments for eligible patients	timetable agreed Identify additional resource required to implement IMN and develop business case if required for consideration by commissioners. Develop service models to support delivery of extreme hypofractionated radiotherapy for eligible patients with prostate cancer if required Identify additional resource required to implement extreme hypofractionated		resource required to support the expansion of the SRS service and develop business case, if required	• Working group established to plan implementation of hypofraction for the treatment of eligible prostate cancer patients (aka SABR for prostate). • Continued engagement with WHSSC on local commissioning of PRRT. Agreement likely to be secured in quarter 1 2024-25 and implementation plan to be delivered thereafter.	

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IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
			with prostate cancer. Develop business case for WHSSC to support expansion of HDR brachytherapy boost service Develop service model and associated pathways to support delivery of new indications for Stereotactic Ablative Radiotherapy (SABR)	radiotherapy for eligible patients with prostate cancer and develop business case for consideration by commissioners Develop business case to support implementation of PRRT service to WHSSC and funding stream for additional revenue resource if required Train Medical Physics Expert to support implementation of PRRT service				

Link to Trust Destination 2032	Objective	Expected Benefits	Key Specific Quarterly Actions for 2023/24				Quarterly Progress Update for Q4	Progress Rating
			Q1	Q2	Q3	Q4		
Trust Strategic Goals 1, 2 and 5	**Implement DHCR phase 2 by 2024/25**		Review learning from phase 1 to support implementation of further phases continue implementation of training plan Identify super users/champions for each service group to continue to support implementation Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of phase 1b (VCS specific) agree scope and prioritisation of phase 2	Review learning from phase 1 Establish revised governance structure	Clarify scope and service delivery requirements	Develop work plan to support implementation.	• Phase 1 closure report and benefits realisation review developed. Lessons learned exercise undertaken.	

IMTP Strategic Priorities Velindre Cancer Services for 2023/24								
Link to Trust Destination 2032	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2023/24**				**Quarterly Progress Update for Q4**	**Progress Rating**
			Q1	**Q2**	**Q3**	**Q4**		
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation by Q4 2024/25**	• Creation and sharing of knowledge across Wales/wider to improved cancer care • Development of network of partners to tackle key issues • Creation of knowledge economy and innovation across Wales • Physical space to support innovation and development working across the region/Wales/wider	Workshop to be held to scope CFCL and ways of working Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	Workshop to be held to scope CfCL and ways of working	Review potential projects aligned to CfCL, e.g. school for oncology, ARC, etc.	Review opportunities for CfCL to support the establishment and delivery of a primary care education and development programme to facilitate improved engagement and pathway delivery between and with primary and community care and Velindre	• CCfLI collaborative workshop undertaken and next steps agreed.	

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KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Trust-wide Initiatives - IMTP Progress Report 2023/24 for Quarter 4 as at 31/3/2024.

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		**Progress Rating**
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q4**	
Digital Initiatives	**Theme 1: Ensuring our Foundations** **Theme 2: Digital Inclusion** **Theme 3: Insight Driven** **Theme 4: Safe and Secure Systems** **Theme 5: A Digital Organization** **Theme 6: Working in Partnership**	• Provide resilient digital services which support excellent care • Seamlessly digitally connect patients, donors, staff and partners with our services and equally value non-digital channels • Become a data driven, insight led organisation where staff take care of and have the right information, at the right time, all of the time • Secure our data, information and services through an effective approach to Cyber Security • Create a digital culture across the Trust of innovation and knowledge sharing that supports the delivery of world class services	• Implementing our digital strategy • Constantly evolving our IT infrastructure and Cyber Security arrangements to meet good practice with a hybrid of cloud and on premise deployment • Implementing a digital transformation programme to drive benefits and create digital services that our patients, donors and staff value and can be accessed close to home • Increasing the speed of development, deployment and functioning of new technologies to increase our productivity • Working in partnership to implement a range of national systems, to support a once for Wales approach • Working with the public and Centre for Digital Public Services and Digital Communities Wales to champion and accelerate digital inclusion • Developing our partnership role with the Digital Intensive Learning Academy and Health Education and Improvement Wales to increase the digital literacy, skills and knowledge of our staff • Identifying opportunities to join digital accelerator programmes and initiatives	Digital Strategy published. Digital Programme now established. Digital Design Authority to be established in April 2024 – delayed from Q4 2023/24. Cyber Security Manager in post – implementation activities against Cyber Security Strategic Plan re-commenced. Ongoing progress in respect of major digital change programmes – i.e. BECS, WHAIS, RISP, ePMA. Further development of relationships with Academia – e.g. Digital Degree Apprenticeships Roadshow planned for Q4 2023/24.	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24

Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		Progress Rating
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q4**	
			• Improve the quality of our data by driving data standards; identifying data champions; and improving data sharing protocols • Transforming our information capability to provide data, information and knowledge to the right person at the right time and introduce new analytical capabilities • Building digital partnerships with partner organisations, academia and digital providers to create value in health, wealth and well-being	Digital Infrastructure Strategy and Supplier Management Framework approved – actions built into 2024/25 digital / IMTP plans. New Assistant Director of Data & Insight commenced in post January 2024. Piloting of 'Agile' delivery model for digital transformation activities due to commence in Q4 2024/25.	🟩
Workforce and Organizational Development	**Theme 1: Wellbeing and Engagement** **Theme 2: Supply and Shape** **Theme 3: Skilled and Developed People**	• Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement. • Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge	• Clinical agreed short and long-term MDT workforce plans • Improved alignment of our education and training functions to the needs of our services • Services delivered at a location and time which best suits our patients and donors • All staff to be proud to, and able to, promote our core values and principles • Improved health and well-being of our workforce.	A Health and Wellbeing Plan has been in place for 2022-23 and 2023-24 overseen by the Healthy and Engaged Steering Group. A highlight report is sent to EMB quarterly. A Trust training plan was developed in 2022/23 and is now a	🟨

| | Theme 4: Leadership and Succession Planning

Theme 5: Digital Ready People

Theme 6: Attracting and Retaining the Best Talent | • Develop a new Trust Strategic Equality Plan that supports the implementation of our Anti-Racist Action Plan and other aligned anti-discriminatory practices

• Implementing an agile approach to working
• Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce
• Improving the ways we celebrate success ensuring our staff feel highly valued for the amazing work they do
• Growing the Trust Inspire Leadership and Management Programme | | standard agenda item for the Education and Training Steering Group. A highlight report is sent to EMB quarterly.

The Strategic Equality Plan 2020-24 has been reviewed as the basis for developing the Strategic Equality Plan for 2024-28. Actions for this are agreed and monitored by the Healthy and Engaged Steering Group.

An Agile Working Programme has been delivered to support hybrid working across the Trust and a comprehensive Toolkit is available to staff and managers to guide them through the process.

During 2023-24, guidance was re-issued on determining Welsh Essential/Desirable in job roles leading to an increase in Welsh skills being sought at appointment. The All Wales Welsh Awareness elearning | |

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q4**	**Progress Rating**
				has been rolled out across the Trust. Language training at all levels is made available in line with service needs and staff requests. The Trust ran a successful Employee Excellence Awards event in 2023 and has a programme of Long Service Awards in place. The Trust Inspire Management and Leadership programme is in its 7th Cohort. An intermediate evaluation was undertaken in 2023 which shaped the taught programme and influenced the wider leadership and management development offer.	

