Public Quality, Safety & Performance Committee

Thu 11 July 2024, 10:00 - 13:00

Hybrid meeting

Agenda

1. STANDARD BUSINESS

1.1. Apologies

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

1.2. In Attendance

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

1.3. Declarations of Interest

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

2. MAIN AGENDA

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

Nil items

3. 2022-2023 ANNUAL REPORTS

3.1. FOR APPROVAL

3.1.1. Infection Prevention & Control Annual Report

To be led by Hayley Harrison Jeffreys, Head of Infection Prevention & Control

3.1.1 QSP IPC Annual Report 23-24 (v3).pdf (30 pages)

3.1.2. Safeguarding & Vulnerable Adults Management Group Annual Report

To be led by Fiona Davies, Head of Safeguarding

3.1.2 Safeguarding Annual Report 2023-24.pdf (23 pages)

3.1.3. Patient & Donor Experience Annual Report

To be led by Tina Jenkins, Head of Quality, Safety & Assurance

3.1.3 Patient and Donor Experience Annual Report 2023-24.pdf (23 pages)

3.1.4. Nursing Strategy Annual Report

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

3.1.4 Nursing Strategy Annual Report 2023-24.pdf (12 pages)

3.1.5. Quality, Safety & Performance Committee Annual Report

To be led by Liane Webber, Business Support Officer

3.1.5 QSP Committee Annual Report 2023-24 v3.pdf (14 pages)

3.1.6. Information Governance Annual Report

To be led by Matthew Bunce, Executive Director of Finance and Senior Information Risk Owner (SIRO)

3.1.6 QSP IG Annual Report-FINAL.pdf (23 pages)

3.1.7. Health & Safety Annual Report

To be led by Steph Williams, Head of Health & Safety

3.1.7 Cover Paper - Health and Safety Annual Report QSP.pdf (6 pages)
3.1.7 V2 HEALTH & SAFETY ANNUAL REPORT2023- 2024 INTERNAL.pdf (28 pages)

3.1.8. Communications Annual Report

To be led by TBC

Deferred to September Committee

3.2. ENDORSE FOR TRUST BOARD APPROVAL

3.2.1. Trust Clinical Audit Annual Report

To be led by Edwin Massey, Medical Director, Welsh Blood Service and Jacinta Abraham, Executive Medical Director

3.2.1 Cover Report_Trust Clinical Audit Annual Report 2023-2024 QSPC (JA).pdf (5 pages)
3.2.1 VUHNST CLINICAL AUDIT ANNUAL REPORT 2023-24 v10.pdf (53 pages)

3.2.2. Putting Things Right Annual Report

To be led by Tina Jenkins, Head of Quality, Safety & Assurance

3.2.2 PTR Annual report 2023-2024.pdf (32 pages)

3.2.3. Duty of Quality Annual Report

To be led by Tina Jenkins, Head of Quality, Safety & Assurance

3.2.3 DOQ cover paper QSP.pdf (6 pages)
3.2.3 Annual Duty of Quality 2023-24 report.pdf (40 pages)

3.2.4. Performance Annual Report

To be led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

3.2.4 QSP 11th July - Velindre University NHS Trust Annual Performance Report.pdf (4 pages)
3.2.4 Annex 1 - QSP 11th July - 2023 - 2024 - Velindre UNHST Annual Performance Report.pdf (52 pages)

3.3. FOR NOTING

Nil items

4. NHS WALES SHARED SERVICES

4.1. Surgical Materials Testing Laboratory (SMTL) Annual Report

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

4.1.0a 2024-07-SMTL-Annual-Briefing.pdf (9 pages)
4.1.0b Appendix-1-2023-UKAS-RA-SMTL-Assessment_Report_232240-03-01.pdf (11 pages)
4.1.0c Appendix-2-2023-UKAS-Schedule-1492-Testing-Multiple.pdf (8 pages)

4.2. Medical Examiner Service (MES) Annual Report

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

4.2.0 MES Annual Report 2023 2024.pdf (10 pages)

4.3. Duty of Quality Annual Report

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

4.3.0 NWSSP Duty of Quality Annual Report 2023 2024.pdf (24 pages)

5. CONSENT ITEMS

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. FOR APPROVAL

5.1.1. Medical Devices Annual Report

To be led by Jacinta Abraham, Executive Medical Director

Deferred to September Committee

5.1.2. Estates Annual Report

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

5.1.2 Estates Annual Report 2023-24 Cover Paper QSP July 2024 1.pdf (6 pages)
5.1.2 ESTATES ANNUAL REPORT 2023- 2024 INTERNAL (7).pdf (22 pages)

5.2. ENDORSE FOR TRUST BOARD APPROVAL

Nil items

5.3. FOR NOTING

5.3.1. Business Continuity & Emergency Planning Annual Report

To be led by Sarah Richards, Head of Planning & Performance Services

5.3.1 QSP BC EP - 2024.pdf (5 pages)
5.3.1 BCEP EMB & QSP - 2024.pdf (2 pages)

5.3.2. Professional Registration/Revalidation Report

To be led by Anna Harries, Head of Professional Standards & Digital, Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Dr Jacinta Abraham, Executive Medical Director

5.3.2 Professional Registration Revalidation Annual Report.pdf (8 pages)

5.3.3. People Strategy Annual Report

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

5.3.3 QSP - PEOPLE STRATEGY ANNUAL REPORT.pdf (14 pages)

6. 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

6.1. July 2024 Analysis of Triangulated Meeting Themes

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

6.2. July 2024 Analysis of Quality, Safety & Performance Committee Effectiveness

To be 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?*
- *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 the Annual Reports and core essential business?*

7. 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

8. ANY OTHER BUSINESS

Prior approval by the Chair required.

9. DATE AND TIME OF THE NEXT MEETING

The Quality, Safety & Performance Committee will next meet on the 12th September 2024 from 10:00-13:00.

10. 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).

11. PRIVATE/PART B SESSION

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

- Cyber Security Strategic Plan Annual Progress Report
- Claims and Inquest Private Annual Report

QUALITY, SAFETY AND PERFORMANCE COMMITTEE	
Trust Infection Prevention and Control 2023/2024 Annual Report	
DATE OF MEETING	11th July 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	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
PRESENTED BY	Hayley Harrison Jeffreys – Head of Infection Prevention and Control
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Trust's Infection Prevention and Control Annual Report provides a comprehensive overview of the developments, outcomes, achievements and challenges for the period 1st April 2023 - 31st March 2024. Throughout the year, the Trust has continued to implement robust infection prevention and control measures to mitigate the risk of healthcare associated infections (HAI's) including rigorous hand hygiene protocols, comprehensive staff education and training programs and effective surveillance mechanisms. The following are the key outcomes:

	• No cases of pseudomonas blood stream infections sustained for a second year • 100% reduction in Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infection • No evidence of transmission of healthcare associated infection • No outbreaks during year 2023 – 2024 • No nosocomial COVID-19 transmission. In addition, the Trust was the first health organisation in Wales to achieved ANTT (aseptic non touch technique) accreditation – achieving Gold. Despite these accomplishments, the report identifies several challenges that need to be addressed. These include: • The emergence of new infectious agents • Increasing prevalence of antimicrobial-resistant organisms • Maintaining staff engagement and adherence to infection prevention protocols remains a priority, requiring continuous education and reinforcement. New technologies incorporated into education will assist in driving forward engagement with staff. Looking ahead, we remain dedicated to using evolving strategies and embracing innovation to strengthen the Trust's infection prevention and control program, and to foster a culture of continuous improvement.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **APPROVE** the Infection Prevention and Control 2023-2024 Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Trust Infection Prevention and Control Management Group	21/05/2024
Trust Integrated Quality and Safety Group	22/05/2024
Executive Management Board	30/05/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The groups all endorsed the report. For onward approval.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full

APPENDICES	
1	Infection Prevention and Control Annual Report 2023 – 2024

1. SITUATION

The Trust is required to publish an annual report regarding its Infection Prevention and Control compliance and performance metrics. The report for 2023 – 2024 has been compiled and is attached to this report in **Appendix 1**. The report requires final approval by the Quality, Safety and Performance committee prior to it being published on the Trust's website.

2. BACKGROUND

The Velindre University NHS Trust's 2023-24 Infection Prevention and Control Annual Report summarises the Infection Prevention and Control performance metrics, key achievements and challenges, and the plans for the year ahead.

The report provides assurance that there is an excellent governance framework regarding Infection Prevention and Control at the Trust, and also provides assurance that all the required performance metrics have been achieved. Key achievements and challenges throughout the year have been highlighted, and the priorities for 2024-2025 have also been identified.

The report has been endorsed and approved by the Trust's Infection Prevention and Control Committee, the Integrated Quality and Safety Group, and the Executive Management Board. Final approval by the Quality, Safety and Performance Committee is now sought.

3. ASSESSMENT

3.1 The Infection Prevention and Control Annual Report provides an overview of the Trust's compliance with the Infection Prevention and Control performance metrics, and provides a summary of the key achievements and challenges over the past year, in addition to a look forward at the priorities for 2024-25.

The 2023-24 Annual Report is attached in **Appendix 1**.

3.2 Assurance is provided within the report that there remains an excellent governance framework in place regarding infection prevention and control at the Trust.

3.3 The Annual Report demonstrates that all infection prevention and control performance metrics for the Trust have been achieved during 2023-24.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The Infection Prevention and Control 2023-24 Annual Report provides an overview of the following:

The key Infection prevention and control outcomes for 2023-24 have been identified and described within the report, and include the following:

- No cases of pseudomonas blood stream infections sustained for a second year
- 100% reduction in Meticillin Sensitive Staphylococcus Aureus (MSSA) blood stream infection
- No evidence of transmission of healthcare associated infection
- No outbreaks during year 2023-2024
- No nosocomial COVID-19 transmission

The key achievements of the Infection Prevention and Control team for 2023-24 have been described within the report, and include the following:

- The Trust was the first health organisation in Wales to achieved ANTT (aseptic non touch technique) accreditation – achieving Gold.
- An IPC Team member completed the IOSH (Institute of Occupational Safety and Health) Managing Safely course
- An IPC Team member successfully completed an accredited Decontamination course

The key challenges for the infection prevention and control team during 2023-24 have been highlighted within the report, and include the following:

- Managing the emergence of sub-variants of Omicron (variant of SARS CoV2)
- Delivering the ongoing IPC agenda when the team staffing resource was challenging (now resolved).

The key priorities for 2024-25 have been identified within the report, and include the following:

- Preparation for the management of emerging pathogens and high consequence infectious diseases and multi-drug resistant pathogens
- Review and improve infection control education across the organisation
- Participate in the national ANTT audit
- Submit work for the Infection Prevention Society conference
- Participate in National infection control projects
- Continue exploring opportunities for research and education
- Quality improvement projects to be led by the team, including sustainability
- Lead on the sustained excellent IPC performance outcomes

4.2 The 2023-24 Annual Report has been reviewed and approved by the Trust's Infection Prevention and Control Management Group, the Trust's Integrated Quality and Safety Group and the Executive Management Board. It now requires final approval by the Quality, Safety and Performance Committee.

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 annual report provides assurance that there is excellent IPC governance and safeguarding at the Trust, and that all performance metrics have been achieved.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.

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
	The data provided within the IPC Annual Report demonstrates that the wellbeing of our staff, patients and donors is well safeguarded from an infection prevention and control perspective.
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 Infection Prevention and Control Annual report provides assurance that there is excellent IPC governance and safeguarding at the Trust, and that all performance metrics have been achieved.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	The IPC Annual report provides assurance that there is excellent IPC governance and safeguarding at the Trust, and that all performance metrics have been achieved.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix	

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Infection Prevention and Control Annual Report 2023-2024

Contents		
1	Introduction	3
2	Key Achievements	4
3	Governance Arrangements and Reporting Framework	5
3.1	Internal Governance and Assurance	5
4	Performance Against Indicators and Standards	5
4.1	Healthcare Associated Infections	5
4.2	Multi-Drug Resistant Organisms	8
4.3	Infection Prevention and Control Audits	8
4.4	Aseptic Non-Touch Technique	10
4.5	Environmental Audits	11
4.6	Infection Prevention and Control Training Compliance	12
5	Staff Influenza Vaccination Compliance	13
6	Antimicrobial Stewardship	14
7	Research and Innovation	17
8	COVID Pandemic	17
9	Incident / Outbreak	17
9.1	Risk	18
10	Safe Water System Management, Building Environmental Improvements	18
11	Decontamination	19
12	New Velindre Cancer Centre	20
13	Infection Prevention and Control Awareness Campaigns	20
13.1	Celebration of Global Hand Hygiene Day – 5th May 2023	21
13.2	International Infection Prevention and Control Week: 16th-22nd October 2023	21
14	Conclusion	22
15	Priorities for 2024 - 2025	23

1. INTRODUCTION

Velindre University NHS Trust (VUNHST) provides specialist services to the people of Wales. There are two core clinical services within the Trust: The Welsh Blood Service and Velindre Cancer Centre.

Welsh Blood Service

Within the Welsh Blood Service, ensuring exemplary infection prevention standards is vital in maintaining the safety of donors, products, and recipients. As such, the Welsh Blood Service operates a robust infection prevention programme which is designed to maintain the thorough standards of care and services required to meet regulatory frameworks.

Velindre Cancer Centre

Velindre Cancer Centre also strives to ensure that high infection control standards are maintained. This is especially important given the vulnerability of our immuno-compromised patient group.

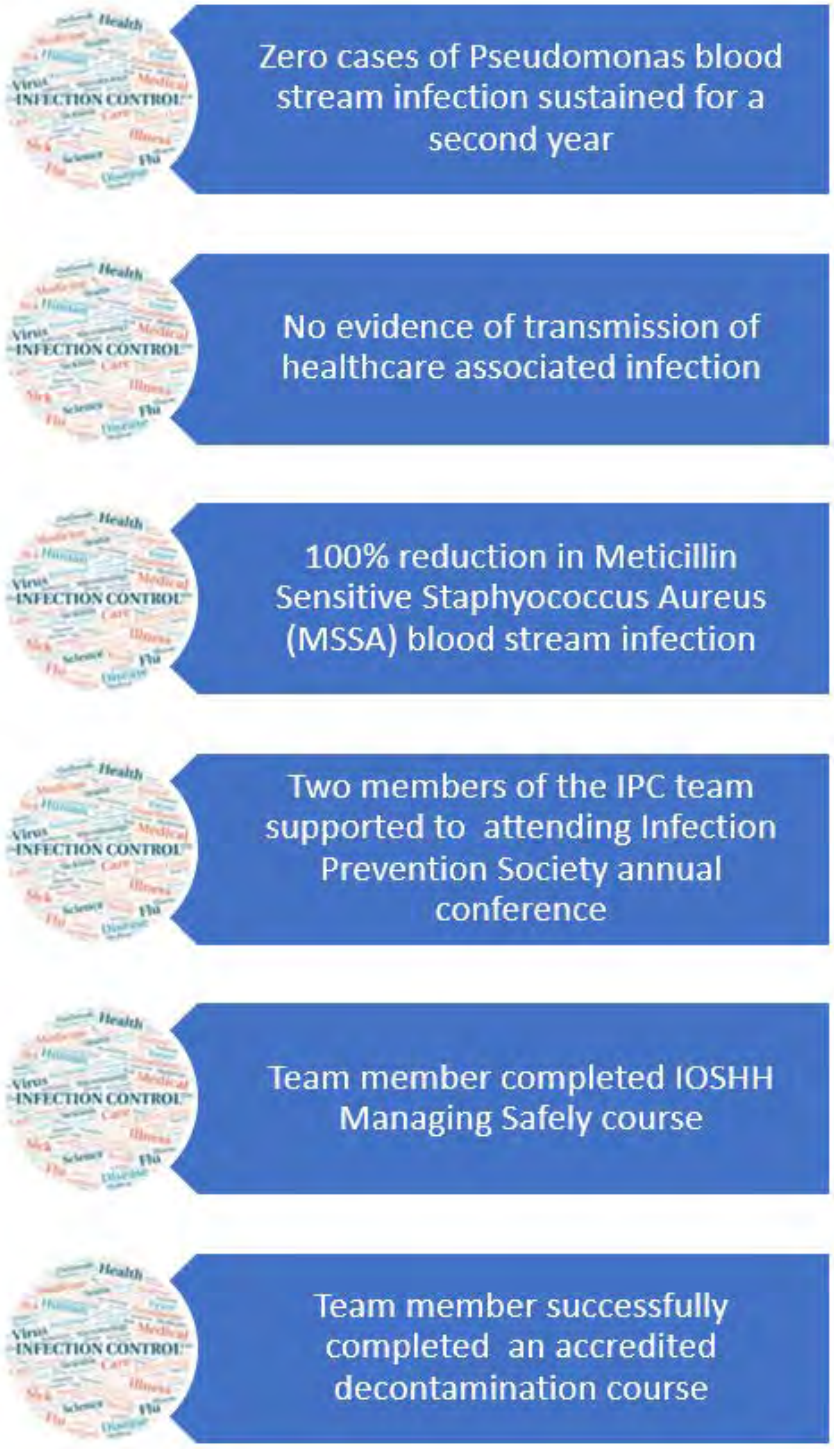
Infection Prevention and Control Team

The Trust's Infection Prevention and Control Team leads in ensuring the continued safety of the Trust's services, by working with the clinical and operational staff to mitigate the risk of patients and donors acquiring infection through contact with our services.

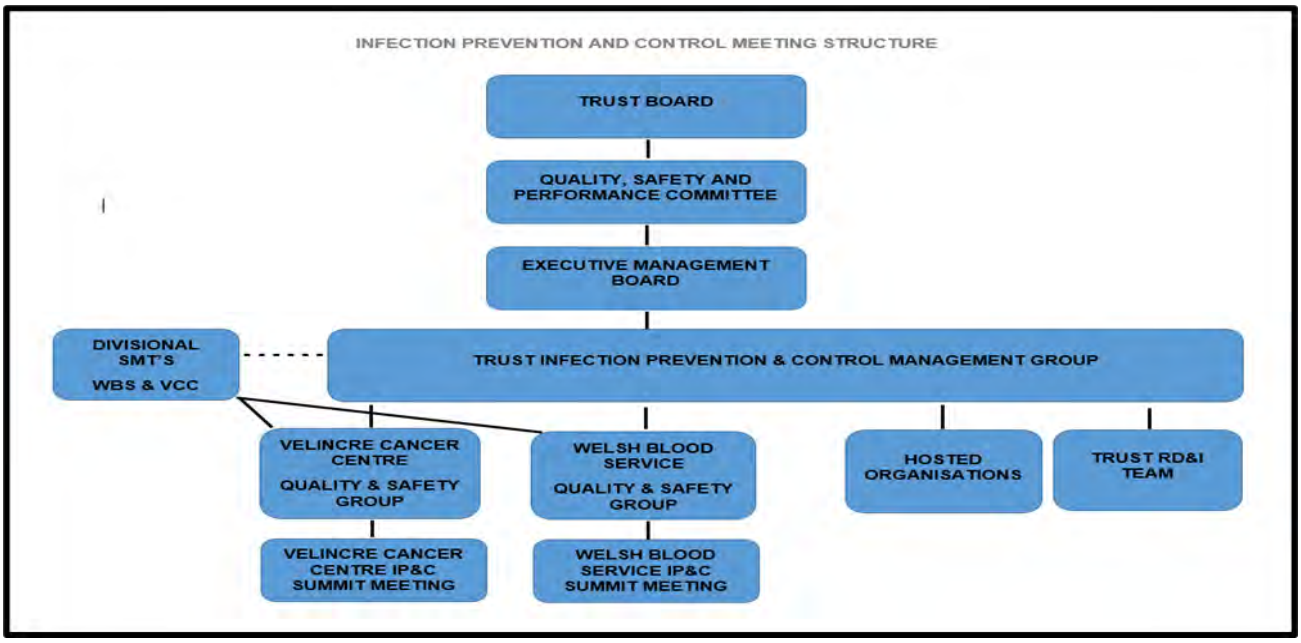
This report provides a summary of the progress, activities and achievements in Infection Prevention and Control, antimicrobial stewardship and decontamination for Velindre University NHS Trust during the period 1st April 2023 to 31st March 2024.

2. KEY ACHIEVEMENTS

Overall, 2023-2024 was a remarkable year for the IPCT, in addition to the Trust returning to business as usual as the COVID-19 pandemic transitioned to endemic, the following has been achieved:



3. GOVERNANCE ARRANGEMENTS AND REPORTING FRAMEWORKS



3.1 Internal Governance and Assurance

For 2023-24 the 2015 health and care standards were replaced with the Health and Care Quality Standards (2023).
Translating these standards to provide evidence of Safe Care, quality and were a priority during this year.

4. HOW DID WE DO? PERFORMANCE AGAINST THE INFECTION PREVENTION AND INDICATORS / STANDARDS

Velindre Cancer Service provides specialist oncological services to surrounding Health Boards, there are 30 in-patient beds. The Trust also, does not have responsibility for population health and provides tertiary services across a large geographic area. As such, it is not possible to directly compare our infection rates with those of Health Boards in Wales or use the national rate calculator, infection rate per 100,000 population. Within Velindre Cancer Service, the infection rate is calculated per 1,000 patient admissions.

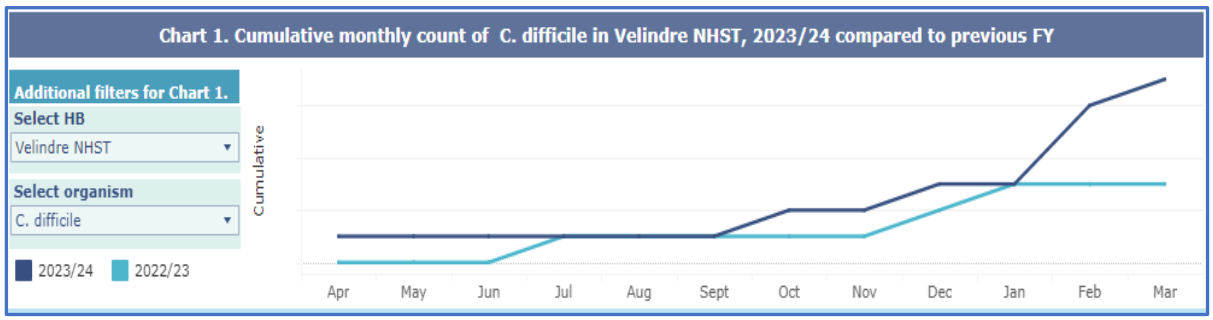
4.1 Healthcare Associated Infection

Healthcare acquired infection is a patient harm indicator and we need to do all we can to prevent patients acquiring such infections. During 2023-2024 the following occurred:

4.1.1 Velindre Cancer Service

- **Clostridioides *difficile* –** 7 patients acquired Clostridioides *difficile* infections**,** a 57% (4 patients) increase from 2022-2023.

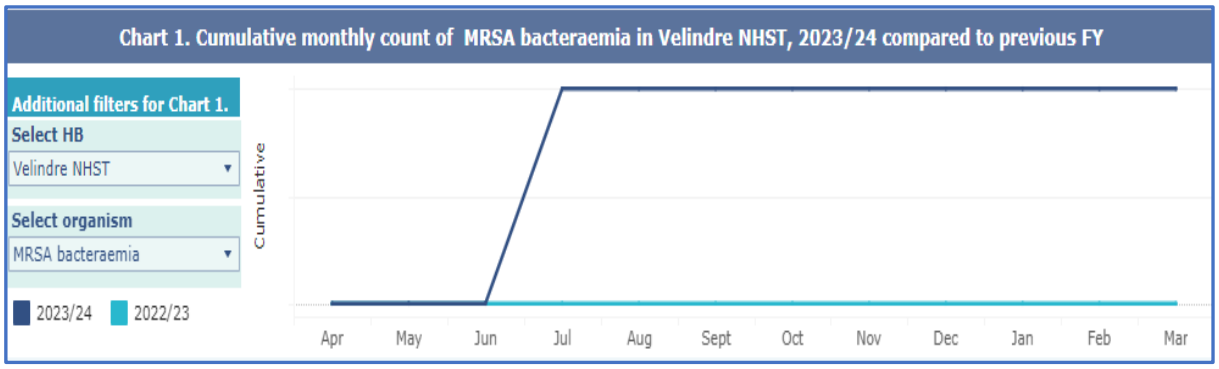
All were investigated thoroughly via a multi-disciplinary approach to establish to establish whether any issues with care occurred which may have contributed to the patient acquiring the infection. Opportunities for learning are identified via this approach with lessons learnt shared and improvements made. Whilst there were no clinical improvements that could have been made in each case revisions that have been made are inclusion of the Visual Phlebitis (VIP) Score are part of the question set and communication methods have been changed to improve engagement and timeliness of investigation.