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Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		Progress Rating
			Our Objectives will be achieved by Delivering	Quarterly Progress Update for Q4	
The Estates Plan	**Theme 1: A safe and high quality estate which provides a great experience** **Theme 2: Healthy buildings and healthier people** **Theme 3: Minimizing our impact to the environment** **Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve**	• Provide an estate which enables the delivery of high quality clinical services • Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience • Provide healthy buildings which support and enhance individual well-being • Minimise the impact of our estate on the environment • Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve	• Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs • Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces • Investing additional resources in the maintenance of the existing estate to maintain a Category B • Implementing our estates, digital, workforce and sustainability strategies • Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles • Identifying innovative ways to adopt renewable energy sources to service our requirements • Identifying facilities we can share the use of with other public bodies and wider partners • Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets • Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services • Delivering a number of transformative capital programmes which have sustainability at their centre of design:	o Engagement with departments through divisional groups to ensure stakeholders requests are being met. o Recently completed a condition survey of both divisions VCC & WBS to address category C & D. o Refurbishment of Linac 3 with a new Varian Halcyon machine that has 40% less operational energy consumption. o Progression of the First Floor Ward inpatient Ventilation system to provide staff and patients safe and high quality environment. o Progress has been made on the	

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	Objectives	Expected Benefits	Key Specific Actions for 2023/24		
			Our Objectives will be achieved by Delivering	Quarterly Progress Update for Q4	Progress Rating
			o Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 o Refurbishment / development of new outreach facilities by 2024/2025 o Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 o Opening of the new Velindre Cancer Centre by 2025	construction of the Radio Therapy Satellite unit at Neville Hall hospital. o Development of the nVCC design through various safety groups to ensure a safe and high quality estate. Expected benefits are on target for the reduction of carbon.	
Sustainability	Theme 1: Creating Wider Value Theme 2: Sustainable Care Models Theme 3: Carbon Net Zero Theme 4: Sustainable Infrastructure Theme 5: Transition to a Renewable Future	• Be recognised as a leading NHS Trust for sustainability nationally • Be a carbon 'Net Zero' NHS organisation by 2030. • Become an anchor organisation in the communities we serve which enhances their economic, social, environmental and cultural well-being • Support the transformation from ill-health to well-being across Wales •	• Developing clinical service models which support sustainability • Implementing our sustainability strategy • Applying the principles of the circular economy into our business processes through design, procurement, re-use and lifecycle. • Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and	• The Trust has developed a sustainability implementation plan. • The Trust has developed a decarbonisation action plan. • Walking aids recycling centers have been completed at VCC completed by local	

			transition to renewable energy for our services and facilities.	business Men's Sheds and is now being fully utilized by Patients at VCC.

Theme 6: Sustainable Use of Resources
 	
Theme 7: Connecting with Nature
 	
Theme 8: Greening our Travel and Transport
 	
Theme 9: Adapting to Climate Change
 	
Theme 10: Our people as Agents for Change
			• Investing in a range of refurbishments and new buildings which will support our carbon reduction and healthier buildings and healthier people approach. These include:
			    o Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025
			    o Construction of a Radiotherapy Satellite Centre at Neville Hall by 2024
			    o Construction of a new Velindre Cancer Centre by 2025
			• Implementing an attractive approach to agile working for our staff which reduces avoidable travel, improves well-being and offers the potential to support money going into local communities
			• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport
			• Using our procurement activities and NHS Wales Shared Services capability to drive a sustainable approach and achieve wider ethical and social value in areas including local employment and prosperity; carbon reduction; anti-slavery and unethical practices.
			• Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprenticeships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes);
				• Continue to support agile working across the trust to reduce carbon and support wellbeing.
				
				• Work has been undertaken in Q4 to plan a active travel day in both divisions VCC & WBS.
				
				• Trust has recently employed a Arts in Health coordinator to develop a arts in health program.
				
				The Trust has recently refreshed the Wellbeing Objectives.