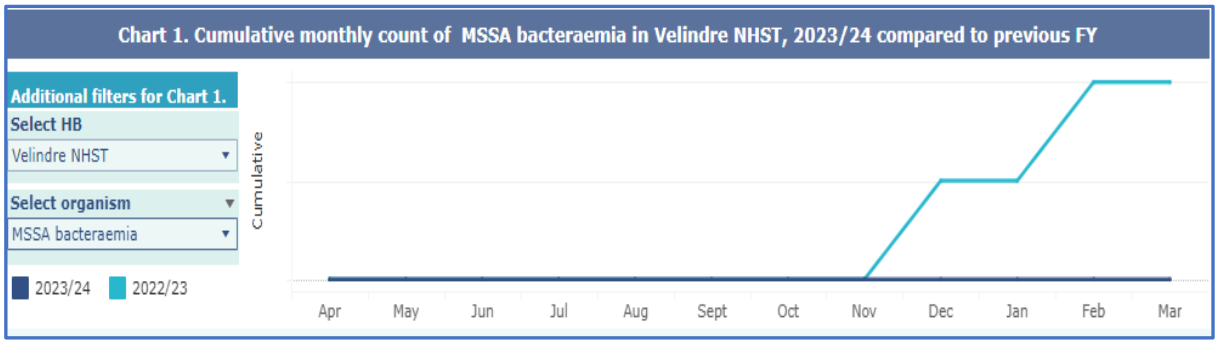
Genotyping of all were undertaken which determined there was no transmission of infection between patients.

The antibiotic requirements of the patients at Velindre Cancer Centre do make these patients more vulnerable to developing Clostridioides *difficile* disease. Microbiology ward rounds are undertaken to ensure appropriate use of antibiotics.

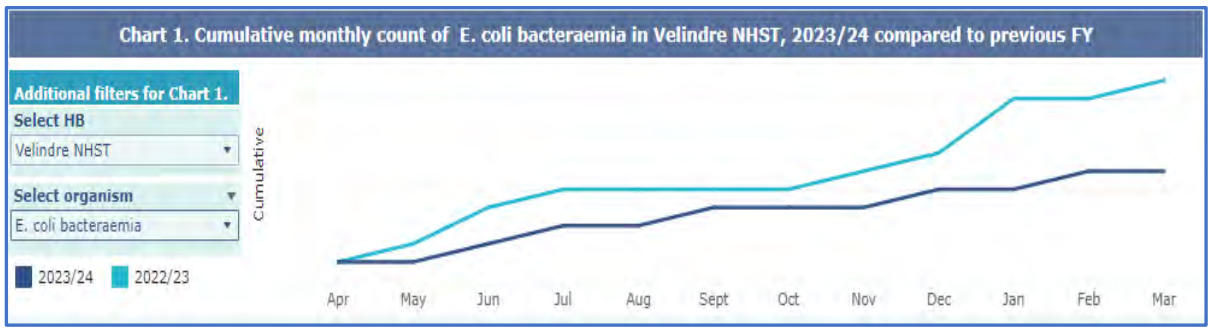
- **Meticillin Resistant Staphylococcus Aureus (MRSA) Bacteraemia -** There have been no healthcare acquired cases of Methicillin Resistant Staphylococcus Aureus (MRSA) acquired bacteraemia (bloodstream infections) since 22nd November 2013. However there has been a community onset bacteraemia which admission screening identified was due to an infected stoma site. To achieve this sustained position many interventions have been undertaken. These include screening all patients on admission and a continual focus on Aseptic Non-Touch Technique (ANTT).



- **Meticillin Sensitive Staphyloococcus Aureus (MSSA) Bacteraemia -** There were no cases of healthcare acquired Meticillin Sensitive Staphylococcus Aureus bacteraemia, which is a 100% reduction compared to 2022-2023.

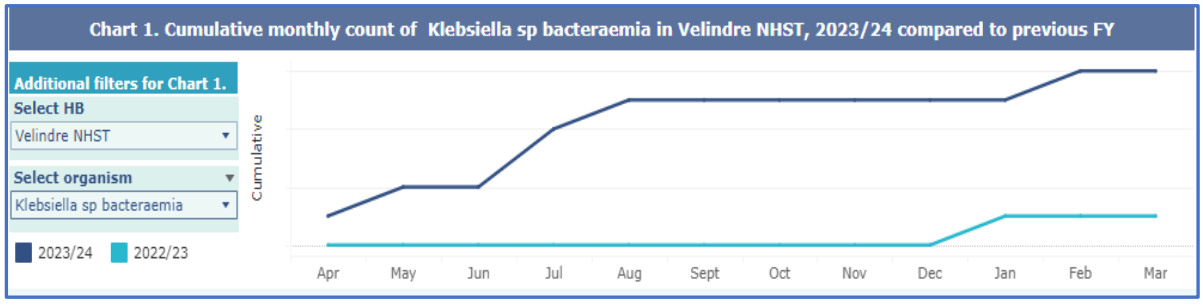


- **Escherichia *coli* (e-coli) Bacteraemia** - The surveillance of Escherichia *coli* bacteraemia began in April 2017, and there has been considerable progress since then with a continuous reduction. There were 6 cases of healthcare acquired E. *coli* bacteraemia identified, 4 of which were inpatients.



E. coli is part of the normal gut flora and investigation of the cases found identified two of the cases had extensive bowel disease. The third was identified as a translocation of the organisms (when the passage of bacteria of the gastrointestinal tract through the intestinal mucosa barrier to mesenteric lymph nodes and other organs). In some cases, the passage of bacteria results in blood stream infections.

- **Klebsiella species bacteraemia** - 6 cases of healthcare acquired Klebsiella were identified, a 100% increase compared with the previous year. 5 of these were in the first two quarters, which prompted a thematic lookback review. Unfortunately, the numbers were reflective of a rising national picture.



The thematic lookback review exercise identified that there was no correlation of infection between the treatments that the patients had received. Three patients had received chemotherapy (different regimens), one had chemotherapy and radiotherapy. In addition, the national reference laboratory could not find any epidemiological or genetic typing link

for these Klebsiella bacteraemia cases indicting that no patient-to-patient transmission had occurred.

- **Pseudomonas *aeruginosa* bacteraemia** – There were **no cases** of P. aeruginosa bacteraemia identified in 2023 – 2024, this is the second year the Trust has achieved zero cases.

4.2 Multi Drug-resistant Organisms (MDRO)

Multidrug resistant organisms are increasingly recognised as a growing public threat both within the hospital and community settings, with most resistant to the first line antibiotics used in hospitals. In addition to a clinical risk assessment on admission, the infection control team has worked with the inpatient ward to incorporate screening as part of the admission tests performed alongside meticillin resistant staphylococcus aureus swabs. Compliance with the screening is fed back to the department weekly.

The Trust infection control team have been part of the review of the national guidance and policy which has been updated to a suite of documents and action plans covering Clinically Significant Anti-Microbial Resistant Organisms (CSARO). Applying this to the Trust is part of the teams' key objectives for the next financial year.

4.3 Infection Prevention and Control Audits

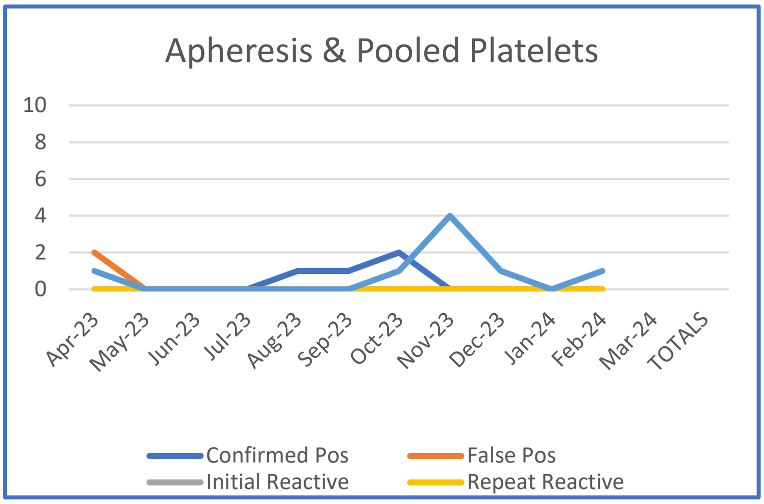
Infection prevention and control audits serve as key practices in healthcare settings to assess and enhance the efficacy of measures aimed at mitigating the spread of infections. Baselines have been previously established and audits are repeated as required to provide a measure which can help prevent the transmission if infection. They also assist in evidencing compliance with evidence based criterial. Progress against the audits reported monthly to the divisional infection prevention and control meetings and the Trust infection control management group (IPCMG).

- ***Welsh Blood Service Pre – Venepuncture Skin Cleaning Audit***
  In the Welsh Blood Service, maintaining donor, product, and recipient safety hinges on effective and evidence-based Aseptic Non-Touch Technique (ANTT), including thorough skin cleansing. Monthly observational audits on donor skin cleansing are conducted by all collection teams across Wales to ensure consistent adherence to the necessary practices. Any instances of non-compliance or suboptimal practices noted during audits are promptly handled with care by the clinical lead. Audit findings and action plans for improvement are then communicated through Infection Prevention and Control (IPC) and Quality and Safety channels at both Divisional and Trust levels. Over the past twelve months, compliance with required skin cleansing practices across all collection teams has remained consistently high, ranging between 99.7% and 100%.

- ***Welsh Blood Service Bacteriological Confirmed Positive Platelet Donations (Apheresis and Pooled)***

The infusion of bacterially contaminated platelets poses a significant risk to recipient health. Hence, the Welsh Blood Service must mitigate any chances of contamination. This is achieved through the implementation of rigorous standards concerning skin cleansing and laboratory infection prevention and control. To uphold these safe practices, the Welsh Blood Service conducts thorough bacteriological testing and monitoring of all platelets. Any positive results are meticulously reviewed and investigated to ensure complete safety.

When interpreting the term 'indeterminate' on the chart, it implies the presence of contamination in either the initial or subsequent tests, or a positive reactivity on both tests that cannot be correlated. This may also be interpreted as an unidentified contaminant. This aspect has been monitored, deliberated upon, and addressed within the quarterly bacteriology report of the Welsh Blood Service Quality and Safety Governance meetings. Some participants attend both these sessions and Infection Prevention Control meetings at the Welsh Blood Service allowing for robust collaborative efforts.

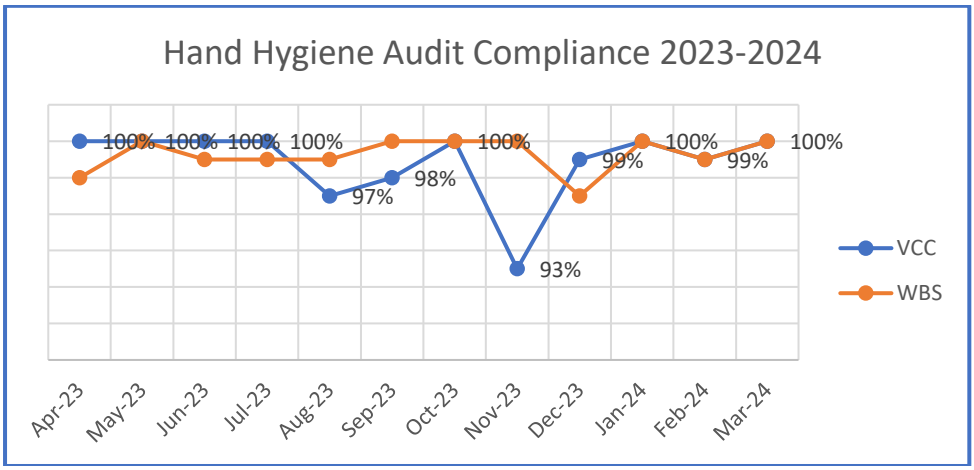


- ***Velindre Cancer Centre Clinical Practice audits***

Clinical practice audits are necessary elements of healthcare as they ensure delivery of high quality and safe patient care. The audits serve as systematic evaluations of practices, processes, and outcomes, aiming to identify areas of improvement and adherence to standards and guidelines. The team are pleased to report no issues were identified. Clinical practice audits include compliance with urinary catheter bundles, central venous catheter maintenance and peripheral cannula care bundles. This high compliance is reflected in the sustained low infection rates.

Hand Hygiene Audits

Hand hygiene compliance has been sustained at high levels across the Trust. Completed hand hygiene training and assessment is now recorded through the NHS Electronic Staff Record. The Infection Prevention and Control Team continue to support the department Hand Hygiene champions, and compliance is reported through both the divisional Infection Prevention and Control Summit meetings and the Infection Prevention and Control Management Group.



As outlined in figure above, throughout the year overall compliance at WBS has been between 93% and 100% and that across the Trust hand hygiene audit compliance has remained above 90% throughout the year.

During audits across departments there has been an increase in non-compliance with uniform policy, particularly bare below the elbow. The team escalated the issue to the Trust board who supports the stance of zero tolerance for non-compliance with policy.

4.4 Aseptic Non-Touch Technique (ANTT)

Velindre University NHS Trust has become the first NHS organisation in Wales to achieve gold accreditation for Aseptic Non-Touch Technique (ANTT). The Gold accreditation is valid until 2025.

The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection.

ANTT is the global standard for safe aseptic technique and the National Institute for Health & Care Excellence (NICE, 2012) defined it as a 'specific type of aseptic technique with a unique theory and practice framework'.

If followed, the framework ensures safe asepsis for invasive procedures whether they take place in a clinical environment or the community setting.

The Association for Safe Aseptic Practice continues to work to improve standards and effectiveness of ANTT in clinical practice to ensure patient safety and a global, standardized approach to ANTT and does this through education, training, research and quality assurance.

One of the core drives to ensure ANTT standards are maintained consistently has been training and education. Nurse educators routinely carry out updates/assessments of nursing staff. Medical staff undergo the same training and assessments. Audits are performed regularly, and the work carried out throughout the Trust helps to maintain our Gold Accreditation for ANTT. There has been an apparent dip in compliance amongst cancer centre staff however a drill down into the data identified that a training needs assessment is required to remove this from some staff group training requirement who do not undertake clinical tasks involving ANTT.

Row Labels	Achieved	Lapsed	Not Achieved	Total number required	Compliance %
120 Corporate Division					
NHS|MAND|Aseptic Non Touch Technique - No Specified Renewal|	4		1	5	80.0%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre ANTT - ASSESSMENT|General	18	2	1	21	85.7%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre ANTT - ASSESSMENT|General	158	23	82	263	60.1%
120 Welsh Blood Service					
120|LOCAL|120 WBS ANTT Practical/Theoretical Assessment (CS 083)|Core	117	7	20	144	81.3%
Grand Total					

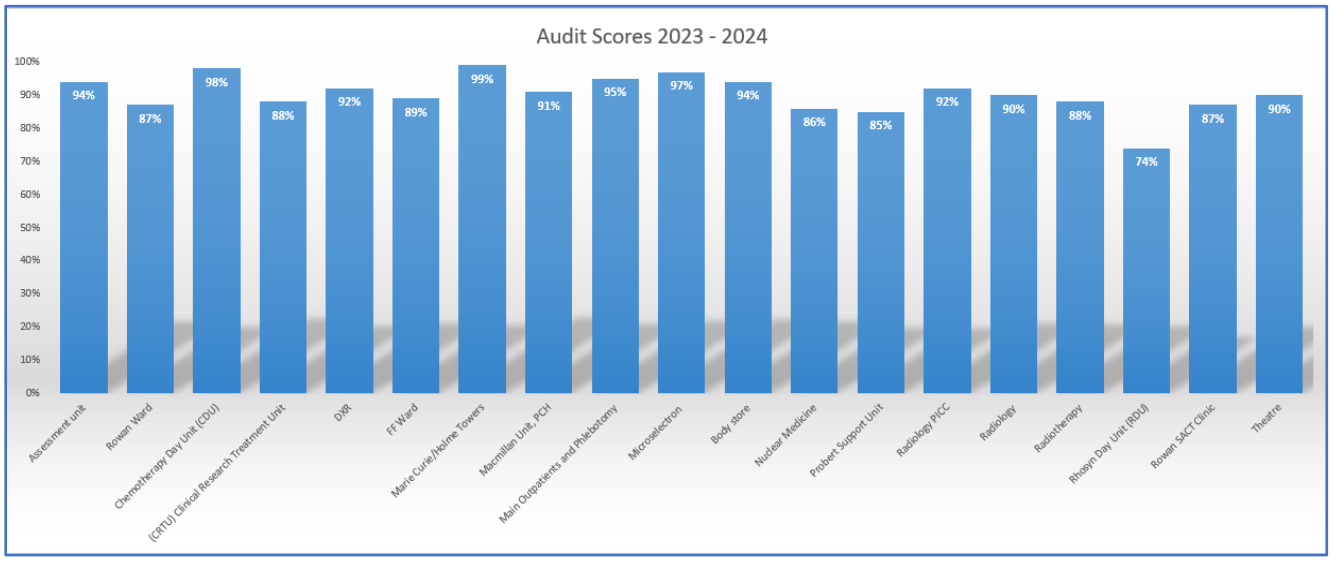
4.5 Environmental Audits

During this year the Trust established the use of the Tendable audit tool for infection prevention and control audits alongside the current MEG audit tool. Work is progressing in 2024 to change the environmental audit to the AMaT audit program to streamline the tools in use, the use of this audit tool will also bring us in line with neighbouring health boards.

The purpose of the environmental audits is to ensure that care environments are fit for purpose from an infection prevention and control perspective and that national standards (EPIC 3) are adhered to. The audit tools are available on mobile devices, and this provides real-time results for auditors and management teams.

The environmental audit programme was expanded during the year with increased focus on areas within the Welsh Blood Service. The audit results were comparable to previous year's audits and continued to highlight the age of the cancer centre building which needs repair and refurbishment.

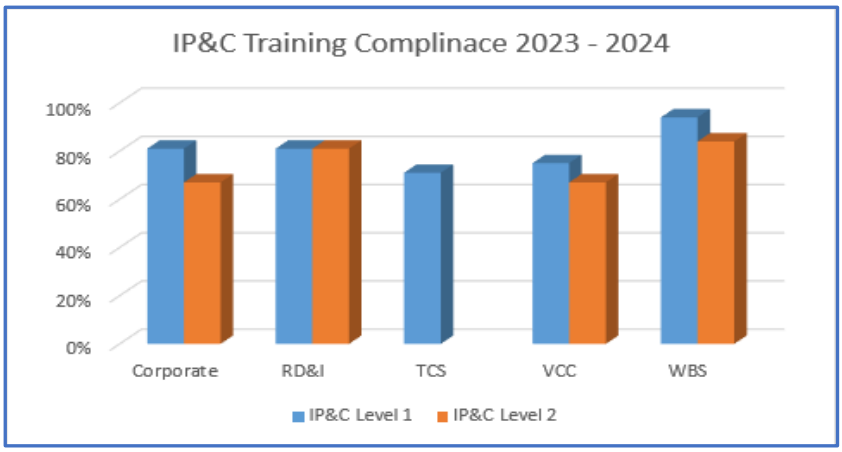
The main themes arising were general wear and tear, and carpet and flooring in some clinical areas. A rolling programme has been put in place to address these issues by the estates team and progress has been visible. Other issues included lack of visible cleaning schedules and dirty laboratory coats `have since been addressed.



4.6 Infection Prevention and Control Training Compliance

Infection Prevention and Control Training is critical to equip staff with the knowledge and skills necessary to mitigate the spread of infectious diseases, emphasising proper hand hygiene practices, and effective use of personal protective equipment.

Level 1 and 3 training has been predominantly provided through the e-learning platform. In addition, the Infection Prevention and Control team continued to be proactive and available to advise and assist as required. A training needs analysis was undertaken across the Trust to assist in identifying who requires specific training such as FIT-testing, donning and doffing training and hand hygiene.



Overall, compliance has fluctuated across the Trust and the table below highlights the compliance amongst the different staff groups. To address this, new champions have been identified and trained and different ways of delivering this training is being explored. Compliance rates are detailed below: divisional IPC summit groups.

Row Labels	Achieved	Lapsed	Not Achieved	Total Required to complete assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	13	8	3	24	54.2%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	25	6		31	80.6%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	449	189	86	724	62.0%
120 Welsh Blood Service					
120|LOCAL|120 Velindre Annual Hand Hygiene|Core	316	22	1	339	93.2%
Grand Total	803	225	90	1118	

Row Labels	Achieved	Lapsed	Not Achieved	Total required to complete the assessment	Compliance %
120 Corporate Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	8	5	1	14	57.1%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	8	4	2	14	57.1%
120 Research, Development and Innovation Division					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	20	6		26	76.9%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	20	6		26	76.9%
120 Velindre Cancer Centre					
120|LOCAL|120 Velindre Donning and Doffing - 1 year|Core	380	139	59	578	65.7%
120|LOCAL|120 Velindre Donning and Doffing ASSESSMENT - 1 year|Core	375	140	62	577	65.0%
Grand Total	811	300	124	1235	

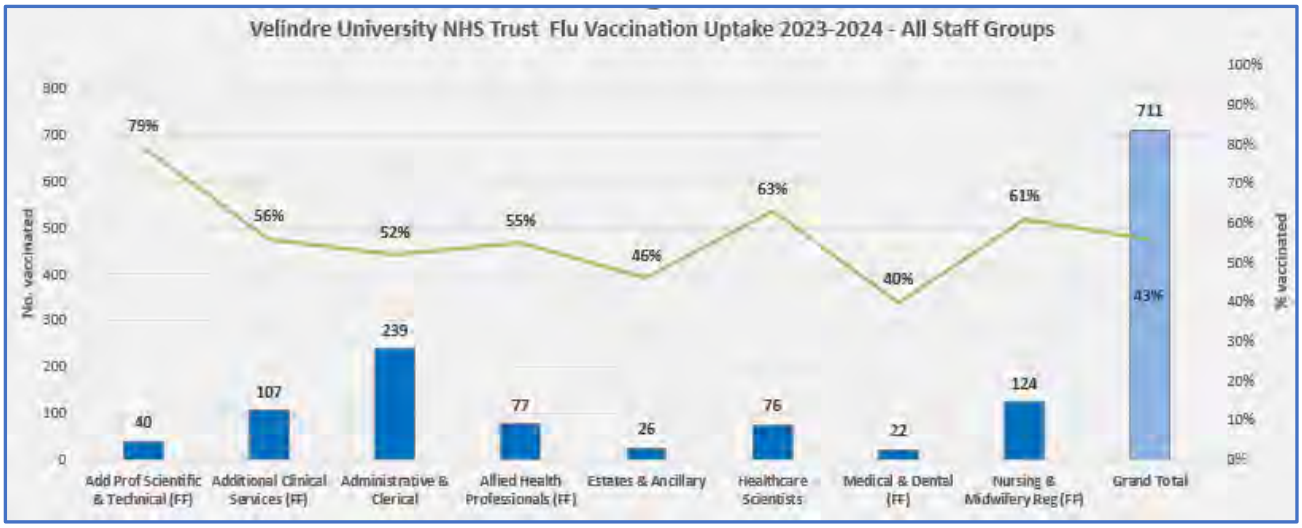
In addition:

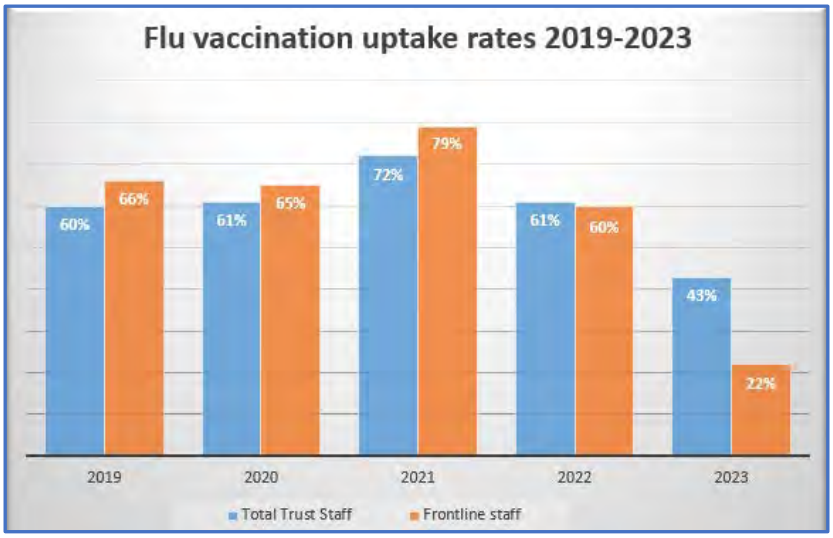
- A second member of the IPCT achieved 'Fit to Fit' Accreditation. This enabled the Trust to provide robust in-house FIT testing training for Velindre University NHS Trust staff
- The Welsh Blood Service developed and delivered a robust training programme that included Hand Hygiene and Donning and Doffing that was delivered within donor facing and laboratory services across Wales to maximise staff education and training opportunities.