IMTP Strategic Priorities Trust-wide Initiatives for 2023/24					
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2023/24**		
			Our Objectives will be achieved by Delivering	**Quarterly Progress Update for Q4**	**Progress Rating**
			becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Governments Foundational economy		
The Financial Plan	We have had an approved Integrated Medium Term Plan (IMTP) since their introduction by Welsh Government (WG) in 2014-15. Central to IMTP approval has been the Trust's ability to consistently achieve a balanced year-end out-turn position annually, whilst maintaining or improving the quality of our services and delivering agreed performance measures.	Our Integrated Medium Term Plan (IMTP) for 2023-2026 sets out our Financial Strategy from 1st April 2023 to 31st March 2026. During this period, the Financial Strategy aims to enable the Trust to meet the anticipated demand for services whilst still in recovery, ensuring that we return to pre-pandemic activity levels and address the backlog. Recovery from the pandemic continues to be further compounded by significant financial challenges due to the system wide exceptional cost pressures, which include energy & fuel cost increases and extraordinary levels of cost inflation, each of which will need to be met by the Trust in 2023-24.	The financial plan for 2023-24 consists of a number of distinct parts: 1. Core Revenue Plan: Balanced 2. COVID-19 Recovery 3. Financial Plan – demand & capacity 4. Income & Cost Assumptions 5. Planned Savings 6. Capital Plans Financial reports and returns	The Trust is forecast to report a breakeven position for 2023/24 financial year and meet its statutory duties.	

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

INTEGRATED MEDIUM TERM PLAN – ACCOUNTABILTY CONDITIONS

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Peter Gorin, Head of Strategic Planning and Performance
PRESENTED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital.
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Following the approval of the IMTP 2023/24 to 2025/26 the Trust received an Accountability Conditions letter, on 2nd October 2023, from the NHS Wales Chief Executive, **see Appendix 1**. A stated requirement within the Accountability Conditions letter was for the Trust to report progress against the conditions on a quarterly basis from quarter 3 (2023/24). This is the current Q4 progress report.

RECOMMENDATION / ACTIONS	The Quality Safety and Performance Committee is asked to: • Note the progress update against the Welsh Government accountabilities conditions in **Appendix 1 and 2**

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board – Run	**30/10/23**
Executive Management Board – Run	**29/02/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The approach for reporting against the accountability conditions was approved by the Executive Management Board.	

7 LEVELS OF ASSURANCE – NOT APPLICABLE

APPENDICES	
1	Velindre University NHS Trust IMTP Accountability Conditions Letter from the Welsh Government
2	Accountability Conditions Progress Quarter 3 Update

1. SITUATION

1.1 The Trust, on 14th September 2023, received confirmation from the Welsh Government that it's IMTP for 2023/24 to 2025/26 had been approved.

1.2 Following the approval of the IMTP, the Trust received an Accountability Conditions letter dated 2nd October 2023, from the NHS Wales Chief Executive **(see Appendix 1)** which laid down the following key accountabilities:

a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risk.

b) Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c) Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

2. BACKGROUND

2.1 The Welsh Government Accountability Conditions letter stated there was an expectation that:
"*The Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year*".

3. ASSESSMENT

3.1 To ensure robust delivery of IMTP objectives and actions, and to discharge the Welsh Government IMTP accountability conditions, the November QSP Committee recommended that quarterly progress reports are submitted to:

- The Executive Management Board (Run)
- The Quality, Safety and Performance Committee
- The Velindre University NHS Trust Board

Note: we currently report progress against the actions included within the Trust IMTP on a quarterly basis. This proposal is specific to the four Welsh Government accountability conditions.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Executive Management Board is asked to:

- Note the progress made against the Welsh Government accountability Conditions for 2023/24 a) to d) as at the end of Quarter 4 in **Appendix 2**

5. IMPACT ASSESSMENT

<table>
<tr>
<td colspan="2">TRUST STRATEGIC GOAL(S)</td>
</tr>
<tr>
<td colspan="2">Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals:</td>
</tr>
<tr>
<td colspan="2">If yes - please select all relevant goals:
• Outstanding for quality, safety and experience   ☒
• An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations   ☐
• A beacon for research, development and innovation in our stated areas of priority   ☐
• An established 'University' Trust which provides highly valued knowledge for learning for all.   ☐
• A sustainable organisation that plays its part in creating a better future for people across the globe   ☐</td>
</tr>
<tr>
<td>RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF)
For more information: <u>STRATEGIC RISK DESCRIPTIONS</u></td>
<td>Not applicable</td>
</tr>
<tr>
<td rowspan="2"></td>
<td>Not Applicable</td>
</tr>
<tr>
<td>The purpose of this paper is to outline the approach for reporting against the Welsh Government IMTP accountability conditions.</td>
</tr>
<tr>
<td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:
For more information:
https://www.gov.wales/socio-economic-duty-overview</td>
<td>Not required</td>
</tr>
<tr>
<td></td>
<td>There are no socio-economic impacts linked directly to the approach outlined within the paper or attached appendices.</td>
</tr>
<tr>
<td>TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT

FINANCIAL IMPLICATIONS / IMPACT</td>
<td>N/A - There are no Trust Well-Being goal implications or impact linked directly to the approach outlined within the paper.

There is no direct impact on resources as a result of the activity outlined in this report.</td>
</tr>
</table>

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	The purpose of this paper is to initiate a discussion in relation reporting requirements against the Trust IMTP accountability conditions. However, there will be a requirement to undertake an IMTP Equality Impact Assessment I support of the development of the Trust IMTP for 2024/25 – 2026/27.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Cyfarwyddwr Cyffredinol Iechyd a Gwasanaethau Cymdeithasol/
Prif Weithredwr GIG Cymru
Grŵp Iechyd a Gwasanaethau Cymdeithasol

Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Mr Steve Ham
Chief Executive
Velindre University NHS Trust
Trust Headquarters
Unit 2, Charnwood Court
Parc Nantgarw
Cardiff
CF15 7QZ
Steve.Ham2@wales.nhs.uk

Llywodraeth Cymru
Welsh Government

2 October 2023

Dear Steve

Integrated Medium-Term Plan 2023-2026

I am pleased to confirm that the Minister for Health and Social Services has approved the Trust's Integrated Medium-Term Plan (IMTP) which you submitted on the 31 March 2023, together with Ministerial priority templates. This approval recognises the development of integrated planning within Velindre, whilst recognising the current challenges and management of risks**.**

Whilst the financial position is extremely challenging for the system, I expect organisations to deliver the commitments set out within their plans, particularly in relation to the Ministerial priorities. You will be aware of parallel discussions with NHS Trusts to proactively explore if there are opportunities to deliver financial improvement beyond the current forecast.

The organisation should continue to progress improvements of a clear triangulated financial position and key trajectories. This is fundamental to the successful delivery of your Board supported IMTP. The organisation will need to:

a)   Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.

b)   Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance.

c)   Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID.

d)   Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.

This will be monitored by the NHS Executive, Financial Planning and Delivery Team on a quarterly basis.

There is an ongoing expectation that the organisation will continue preparing robust financial plans for future years, that considers all choices and options to meet the requirements of the Finance Wales Act 2014.

I expect the Board to scrutinise the plan and ensure that progress is monitored effectively over the forthcoming year, in particular against the Ministerial priority templates you submitted. A copy of your Board reports should be forwarded on a quarterly basis to HSS-PlanningTeam@gov.wales. Organisations should refresh their Minimum Data Set (MDS) on a quarterly basis for as part of their internal review of plans. Please submit your quarter two MDS returns to HSS-PlanningTeam@gov.wales by 27th October 2023.

The Minister is clear that progress in delivering key priorities will form part of the ongoing discussions with Chairs. The delivery of plans will also form the agenda for our Joint Executive Team (JET) meetings going forward. The Welsh Government Planning team will continue to engage and support local planning teams and track progress. Performance and delivery discussions on areas of priority and risk will continue to be scrutinised via the regular Integrated Quality Planning and Delivery (IQPD) meetings.