5. STAFF INFLUENZA VACCINATION CAMPAIGN

The annual staff influenza vaccination programme for front-line health care professionals has been in place for many years. In view of the additional challenges during the winter of 2023-24, due to a combination of respiratory viruses and COVID-19 the Welsh Government advised of the need to increase the update of staff vaccinations.

Many staff reported vaccination fatigue and a compliance rate of 43% was achieved against a national target of 60%. The first graph below highlights the uptake overall for 2023-2024 and the second graph the uptake over the past 5 years.





6. ANTIMICROBIAL STEWARDSHIP

The term 'Antimicrobial Stewardship' is defined as 'an organisational or healthcare-system-wide approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness' - NICE Guidelines [NG15] - Aug 2015
Antimicrobial Stewardship aims to:

- Promote the appropriate use of antimicrobial agents.
- Improve patient outcomes.
- Reduce healthcare associated infections such as Methicillin Resistant Staphylococcus Aureus and Clostridioides *difficile* and prevent antimicrobial resistance.

Antimicrobial Stewardship is essential within Velindre Cancer Centre (VCC) given the vulnerability of our patient population, especially those on cytotoxic chemotherapy who have a compromised immune system.

One of the processes undertaken throughout NHS England and Wales to ensure that good

Antimicrobial Stewardship practices are adhered to is an audit against the nationally approved 'Start Smart Then Focus' (SSTF) audit criteria. This audit aims to promote the principles of Antimicrobial Stewardship as outlined not only by the National Institute for Health and Care Excellence (NICE) but also by the Welsh Health Circular 2023/031 Improvement Goals

The main SSTF audit criteria are listed below: (*the audit target of 100% compliance for all measures*):

1. Documentation of clinical suspicion of infection on chart– whether it is 'probable' or 'possible'.
2. Whether the indication for treatment was documented.
3. Whether the prescribed treatment was compliant with either local guidelines, based on the results of cultures and sensitives or based on microbiology advice.
4. Whether there was a documented review date / stop date on initiation of treatment.
5. Whether there was a documented senior review at 72 hours.

In addition to the above criteria, data is also collected on the outcome of the 72-hour review. Although this additional criteria does not have a specific targets, it is useful to identify local prescribing trends and can be benchmarked against other hospitals.

Within VCC, inpatient prescribing of antimicrobial agents is audited against these SSTF audit criteria to ensure that prescribing is appropriate, evidence basis, regularly reviewed and does not continue for longer the necessary.

Historically, audit data is collected on 10 patients each month using 'point prevalence' methodology; this approach is in line with all other hospitals across Wales. However, from November 2023, VCC pharmacy have been piloting data collection on all patients prescribed antimicrobial agents throughout the month, therefore providing more comprehensive data and a more accurate picture of our compliance against these SSTF national standards. This data is reported to both Velindre Cancer Centre Quality and Safety Committees and the Infection Prevention and Control Management Group. The data is also fed into a national database so that benchmarking can be undertaken against other NHS health boards within Wales.

In March 2021, VCC implemented the all-Wales Antimicrobial Review Kit (ARK) Chart as the standard inpatient medication chart across all clinical areas within the cancer center. This chart encourages these SSTF measures to be completed when antimicrobial agents are prescribed and reviewed.

Over the 2023/24 financial year, compliance against these five measures has either improved or remained broadly consistent when compared to the previous year, and compliance is favourable within VCC when compared to the national average.

The table below identifies current average compliance of SSTF over the year 2023/24. It must be noted that there is still one month of audit data left to collect (March 2024).

Table 15. Average compliance of "Start Smart Then Focus".

Measures	VCC average compliance 2022/ 2023	VCC average compliance 2023/ 2024	All Wales average compliance 2023/2024
Suspicion of infection documented as probable or possible on medication chart.	not collected	46%	39%
Documented Indication for treatment	80%	89%	88%
Compliance with guidelines, C+S or microbiology advice	97%	94%	89%
Documented review / stop date	90%	95%	88%
Documented senior review at 72 hours	95%	95%	81%

The table below shows the outcome of the 72-hour review. To re-iterate, there is not any specific targets set for this data.

Table 16: Outcomes of 72-hour antibiotic review

Outcome of 72-hour antibiotic review	VCC Average Compliance 2023/24	All Wales Average Compliance 2023/24
STOP antibiotic	7%	19%
IV to oral switch	26%	9%
Outpatient Parenteral Antimicrobial Therapy (OPAT)	0%	0%
Change antibiotics (escalate or de-escalate)	10%	9%
Continue same antibiotic	58%	62%

Over the 2023/24-year period, a comparison of compliance against the national average is favourable for VCC with regards to all of the Start Smart than Focus (SSTF) measures. A 3% decrease has occurred in compliance with guideline in 2023/24 compared to the previous financial year. This will be monitored closely over the next 6-12 months and fed back as appropriate. Although the documentation of an infection as probable or possible is still low, Velindre Cancer Centre compliance remains higher than the All-Wales average.

With regards to the outcome of 72-hour antimicrobial review, prescribing trends within Velindre Cancer Centre are similar or slightly better than the All-Wales average with a larger percentage of patients at Velindre Cancer Centre being switched from Intravenous to oral treatment but a lower percentage of antibiotics are stopped as a result of the 72-hour review in comparison to the All-Wales average. This may be explained by the fact that many of our patients are immunosuppressed and at high risk of serious illness in infection.

Going forward, it is important that a multidisciplinary team approach is undertaken including medical, pharmacy and nursing staffs to continue to promote antimicrobial stewardship, and to use the SSTF audit data to identify areas of concern and drive improvement.

7. RESEARCH AND INNOVATION

The infection control team has investigated research opportunities into new, sustainable cleaning technologies and air decontamination units that could benefit both the current environment and the new cancer center. They are keenly following HOCL which is a Cardiff based company which is leading the way in sustainable, green methods for the decontamination of the clinical environment. They are at the clinical trial stage which will produce evidence of efficacy which is required before trialing the product.

The team has also worked closely with the Ventilation Group and estates to introduce Novaerus portable air handling units to safely reduce pathogens, mitigate odours and neutralise environmental contaminants in indoor air. These units have been purchased as part of the ventilation system on First Floor ward cubicles. This is the first stage of a gradual roll out of the product to other areas.

8. COVID-19 PANDEMIC

The emergence of sub variants of Omicron (variant of SARS-CoV2) continued to have an impact on the service, especially during the winter months with other respiratory viruses in circulation. Guidance from the Welsh Government recommends that staff testing is not required, and local guidance has reflected these changes.

The Trust Respiratory Infection cell has taken a pragmatic approach to the changes in the guidance and considered the clinically vulnerable patient population and the scare caring for them. Occasionally the cell has agreed to stagger guidance when removing masks from clinical departments, however with this approach there has not been a case of nosocomial infection since October 2022.

The Nosocomial Scrutiny Panel has reviewed all cases of all healthcare associated cases to date.

9. INCIDENT / OUTBREAK

There have been several periods of increased incidence of COVID-19 and other respiratory infections within different staff groups, and all have been managed with no impact to service delivery. There were no outbreaks of infection during the year.

There has been one incident in pharmacy regarding the identification of mold in the aseptic suite, on investigation by Public Health Wales this was found to be part of a cluster outbreak involving two other aseptic suites in Southeast Wales. Recommendations including regular

fogging with Hydrogen Peroxide were made which is now in place. The Infection Control Doctor provided assurance that the Trust has taken all appropriate risk reduction actions.

9.1 Risk

There have been three infection control risks added to the Trust Risk Register which are reviewed regularly via the management group. In addition, all risks are routinely reviewed by the team monthly.

While two identified low risk are related to workforce and service delivery, measles, and low uptake of seasonal flu vaccine and third identified risk regards to patient and staff safety which is resulting from the response to the management of High Consequence Infectious Diseases.

10. SAFE WATER SYSTEM MANAGEMENT, BUILDING ENVIRONMENTAL IMPROVEMENTS

The Infection Prevention and Control Team and Estates Department have made considerable progress and have continued to work very closely to maintain high standards of water safety throughout the Trust.

Water

The Estates Team manage the major water infrastructure services. Both the Welsh Blood Service and Velindre Cancer Centre Trust Water Safety Group meets regularly to discuss progress against the annual water safety plan and any actions in response to positive water samples. Recently the Trust has revised the water safety plans for both sites to ensure that the process and training requirements and relevant appointments for Responsible persons are achieved. Assurance of water safety is reported through the divisional Infection Prevention and Control summit meetings and the Trust Water safety group. The Trust has an annual report undertaken by the appointed Authorising Engineer (AE) employed by NWSSP-SES. This year's audit was undertaken in February 2024 and the Trust is the first in Wales to received **substantial compliance.**

Verification of critical ventilation units:

The Trust has an annual verification report undertaken on all critical ventilation plants on site at VCC and WBS by the appointed Authorising Engineer (AE) employed by NWSSP-SES. On the back on these verifications a risk rated action plan is created for each critical ventilation plant and actioned immediately either by estates or an external contractor to ensure that all the ventilation equipment is compliant and at a good standard. The Trust is currently increasing the number of ventilation Authorised Person (AP) and ventilation Competent Person (CP) to better the tri annual audit.

Following IP&C Environmental audits:

Estates having a good working relationship with IP&C and working closely together, when IP&C environmental audits are reported on estates creates a risk rated action plan and remedial works are completed in a timely manner that include, decoration improvement works, flooring repairs and or replacement and lighting upgrades, etc., has required.

The refurbishment projects undertaken this year are:

- Decoration in various parts of VCC on going annually as required from audits carried on around the sites
- First floor ward ventilation started February 2024 for a permanent ventilation system on the First-Floor ward
- Ongoing water services dead leg removals including risk assessments
- Flooring replacement schemes throughout site
- Refurbishment of various LINAC Accelerators (LA6, LA5, LA3)
- Various roof repairs as and when required

Furthermore, there will be an infection prevention and control estates budget ring fenced this financial year to address environmental recommendations along with a four-year operational plan to target areas within the hospital. Estates continue to work closely with specialist estates services to undertake annual verifications of critical air handling plant onsite at VCC. All aspects of compliance are being reviewed on air handling units and recommendations made by SES will be addressed under this year's estates discretionary budget allocation.

Condition survey:

Estates has recently had a conditional survey of all sites carried out by and external contractor and this report will secure additional funding for the aging estate until the completion of NVCC.

11. DECONTAMINATION

Healthcare organisations have a duty of care to patients, their workforce, and the public to ensure that a safe and appropriate environment for healthcare is provided.

The Welsh Government Welsh Health Circular (WHC/2015/050) issued a Decontamination Improvement Plan for organisations across Wales to ensure that re-usable medical devices are safe for use on a patient and for staff to handle without presenting an infection risk.

A Peer Group review of decontamination of Semi-critical Probes using High Level Disinfection (HLD) was undertaken by the Senior Decontamination Engineer NHS Wales Shared Services Partnership in May 2022. The review is a follow up to the 2018 survey and provides a measure of reassurance that all the processes involved in decontamination of non-lumen probes comply with regulatory requirements and accord with guidance developed to help ensure patient safety and ensure compliance against the decontamination standards specified in the Welsh Health Technical Memorandum 01-06, (Decontamination of flexible endoscopes). These, gold standard, systems are in place in in the Cancer Centre and the processes are embedded.

The Service Level Agreement with Cwm Taff Bro Morgannwg Health Board continues for the Welsh Blood Service whereby sterile items are decontaminated at Royal Glamorgan hospital. A member of the Infection Prevention and Control Team is undertaking accredited Decontamination training in April 2024, to provide additional resilience within the team on this aspect the Infection Prevention and Control work.

There were no issues with decontamination or compliance during the reporting period.

12. NEW VELINDRE CANCER CENTRE

During the year there has been robust Infection Prevention and Control oversight in relation to the planning of the new hospital, ensuring that it will be fit for purpose to minimise and prevent risks from healthcare associated infections. Every system, every room and logistics of the use of these systems and spaces generally have one of more elements that have implications for infection prevention and control.
Specialist expert Infection Prevention and Control expertise from Public Health Wales has been liaising with architects, engineers and programme leads to ensure all required standards are being met. This has included reviewing all room plans scale1:200 to 1:50 with room data sheets and then revisions to check compliance with Welsh Health Technical Memorandums and Welsh Health Building Notes, best practice and attending associated meetings. During 2023-2024 the focus was on Stage 3 of the design and meeting financial closure. Documented infection prevention and control specialist advice across the whole build has been provided on:

- Surfaces – walls, floor, ceilings, worktops etc., to reduce carbon emissions
- Furnishings – curtains, blinds
- Hand Hygiene – sinks number, type and their placement, dispensers, bins, alcohol-based hand rub strategy
- Personal Protective Equipment – placement, dispenser numbers and types
- Waste disposal – disposal points, storage, collection points, pneumatic tube, sterile services
- Key risks – from water and ventilation flow to humidity and temperature

Additional specialist advice provided for:

- Decontamination areas, including flow, layouts, and rooms for High Level Decontamination of equipment, GM waste, cleaning services, lines/laundry, dirty utility and care equipment
- High risk areas – brachytherapy theatres, inpatient isolation provision, SACT and CT
- External spaces – rooves, balconies, ground water, playground and pest control

A number of challenges on planning process for infection prevention control during 2023 – 2024 included confirming correct specification for the negative pressure suite, strategy for curtains and blinds, correct placement and numbers of clinical hand wash basins, room layouts for decontamination, agreeing use of low emission materials for walls, ceilings etc.

Stage 4 is now beginning for 2024 – 2025 and will focus on revisiting scale 1:50 plans, reviewing rooms or spaces not previously reviewed, those issues yet to be resolved in stage 3 like curtains and blinds, confirming final ventilation and water plans and commissioning.

13. INFECTION PREVENTION AND CONTROL AWARENESS CAMPAIGNS

The Infection Prevention and Control newsletter continues to be published on a quarterly basis. Newsletters focus on different topics such as updates of seasonal respiratory illnesses and how we can protect ourselves and others from contracting viruses, education and advice for topics such as recent outbreaks of disease within the community and ways in which we

can prevent spread of disease.

13.1 Celebration of Global Hygiene Day: 5th May 2023

World Hygiene Day serves as a yearly reminder that hand hygiene is one of the most important steps, we can take to avoid getting sick and spreading germs to others.

Annually, on 5th May, the World Health Organisation (WHO) celebrates the Save Lives: Clean Your Hands campaign and highlights the importance of effective hand hygiene in healthcare. Each year the WHO develops a new global campaign with a different theme to help reinforce the 'clean your hands' message. The theme that has been developed for 2024 centres around '*promoting knowledge and capacity building of health and care workers through innovative and impactful training and education, on infection prevention and control, including hand hygiene*.

Preventing the spread of infection is a daily challenge throughout healthcare, whether that is in a domestic or global situation. Through sharing innovative practice and training information using campaigns such as the Save Lives campaign, we as health care workers can ensure safe and effective hand hygiene practice and reduce the risk of infection within healthcare.

The IPC team at VUNHST continues to emphasize the importance of effective hand hygiene through supporting the teaching and training of the concept to all staff and highlighting the significance of the 5 moments of hand hygiene. Regular audits are carried out in clinical areas which help to monitor the success of the training and assessment provided to our healthcare workers.

13.2 International Infection Prevention Control week: 16th - 22nd October 2023

International Infection Prevention Control Week (IIPW) falls annually in October. It is organised by the Association for Professionals in Infection Control and Epidemiology (APIC), whose mission is to create a safer world through prevention of infection.

For 2023, IIPW focused on the fundamentals of infection prevention and control which aimed to take health care workers back to basics and help remind us why IPC in healthcare is so important. For the 2023 campaign, VUNHST IPC team provided a daily informative slide focussing on a different fundamental topic for each day. At the end of the week a quiz was held, and prizes were awarded which showed us that the campaign had been successful.

The campaign for 2024 is yet to be announced, however we hope to experience the same success as in previous years regarding education and information sharing of IPC and rejuvenate enthusiasm amongst the workforce for continued infection prevention and control.

14. CONCLUSION

In conclusion, this year's infection prevention and control's efforts have been instrumental in safeguarding the health and safety of the Trust. The team set out an ambitious range of priorities for 2023-24 and through comprehensive surveillance, education and implementation of best practices significant strides have been made in mitigating the spread of infections and protecting staff, donors and patients amidst challenging circumstances.

Not only are VUNHST the first Trust / Health Board in Wales to achieve accreditation but we strived and achieved Gold Accreditation. This work was presented at the Infection Prevention Society Annual Conference 2023. The team have taken a proactive role in national groups including Decontamination Group, Multi-Drug Resistance Organism working group, Infection Prevention Society South Wales Branch and the newly formed Clostridioidies difficile working group.

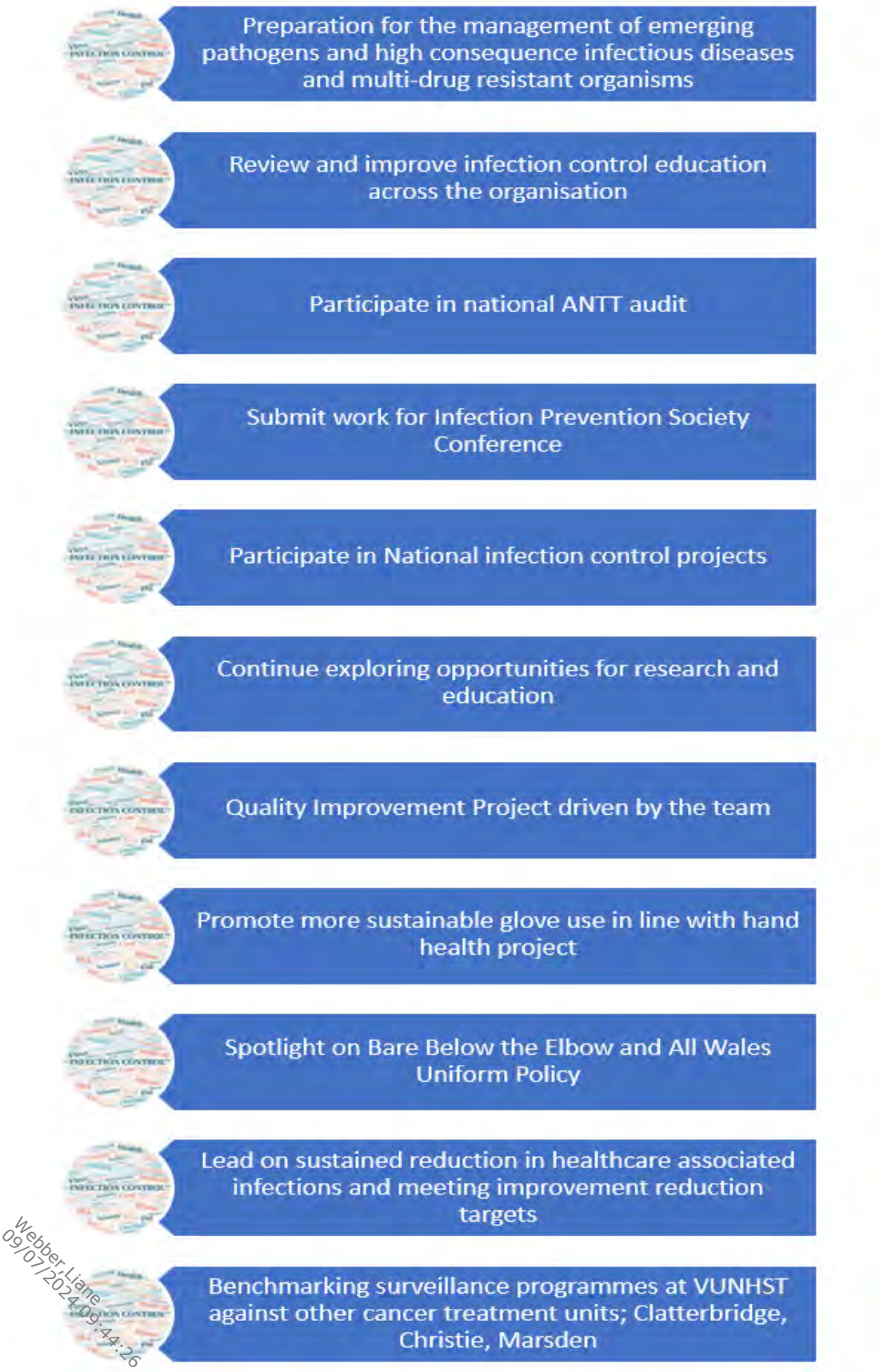
The resumption of the anti-microbial resistance group has been key to reduce in multi-drug resistance which will continue to be a priority for the coming year. There have been good outcomes in relation to infection reductions in MSSA, E. coli and Pseudomonas however increases were seen in healthcare acquired Clostridioidies *difficile* and Klebsiella cases, which is reflective of the national trend. This year the level of flu vaccination uptake was extremely low 47% with many frontline staff declining to be vaccinated.

Progress has also been made increasing support to Welsh Blood Service and the environmental audit plan has been rolled out to these areas.

Looking ahead we remain dedicated to evolving strategies, embracing innovations and we are poised to build upon these achievements, further refining our developments to ensure continued success in maintaining a safe and healthy environment for all.

15. PRIORITIES FOR 2024 -2025

The following are the identified priorities for 2024/25:



QUALITY, SAFETY & PERFORMANCE COMMITTEE

Safeguarding and Vulnerable Persons 2023- 2024 Annual Report

DATE OF MEETING	11th July 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	Fiona Davies, Head of Safeguarding and Vulnerable Persons
PRESENTED BY	Fiona Davies, Head of Safeguarding and Vulnerable Persons
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Safeguarding and Vulnerable Persons 2023/2024 Annual Report covers the period 1st April 2023 to 31st March 2024. Despite 3.5 months where there was a vacancy of a head of safeguarding & vulnerable persons the following key outcomes were achieved: • Velindre University NHS Trust fulfilled all duties and statutory obligations to safeguard and support patients, donors, staff. • New Head of Safeguarding & Vulnerable Persons commenced post October 2023. • Overall Training compliance for the Trust is consistent with the figure for 2022-23. This is due to the robust training programme of delivering face to face Safeguarding, Mental Capacity Act/Deprivation of Liberty Safeguards, Tier 2 Dementia Care, and Group 2 Ask & Act training during Quarter 3 and 4 of

	this reporting year. • Successful in obtaining Welsh Government funding to employ a Practice Educator for Mental Capacity Act/Deprivation of Liberty Safeguards. This has improved training compliance by 11% on 2022-23 figures, the Trust's enhanced observation policy has been updated to reflect legislation and all MCA/DOLS resources on the Trust intranet have been reviewed and refreshed. • Appointment of a Person- Centred Dementia Care Support Nurse who is driving forward the Dementia work plan. A cognitive impairment symbol has been developed to assist staff in recognizing patients who require additional support whilst inpatient on first floor ward, A self- assessment has also been carried out on First Floor Ward with changes made to signage. Resources have been updated and **6** out of the **20** *All Wales Dementia Care Pathway of Standards* for caring for people living with dementia have been mapped as applicable to the Trust.

RECOMMENDATION / ACTIONS	To **APPROVE** the 2023-2024 Velindre University NHS Trust Safeguarding and Vulnerable Persons Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Safeguarding & Vulnerable Persons Management Group (SGVPMG)	18.06.24
Executive Management Board (EMB)	25.06.2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
• ***SGVPMG:*** The annual report was amended to reflect the comments and endorsed during the meeting. • ***EMB:*** Endorsed for onward approval.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 6 - Outcomes realised in full The Safeguarding and Vulnerable Persons annual report 2023/2024 demonstrates evidence of delivery of all agreed actions within statutory and national standards. With further evidence of key achievements as desired outcomes within both portfolios.

APPENDICES	
Appendix 1	Velindre University NHS Trust Safeguarding and Vulnerable Persons 2023-2024 Annual Report

1. BACKGROUND

Safeguarding and public protection is underpinned by an increasingly complex statutory framework to support and protect Children and Adults at Risk, experiencing or at risk of abuse or neglect. The safeguarding agenda is broad and diverse and is ever evolving with further workstreams to support other vulnerable persons within Velindre University NHS Trust and meet aims of relevant national standards and service improvement initiatives.

This report is provided annually as part of the Trusts Assurance mechanisms.

2. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The Safeguarding and Vulnerable Persons Annual Report of Velindre University NHS Trust (hereafter 'the Trust') is attached in ***Appendix 1*** and summarises safeguarding activity and developments within the Trust through the year April 2022 to March 2023.

It is intended to provide assurance to the Trust Board in relation to compliance with statutory requirements and obligations to Children and Adults at Risk, and developments to support other vulnerable groups.

Within the reporting period the role of the Trust safeguarding lead was reviewed and resulted in a new position of Head of Safeguarding and Vulnerable Persons with a widened portfolio to include strategic leadership for workstreams supporting vulnerable persons.

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*	Not yet completed - Include further detail below why
	Relevant legislation, procedures and workstreams promote person centred care and protection of marginalised groups. No perceived equality impacts.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The trust has a statutory obligation to comply with safeguarding legislation

5 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Velindre University NHS Trust

Safeguarding and Vulnerable Persons Annual Report
1st April 2023-31st March 2024

VCC.Safeguarding@Wales.nhs.uk

Contents

VCC.Safeguarding@Wales.nhs.uk

Introduction

Velindre University NHS Trust's (hereafter the Trust) achievement in safeguarding is driven by a strong organisational culture, which embeds the Trust's values and behaviours, fosters professional curiosity, encourages scrutiny and supports the actions required to protect those at risk of abuse or in need of care and support.

The Safeguarding Annual Report provides the Trust with assurances that the Trust is meeting the statutory duties under the Children Act 2004, the Social and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, the Domestic Abuse Act 2021 and the Wales Safeguarding Procedures.

Executive Summary

The Key outcomes of the Safeguarding and Vulnerable Persons 2023/24 Annual Report are:

- Velindre University NHS Trust fulfilled all duties and statutory obligations to safeguard and support patients, donors, staff and the organisation.
- Analysis of the last year highlighted no adverse incident occurred within portfolios of safeguarding and public protection and supporting vulnerable groups.
- A workplan is in place to continue improvements within both portfolios during the next reporting year.

The Executive Director of Nursing. Allied Health Professionals & Healthcare Science is the Trust's executive lead for safeguarding and vulnerable persons. The Head of Safeguarding & Vulnerable Persons is the Trusts 'Named Professional' for Safeguarding Children as well as Adults at Risk and takes the organisational strategic lead on all safeguarding and vulnerable persons related matters, with the Trust Safeguarding and Vulnerable Persons Management Group is responsible for operational oversight and proposing strategy development of safeguarding adults, children, dementia, learning disabilities as well as other vulnerabilities.

The Head of Safeguarding works collaboratively with senior managers and colleagues within the Trust to promote a transparent safeguarding culture, at all levels organisation. External partnership working is also integral and the Trust's contribution to the work of our partner agencies will be highlighted in this report.

During this year we were supported with an interim Safeguarding lead on secondment from WAST and have successfully recruited a new Head of Safeguarding & Vulnerable Persons

Challenges 2023-2024:

The year has not been without its particularly due to the Head of Safeguarding & Vulnerable Persons post being vacated. This adversely impacted on:

- **Training compliance for Ask & Act Group 2 at 29.7%.**
- **Safeguarding Adult Level 3 training compliance at 14%**
- **Pausing the development of Service level Safeguarding and Ask & Act champions resulted in the loss of safeguarding expertise at an operational level and suspended the roll out of the champion role to other directorates across the Trust e.g, Welsh Blood Service and Therapies.**
- **Safeguarding intranet development resulting in a lack of up- to- date resources for staff to access.**
- **Progressing the Trust's commitment in the vulnerable persons work programme, which impacted on the delivery of key priorities for 2023/24**

Key Achievements 2023-2024:

Despite personnel gaps and changes the following was achieved:

- **Maintaining safeguarding leadership demonstrated by a temporary secondment to the position of the Head of Safeguarding & Vulnerable persons and leadership from the interim Deputy Executive Director of Nursing.**
- **Appointment of a Practice Educator in Person-Centred Dementia Care, resulting in the development and delivery of training, increase in tier 2 training of 14% compared to 2022-23, updating resources, providing support and commencing work on dementia care priorities identified within the Vulnerable Persons workplan 2023/24**
- **Temporary appointment of a Practice Educator for Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DOLS) resulting in an increase in MCA/DOLS training figures of 11% compared to 2022-23, updating staff resources and supporting the Vulnerable Persons workplan 2023/24**

Safeguarding People Activity

It is essential that all Trust employees provide safe and effective care which protects people at risk of abuse and neglect as well as those in need for Care and Support and are quickly identify signs of risk or neglect. Crucial to this is reporting concerns appropriately to the relevant agencies and utilising appropriate services to signpost/support victims including those who are affected by domestic abuse and sexual violence. It is important to remember that whilst the Trust is based in one local authority area, Velindre Cancer Centre (VCC) serves populations from 16 local authorities and 6 local health boards (LHBs) in Wales, with Welsh Blood Service (WBS) serving all 22 local authorities and 7 LHBs. In 2023-24 there were 335,025 patient and donor contacts.

Reporting Rates

As detailed in *table 1* the number of safeguarding issues reported to Local Authorities by the Trust has remained consistent over the last 2 years. 13 of the reports were generated from VCC and one from WBS. This variation is to be expected given the very different service user profile between the two services. However, further assurance work will be undertaken in relation to WBS collection teams in respect of identification of any possible safeguarding issues as staff have reported that the openness of the collection environment is not always conducive to identifying and exploring safeguarding concerns.

Additional work is required regarding raising the safeguarding profile in both VCC and WBS which requires a collaborative approach from the Heads of Nursing for both divisions, providing staff with guidance to support their decision making and how to share information appropriately, timely and in accordance with legislation, and to strengthen the champion role within both divisions.

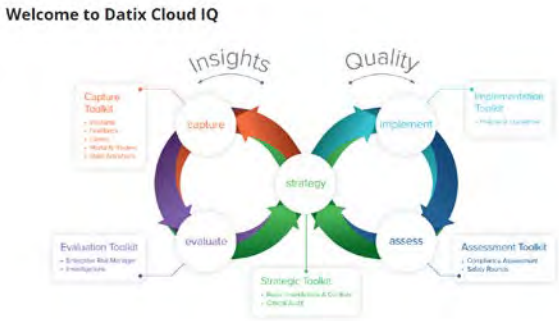
Currently, the safeguarding report does not reflect the huge amount of work undertaken by the supportive care team who regularly make referrals to partner agencies, for patients, carers and their families who require additional support to meet their needs. The aim is for this to be captured via the Supporting Vulnerable Groups Forum which will enable the Trust to have a more accurate picture of the safeguarding and wellbeing activity undertaken across the Trust.

Table 1.

Report Type	2021/22	2022/23	2023/24
Adults at Risk	7	11	13
Adults in Need for Care & Support	0	0	0
Child at Risk	1	3	1
Child in Need for Care & Support	0	0	0
Total	**8**	**14**	**14**

VCC.Safeguarding@Wales.nhs.uk

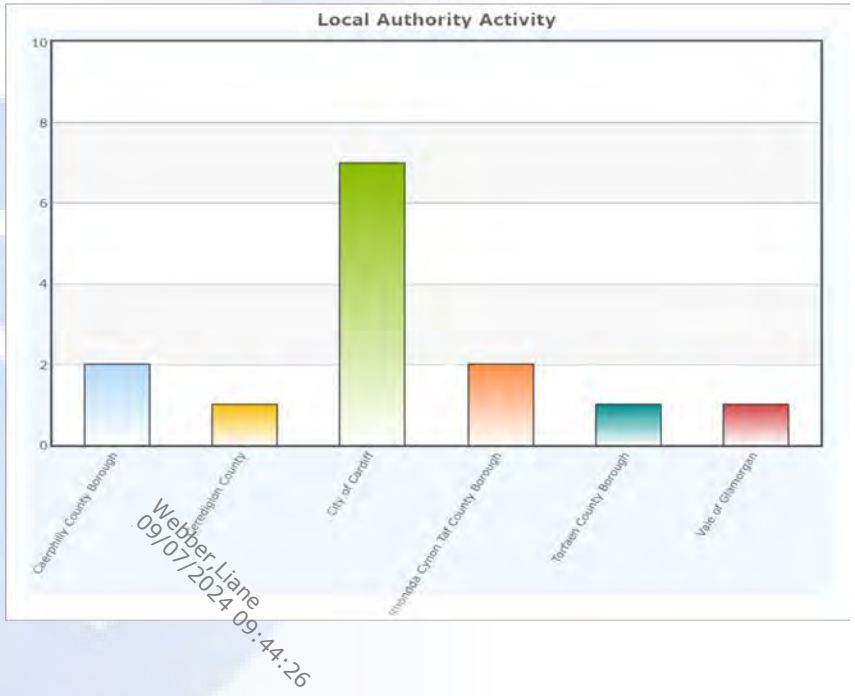
Safeguarding People



The trust has implemented the Once for Wales safeguarding module on DATIX which enables us to log all safeguarding activity including managing allegations/concerns against a person in a position of trust.

Whilst the safeguarding module is continuing to evolve, it provides an opportunity for the Trust to have access to data such as, which local authorities receive our submitted reports and the categories of abuse we are reporting. This is illustrated in Graph 1 and 2 respectively.

Graph 1.



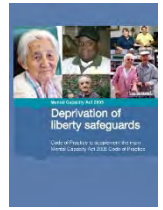
Graph 2.

Graph 1 illustrates that Cardiff Local Authority has received the highest number of reports from the Trust. With all reports sent to Local Authorities in the South- East region generated by VCC and the 1 report to Ceredigion submitted by WBS.

Graph 2 illustrates that Emotional/Psychological abuse has been cited in 11 of the safeguarding reports submitted. It is important to note that figures include concerns raised where the individuals were experiencing more than one category of abuse.

VCC.Safeguarding@Wales.nhs.uk

Mental Capacity Act & Deprivation of Liberty Safeguards



Deprivation of Liberty Safeguards continue to be the formal procedures to protect people who, for their own safety and in their own best interests, need care and treatment that may deprive them of their liberty but who lack capacity to consent, and where detention under the Mental Health Act 1983 is not appropriate.

During this reporting period the Trust successfully welcomed an experienced and knowledgeable practitioner to the role of practice educator for MCA/DOLS. This has provided the Trust with an opportunity to strengthen MCA/DOLS training within the cancer centre and to support staff with the practical application of the Mental Capacity Act and capacity assessments across the Trust.

Chart 1.

The chart *(on the left)* provides an overview of DOLS applications made across all four quarters. Quarter 3 saw the lowest number of applications made, which has impacted on the yearly figure as demonstrated in Table 3.
Further deep dive analysis of this reduction was undertaken on First Floor Ward by the Practice Educator. This identified that staff did not always consider making a DoLS application where they felt that a patient's confusion, disorientation was attributable to a cause that was short lived e.g side effect of medication.

Year	Q1	Q2	Q3	Q4	Total
2020-21	5	3	0	0	8
2021-22	1	5	3	4	13
2022-23	5	1	6	1	13
2023-24	2	3	1	4	10

Weekly ward visits have since been undertaken that provide an invaluable opportunity for staff to have 1:1 support from a subject matter expert and access to updated MCA resources held in hard copy on the ward and available on the intranet. Following this work there was an increase in DoLS applications in Quarter 4.

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Social Services and Wellbeing (Wales) Act 2014, the Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, along with key guidance within 10,000 Safer Lives – Domestic Abuse Project and NICE (2014); recommended an improved multi-agency service delivery with integrated care pathways for identifying, referring and providing interventions to support people who experience forms of domestic abuse and sexual violence.

Domestic abuse causes long-lasting physical and mental health harm. It can impact on cancer care, treatment, recovery and a person's ability to attend and donate in donor sessions. Working in the Cancer Centre and Welsh Blood Service provides a unique window to **'Ask & Act'.**

Currently the Trust supports victims/survivors who experience these forms of abuse by:

- **Displaying the Live Fear Free Helpline in public areas. Empowering victims/survivors to access this specialist service**
- **Providing training to staff at all levels to recognise and respond to issues related to VAWDASV.**
- **The ability to offer a safe space and time to allow victims/survivors to disclose during appointments or collection clinics**
- **Providing victims/survivors with communication support such as access to translators during appointments.**
- **Facilitating access to Independent Domestic Violence Advisers (IDVAs) who can support victims/survivors living within their Health Board areas.**
- **Referring high risk victims of VAWDASV to the Multi Agency Risk Assessment Conference (MARAC)**
- **Ensuring Safeguarding processes are triggered where an adult or child at risk is affected by these issues.**

However, there is a need to further strengthen the support that the Trust can offer victims/survivors of VAWDASV and the key priorities for 2024/25 are:

- **Promote the Cancer and domestic abuse: A toolkit for professional across VCC. This will complement the Ask & Act training as it provides a bespoke resource for staff to access.**
- **Work with senior leadership team within WBS to explore whether a routine enquiry question related to VAWDASV could be included on the questionnaire completed by donors when they attend sessions.**
- **Work with the senior leadership teams across VCC and WBS to develop a 'targeted enquiry' pathway which will support staff to facilitate contact between victims/survivors of VAWDASV and the Live Fear Free Helpline.**
- **Explore a robust mechanism for capturing data in relation to VAWDASV activity.**

Supporting Vulnerable Groups

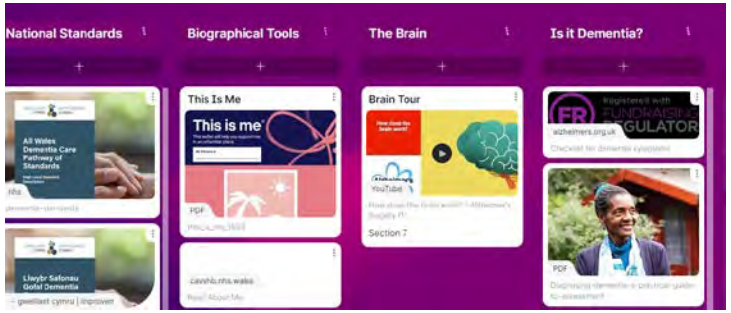
Supporting patients and donors with additional needs to have equitable access to services the Trust offers remains a priority. During this reporting year, some actions of the workplan of the Supporting Vulnerable Groups Forum were put on hold, this was due to the new Head of Safeguarding and the Practice Educator of Person- Centred Dementia Care commencing post in October. However, since joining the Trust both have prioritised progressing this work, with great strides being made in person centred dementia care, and links re-established with Learning Disability teams and the NHS Executive Learning Disability Improvement Cymru Team. More work is required but some of the key highlights for this reporting year are:

Guided by the *Good Work: A Dementia Learning and Development Framework for Wales* *an* effective dementia learning and development programme is in place. It identifies learning for three groups:

- All staff to be *informed* by understanding what dementia is, how it affects a person and how to communicate effectively.
- Secondly *skilled*- A bespoke Dementia Tier 2 training package has been developed for staff with patient contact providing knowledge about dementia, suitable to their role. In house training commenced December 23. **62** staff, 8% of those who require it have received training so far, with attendees covering different divisions across the Trust, with additional divisions (March 2023) of catering, porters and domestic staff identified as also requiring training..
- Thirdly an *influencers* –Tier 3 'Champion' - training package is being piloted over 2024, for skilled staff who have the ability to inspire, lead or influence others, with themes on: managing dual diagnosis of dementia and cancer, environmental factors, meaningful occupation, understanding behaviour and the role of the dementia champion.

By providing dementia training to **ALL** staff across the Trust ensures that we have a confident and competent workforce who can respond, support and advise patients, and their carers who are affected by a dementia diagnosis.

A Dementia Padlet a digital bulletin board, has been developed and is continually updated to provide information to support staff on national standards, types of dementia, biographical tools, training videos and lived experience videos.



VCC.Safeguarding@Wales.nhs.uk

Supporting Vulnerable Groups

6 out of the **20** *All Wales Dementia Care Pathway of Standards* for caring for people living with dementia have been mapped as applicable to the Trust. A developing workplan ensures that the Trust is compliant with these standards and delivering the best possible care to patients with Dementia. Part of this ongoing work has been:

- Introduction of a cognitive impairment symbol which will assist staff in supporting patients who have been diagnosed with a cognitive impairment. Training on its use has been rolled out to staff on First Floor ward including those who attend the ward for catering or porter services.
- Promoting Read About Me biographical tool, which is a person- centred toolkit ensuring continuity of care for people with dementia or a cognitive impairment throughout their journey. There is also a plan to audit its use.
- Creation of a person- centred assessment
- Practice Educator for Person- Centred Dementia Care available to provide support to staff, patients and their relatives, as required. This provides an additional layer of support from a subject matter expert.

Kings Fund Environmental assessment has been completed on First Floor Ward, with further assessments planned for Radiotherapy and Outpatient areas. Initial links have been made with the transforming cancer services team sharing information and evidence- based tools.
Carefit for VIPS: Self- assessment for First Floor commenced at the end of this reporting period and will continue into the 2024-25 workplan with outcomes focusing on developing: activity tool- boxes, staff person centred ideas, dementia induction information and capturing patient experiences.

Excellent work has already progressed within the Trust to support patients, their relatives and carers living with dementia or a cognitive impairment which will continue to strengthen during 2024/25. There are plans for the Practice Educator for Person-Centred Dementia Care to work closely with the teams involved in planning the new Cancer Centre to ensure that the new Hospital will be cognisant to the needs of individuals living with dementia or a cognitive impairment

Supporting Vulnerable Groups cont…

The Paul Ridd Learning Disability Awareness training was launched across Wales on the 1st of April 2022. The key outcomes for the training are:

- Healthcare staff to have a clear understanding of what a learning disability is
- Understanding what can be done to ensure patients with a learning disabilities get the care they deserve
- How staff can use this knowledge to make changes for the better.

The end of year total for staff compliance is **69%,** and whilst it is still short of the target of **85%,** it is an improvement of **28%** on 2022/23 figures.

An example of using knowledge to make changes for the better involves a gentleman who had been receiving ambulatory chemotherapy treatment at VCC for a couple of years. However, the team and his carers started to notice that the gentleman was becoming more agitated on his journey to the Hospital and during his treatment, to the point where he had started to refuse to have bloods taken and cannulas inserted. As the patient had communication difficulties, discussions were held between family, carers, the learning disability team, VCC consultant and clinical nurse specialist, co-ordinated by the practice educator for MCA/DOLS. The carers felt that the patient was unhappy with making two trips to the Hospital, one for bloods and then a separate one for treatment. He had not refused to have bloods taken at home by the district nurse team. Therefore, going forward the plan was for bloods to be taken at home and then to only come in for his treatment. To date this has been a successful reasonable adjustment.

Links have been re-established with NHS Wales Executive Learning Disability Improvement Cymru team and health led community- based learning disability teams to support the Trust in its commitment to ensuring that people living with a learning disability have safe, fair and equitable access to Trust services. There is still much work to do to support both staff, patients and relatives with the key priorities for 2024-25 being:

- Re-launch of **The Health Profile for Adults** across the Cancer Centre and audit its use to ensure patients living with a learning disability receive the right care at the right time.
- Review appointment letters to determine if adjustments can be made to develop **easy read** versions using patient and carer feedback to make improvements as required.
- Review the use of 'bedside boards' on First Floor Ward in VCC, enabling patients to inform staff of what is important to them during their stay. Monitoring patient, carer feedback to establish their effectiveness on nursing care and patient experience.

Education & Training

The Trust's annual training plan continues to support statutory safeguarding requirements. Working in partnership with our dedicated Workforce & Organisational Development team, Education and Development colleagues and becoming a member of the Trust's Trainer Group helps to contribute to the corporate vision of a robust safeguarding program across the Trust.

Safeguarding training is delivered as e-learning modules and face- to- face sessions. All staff are trained to a level commensurate to their role, and in accordance with the inter collegiate documents for adults and children. Trust staff access all in person training at VCC or WBS, which enables staff to attend sessions as part of their working day, receive training that they can apply to their areas of work and with colleagues where they feel safe to share safeguarding experiences which adds to the learning environment.

- ❑ All face-to- face training package have been developed which incorporated learning from Reviews such as **Professional Curiosity, adverse childhood experiences (ACEs) and the Voice of the adult or child.** It also includes **Rights Based Approach** and **case studies** where staff identify the safeguarding concerns and complete a mock safeguarding report. All have been updated to reflect current legislation.
- ❑ Staff attendance remains a challenge in VCC due to operational demands. Given the risks it is vital that staff are released to attend this training. This has been escalated to the Senior Leadership Team for resolution.
- ❑ **12** staff from across the Trust have volunteered for the role of safeguarding champion, this includes staff from clinical areas, therapies, radiotherapy and WBS. All champions are provided with additional safeguarding training, opportunities to visit multi agency safeguarding hubs (MASH) and quarterly meetings with the head of safeguarding to discuss the role, complex cases, learning from reviews and provide support.
- ❑ **47** staff across different directorates across the Trust have volunteered for the role of VAWDASV champion, this will ensure that staff supporting patients who experience these issues will have additional support. VAWDASV champions will be afforded the same support as their safeguarding champion colleagues.
- ❑ Support from WBS to release a practitioner to attend Welsh Women's Aid Group 2 Train the Trainer. This is a free 2- day accredited course which will provide resilience to the 'Ask & Act' training programme.
- ❑ Training needs analysis has been undertaken for staff who require Ask & Act Group 2 and MCA/DoLS Level 2 training. This has increased the number of staff requiring training for both modules, providing assurance to patients, service users and the Trust that we have competent and confident staff that can work within the legislative remit and always act in the best interest of patients.
- ❑ Plan to deliver MCA/DOLS training to staff working in WBS.

Gofyn a Gweithredu
Ask and Act

Education & Training cont…

Compliance comparison over a 3-year reporting period

Graph 3.

The graphic on the left illustrates the training trend over the last 3 years. It is important to note that whilst the overall compliance appears on a par with previous figures this is in part due to the number of face-to-face training sessions delivered during Q3 and Q4 for Safeguarding Level 3, Ask & Act Group 2, MCA/DoLS Level 2 and Dementia training Tier 2. The vacancy in the role of head of safeguarding & vulnerable persons, did impact on the ability to deliver and monitor training. This was identified as a risk on the organisational risk register. The commitment to improve compliance during the latter end of the reporting period has proven successful as demonstrated by **Graph 3**.

There has also been a drop in compliance in relation to **PREVENT** training. To ensure that the Trust is compliant with the Home Office recommendation that staff should complete this module every 3 years, the no renewal status was removed. This provided a more accurate picture of staff who had completed this training within the last 3 years.

STAFF FEEDBACK

Training evaluation and staff feedback is integral in ensuring the content and the style of the packages delivered are meeting the needs of the staff and where they feel they can apply knowledge into practice. The following are a few examples of the comments already received.

Better understanding of the Mental Capacity Act and consent issues

Ensure correct forms are used to gain consent or make decisions in best interests

MCA/DoLS Level 2

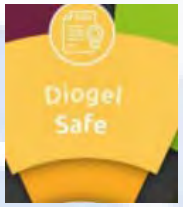
Great session around a difficult topic to discuss. All staff should take this course in my opinion'.
this is something we all need to be aware of so we can provide support in finding the right help for those experiencing violence or threat of violence.

Ask & Act Group 2

Quality Improvement

The priority for quality and quality improvement has been to re-establish the requirements set within the Safeguarding workplan 2023/24 and to focus on the safeguarding and vulnerable persons contributions in the delivery of the Integrated Medium-Term Plan; as well as to identify any actual or potential risks to deliverables during this reporting period and beyond.

Work has also commenced on mapping how the Trust can evidence Safeguarding quality and assurance against the new Health & Care Quality Standards (2023). The progress on quality improvement work has been influenced by the vacancy in the head of safeguarding and vulnerable persons during this reporting period. However, the following priorities were achieved.



- Colleagues across the Trust have safeguarding policies and procedures which are current and up to date and provides clarity for staff of their roles and responsibilities to safeguard the most vulnerable in our communities who access Trust services.
- Continually improving safeguarding training compliance which ensures that staff are confident and competent to recognise and respond to concerns relating to safeguarding and VAWDASV.