Risks or challenges that develop during the year will need to be discussed and agreed at your Board and communicated to Welsh Government via the governance arrangements (e.g. IPQD meetings). Where this necessitates any material changes to the plan in year, you will be required to advise me of these changes through an 'Accountable Officer' letter.
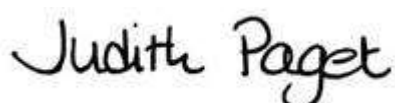
As articulated in the Ministerial letter, approval of the Integrated Medium-Term Plan does not equate to agreement to the detailed service changes, business case proposals or capital assumptions indicated within it. Nor does the plan approval confirm any validity in funding assumptions around additional revenue or capital funding other than that specified below. All service change and business case proposals will still be subject to:

- compliance with extant requirements set out in guidance or in legislation, and
- business cases and bids being subject to the normal business case approval process, including capital, and Invest to Save bid approval processes.

You will be aware that I wrote to you separately on 11th September confirming there will be no change in your escalation status, which remains at "routine arrangements".

The organisation has not requested financial flexibility as part of the IMTP, and none has been granted. I trust that this letter provides clarity on our expectations, but should you have any queries then please do not hesitate to contact me.

Yours sincerely

Judith Paget

Judith Paget CBE

cc: Nick Wood, Deputy Chief Executive NHS Wales
        Samia Edmonds, Planning Director
        Jeremy Griffiths, Director of Operations
        Hywel Jones, Director of Finance

Integrated Medium Term Plan 2023/24 – 2025/26 Accountability Letter 2 October 2023

Quarterly Actions Monitoring Document 2023/24 – New Conditions 2023/24

Accountability Conditions (Judith Paget Letter dated 2/10/23)	Quarterly Actions Progress to comply with IMTP Accountability Conditions			
	Q1	**Q2**	**Q3**	**Q4**
a) Demonstrate delivery of a robust savings plan supported by an opportunities pipeline to maximize its improvement trajectory and develop robust mitigating actions to manage financial risks.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Savings** The Trust is currently planning to fully achieve the revised savings target of £1.8m during 2023-24. During July additional non-recurrent savings schemes were identified to replace several schemes that had been assessed as non-deliverable i.e. Red Status. Enacting service re-design and supportive structures continues to be a challenge due to both the high level of activity growth and sickness levels limiting the capacity of service	**Savings** Trust is currently planning to fully achieve the savings target of £1.8m during 2023-24 **Opportunities pipeline** The Trust has identified some initial opportunities that could be explored but these require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.

| | | | leads to implement changes.

The procurement supply chain saving schemes have again been affected by procurement team personnel changes and capacity constraints and current market conditions during 2023-24. | |
|---|---|---|---|---|
| b)
Demonstrate actions are being taken to mitigate expenditure in volume and inflationary growth pressures beyond funded levels, as far as possible, throughout the financial year to ensure you maintain financial balance. | Accountability Letter not received until October 2023 Progress monitored from Q3 | Accountability Letter not received until October 2023 Progress monitored from Q3 | The Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures in response to national financial pressures.

As set out to EMB Shape in September, the purpose of the Finance and Investment Enhanced Monitoring agenda item is to strengthen the control environment by | Further to the update provided for Q3, the Trust has reviewed the non-recurrent reserve for 2023/24 and has been able to release a further £0.5m back to the system. This brings the total contribution by the Trust to £2.5m in 2023/24 which will contribute towards the reduction of the NHS Wales deficit. |

			ensuring accountability at an Executive level in relation to:	
			1. Savings delivery 2. Cost control 3. Choices and Options which could contribute towards wider system financial pressures 4. Impacts of spending decisions considering quality, safety, experience and value This process will also help to address the strategic risk theme of Financial Sustainability and Long-Term Value for the Trust. In response to the financial pressures faced by NHS Wales, the Trust identified costs savings	

			proposals to the sum of c£2m which have been delivered to support the delivery of a reduction in the overall NHS Wales deficit.