- The importance of Person centred and rights- based approach within safeguarding has been communicated during safeguarding training. Evidence within safeguarding reports that staff are more cognisant in capturing the views, wishes and feelings when completing a Once for Wales report.

- The Head of Safeguarding & Vulnerable persons has supported the Trust's Strategic Equality Plan and provided policy assurance assessments in relation to dementia care and learning disability. Ensuring that there is parity in considering the needs of vulnerable people across the Trust and in the development of the new Cancer Centre. A Collaborative approach prevents departments working in silos and duplication of work.

‘Putting Things right’ and improving the quality of services we provide.

The Head of Safeguarding is fully committed to supporting the Trust’s legislative responsibility regarding **Duty of Candour**. Therefore, ‘Putting things right’ is fully embraced as a process for highlighting, investigating and learning from concerns.

A close and collaborative working relationship exists between Safeguarding and the Quality and Patient safety team. Our working together provides assurance that any incidents that involve safeguarding issues are responded to correctly.

One safeguarding concern was identified during 2023/24, this related to an incident where the nutritional needs of a patient were not met. Following a review of the information shared, the Local Authority Designated Officer (LADO), concluded that the incident did not meet the threshold for a s126 adult at risk investigation. A robust root, cause and analysis was undertaken with the findings shared with the Local Authority.

The Head of Safeguarding regularly attends the Pressure Ulcer Prevention and the Falls Scrutiny panels to consider any safeguarding implications. This allows for all aspects of the incident to be scrutinised, to ensure the Trust has met all standards of care in relation to All Wales Pressure Ulcer Reporting and Investigation as well falls preventions.

There were no incidents of Velindre acquired pressure damage or incidents of falls reported through safeguarding during 2023/24

Safeguarding Maturity Matrix.

The Safeguarding Maturity Matrix (SMM) is a self-assessment tool developed and managed by the National Safeguarding Service for Public Health Wales. It addresses the interdependent strands regarding safeguarding, service quality improvement, compliance against agreed standards as well as learning from incidents and reviews.

The focus of the SMM is for each organisation to develop improvement plans which support a consistent approach to Safeguarding across Wales.

Reviewing measures within the SMM identified the following achievements:

- **Training packages and safeguarding resources reflect Rights based approach, Voice of the Adult/Child and Adverse Childhood Experiences (ACEs).**
- **The Practice Educator for MCA/DOLS has improved the profile of Mental Capacity awareness across the Trust and worked collaboratively with advocacy services to support patients through their cancer diagnosis.**

The following improvements were also identified during the self-assessment process:

- **Further strengthen the relationship with People Services and Organisational Development and work collaboratively to review the current arrangements in relation to Disclosure Barring Service checks for established staff.**
- **Safeguarding restorative supervision to be included in the Trust’s implementation of a clinical supervision framework.**

Multi-Agency Partnership Working

NHS Executive Sexual Safety

In 2023 the Women's Rights Network (WRN) published 'when we are at our most vulnerable', a report which looked at the extent of rapes and sexual assaults in hospitals.

In response the NHS Executive in Wales tasked a National Coordinating Group to scope a national understanding of the current position in Wales and look at the feasibility of implementing the six recommendations of the WRN report on a national level.

The Trust has provided the NHS Executive in Wales its current position in relation to the six recommendations, with the Executive Management Board agreeing to support the head of safeguarding in collaboration with people services to explore the sexual safety landscape within the Trust. This will provide a more accurate picture of the culture and establish whether further work is required to make the Trust a safe space for all.

Safeguarding objectives can only be achieved by effectively working together with a wide range of services and professionals to achieve good outcomes for people who access the services of the Trust. This requires the Head of Safeguarding and Vulnerable Persons to establish strong relationships with all departments and divisions within the organisation as well as within the wider safeguarding arena in Wales.

During this reporting year the head of safeguarding and vulnerable persons ensured that the Trust continued to meet its legislative partnership responsibilities.

- The Trust is represented at the Cardiff & Vale Regional Safeguarding Board, as well as the board subgroups for training and case reviews.
- Engagement with the National Safeguarding Service work programmes such as VAWDASV steering group, training & education and a national safeguarding strategy.

The head of safeguarding and vulnerable persons is also engaged in the national work relating to sexual safety and the freedom to speak up safely.

Freedom to Speak Up Safely.

Following the publication of a Healthier Wales and the creation of the Workforce Strategy for Health and Social Care, it became clear that NHS Wales needed to develop its approach to organisational culture and behaviour.

The Trust, is committed to successfully implementing the 'freedom to speak up safely framework' to achieve a culture that is seen as compassionate, works collectively to promote healthier and fairer behaviours, workplaces and organisations. This will help to protect patients, the public, staff who work across the Trust. Organisation where freedom to speak up safely is embedded into practice also evidence that there is an improvement in patient care.

The head of safeguarding is also a member of the NHS Wales Speaking up Safely Community of Practice, which provides an opportunity to learn from other organisations.

Support, Advice & Guidance

The Head of Safeguarding and the Practice Educator for MCA/DOLS appreciates that working to ensure good outcomes for children, adults at risk, vulnerable individuals and victims of domestic abuse/sexual violence can be demanding and distressing work.

Supporting colleagues requires a collaborative approach which facilitates the promotion of good standards and ensures confident and competent practitioners who are able to make sound professional judgements

Obtaining feedback from social services in relation to safeguarding reports remains sporadic.
Any feedback received is sent to the member of staff who raised the report which facilitates learning to improve practice.

"Thank you for your referral. We have requested the social work team to conduct a wellbeing assessment and explore the current informal care arrangements. It is recognised this patient has needs for care and support under Part 3 of the SSWB Act 2014.".
Cardiff Adult Safeguarding Team

What do we offer

- Safeguarding Advice
- Bespoke 1:1 training
- Central Resources
- 7-Minute briefings

What else can we offer

- Safeguarding/Restorative Supervision
- Shadowing Experience

Safeguarding Hub on Trust Intranet modernised and updated

Conclusion

In conclusion the Safeguarding Annual Report reflects the contribution which the Trust, Head of Safeguarding and VUNHST colleagues have made in ensuring people are safeguarded from harm.

This reporting year has had its challenges, and despite a period of 3.5 months where there was a vacancy in the position of head of safeguarding & vulnerable persons the Trust continued to develop it safeguarding and vulnerable persons agenda which included:

- **Maintaining overall training compliance which is on par with the figure for 2022-23**
- **Reviewing the All- Wales Dementia Care Pathway of Standards and implementing the standards that apply to the Trust, which has included the introduction of a cognitive impairment symbol, an improvement in Tier 2 dementia training and a Care Fit for VIPS self- assessment for First Floor Ward.**
- **Practice Educator for MCA/DOLS has reviewed and updated relevant resources, improved training figures, updated the Trust's enhanced observation policy to ensure the Mental Capacity Act is recognised and that the DOLS process is utilised at appropriate levels.**
- **Establishing a further 7 members of staff to undertake the Safeguarding Champion role increasing the figure to 12 in total, and identifying 47 members of staff across the Trust who have volunteered to become VAWDASV champion.**

The Trust is able to start the new reporting year from a stable position. The head of safeguarding & vulnerable persons is dedicated to provide continual advice, guidance and support to colleagues at all levels.
The Trust's proactive engagement with safeguarding multi-agency activity will strengthen our working relationships and reputation; both internally and externally.
The work streams commenced during this reporting period provide focus for the head of safeguarding and vulnerable persons to continue to progress into 2024-25.

VCC.Safeguarding@Wales.nhs.uk

Moving Forward 2024/2025

Building on the Safeguarding achievements during 2023-24 the following priorities have been identified:

- We will provide training, support and development for staff who are Safeguarding or VAWDASV champions. This will build further safeguarding resilience and provide timely safeguarding support at an operational level.
- We will continue to monitor and review the Trust's position against Dementia Care Pathway of Standards and the Learning Disability Care Bundle to ensure that we provide an equitable service.
- Develop a pathway to facilitate contact between victims of domestic abuse/ sexual violence and specialist services, which will enable us to monitor Trust activity in supporting individuals affected by these issues.

QUALITY, SAFETY & PERFORMANCE COMMITTEE
Patient and Donor Experience 2023-2024 Annual Report

DATE OF MEETING	11th July 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	Sharon Wilson and Jade Coleman, Quality, Safety and Assurance Managers, Jayne Rabaiotti, Claims, Redress & Inquest Manager & Chris Kelly, Deputy Head of Quality & Safety
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The 2023-24 Patient and Donor annual report covers the period 1st April 2023 - 31st March 2024. Report highlights are: • **1434** patients / families (0.6% of 245,535 contacts) provided experience feedback in relation to care, and treatment received at Velindre Cancer Service via the CIVICA electronic real-time patient experience system with **97%** reporting that their experiences were 'excellent'. • **12,188** donors (13.6% of 89,490) of the Welsh Blood Service provided 'real time' feedback about their experience with 98% saying that they

	were 'completely satisfied' with their overall donation experience. • **202** concerns were raised which is higher than previous years (154 in 2022-23, 190 in 2021-22 and 183 in 2020/21). .

RECOMMENDATION / ACTIONS	To **APPROVE** the 2023-2024 Trust Patient and Donor Experience Annual Report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Meeting	22nd May 2024
Executive Management Board	25th June 2024
Endorsed for onward approval following minor amendments	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

1. SITUATION

The 2023-2024 Velindre University NHS Trust Patient and Donor Experience Annual Report summarises the experience feedback received from patients and donors and how this has been used by divisions to make changes to further improve the experience of their patients and donors during the period 1st April 2023 to 31st March 2024.

2. BACKGROUND

Velindre University NHS Trust's Strategy and Quality & Safety Framework places patients and donors at the heart of everything we do, seeking to ensure that all of our patients and donors receive positive care and great experiences. Therefore, it is critically important that managers and divisions receive real-time feedback in respect of the experiences their patients and donors are having so that they hear what the care and services they are responsible for are like for our patients and donors and that they can use this to improve the services they provide. We must also ensure staff at all levels receive this feedback to drive improvements and to further enhance the experiences of our patients and donors. It is only through openly listening that we can ensure our services continuously improve, are a safe environment and are truly patient and donor centred.

3. ASSESSMENT AND SUMMARY OF MATTER FOR CONSIDERATION

The 2023/2024 Trust Patient and Donor Annual Report is attached in ***Appendix 1***.

4. 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:
YES - Select Relevant Goals below</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 X
• 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: STRATEGIC RISK DESCRIPTIONS</td><td>06 - Quality and Safety</td></tr>
<tr><td rowspan="3">QUALITY AND SAFETY IMPLICATIONS / IMPACT</td><td>Yes -select the relevant domain/domains from the list below. Please select all that apply</td></tr>
<tr><td>Safe X
Timely X
Effective X
Equitable X
Efficient X
Patient Centred X</td></tr>
<tr><td>Feedback received from patients and donors whether good or bad has allowed us to continually improve our services and helped to inform decision making and prioritisation. Openly listening to our patients and donors has assisted in taking efficient improvement actions where required, preventing reoccurrences. The CIVICA feedback system has allowed the Trust to connect directly with patient and donors within each service area for a more effective approach in engaging service users.</td></tr>
<tr><td>SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:</td><td>Not required</td></tr>
</table>

For more information: *https://www.gov.wales/socio-economic-duty-overview*	There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.
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
	Obtaining feedback from patients and donors contributes greatly to understanding where service improvements can be made, leading to huge benefits in the future care and service provided within the Trust.
	There is no direct impact on resources as a result of the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	**Source of Funding**: Other (please explain) No financial request or impact as a result of this report
	Not required - please outline why this is not required
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required
	There are no specific legal implications related to the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Putting Things Right Regulations (2011) Wales Quality & Engagement Act (2020)

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
All risks must be evidenced and consistent with those recorded in Datix.	

Velindre University NHS Trust 2023- 2024
Patient and Donor Experience Annual Report

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Contents

Introduction

This report covers the year: 1st April 2023 – 31st March 2024.

Velindre University NHS Trust provides specialist services to the people of Wales and is committed to ensuring that patient and donors are at the heart of everything that we do, striving to ensure that all our patients and donors have a positive experience. The operational delivery of services is managed through Velindre Cancer Service and the Welsh Blood Service.

- Velindre Cancer Service delivers specialist cancer services, and is a leading organisation in for teaching, research, and innovation for non-surgical oncology.

- The Welsh Blood Service provides blood, blood products and transplantation products for the population of Wales. The service ensures that the donor's gift of blood is transformed into safe and effective blood components, including bone marrow donations, stem cells and immunogenetics services, helping to improve and save the lives of many thousands of people in Wales every year.

During the year:

- Velindre Cancer Service obtained feedback from 1434 patients who were treated or attended (0.6% of contacts).

- 89,490 donors attended Welsh Blood Service collection clinics, with 12,188 providing feedback (13.6% feedback rate).

Receiving real time feedback on the experiences of our patients and donors is extremely important so that we can take early action to share positive experiences and to further improve experience of our donors and patients. A summary of the changes we have made can be found on pages 8 & 12.

Trust staff are grateful to receive positive feedback and compliments from patients and donors about their experiences.

Have we delivered our 2023-2024 priorities ?

We said we would continue to actively listen to its patients (their carers) and donors, putting things right where things have gone wrong. We have continued to listen to our patients, their carers, and our donors, putting things right where things have gone wrong. The Trust has continued to adhere to the Putting Things Right regulations, reporting and recording concerns, and acting on feedback received, learning from what we find, and putting in place actions to improve. **We promised to fully implement and embed the new requirements of the Health and Care Quality Standards.** The Trust has adopted the Standards in full, including the new Duty of Candour. We have put quality at the heart of our processes and decision making and built robust quality governance structure to ensure this continues.

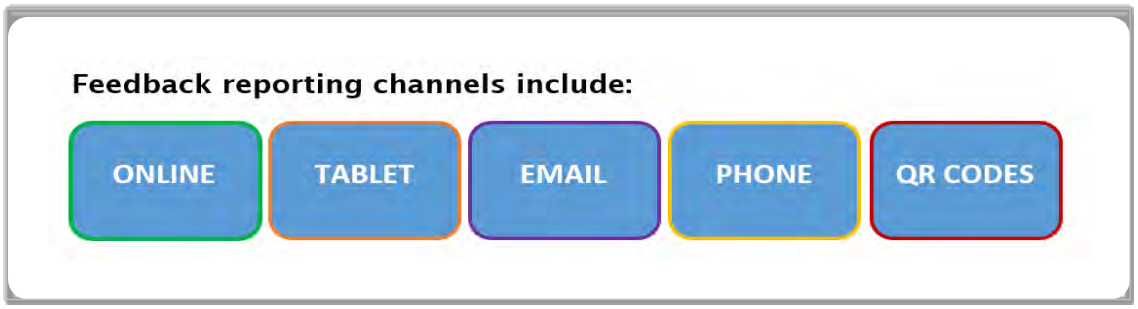
The Quality and Safety Team will develop a Trust wide repository where learning and outcomes from patient and donor experiences can be saved and shared. A Learning Framework was developed during the year, which underpins the Trust's commitment to ensuring the sharing of learning from not only adverse events but from positive learning also. The 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. The Trust has also introduced a Quality and Safety Regulatory tracker which supports the practical management of raising recommendations, through to the closure of actions.

The Trust will establish "Always on" reporting metrics to aid continual improvement opportunities and real time investigation of concerns that are raised. Initial "Always on" reporting metrics were introduced and are available to view on the Trust Intranet site. The Trust are keen to develop further "Always on" reporting metrics during 2024-25.

Capturing Patient & Donor Feedback

The Trust has several different mechanisms to encourage and obtain patient and donor feedback. Patients, donor's relatives, and carers regularly contact the Trust to let us know about the care and service they have received, concerns and compliments are received via many different routes including, verbally or via social media, by letter and messages in cards.

The introduction of the CIVICA feedback system in 2022 has made a demonstrable difference in the way the Trust captures the experiences of our service users, enabling real time capture of feedback and the ability to make real time changes as a result of the feedback received. The CIVICA system provides patients and donors with a wider choice of channels to use to provide their feedback.



The All-Wales Patient Experience survey includes a suite of standard experience survey questions, including the Friends and Family Test. The Trust is also able to generate more in-depth surveys to gain feedback within particular service areas and projects. This allows for an adaptable approach to gathering information on performance. The links to all of these surveys can be published or emailed independently of the system by the Trust.

The Trust also utilises the Friends & Family Test in the Cancer Centre that asks people if they would recommend the services they have used and offers a range of responses. 95% of those asked said they would recommend the service.

All patient and donor surveys and reviewed and anonymised prior to the data being used by the Trust. Service users always have the option to opt out of live and future surveys.

Patient and Donor Experience is also reported at meetings in the Trust. The below flow chart demonstrates how the information is shared across the Trust, to ensure that patient and donor experience is shared to inform learning and provide assurance.

Each Compliment or Concern inputted through the Civica system is reviewed by the department Civica lead. The outcome(s) from the information provided promotes service improvement, informs department, "You said, We did" Boards and also feeds the Trust Quality and Safety Management reports that are submitted monthly to the Trust Executive Management Board.

What Velindre Cancer Service patients said about their experience

Velindre Cancer Service receive feedback from its patients, carers, and family members in relation to the care and treatment received every day. The feedback provides an invaluable opportunity to not only learn and improve but to also share good practice.

During the year experience feedback was received from **1434 (0.6% of contacts)** *(2022-23 1036)* patients and or their family members who were treated or attended for an Outpatient referral, phlebotomy, home Systemic

Although only 4% of service users said they were dissatisfied with the waiting times across the Cancer Centre, it is important that any areas of quality improvement are identified.

A total of 1434 surveys returned. (1st April 2023 to 31st March 2024)			
	97.4% scored their experience as 'Excellent' (5 and above).		99.8% stated they felt cared for.
	99.5% felt they were listened to.		95.7% said their time either shorter than expected or about right.
	99.8% felt they had assistance when they needed it.		99.5% understood what was happening with their care.
	99.8% said explanations were given in a way they could understand.		99% felt they were involved as much as they wanted to be in decisions about their care.

Negative responses received regarding waiting times, the outpatient department experienced the majority of negative comments and as a result waiting times are being addressed and processes have been reviewed to improve the service.

The Trust is looking to re-introduced Volunteers throughout the Cancer Centre who will assist with the communication on a number of topics, including updates on the waiting times etc.

See infographics below for Velindre Cancer Centre Patient Feedback and Welsh Blood Service Donor Feedback captured on the CIVICA system.

Velindre Cancer Centre Patient Feedback

Canolfan Ganser Felindre
Velindre Cancer Centre

VELINDRE CIVICA SURVEY'S

The most frequently used patient experience questionnaire used is the CIVICA compliments and concerns survey. This contains a total of 24 questions, these include specific questions regarding experience, patient demographics and questions to suggest improvements. This is a National Survey template.

Department/ Clinical areas	CIVICA push report for every department with an expectation to be discussed in teams meeting. To inform the You Said, We did Boards
Velindre Quality and Safety Management Group	Overview CIVICA report and heat map
Trust Intergrated Quality and Safety Meetings	Clinical Quality & Governance Lead Nurse) - (Interim Deputy Head of Nursing Service Development Frequency - Monthly
Executive Management Board	Performance Management Framework Frequency - Monthly
Quality, Safety and Performance Committee	Report - Velindre Cancer Centre Director Head of Quality and Safety, Deputy Director. Quality Assurance Frequency - Monthly
Always on Reporting	Trust/Velindre Cancer Centre internet Frequency - Monthly
Wall of Thanks	Trust/Velindre Cancer Centre internet Frequency - Monthly

Welsh Blood Service Donor Feedback

Gwasanaeth Gwaed Cymru
Welsh Blood Service

WELSH BLOOD SERVICE CIVICA SURVEY'S

The most frequently used donor experience questionnaire used is the CIVICA compliments and concerns survey. This contains a total of 18 questions, these include specific questions regarding experience, donor demographics and questions to suggest improvements. This has been developed specifically for Welsh Blood Service.

Deputy Head of Collection Services/ Operation Managers	Report through CIVICA Management system/Email from Donor Experience Manager. You said, We Did Boards. Frequency - Monthly
Trust Intergrated Quality and Safety Meetings	Welsh Blood Service, Clinical Quality & Governance Lead Nurse) - (Welsh Blood Service, Interim Deputy Head of Nursing Service Development Frequency - Monthly
Executive Management Board	Performance Management Framework Frequency - Monthly
Quality, Safety and Performance Committee	Report - Welsh Blood Service Director Head of Quality and Safety, Deputy Director. Quality Assurance Frequency - Monthly
Always on Reporting	Trust/Welsh Blood Service internet Frequency - Monthly
Wall of Thanks	Trust/Welsh Blood Service internet Frequency - Monthly

Velindre Cancer Service Patient Satisfaction Scores

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	
1434	97	96	93	89	97	97	96	97	96	92	95
Overall	97	96	93	89	97	97	96	97	96	92	95
Benchmarks	85	85	85	85	85	85	85	85	85	85	92

The box below captures some of the compliments received:

The staff at the Velindre are second to none. This hospital should be recognised for the outstanding world class service that it provides.

All the staff in the department, including reception were friendly and respectful, and sensitive to my needs which made the treatments less stressful situation.

Everyone was exceptional. Cannot fault the care of all the staff and service. Thank you.

The staff are excellent in every care that is needed for the patient to settle down from the minute they are admitted through the front door until they are discharged back to home. The care and treatment from the porters to the directors is second to none.

Everything I said taken very seriously, great care shown, helpful and supportive staff, nothing too much trouble, could not fault any aspect, everything happened as and when and how instilled confidence in me as a patient.

Always treated with dignity and consideration. Most excellent professional standards applied and never rushed during consultations. Treatment always exemplary.

The first-class care, support, attentiveness, and sincere empathy from everybody at all levels.

Diolch o gallon heartfelt thanks for the very kind care.

All of the staff are incredible, they're the best. I feel very well cared for and treated like a person, not just a patient. Thank you all so much.

You Said …. We Did….

The reason for capturing feedback is to hear what our services are like for our patients, to share this with staff at all levels, celebrate good practice and to learn and improve when experience has not been so good so that we always strive to be the best we can.

The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year through CIVICA surveys.

You Said	We did
The food could be improved including more vegan options on the menu.	New menus have been introduced and catering have facilitated this.
There is not enough appointment availability outside core hours within the Therapies Clinicians.	An evening clinic has been introduced.
Waiting room seating areas feel crowded.	Chairs repositioned to make better use of the available space.
When there are long waiting times for appointments, refreshments would be nice.	A water fountain is available, and Velindre Cancer Centre is looking at the return of the Royal Voluntary Service.
Lack of communication regarding delays and waiting times within clinics	A digital system displays expected daily clinic delays.
Waiting area floor looking aged.	The area has now been painted and a new floor laid.
Electronic display or Tanoy for calling patients.	New Tanoy system being installed and investigating an appropriate electronic display system.
Waiting times for blood tests is an issue in Outpatients.	An additional blood collect chair has been added to the outpatient department to increase capacity.

Velindre Cancer Service Patient Engagement

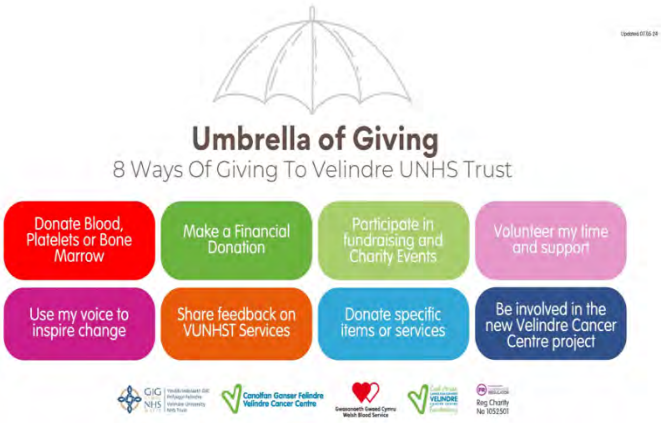
Velindre University NHS Trust Patient Engagement Strategy

Patient engagement is the umbrella term used to describe the wide range of activities and interactions with our patients, past and present, and those who care for them.

The Strategy, agreed by the Board in 2022 sets, out a plan for the ambition, mechanisms and structures that will enable the delivery, including plans for a revision of the Patient Liaison Group and managing the work carried out by our volunteers.

The feedback from the engagement activit

- Patient Voices
- Patient Empowerment
- Patient Choice
- Patients First
- Patient Information
- Patients and Research
- Patient Promise



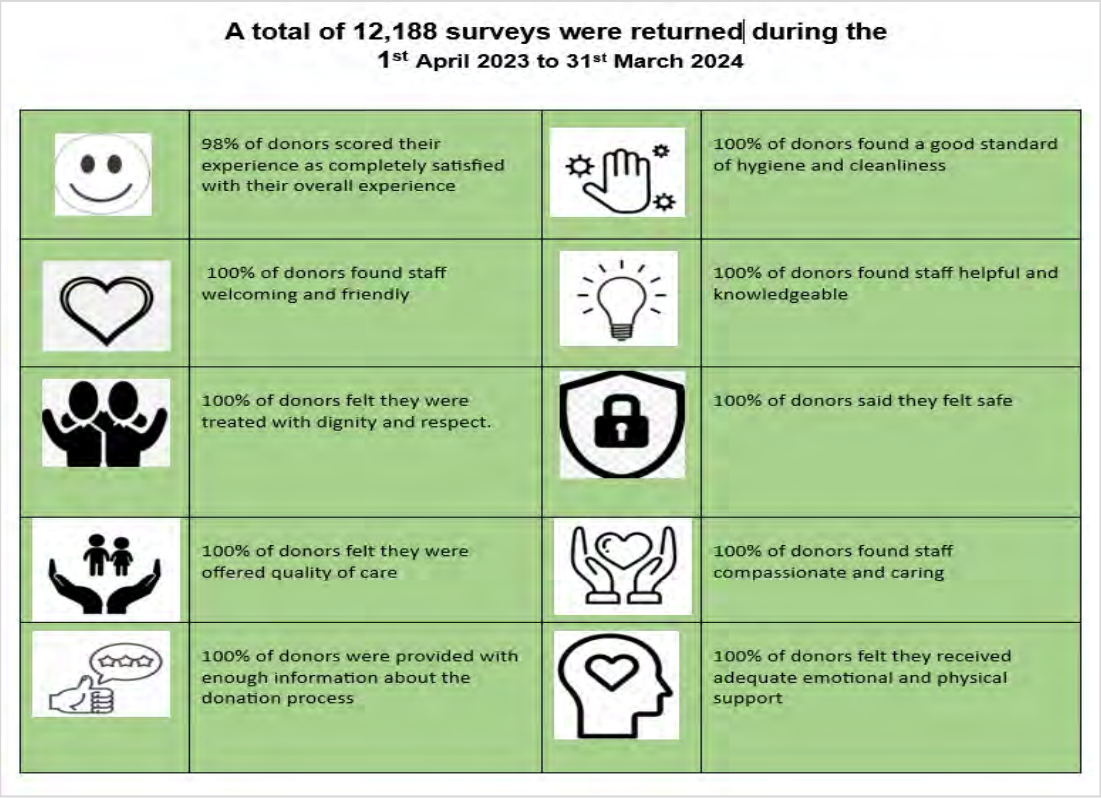
Velindre Voices

Velindre Voices provides an opportunity for anyone, whether they are current or past patients, their loved ones, carers, members of the public and local community to register on a digital platform to become a member of our engagement community. Members of Velindre Voices: Attend focus groups and sit on panels, share their personal stories, Highlight, and become involved in-service improvement, Review business cases/proposals, Help influence our work on the new Velindre Cancer Centre.

The Quality & Safety Team will be working collaboratively with the patient and donor engagement teams going forward to ensure that we are able to listen, learn and improve from our patients and donors' experiences.

What Welsh Blood Service donors said about their experience

The Welsh Blood Service continue to receive high numbers of engaged donors who actively share and communicate suggestions for areas for improvement. The feedback received provides invaluable insight into the experiences our donors have whilst donating. During this year **12,188** donors have given feedback. **89,490** donors were registered through the Welsh Blood Service clinics (that's **13.6%**



Although only 2% of donors stated they were not completely satisfied with their overall experience, it is important that any areas of quality improvement are identified. On review of the information that impacted on satisfaction scores, issues relate to venues being too cold, lack of sufficient signage to help donors locate the room to donate and there not being enough vegan or gluten free snack options.

All feedback has been addressed as follows:

- Each collection team has been provided with a Dyson hot and cold heater that can be utilised in all temperature conditions.
- Ongoing Service Improvement Project's (SIP) are underway to look at venue signage. This piece of work is concentrating on sourcing and developing new signage that will direct donors from the carpark to the donation room.

- An improvement across all departments was undertaken to source vegan, gluten and dairy free options for donors to enjoy.

Welsh Blood Service Donor Survey Satisfaction Scores

Benchmark Met
1 - 5 points below the Benchmark
More than 5 points below the Benchmark
Start Date: 01/04/2023 12:00:00 AM End Date: 31/03/2024 11:59:59 PM

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 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)
Bangor Team	940	99	100	100	100	100	100	100	100
Donation Clinic (TG)	78	95	100	100	100	100	100	98	100
East A	2102	98	100	100	100	100	100	100	100
East B	2249	97	100	100	100	100	100	100	100
East C	1339	98	100	100	100	100	100	100	100
West Team	3493	99	100	100	100	100	100	100	100
Wrexham Team	1742	98	100	100	100	100	100	100	100
	Overall	**98**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	Benchmarks	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**

Benchmark Met
1 - 5 points below the Benchmark
More than 5 points below the Benchmark
Start Date: 01/04/2023 12:00:00 AM End Date: 31/03/2024 11:59:59 PM

Location	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	
Medical Team	256	100	100	100	100	100	100	100	98	100
	Overall	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**98**	**100**
	Benchmarks	**95**	**95**	**95**	**95**	**95**	**95**	**95**	**95**	

We appreciate the time taken by Donors to let us know about their experiences and during the year, qualitative feedback received was mainly very positive. The wordle summarises the key words used in the narrative within the CIVICA responses, and a snapshot of compliments received during the year have also been included:

Comments received into Welsh Blood Service

Donors regularly contact the Trust to feedback about the experiences they have received whilst using the service. Comments and compliments are received via many different routes including, verbally or via social media, by email and by letter. The introduction of the CIVICA feedback system has helped improve the way we capture Donor feedback, enabling specific data to be reviewed in an effective, timely and meaningful way.

Each month the Welsh Blood Service also issue surveys to 50 donors referred to the Clinical Support Team by the Donor Contact Centre for assistance with eligibility inquiries or post-donation care and advice are randomly chosen to participate in a satisfaction survey.

Welsh Blood Service Learning

An important part of receiving feedback is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The Trust have a range of processes in place to share learning, including direct feedback to staff members involved, team meetings, reports, newsletters, and clinical audits.

The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

YOU SAID	WE DID
➢ **Parking facility improvement** ➢ **Finding parking difficult as very few places** ➢ **The car park could be bigger for patients but that is all.**	Feedback received from service users in relation to parking at the Welsh Blood Service site led to a review carried out by the estates team who worked in collaboration with staff to facilitate the management of appropriate parking on site. Implementing an informative sign to guide and support has allowed Welsh Blood Service visitors to park with ease of access at the front of the building. Since the change has been implemented service users have fed back that Welsh Blood Service have great facilities, easy and accessible parking, and friendly staff. 
➢ **Give better directions to clinic.** ➢ **Improve signage to clinic within venue.** ➢ **Directional signage within the car park to show where to go.** ➢ **Needed a sign by the front door to help find the room.**	Ongoing Service Improvement Project's (SIP) are underway to look at current venue signage across all the collection teams. This piece of work is concentrating on sourcing and developing new signage that will direct donors at the venue site, from carpark to donation room.

➢ **Milk alternatives for the tea!** ➢ **Offer crisps as a snack.** ➢ **Have gluten/dairy free snacks.** ➢ **Provision of vegan-friendly snacks**	Since the introduction of a variety of vegan and gluten free biscuits, and dairy free milk across the collection teams, the Welsh Blood Service has received less feedback in relation to this theme. Some very positive feedback demonstrates donors continue to enjoy alternative snack options. Donors are also enjoying the Savory snacks introduced as part of feedback received, "I like the mini cheddars, they were a lovely change". Each collection team displays a bilingual poster to advertise the alternative options available for all donors to enjoy.
➢ **Sadly, the building was very cold.** ➢ **The temperature in the room was on the cold side but otherwise felt the experience was good.** ➢ **It was very cold and could do with more heating.** ➢ **I appreciate it is January, but it was freezing in the hall.** ➢ **I arrived quite cold so it could have been a little warmer.**	Dyson Air Heaters/Coolers have been sourced for each collection team and can be used to cool or heat a room accordingly. Some venues are cold on arrival and take some time to warm up, that said, the room must be at a desired temperature for the integrity of the blood/product collected.
➢ **No dedicated**	The facilities manager working in collaboration with estates have introduced a designated motor bike parking area at the rear of

motorcycle parking	the Welsh Blood Service building with clearly displayed signage to the area.  

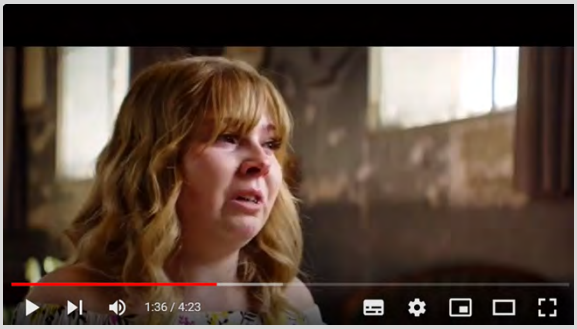
Patient and Donor Stories

Our public, communities, staff, and partners are at the centre of everything we do. There is no better, and more important way of developing or improving services than by listening to what individuals think, feel and experience throughout their journey of using our services. This forms an integral part of any quality and improvement journey for all NHS Wales Organisations. The Trust is developing its use of patient stories as a powerful tool for learning. Enhancing our ability to develop patient and donor stories will be a key priority for next year.

Follow the links below to hear what some of our patients and donors told us about their experiences.

https://youtu.be/j_DQnEgMXGw

https://youtu.be/CoRIzRRIRzo



https://www.youtube.com/watch?v=ObhS6zdgbx4

2024/2025 Priorities

1. The Trust will further develop our opportunities to collect staff and patient/donor stories. We will use these stories to promote learning and improvement. These will involve:
    - Reaching out to patients/donors to obtain feedback
    - Taking opportunities to encourage staff to share their experiences to shape and improve our services
    - Exploring the use of the CIVICA patient experience system to develop Digital Stories for sharing and learning. This will include short films and audio recordings
2. The Trust will establish a dedicated working group. They will work collaboratively to ensure that there is a robust process and agreed pathway to ensure that patients and donors are fully involved in quality & safety developments.
3. To further develop 'Always On' reporting metrics. Always On reporting will make sure that we make information about our services readily available to our population. To do this we will engage with patients and donors to find out what information is meaningful to them, how they would like quality & safety information presented. This will allow us to ensure that information about the quality of our service is meaningful and readily available.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

Nursing Strategy Update 2023-2024

DATE OF MEETING	11th July 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	Anna Harries, Head of Nursing for Professional Standards and Digital
PRESENTED BY	Anna Harries, Head of Nursing for Professional Standards and Digital.
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	This paper provides an overview of what has been delivered in respect of the Trust's 2023-26 Nursing Strategy during the period 1st April 2023-31st March 2024. 28 SMART actions were developed in line with the three strategic aims. 10 Actions have been completed since the launch of the Trust Nursing Strategy. Key deliverables have been: • Approval of a Clinical Supervision Framework and the offer of clinical supervision made to Clinical Nurse Specialists, new registrants and overseas nurses. • Considerable progress made in relation to increasing nurses' access to research opportunities: a new PhD Fellowship has commenced and two Velindre Introduction to

	Research Awards have commenced. Four new opportunities are available for 2024/25. • Successfully recruited Internationally trained nurses and new registrants for the first time into Velindre Cancer Service.
RECOMMENDATION / ACTIONS	To **APPROVE** the 2023-24 Nursing Strategy Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum – endorsed end of year position against the strategy deliverables.	28th May 2024
Executive Management Board – endorsed the report	25th June 2024

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 4 - Increased extent of impact from actions

1. BACKGROUND

In May 2023 the Trust Board approved its first three-year Nursing Strategy 2023-2026. The Strategy was written by our nurses, for our nurses and sets out our aim and ambition to build on past achievements and provide a clear strategic direction for 2023-2026.

Our Vision is to be a nursing employee of choice by valuing each and every nurse and supporting them to reach their full potential. To recognise the challenges of the profession, as well as the opportunities. The Trust aims to support and promote our nurses' wellbeing and provide opportunities to develop their practice and equip them with the skills to deliver excellent care to our population. Our three main Nursing strategic aims and priorities are:

- Nurses will actively listen to our patients, their carers and our donors and deliver kind, safe, and effective, evidence-based care.
- Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future.
- Nurses will maximise research innovation and continual improvement opportunities.

2. ASSESSMENT AND SUMMARY OF MATTER FOR CONSIDERATION

The Nursing Strategy Update is attached in ***Appendix 1***.

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*	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
	There are no items or matters arising within the report that have an adverse impact on social economic equality issues or experiences.

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
	There is no direct impact on resources as a result of the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	**Source of Funding**: Other (please explain) No financial request or impact as a result of this report

EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Appendix 1.

Velindre University NHS Trust

Nursing Strategy Update 2023-2024

Velindre NHS Trust Nursing Strategy

Velindre University NHS Trust has developed a three-year Nursing Strategy. The Strategy empowers nurses to lead compassionately and deliver the best care to our patients and donors. The Trust is very proud of our nurses, both registered and unregistered, who provide the most amazing care and services to our patients and donors.

Our Vision is to be a nursing employee of choice by valuing each and every nurse and supporting them to reach their full potential. To recognise the challenges of the profession, as well as the opportunities. The Trust aims to support and promote our nurses' wellbeing and provide opportunities to develop their practice and equip them with the skills to deliver safe, timely, effective, equitable, person-centred care to our population.

Professionalism is of utmost importance and compliance with the NMC Code of Professional Practice for our registrants is essential. The NMC Code is structured around four themes, these form the basis of our nursing strategy: practise effectively, preserve safety, promote professionalism and prioritise people.

These themes are being used to strengthen the delivery of the strategy and drive quality of care in our services across the Trust.

In May 2023, we proudly launched the Nursing Strategy which was developed in consultation with our dedicated nursing workforce. The strategy was developed in a two-stage consultation process. The three main Nursing Strategy aims and priorities are:

Nursing Strategy Aims:

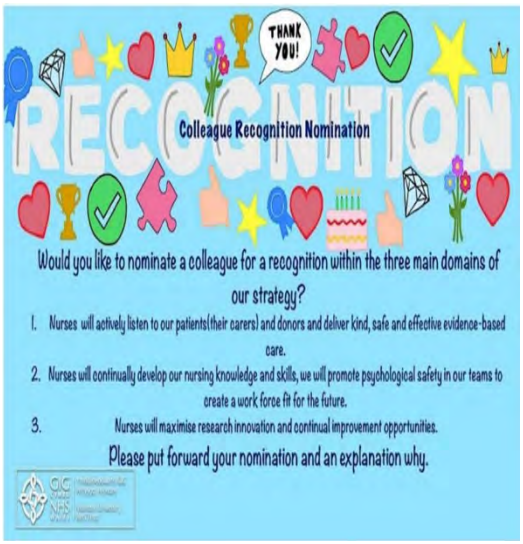
- Nurses will actively listen to our patients (their carers) and donors and deliver kind, safe, and effective evidence-based care.

- Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future.

- Nurses will maximise research innovation and continual improvement opportunities.

First Nursing Conference: 12th May 2023

On International Nurses' Day, 12th May 2023, we hosted our inaugural Trust-wide Nursing Conference and introduced the Velindre University NHS Trust Strategy for 2023-2026.

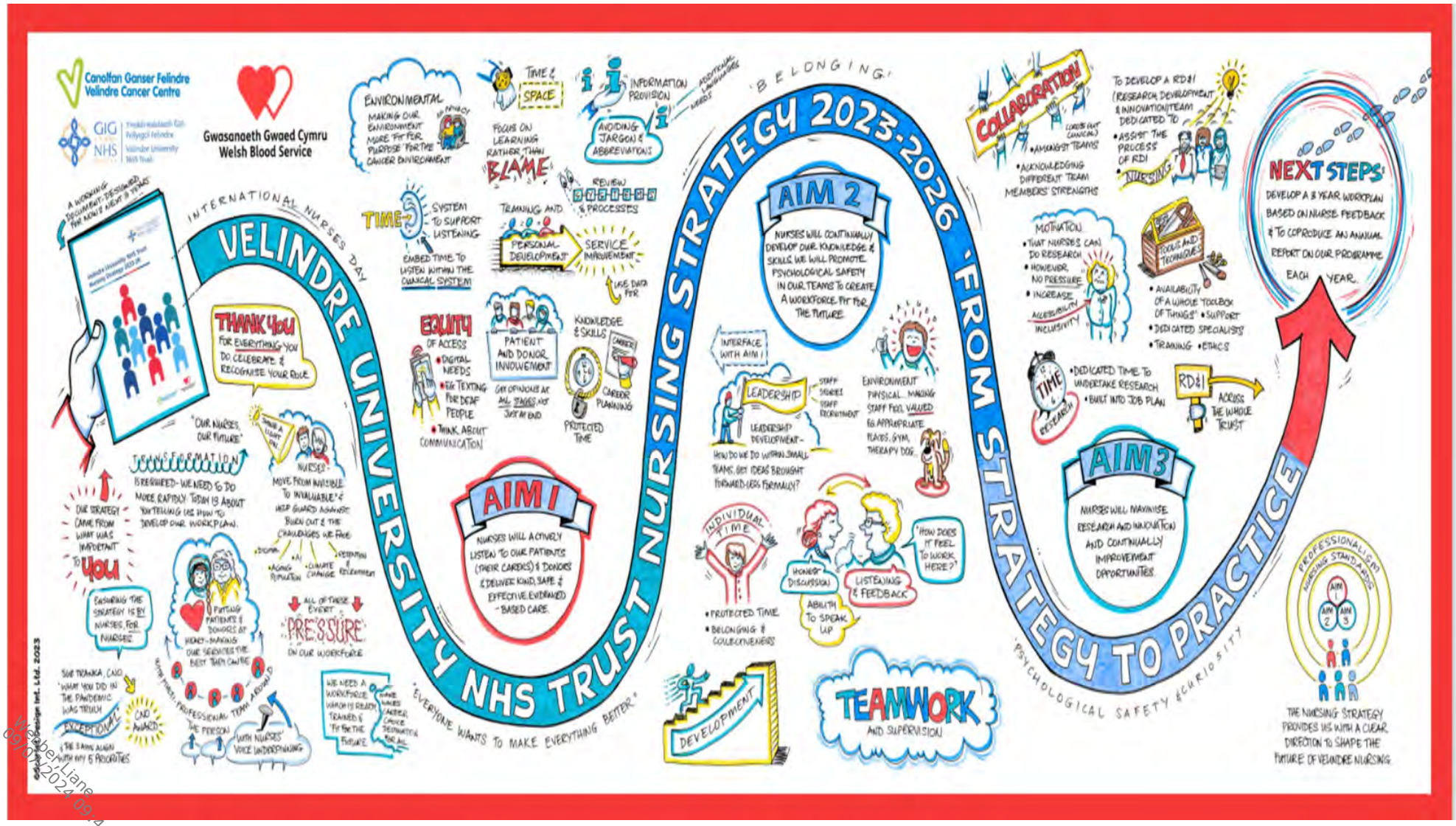


The conference was a huge success and gave us opportunity to recognise some of our excellent nursing colleagues across the Trust.

From Strategy to Practice

The conference offered a dedicated time for workstream breakout sessions, enabling participants to discuss and explore the transition from strategy to practice. A nominal group technique was utilised in the breakout sessions, fostering creativity and providing a safe space to efficiently generate a list of ideas on how to achieve the priorities within the Trust Nursing Strategy.

The valuable feedback received at the conference enabled the development of a nursing strategy delivery plan that was approved and monitored through the Trust Professional Nurse Forum. The delivery plan is available from Executive Director of Nursing, AHP & Health Science if required.



Achievements 1 year on…

Nurses will actively listen to our patients (their carers) and donors and deliver kind, safe, and effective evidence-based care

- Increased Delegation awareness with new guidance from HEIW and new National Job Descriptions across all nursing roles for the Trust – this was an urgent requirement with new nurses due to commence early 2024. Included in nurse induction and featured within the nursing hub after relaunch.

- Reduced nursing time on unnecessary or administrative tasks for registered nurses to spend more time on direct patient and donor care. This has included workforce redesign to ensure required support infrastructure is in place such as clerks and healthcare support worker roles.

- Trust's first Associate Practitioner (Band 4 HCSW) has completed their academic training.

- Approval of a Clinical Supervision Framework and the offer of clinical supervision made to Clinical Nurse Specialists, new registrants and overseas nurses. This is expected to impact greatly on staff retention.

- Communication skills training available to all. Dealing with difficult conversations, delivered by Hazel Perrett. Awaiting staff training figures to capture measures. Offered to all, but uptake in nursing has been low due to site pressures.

Nurses will continually develop our knowledge and skills. We will promote psychological safety in our teams to create a workforce fit for the future.

- Incident framework and learning framework approved, next step is to embed across organisation and outcome measures to be recorded.

- Two successful Nursing conferences held with focus on psychological safety, empowerment and being the best we can be.

- Psychological Safety focus through all workstreams with Leadership visibility.

- A Nurse Retention Lead was appointed in November 2023 who is developing the Trust Nurse Retention Action Plan, and, is supporting the delivery of a number of nursing infrastructural improvements such as clinical supervision.

- All Senior Nurses have access to the Gwella (leadership) platform.

- Successfully recruited Internationally trained nurses and new registrants for the first time into Velindre Cancer Service.

Nurses will maximise research innovation and continual improvement opportunities

- Considerable progress made in relation to increasing nurses' access to research opportunities: a new PhD Fellowship and two Velindre Introduction to Research Awards have commenced. Four new opportunities are available for 2024/25.

- Successful implementation of mandatory New Nurse Development Programme for newly registered, and internationally trained nurses.

Next steps 2024/25 Priorities

- Implement the Clinical Supervision Framework across the Trust.

- Ensure a process is in place for staff debriefs and ongoing support following incidents across the Trust.

- Implement Schwartz Rounds.

- Collate and add to workplan outcomes from staff strategy in action sessions at the 2024 Nursing Conference.

- Embed the Speaking Up Safely Framework and ensure psychological safety focus with Leadership visibility.

- A research training package which includes:
  - Writing for publication
  - Abstract coaching
  - Training sessions
  - Nurse research maturity matrix assessment.

- Planning the third Nursing Conference, 12th May 2025.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Quality, Safety & Performance Committee 2023-2024 Annual Report

DATE OF MEETING	11th July 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	**DISCUSS** AND **ENDORSE**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Liane Webber, Business Support Officer/Committee Secretariat
PRESENTED BY	Liane Webber, Business Support Officer/Committee Secretariat
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Science
EXECUTIVE SUMMARY	This Quality, Safety & Performance Committee annual report summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee during the period 1st April 2023-31st March 2024.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **DISCUSS** the content of the report and **ENDORSE** the Quality, Safety & Performance Committee 2023-2024 Annual Report prior to submission to Trust Board.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	25/06/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Endorsed for onward approval.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	Quality, Safety and Performance Committee Annual Report 2023-24

1. SITUATION

Under Standing Order 4.3.2, each Sub-Committee of the Board is required to submit an annual report ***"setting out its activities during the year and detailing the results of a review of its performance.***

This report details the key areas of business undertaken by the Quality, Safety & Performance Committee between 1st April 2023-31st March 2024.

2. BACKGROUND

The Quality, Safety & Performance Committee Annual Report (attached in ***Appendix 1***) summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee during 2023-24 and reflects the Committee's key role in the development and monitoring of the Trust's quality, safety and performance agenda.

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	Choose a domain/domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	*There are no socio-economic impacts linked directly to the activity outlined in this 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
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	
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*	*There is no direct equality impact in respect of this report.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

Quality, Safety & Performance Committee
2023 – 2024 Annual Report

1. Introduction and Background

This report summarises the key areas of business activity undertaken by the Quality, Safety & Performance Committee during the period 1st April 2023-31st March 2024.

The Quality, Safety & Performance Committee's annual business cycle ended on 31st March 2024 and this report reflects the Committee's key role in the development and monitoring of the Trust's quality, safety and performance agenda.