Additionally, the non-recurrent reserves position continues to be monitored against financial risks. If it is not required, it can be utilised to support the NHS Wales position on a non-recurrent basis. | |
| c)
Demonstrate actions are being taken to mitigate any residual costs in relation to the legacy of COVID. | Accountability Letter not received until October 2023 Progress monitored from Q3 | Accountability Letter not received until October 2023 Progress monitored from Q3 | **Covid Programme Costs**

In line with the WG approval letter the Trust is at present only expecting to draw funding from WG towards PPE costs with current forecast | **Covid Programme Costs**

Update as per Q3. |

			for 2023-24 reduced to £0.053m. **Covid Recovery and Planned Care Capacity** Funding for Covid recovery and planned care capacity investment flows through the LTA marginal contract income from commissioners. The Trust's Medium-Term Financial Plan assumed that the growth in activity levels may not be sufficient to recover the costs of investment made in the additional capacity. The latest LTA income trajectory based on activity delivered from April to Nov '23 is that income will cover the cost of the additional capacity.	**Covid Recovery and Planned Care Capacity** Update as per Q3. The latest LTA income trajectory based on activity delivered from April to February 2024 is that income will cover the cost of the additional capacity.

			The activity levels and Commissioner demand for services will continue be closely monitored over the remaining months of the year.	
d) Continue to make progress with the organisations' approach to allocative value and the population health resource agenda where possible.	Accountability Letter not received until October 2023 Progress monitored from Q3	Accountability Letter not received until October 2023 Progress monitored from Q3	**Value Based Healthcare Programme** The scope of the Value Based Healthcare programme at Velindre includes the Value Intelligence Centre, Preoperative Anaemia Pathway Project and the Velindre Food Mission. The Value Based Healthcare Programme received funding from Welsh Government to progress two key Value Based Healthcare initiatives across the Trust as follows:	**Value Based Healthcare Programme** Further to updates provided in Q3, the following updates apply for Q4. **Pre-op anaemia pathway (Welsh Blood Service)** The project team is working with DHCW to incorporate data feeds relating to transfusion from health boards into a central repository. This will have a wider benefit than for the pre-operative anaemia project alone. A proposal has been submitted to increase the funding to this

			Preoperative Anaemia Pathway Project with the Welsh Blood Service (WBS) Value Intelligence Centre across the Trust	programme to enable the team to widen the remit to incorporate the diagnosis and management of anaemia within Primary care, Paediatrics and Obstetrics.
			A VBH Programme update and governance proposal was provided to EMB Shape in October 2023. The governance, terms of reference and implementation plan was approved.	**Value Intelligence Centre** The Site-Specific Team wide dashboard was launched at the beginning of March. This now enables Clinical and Operational teams to
			Pre-op Anaemia Pathway (WBS) This project addresses the variation in the diagnosis and management of patients prior to major surgery. It is funded as a 2 year project to implement an All-Wales Pre-operative Anaemia Pathway (up to December 2024).	generate insights from linked data sets, e.g. comparing treatment types by clinical outcome (toxicity and survival) and cost. This theme will now focus on embedding this new tool into existing review meetings within VCS.

			Value Intelligence Centre	Food Mission
			A detailed programme plan was approved by the VBH Steering group in November 2023 and is set out in the table below. This includes specific, prioritised work packages and resource requirements taking into account the following interdependencies: • other Velindre programmes (e.g. Data and Insights Data Warehouse, Workforce changes, Quality and Safety, Digital etc.) • National PROMs procurement • Organisational dashboard development workplan • Varian's Noona implementation (as part of the	Food Mission was approved by the Trust Board in March 2024 and an action plan is now being developed to take forward.