2. Roles and Responsibilities

The purpose of the Quality, Safety and Performance Committee "the Committee" is to provide evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to quality, safety, planning and performance of healthcare. This will include (not limited to):

- Compliance with Duty of Quality and Duty of Candour legislation
- Integrated and triangulated quality and safety outcomes, including:
    - safeguarding and vulnerable groups
    - patient, donor and staff experience
    - Health and Care Quality Standards (2023)
    - Infection prevention and control
    - Putting Things Right regulations
    - Quality and safety framework compliance
    - Mortality
    - Information governance
    - Divisional quality oversight
- all aspects regarding the workforce (including staff experience)
- digital and cyber security
- relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015
- financial performance
- regulatory compliance
- organisational and clinical risk
- Trust Assurance Framework

3. Membership of the Quality, Safety & Performance Committee:

The membership of the Committee during 2023/24 was as follows:

Chair: Mrs Vicky Morris, Independent Member

Members: Professor Donna Mead OBE, CStJ**,** Chair of the Board
Stephen Harries, Independent Member
Hilary Jones, Independent member

4. Quoracy and Frequency

The Quality, Safety & Performance Committee Terms of Reference specifies that the Committee shall have at least two members present to ensure the quorum of the Committee, one of whom should be the Committee Chair. If the Chair is not present an agreement is made as to who will Chair from the Independent Members in their absence.

Meetings shall be held no less than bi-monthly and otherwise as the Chair of the Committee deems necessary.

5. Meetings and Attendance

The Quality, Safety & Performance Committee met seven times during the year, one of which (21st March 2024) was an extraordinary joint meeting between the Quality Safety & Performance Committee and Audit Committee. This is in line with the Committee's Terms of Reference.

Attendance by Committee Members and Trust Officers across the year is detailed in the table below:

Committee Members	16 May 2023	13 July 2023	14 Sept 2023	16 Nov 2023	16 Jan 2024	14 Mar 2024	21 Mar 2024	Attendance %
Vicky Morris (Chair) *Independent Member*	✓	✓	✓	✓	✓	✓	✓	100%
Prof. Donna Mead *Chair of the Board*	✓	✓	✓	✓	✓	✓	×	86%
Stephen Harries *Independent Member*	×	×	✓	✓	✓	✓	×	57%
Hilary Jones *Independent Member*	✓	✓	✓	✓	✓	✓	✓	100%

Trust Officers	16 May 2023	13 July 2023	14 Sept 2023	16 Nov 2023	16 Jan 2024	14 Mar 2024	21 Mar 2024	Attendance %
Nicola Williams (Exec Lead) *Executive Director of Nursing, AHPs and Health Science*	✓	✓	✓	✓	✓	Partial (on A/L)	×	79%
Jacinta Abraham *Executive Medical Director*	✓	✓	✓	✓	✓	✓	✓	100%
Lauren Fear *Director of Corporate Governance & Chief of Staff*	✓	✓	✓	✓	✓	×	✓	86%
Steve Ham *Chief Executive Officer*	✓	×	×	×	×	×	✓	29%

Matthew Bunce *Executive Director of Finance*	✓	✓	✓	✓	✓	✓	✓	100%
Sarah Morley *Executive Director of Organisational Development & Workforce*	✓	✓	×	✓	✓	✓	×	71%
Carl James *Executive Director of Strategic Transformation, Planning & Digital*	×	×	✓	✓	✓	×	✓	57%
Cath O'Brien *Chief Operating Officer*	×	✓	✓	×	×	≠	≠	29%

(≠Cath O'Brien was no longer in post at the time of these meetings)

6. Agenda Planning Process/Action Log

In-line with the agreed Quality, Safety & Performance Committee Cycle of Business the Chair, in conjunction with the Executive Director of Nursing, Allied Health Professionals and Health Science set the agenda for all Committee meetings. The cycles of business is the main agenda setting vehicle.

In order to monitor progress and any necessary follow up action, the Committee has an Action Log that captures all agreed actions. This provides an essential element of assurance to the Committee and from the Committee to the Board.

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

7. Planning and Review

The Quality, Safety & Performance Committee Terms of Reference and Operating Arrangements were reviewed and approved on 9th May 2024. This included:

- Review and approval of its Terms of Reference
- Approval of the Cycle of Business/Work Programme

8. Public Quality, Safety & Performance Committee Activity

8.1 Standing Agenda Items

8.1.1 Patient, Donor and Staff Stories

Each Committee meeting commences with a patient, donor or staff story. This is to frame the Committee around the experiences our patients, donors and staff are receiving from Trust services. The following stories were received:

- ***May 2023: Velindre Cancer Service Patient Story -*** outlining the experience of a Velindre Cancer Service Nurse who was also a patient. The story outlined the

advantages, challenges and learning that the care and treatment of a colleague had brought to the service.

It became apparent that published literature on caring for a colleague is extremely limited, and as such the Committee endorsed the recommendation to explore research options in relation to caring for a patient who is also a colleague, with a view to increasing the level of literature available on the subject to enable staff and colleagues in the wider NHS community to be better prepared for such circumstances.

- **July 2023: Staff Story -** from the Trust's Organisational Development Manager, Equalities, Diversity & Inclusion, who shared her experiences and workplace challenges as a member of the deaf community. The Committee heard an overall positive report of her experiences since joining Velindre, but outlined the challenges she continues to experience, such as delays in booking British Sign Language interpreters to enable her attendance at workshops, conferences and other events. The Committee welcomed further discussion around experiences of the Velindre induction process, with a view to improving delivery to those new to the organisation, the NHS as a whole and those with additional needs/requirements.

- ***September 2023: Welsh Blood Service Donor Story -*** outlining the post-COVID recommencement of the Donor Awards and the importance that these events have in retaining donors.

- ***November 2023: Velindre Cancer Service Patient Story*** - relating to a patient who had received the Five Fraction Radiotherapy Regime for prostate cancer. This approach, which utilises technology developed within the last few years, delivers a higher, more targeted dose of radiotherapy, sparing more organs at risk and patients can receive their treatment five times over ten days, rather than having to visit the Service 20 times over a four-week period. This has substantial benefits for both the patient and the Trust, as with an average of 30 patients per month, this brings a Linac saving time of 62½ hours, significantly increasing the capacity. The patient described a very positive experience whilst receiving this treatment.

- ***January 2024: Welsh Blood Service Donor Story*** - that provided an insight into some of the actions being implemented in order to meet the Service's annual target to recruit 4000 new bone marrow donors and outlined the campaign to highlight the need for more donors in Wales, particularly those of a minority of mixed-race background. This campaign has proven to be successful, with a substantial increase in the number of stem cell donor recruits noted as a result.

- ***March 2024: Velindre Cancer Service Patient Story -*** which outlined the experiences of a current Velindre Cancer Service receiving SACT treatment. The story demonstrated several areas of good practice within the service, although a number of key issues were highlighted 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. 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.

8.1.2 Trust Risk Register

At each meeting* the Committee received the Trust Risk Register, the structure of which has changed significantly over the year following feedback from the Committee and other Trust governance fora. The Risk Register report is provided to inform the Committee of the status of risks reportable to the Trust Board, in line with the renewed risk appetite levels. In addition, the report updates on progress against the Risk Management Framework.

The Committee agreed to undertake formal 'deep dives' into selected individual risks at each meeting and this has continued through the year. Positive changes have been noted, resulting in positive levels of assurance.

**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 the March Committee. An extraordinary QSP/Audit Committee was held on the 21st March to consider the Trust Risk Register and Trust Assurance Framework, prior to Board consideration.*

8.1.3 Trust Assurance Framework

Following collaboration with the Divisional Senior Leadership/Management Teams, Committee members, Executives and Independent Members, a review of the Trust Assurance Framework, including a refresh of the Strategic Risks was undertaken and was received by the Committee in 16 January 2024. Whilst the review was being undertaken there was unfortunately a 6-month period when the Committee did not receive the TAF. This was escalated formally to the Board in its highlight report, which triangulated with concerns raised by Audit Committee on the same issue of escalation.

During this year, the Committee requested an alignment of the Trust's strategic objectives from the IMTP into the Trust Assurance Framework template, in order that the Committee can enhance its provision of assurance to the Board. This is still work in progress. It is anticipated this will be brought to the September 2024 Committee.

8.1.4 Performance Management Framework (PMF) Report and Supporting Analysis

The Performance Management Framework (PMF) report provides an overview of Trust-wide performance against key performance metrics for the Velindre Cancer Centre, the Welsh Blood Service and Trust-wide Corporate Services.

Each section of the PMF report is presented separately by divisional leads and discussed in detail at each meeting, with any items of concern highlighted to ensure appropriate actions/monitoring procedures are put in place. The main area of escalation where performance was not improving and required targeted improvement action was SACT (Systemic Anti-Cancer Treatment). SACT improvements are being overseen through business continuity arrangements.

8.1.5 Workforce Supply and Shape and Associated Finance Risks

The workforce challenges in the Trust relate to the Supply and Shape of the workforce. The availability (Supply) of the right workforce in the right place with the right skills and the need to moving away from traditional staffing models to deliver a changing service requires a different shape to the workforce. This requires finance to be allocated across different teams and different staff groups. The key to ensuring a robust plan around workforce supply and shape is to strengthen the current workforce planning approach.

The Trust's Workforce Development Framework is aligned to the All Wales Workforce Planning Strategy and contains a number of workforce levers to ensure the Trust recruits, retains, skill and develop the workforce and manage the health and engagement of our staff effectively to ensure the Trust are the employer of choice and meeting the Trust's People Strategy commitments.

The Committee received an update at each meeting to highlight the key integrated actions the workforce team is taking to address the challenges, together with service and finance colleagues, to ensure risk mitigation, performance improvement and the associated financial risk of supply issues are provided.

During the year the Committee requested enhanced focus on the action plans in place to underpin the delivery of the Strategies developed and increased clarity on progress being made so that the Committee can seek and provide assurance to the Board on these issues. The Committee received internal and external Audit reports on a range of workforce issues, which have also highlighted the same key issues.

8.1.6 Finance Report

The Finance Report outlines the financial position and performance for each period and the forecast year end performance which was slight underspend position. The Finance Director pulls out the key workforce issues to provide a triangulation of information for the Committee to consider. This has been extremely helpful to the Committee over the last year.

8.1.7 Integrated Quality and Safety Group (IQSG) Highlight Report

The Trust Integrated Quality and Safety Group was established in October 2022 to provide oversight to support the Board, Executive Team, and Divisional Senior Leadership Teams in meeting their Quality and Safety responsibilities. This includes meeting legislative and national requirements of the 'Duty of Quality' responsibilities to help ensure quality is at the centre of all decision making across the Trust. During the year, the Committee received a highlight report detailing the key outcomes and deliberations of the IQSG meetings held during the preceding period. The Committee has overseen the maturity of the IQSG during the year.

Due to significant duplication of reporting it has been agreed that, from April 2024, this report will no longer be included as a standing item. A highlight report will be produced following each IQSG meeting (i.e., monthly) and submitted to the Executive Management Board and Divisional Senior Leadership Teams/Senior Management

Teams covering key highlights, assurance, exceptions and escalation. Only if there are any significant exceptions or points of serious escalation will a highlight report be provided to the Quality, Safety & Performance Committee. All other matters will be covered through a quarterly comprehensive Quality and Safety report.

8.1.8 Integrated Medium Term Plan (IMTP) Quarterly Actions Progress

The 2023 – 2026 Integrated Medium Term Plan (IMTP) 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.

This quarterly report provided the Committee with an overview of progress made in the delivery of actions at the end of each quarter. As reported earlier in the report, the Strategic objectives will be incorporated into the Trust Assurance Framework for 2024/2025 to enhance the ability for the Committee to have oversight of the risks or assurances against delivering its key objectives.

8.1.9 NHS Wales Shared Services Partnership - Transforming Access to Medicine / Clinical Pharmacy Technical Services Update

During this year the Committee received a quarterly report that provided assurance on the current performance of the Pharmacy Division within NHS Wales Shared Services Partnership, for onward escalation to the board any matters of exception that increase the risks of service delivery. Key points to note were as follows:

- A programme of work is underway on an ad-hoc basis between Velindre Cancer Service (VCS) and NHS Wales Shared Services Partnership (NWSSP) to support the Pharmacy capacity issues.
- 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.

Additionally, the Committee were advised that the Medicines Value Unit within NWSSP, which sits within the pharmacy division, is 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.

8.1.10 NHS Wales Shared Services Partnership - Implementation of Duty of Quality Update

The Duty of Quality which applies to both clinical and non-clinical services came into force in April 2023. This report was provided to the Committee in November to outline

the progress made in respect of implementation of the Duty of Quality for NHS Wales Shared Services Partnership.

8.1.8 Highlight Report from the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee

The Transforming Cancer Services Programme Scrutiny Sub-Committee meets on a monthly basis. A highlight report giving an overview of the key issues considered at each meeting and associated actions taken is provided to the Quality, Safety & Performance Committee for information. The following key matters were discussed for the reporting period:

- TCS Programme Finance Report
- TCS Communications and Engagement
- TCS Programme Directors Report

8.1.9 Highlight Report from the Research, Development and Innovation (RD&I) Sub-Committee

The Research, Development and Innovation (RD&I) Sub-Committee meets on a quarterly basis. A highlight report giving an overview of the key issues considered at each meeting and associated actions was provided to the Committee.

8.2 Policies and Procedures

8.2.1 The Committee **APPROVED** the following policies and procedures during the period:

- Safeguarding & Public Protection Policy
- Policy for the Management of Safeguarding Allegations/Concerns about Practitioners and those in a Position of Trust
- National Policy on Patient Safety Incident Reporting and Management
- Freedom of Information/Environmental Information Regulations Standard Operating Procedure

Health and Safety Policies

- Management of Violence & Aggression Policy
- Safe Use of Display Screen Equipment (DSE) Policy
- Safer Manual Handling Policy
- Control of Substances Hazardous to Health (COSHH) Policy
- Policy for Management of Latex and Latex Allergy

Infection, Prevention and Control Policies

- Framework Policy for Infection Prevention and Control
- Transport of Specimens Policy

Planning, Performance and Estates Policies

- Medical Gas Piped Systems Policy
- High Voltage Electricity Supply Systems using a Contractor as the Authorised Person
- High Voltage Electrical Supply System Operational Policy

- Electrical Low Voltage Policy
- Ventilation Policy

8.2.2 The following policies were **ENDORSED** by the Committee:

- Trust Claims Policy, Handling Concerns Policy
- NHS Wales Red Cell Shortage Plan.

Organisational Development & Workforce Policies

- All Wales NHS Dress Code
- Annual Leave Policy
- Redundancy and Security of Employment Policy
- Recruitment and Selection Policy

The Committee received policy compliance review updates which highlighted that compliance was improving from 45% reported in March 2023 to 54.87% reported in March 2024. However, the Committee requested the need for enhanced oversight of policy reviews and requested an action plan to address those policies past their review date.

9. Triangulated Meeting Themes

During the year the following triangulated meeting themes were identified:

- Effective management and reporting of risk.
- Trust Performance - positive performance issues outlined within reports but also challenges with the implementation of new stretch targets.
- Quality and experience focus.
- Recognition of staff resilience and dedication to ensuring the best services for patients, despite workforce constraints in areas.
- Digital capability and impact on clinical delivery, patient/donor safety and risk.
- The Risk Register and Trust Assurance Framework were noted as widely recurring themes, with risks around workforce issues continuing to be highlighted as particular points of concern. Staff sickness continue to contribute to fatigue and burnout amongst many areas of the workforce, and recruitment challenges for core staff vacancies present many operational constraints, particularly in terms of business intelligence capacity.
- Increasing service pressures at the Cancer Service and the associated impact on all areas of delivery.
- Further refinement is required in respect of how the seven levels of assurance framework is reflected.
- Increasing demand on both divisions and complexity with delivery being impacted by workforce deficits/challenges.
- 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.

10. Discussions held in Part B Private Committee

There is facility for the Committee to consider reports that contain commercially sensitive or potentially identifiable/sensitive information in Part B Private Committee. Key items received in the Part B Private meeting during the period were:

- Employee Relations Review
- Annual Progress Report – Cyber Security Strategic Plan
- National Reportable Incident Briefing
- COVID-19 Inquiry Update
- Professional Concerns
- Infected Blood Inquiry Update
- TCS Programme Scrutiny Sub Committee Highlight Reports that covered the following private matters:
  - nVCC Plan and Approvals Overview
  - Old Whitchurch Hospital Land Transfer Proposal
  - Progress to Financial Close
  - nVCC Full Business Case
  - Integrated Radiotherapy Solution Project Updates
  - Radiotherapy Satellite Centre Project Updates
  - Outreach Project Updates
  - Nuffield Recommendations Update

11. Reporting the Committee's Work/Highlight Report

The Chair of the Quality, Safety & Performance Committee reports the key issues discussed at each of its meetings by way of a Highlight Report to the Trust Board.

The Highlight Report provides the facility for the Committee to alert/escalate; advise; assure; or inform its overarching Committees in relation to quality, safety, performance and strategic matters. Committee papers, including minutes, are published on the Trust's internet pages.

12. Quality, Safety & Performance Committee Annual Effectiveness Survey

The Quality, Safety & Performance Committee has engaged with a formal Committee Effectiveness Review Process which took place in April 2024 and determines the effectiveness of the Committee in meeting its operations in accordance with its Terms of Reference and the Trust Standing Orders.

In addition to the Annual Effectiveness Survey the Committee continued to review its effectiveness throughout the year to ensure effective use of time and ensure it fulfilled its role to provide assurance to the Board, via a committee effectiveness survey containing six key questions, circulated to attendees following each meeting.

Changes made as a result of effectiveness surveys include:

- Executive leads ensure papers are concise and contain focused detail targeted for the audience
- Refining of meeting papers supported through the Integrated Quality & Safety Group
- Evidence that the 7 levels of assurance are starting to be utilised in papers.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Information Governance – Annual Report 2023-2024

DATE OF MEETING	11th July 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	IAN BEVAN, HEAD OF INFORMATION GOVERNANCE AND DATA PROTECTION OFFICER
PRESENTED BY	MATTHEW BUNCE, EXECUTIVE DIRECTOR OF FINANCE AND SENIOR INFORMATION RISK OWNER (SIRO)
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The report provides assurance that the Trust is meeting its mandatory and statutory obligations for Information Governance (IG) by providing a summary of the key IG activities, achievements and issues for the period 1st April 2023 to 31st March 2024. It has been again a busy and challenging year for IG, which has included extensive work to

	support the Trust's obligations to comply with the needs of the COVID 19 Inquiry. It has meant that resources have necessarily been diverted to this activity as it is a requirement under the Inquiries Act 2005 for Trust's to respond to requests for information It has also included the continued provision of advice and guidance to service areas to facilitate change, the continued increased provision of training and awareness and support to Corporate Governance for the Freedom Of Information (FOI) function up to November 2023 as well as the continuing need to review risks associated with new digital systems using the Data Privacy Impact Assessment (DPIA) process. The 2023-24 IG Self-Assessment Toolkit was completed in March 2024 informing the majority of the IG Action Plan with priority actions implemented throughout the year. The Trust continues to make good progress in improving IG using the priorities identified from IG Self-Assessment for 2023-24.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to approve the 2023-2024 Velindre University NHS Trust Information Governance Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group (IQSG)	19.6.24
Executive Management Board (EMB)	25.6.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

ENDORSED BY IQSG FOR DISCUSSION BY EMB FOR SUBSEQUENT APPROVAL BY THE QUALITY, SAFETY AND PERFORMANCE COMMITTEE DISCUSSED AND ENDORSED BY EMB FOR APPROVAL BY THE QUALITY, SAFETY AND PERFORMANCE COMMITTEE

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
Appendix 1	List of acronyms / abbreviations

1. SITUATION

The 2023-2024 Velindre University NHS Trust Information Governance Annual Report is provided to the Quality, Safety and Performance Committee for approval.

2. BACKGROUND

The Trust operates an Information Governance (IG) Framework that ensures the Trust meets its Mandatory and Statutory obligations and other standards in relation to applicable legislation. Applicable legislation includes but is not exclusive to legislation which supports the principles of the European Convention on Human Rights, Human Rights Act 1998, Protection of Freedoms Act 2012, Investigatory Powers act 2016, Lawful Business Practice Regulations 2000, Employment Practices Code (Section 51 DPA 18) the Data Protection Act 2018 (includes the retained EU General Data Protection Regulations 679/2016 (UK GDPR)), Freedom of information Act 2000, Environmental Information Regulations 2004, Common Law Duty of Confidence, Public Records Act 1958 and the Access to Health Records Act 1990.

This legislation is supported by non-legislative guidance such as: the Surveillance Camera Code of Practice 2021, Caldicott Principles and the Records Management Code of Practice for Health and Social Care 2022 which is based on the Freedom of Information Act's Section 46 Information Management Code of Practice.

The Report sets out the Trust's compliance activity against its legislative obligations during the reporting period, it includes the accountability of key posts, highlights incidents where external reporting has been necessary (which includes assessment of risk and impact), compliance statistics results of review activity across the divisions and training attainment. The report also sets out a forward look to work programmed for 2024-25, the basis of which is underpinned by the 2023-24 self-assessment.

3. SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Key IG Objectives 2023-24

The IG Self-Assessment Toolkit for 2022-23 set out the Trust's Action Plan for its objectives in relation to Information Governance for 2023-24. There was some considerable success in achieving the objectives whilst some remain as it is activity that will take the Trust longer to achieve.

The key IG objectives that were achieved for 2023-24 were:

- Conducted a review of the All-Wales IG Policies which are expected to be presented for approval by NHS Wales Trust and Boards in July/August 2024.
- Updated the Data Sharing Agreement template to reflect the need to conduct Transfer Risk Assessments (where the UK-UK Data Bridge is not applicable), International Data Transfer Agreement where the data is exported outside the UK/EEA and record it in the Data Sharing/Processing Agreement register with cross referral to the DPIA Register.
- Updated the Data Processing Agreement template to reflect the need to conduct Transfer Risk Assessments (where the UK-UK Data Bridge is not applicable), International Data Transfer Agreement where the data is exported outside the UK/EEA and record it in the Data Sharing/Processing Agreement register with cross referral to the DPIA Register.

- Updated the DPIA screening process.
- Instigated a midway DPIA template for use when the full DPIA template is not proportional to the processing need and abridged version is too light touch.
- Maintained an IG Risk Register to support recording of risks within DATIX.
- Updated the DPIA template for cloud processing , it remains under annual review.
- Included Service, IG and Cyber risks in the DPIA register to ensure that a risk based approach is taken to the support of projects in the Trust.
- Developed Information Asset Registers (IAR) to be owned by Information Asset Owners (IAO) across all Divisions of the Trust to support the Record of Processing Activity (ROPA). To be implemented in 2024.
- Developed Information Asset Owners training (IAO) across all Divisions of the Trust to be implemented in 2024 to support the Record of Processing Activity (ROPA).

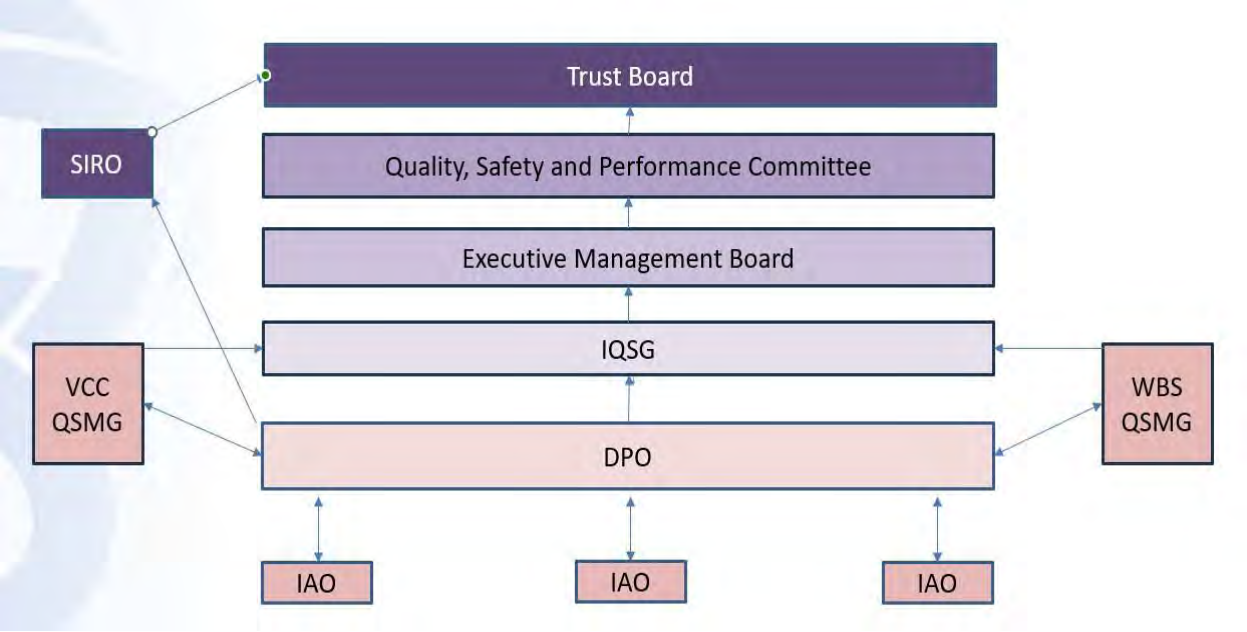
There are IG objectives that require further work in 2024-25, these are articulated as a forward look in Section 4.