			Integrated Radiotherapy Solution)	
			Food Mission This workstream focuses on improving the health and wellbeing of patients, donors and staff whilst contributing to the local economy and environmental sustainability of food production through increasing access to healthy food across the Trust.	

QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE
TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	14th January 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 25th January 2024.

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

1.3 Quality, Safety & Performance Committee 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 Quality, Safety & Performance Committee.
ADVISE	There were no items to advise the Quality, Safety & Performance Committee.
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	**TCS Programme Finance Report** The year-to-date spend for the TCS Programme is £15.412m Capital and £0.566m revenue, with a forecast expenditure for the current financial year of £18.834m Capital and £0.785m Revenue against budgets of £16.462m and £0.785m respectively. The overall forecast outturn for the Programme is an overspend of £3.157m for the financial year 2023-24 against a budget of £16.4622m. Capital funding has not been allocated for the FBC phase of the nVCC Project for this financial year. The funding request for c£2.800m made to Welsh Government will be increased to c£3.140m. Capital funding of £0.898m (including VAT) for the Advanced Works Agreement for the nVCC Project was allocated by Welsh Government on 9th January 2024. Revenue funding has been allocated for Project Delivery and Judicial Review elements of the nVCC project for this financial year from the interest incurred by the Escrow account. This supersedes the proposed funding request of £0.041m which was to be made to the Trust. The TCS Programme Scrutiny Sub-Committee **NOTED** the financial position for the TCS Programme and Associated Projects for 2023-24 as at 31st December 2023.
APPENDICES	None.

QUALITY, SAFETY & PERFORMANCE COMMITTEE	

HIGHLIGHT REPORT FROM THE CHAIR OF THE **TCS PROGRAMME SCRUTINY SUB-COMMITTEE**	

DATE OF MEETING	9th May 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 18th April 2024.

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

1.3   Quality, Safety & Performance Committee 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 Quality, Safety & Performance Committee.
ADVISE	**TCS Programme Finance Report** The overall outturn for the Programme is an underspend of £0.030m for the financial year 2023-2024 against a budget of £20.948m. Additional capital funding of £1.229m was allocated by Welsh Government to the ADDA Project for this financial year in March 2024. It was reported as being fully utilised. There are four new elements to the Enabling Works Project that require additional funding as previously noted, totalling £2.900m. Ministerial approval will be sought for this additional funding as part of the Enabling Works Full Business Case Addendum. There is a risk of a lack of funding for the Whitchurch Hospital Site, which is being mitigated by securing additional funding from Welsh Government. It was reported that the delay on s.278 works was offset by an element of nVCC overspend. It was confirmed Welsh Government were informed and aware of the slightly higher than expected National Grid costs. The TCS Programme Scrutiny Sub-Committee were assured the transfer of the Whitchurch Hospital Site is imminent. The first meeting regarding the Whitchurch Hospital site disposal which is being led by Shared Services will be brought back to the TCS Programme Scrutiny Sub-Committee when more information is known. Welsh Government have confirmed that the security costs and disposable fees will be covered. The TCS Programme Scrutiny Sub-Committee **NOTED** the TCS Finance Meeting.

	New Velindre Cancer Centre: Implementation of Arrangements for Next Phase The TCS Programme Scrutiny Sub-Committee were made aware Financial Close was reached on 28th March 2024. The Project Board is overseeing and coordinating the transition from previous project arrangements into the revised set out within the Management Case. Four new workstreams are being established which includes: construction, transition, digital and engagement. The TCS Programme Scrutiny Sub-Committee **NOTED** the New Velindre Cancer Centre: Implementation of Arrangements for Next Phase.
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	**Communications & Engagement** The Trust are working closely with Acorn and Sacyr who have their own community engagement officer established within their programme and the activity will be aligned via the Engagement workstream of the project going forwards, The TCS Programme Scrutiny Sub-Committee received and **NOTED** the Communications and Engagement report.
APPENDICES	None.