- Align the WBS Contract Register to the Trust DPIA Register.
- Complete the review of legacy Trust systems to ensure that risks associated with such systems are recorded in DPIA's where necessary and that those DPIA's are reviewed annually.
- Develop the Records Management Strategy.

The 2023-24 IG Self-Assessment identified current compliance with data protection legislation and sets the work plan for 2024-25 contained within Section 3.6.

3.2 Key Trust Roles and Reporting Structure

The diagram below sets out the linkage between key roles and the reporting structure for Information Governance within the Trust:

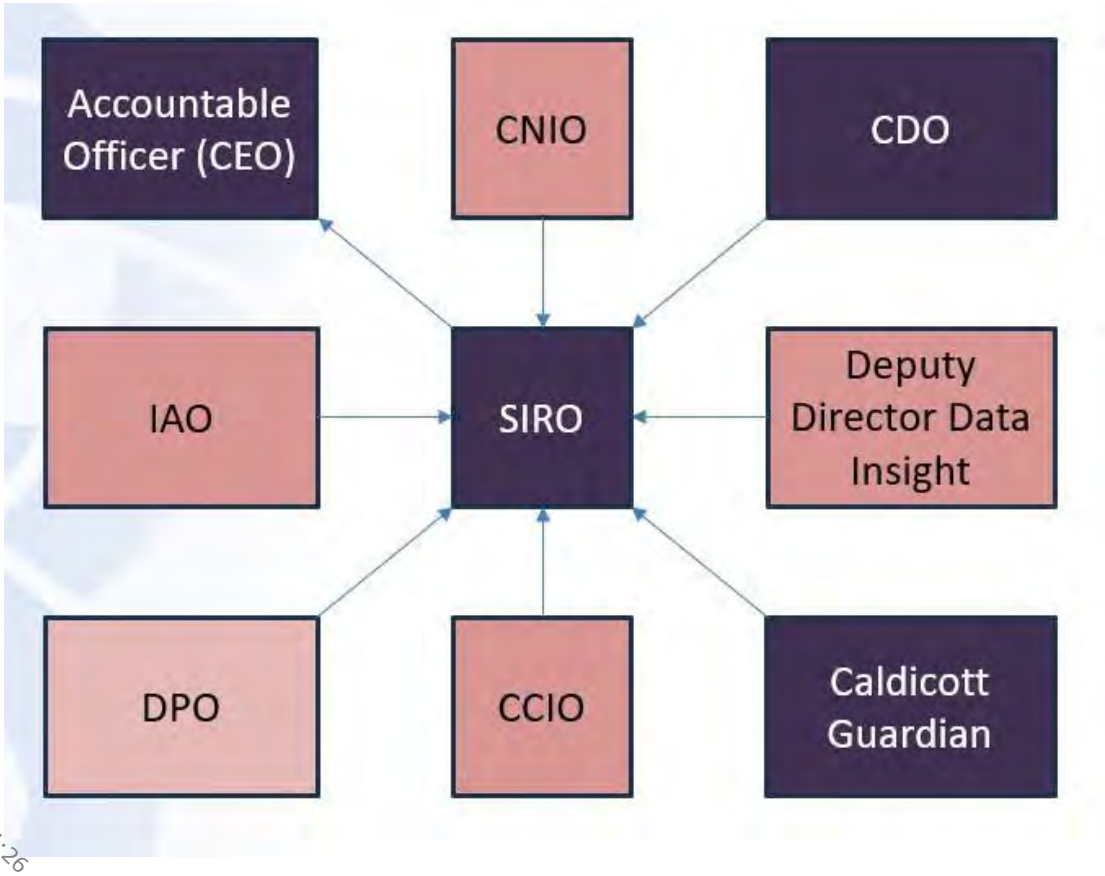


Each element performs a different function in terms of provision of assurance:

Role	Activity
Trust Board	Responsible for the Trust's overall system of governance and control, which includes robust risk management, and therefore must seek and be provided with assurance on the effectiveness of the systems and processes in place for meeting the Trust's strategic objectives.
Quality, Safety and Performance Committee	To provide evidence based, timely **advice** and **assurance** to the Board, to assist it in discharging its functions and meeting its responsibilities through its arrangements and core outcomes with regard to quality, safety, planning and performance of healthcare.
Executive Management Board (EMB)	Responsible for overseeing the management and setting direction for the delivery of the Trusts accountabilities and responsibilities.
Integrated Quality and Safety Group (IQSG)	The group responsible for the triangulation of Quality and Safety risks at Corporate

	level. IG forms part of this group.
Data Protection Officer (DPO)	A senior Trust Officer who has duties of compliance with Article 39 UK GDPR
Quality and Safety Management Group (VCC and WBS)	The group responsible for the identification and recording of Quality and Safety risk at a divisional level. IG forms part of this group.
Information Asset Owner (IAO)	The individual responsible for ensuring that the risks to, and the opportunities for the information asset they are accountable for are monitored.

The Integrated Quality and Safety Group (IQSG) consists of Quality and Safety professionals and links the operational Quality and Safety Groups within an integrated group at corporate level. IQSG reports to the Executive Management Board and includes the Information Governance function.



The Diagram above sets out the interconnectivity of roles that include IG within their responsibilities. An explanatory table is below:

Role	Overview
Accountable Officer (CEO)	The Accountable Officer is the CEO and the role is accountable to the Welsh Government for compliance with applicable legislation, codes of practice and standards across the Trust including IG. The CEO is a member of Trust Board
Senior Information Risk Owner (SIRO)	The SIRO is a member of IQSG, EMB, QSP and Trust Board and provides board-level accountability and greater assurance that information risks are addressed.
Caldicott Guardian	The Caldicott Guardian is defined by the UK Caldicott Guardian Council as a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. The Trust Caldicott Guardian is its Medical Director and is a member of IQSG, EMB and Trust Board.
Chief Digital Officer (CDO)	The Chief Digital Officer is accountable for the security and delivery of digital systems across the Trust, it includes Cyber Security. The Chief Digital Officer is a member of IQSG,EMB, QSP and Trust Board
Chief Clinical Information Officer (CCIO)	The Chief Clinical Information Officer is a senior Consultant within the Trust who is responsible for ensuring that the Trust has in place appropriate systems to enable medical staff to carry out their clinical functions.
Chief Nursing Information Officer (CNIO)	The Chief Nursing Information Officer is a senior Nurse in the Trust who is responsible for ensuring that the Trust

	has in place appropriate systems to enable nursing staff to carry out their clinical functions as well as ensuring that the Trust has in place appropriate enabling platforms such as electronic roster systems.
Deputy Director Data Insight	The Deputy Director Data Insight is a business intelligence and information specialist whose role is to ensure that the Trust has in place technical and organisational measures to support the treatment of patients and donors.

The Trust's Executive Director of Finance is the designated Senior Information Risk Owner (SIRO) who holds responsibility for information risk to the Trust Board. The Trust also has in place a Caldicott Guardian, which is the Trust's Executive Medical Director. The two main Divisions of the Trust each have a Caldicott Guardian. Cyber security as integral element of Information Security rests within the portfolio of the Trust's Chief Digital Officer.

The Trust as a public authority is required under UK GDPR Article 37(1)(a) to appoint a Data Protection Officer (DPO). The Head of Information Governance (HoIG) as the Trust's lead for Information Governance is the Trust's appointed DPO. The tasks of the DPO are contained in UK GDPR Article 39 which are to ensure that there are effective controls and mechanisms in place to ensure that the Trust complies with its Mandatory and Statutory obligations as well as supporting staff ability via the delivery of training and awareness to comply with Information Governance fundamental principles and procedures.

The SIRO, Chief Digital Officer, DPO and Caldicott Guardians meet at regular intervals throughout the year so that a rounded approach to Information Governance is undertaken.

The DPO took over the role of the Chair of the All-Wales Information Governance Management Advisory Group (IGMAG) in July 2023. IGMAG brings together all DPO's across Wales to share best practice in data protection legislation as well ensuring that where possible aligned approaches are taken when considering All-Wales projects which require Information Governance input. It is envisaged that during 2024-25 the group will link more closely with a re-established All-Wales

SIRO group, the All-Wales Medical Directors Group and the Welsh Government. This will provide a more cohesive approach to IG and as a consequence provide assurance to the Trust that it is meeting its obligations under data protection law.

The Trust IG Peer Group meets throughout the year focussing on tasks to ensure that Trust activity requiring IG consideration are undertaken compliantly.

3.3 Information Governance – COVID Inquiry

During 2023-24 and continuing into 2024-25, the IG team have been involved in the Trust's response to the UK Wide COVID 19 Inquiry. The remit of the IG team was to conduct detailed, thorough and robust searches against set parameters for the following types of information:

- Emails
- Documents
- Records

An early lesson from the Inquiry activity was the need to increase compliance with the Records Management Code of Practice and Trust Policy. This aligned with the previous assessment that Information Asset Registers are a key risk management tool and that Information Asset Owners are required to provide an assessment as to the value of the information they are accountable for and any risks to it.

It is anticipated that further support will be required on an ad hoc basis during 2024-25 and up to the completion of the Inquiry in 2026.

3.4 Reviews of internal processes and activity

The tasks of the DPO as defined in Article 39(1)(b) include:

> "*to monitor compliance with this Regulation, with other domestic law relating to data protection and with the policies of the controller or processor in relation to the protection of personal data, including the assignment of responsibilities, awareness-raising and training of staff involved in processing operations, and the related audits*;"

Velindre Cancer Centre (VCC)

Subject Access Requests

During 2023-24, the DPO undertook a review of compliance with data protection law by the VCC Medical Records Department in respect of its activity under "information rights" via the Subject Access Request process. The report was presented to the Trust via the VCC Senior Leadership Team (SLT). The following recommendations were made:

- The observations and recommendations within the audit report appendix be turned into an actionable plan.
- The action plan be used as a "get well package" with weekly checkpoints by the Service Lead to assess continued and sustainable improvement by the Service area.
- A follow up Audit be conducted at an interval agreed between the Divisional Director, Operational Lead, Service Lead and DPO review progress and thereby provide assurance to the Trust of compliance with applicable Legislation, Codes of Practice and Trust Policy.

Email Use

A review was undertaken into the use of email across VCC and a report was presented to the Trust via the VCC SLT. The following recommendations were made:

- Develop an overarching Standard Operating Procedure (SOP) for the use of email by Staff to include email etiquette, avoidance of duplication of emails, excessive sharing and whether the use of email is appropriate for the task.
- Develop a user guide for the use of email by Staff which concentrates on in depth guidance for the use of email.
- Investigate alternative methods of communication to email using the most appropriate and efficient methodology.
- Maintain staff contact lists and keep them accurate and up to date.
- Consider an SOP for use between Medical Records and the Systemic Anti-Cancer Treatment (SACT) department.
- Ensure that out of office is placed when staff are absent so that messages can

be dealt with efficiently.

Welsh Blood Service (WBS)

The DPO conducted generic IG reviews in the following areas:

- Automated Testing and microbiology
- Donor Contact Centre
- WBS Facilities
- Manufacturing and Distribution
- Quality Assurance Laboratory
- Quality Assurance Systems
- Red Cell Immunohematology

Reports were presented to the Trust via the WBS Quality Assurance (QA) Department for further consideration. The WBS QA department track compliance with recommendations made via the Q-Pulse Quality Management System (QMS). The QA staff conduct regular follow ups with section leads identifying and escalating non-compliance appropriately.

3.5 Information Governance Training

During 2023-24, the Trust has continued to conduct extensive training linking together Caldicott Principles, the Data Protection Principles in Article 5 UK GDPR, the Common Law Duty of Confidentiality and the role of the National Data Guardian under the Health and Social Care (National Data Guardian) Act 2018.

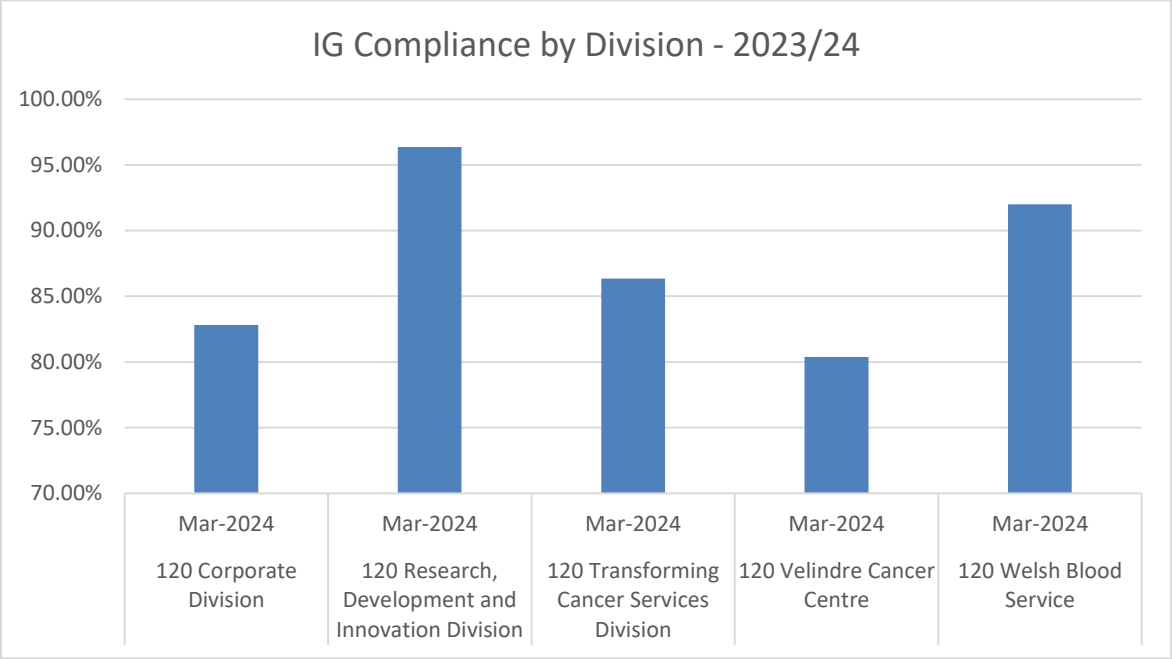
The Trust provides training on these key IG areas and principles for all new staff as part of the 'Croeso' induction programme. It remains a key part of each years workplan. The induction programme has also included Counter-Fraud training as it is estimated that at least 80% of fraud is facilitated through cyber enabled events which are linked to information security principles which fall within the Information Governance remit.

During 2024-25, the training package will be extended to include procurement training, this is to ensure that the link between IG and procurement is clearly understood by employees and links with previous and ongoing work to ensure that contract risks as they apply to cyber security and data protection principles are

understood by staff.

Workshops are also provided where an incident has occurred to ensure that individuals and teams understand their obligations in relation to Information Governance.
Electronic Staff Record (ESR) reports are received monthly which enables the DPO to target groups and individuals where compliance is low.

The minimum standard for IG training compliance is 75%. The Trust achieved an average of 84.45% for 2023-24. The Bar chart below sets out the Divisional attainment for 2023-24:



3.6 Information Governance Self-Assessment Toolkit

The Trust utilises the Welsh Information Governance Toolkit (IG Toolkit) to measure its level of compliance against national IG standards and legislation and identify areas of IG risk. The toolkit is completed annually by the HoIG and reviewed by the SIRO and provides evidence of areas of improvement achieved and identifies actions for the following year. The toolkit identified the following actions for inclusion in the 2024-25 workplan:

- Develop and implement a Bring Your Own Devices (BYOD) Policy
- Implement and maintain a record of all individuals who have access to personal information on electronic systems
- Conduct an effective test of the Business Continuity and Disaster Recovery Plan
- Continue to maintain a Data Processing/Sharing Agreement Register
- Update the Trust Privacy Notice
- Instigate and maintain a process to record confirmation that all staff have read and are aware of relevant policies and procedures
- Continue to proceed with the Information Asset Register Plan and provide training to Information Asset Owners
- Conduct routine reviews across all Divisions of the Trust following a risk based approach
- Investigate and procure training opportunities for SIRO, Caldicott Guardian and HoIG
- Continue to drive the renewal of currently out of date All-Wales IG policies for approval via the Welsh Information Governance Board (WIGB)
- Continue to cross refer the DPIA and Contract Registers to ensure that IG is properly considered as "*data protection by design and default*"
- Continue targeted training workshops across the Trust.
- Develop a Records Management Strategy that includes digitisation as a key element.
- Continue to support FOIA activity as the Trust's FOIA reviewer.

3.7 Data Protection by Design and Default

The Trust continues to process personal data using the mandated "Data Protection by Design and Default" approach (Article 25 UK GDPR) when procuring new systems and maintaining existing ones where personal data is processed. "*Data Protection by Design and default*" enables the Trust to consider IG risk by using the Information Commissioners Office (ICO) mandated Data Protection Impact Assessment (DPIA) process.

The process helps analyse, identify and minimise the data protection risks of a system (both electronic and manual records). Article 35 of the UK GDPR states that DPIAs are a legal requirement for processing data that is likely to result in high risk to the rights and freedoms of individuals. The ICO advises that the completion

of a DPIA is good practice when processing personal data. A DPIA does not have to eradicate all risk but should help to minimise and determine whether the level of risk is acceptable in the circumstances. Under UK GDPR, failure to carry out a DPIA when required may leave the Trust open to an enforcement notice where the ICO will tell the Trust that it MUST carry out an action and if it does not, the ICO may either; publish an enforcement notice on its website and more widely which could negatively affect the Trust's reputation or impose a financial penalty at the higher rate of up to £16.52m or 4% of annual turnover, whichever is the highest.

In the period 1 April 2023 – 31 March 2024, 28 DPIAs were approved with another 25 in progress. The DPIAs that remain in progress are related to ongoing long term projects, some of which are multi-year projects, such as the Integrated Radiotherapy System.

The DPIA process can be lengthy and is undertaken on a risk based approach whereby those systems which present the highest risk in terms of potential service delivery impact are prioritised over those that present a much lower level of service delivery risk.

In relation to legacy Trust systems, the procurement of HALO in November 2023 as an Information Technology Service Management (ITSM) platform is estimated to be able to contribute to the full establishment of a service catalogue of systems in operation within the Trust. The delivery date is currently estimate to be at the latter end of Q2 2024/25. HALO will enable the identification of legacy systems that do not have a DPIA in place.

3.8 <u>Individual Rights – Subject Access Requests</u>

In relation to Subject Access Requests (SAR) made under the Data Protection Act 2018, the Trust received the following number of requests with an average compliance against the statutory timeframe of 67%:

VCC Medical Records Department will be recruiting a new Medico-Legal Clerk during Q2 2024/25, the role will be line managed by the VCC Health Records Manager but professionally accountable to the DPO.

Medical Records

1st April '23 – 31st Mar '24 Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	54	45	83.33%
2	44	30	68.18%
3	40	29	72.5%
4	51	26	50.98%
Total for FY 23/24	189	130	68.78%

Corporate

1st April '23 – 31st Mar '24 Quarter	Number of requests	Number of requests completed within statutory timeframe	Percentage compliance
1	0	0	N/A
2	2	2	100%
3	1	1	100%
4	1	1	100%
Total for FY 23/24	4	4	100%

3.9 Data Security Incidents and Investigations

ICO Reports

During 2023/24 the Trust reported 4 personal data breaches to the ICO, a summary of each breach is outlined below:

- On 6th June 2023, a report was submitted to the ICO regarding email

misdirection. The report was made within the 72 hour timeframe and no further action was undertaken by the ICO.

- On 26th July 2023, the ICO contacted the Trust regarding a complaint received and requested that the Trust take action to address the complaint, which was completed within the requested timeframe of 28 days and the incident closed.
- On 13th September 2023, a report was submitted to the ICO regarding the loss of a photocopied set of Medical Records by the Royal Mail. Despite extensive searches the records were not found and the Royal Mail declared that they in all probability had been destroyed. No further action was undertaken by the ICO.
- On 9th January 2024, a report was submitted to the ICO reporting the theft of an electronic device from a motor vehicle alongside handwritten notes. The incident was reported to the Police and a door to door search undertaken by local police officers. The final response from the ICO is awaited.

In all cases, the breaches have been reported to the Executive Management Board (EMB) and Quality, Safety and Performance Committee who have been kept fully informed as to progress of the incidents.

Cyber Incidents

During 2023/24, three Cyber incidents took place which necessitated the involvement of Senior Trust management and regular reports to the EMB and Trust Board. It was assessed after extensive review of each incident that Trust systems were not compromised at any time and that risk of compromise was low. The need for continued vigilance by Trust Staff as an important part of the Trust's cyber defences was communicated internally.

Cyber Audit – February 2024

The Trust was subject to a Cyber Security audit by the Cyber Resilience Unit of Digital Health and Care Wales (DHCW) in February 2024. Recommendations from the audit have been received and form an action plan for delivery during 2024/25 which is subject to monthly progress reviews..

Incidents that do not meet the Threshold of external reporting

Incidents that do not reach the threshold of reporting to the ICO continue to be reported and investigated via DATIX. Common themes continue to be confidentiality breaches:

- patient records/information sent to wrong recipient (misdirection)
- staff records/information sent to wrong recipient (misdirection)
- staff records/information inappropriately accessed (inappropriate access)

Where the cause of the incident is not immediately clear the DPO will conduct a more in depth investigation.

Quarterly IG assurance meetings between the Independent Member (IM) for IG and Digital, SIRO and DPO continue to take place to provide additional assurance to EMB and the Quality, Safety & Performance Committee.
Caldicott meetings continue to take place, at which the Caldicott Guardians, SIRO, HoIG, CDO, and Chief Clinical Information Officer discuss incidents, actions being taken to learns lessons and improve education, awareness, systems and process.

3.19 Trust Policies

The following Trust IG policies remain in date: ,

- Confidentiality Breach Reporting Policy
- Data Protection and Confidentiality Policy
- Freedom of Information Act Policy
- Records Management Policy

The workplan for 2024/25 includes the review and update as necessary to the Policies to ensure that their renewal date of July 2025 is achieved. It should be noted that the new Data Protection Bill is currently progressing through the UK Parliament, but due to the political landscape in the UK it is not clear whether they will become law in 2024/25. If a change does occur, then the policies will be updated accordingly.

The All-Wales IG policies review and update was January 2023, which was not met, however the existing policies remain extant. Re-publishing the revised

policies has proven to be problematic due to the different approaches in approving the Policies in each Trust/Health Board. The policies are:

- NHS Wales Email Use Policy
- NHS Wales Information Governance Policy
- NHS Wales Information Security Policy

To resolve the situation the DPO led work to replace the three policies (which contain much repeated information) with an overarching IG policy. This Policy is currently in its final stages of consultation across NHS Wales and is expected to be approved during Q2 2024/25.

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*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐

	Efficient ☒ Patient Centred ☒
	The aim of Data Protection by design and default relies on: • *timely* engagement (at the design stage of a project); • to enable the protection of the rights and freedoms of data subjects (*safe*), the impact is then; • *efficient* and *effective* systems that deliver *patient centred* care. Combining all the elements contained within this report all contribute to that aim.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required
	Compliance with data protection legislation is an obligation of the Trust.
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
	The delivery and use of systems that are compliant with legislation contribute effectively to "*A Healthier Wales*"
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Information Commissioners Office has the power to impose financial penalties (fine of up to 20 million euros (approx. £17.5m) and issue enforcement action.

	Costs associated with any IG incident, for example compensation, recovery, restoration etc. **Source of Funding**: Trust Reserves Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Up to 4% of annual turnover of £17.5m whichever is the highest **Type of Change** **Other (please explain)** Please explain if 'other' source of funding selected: A financial penalty would be set by the ICO which would require significant Trust Board involvement
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 *Compliance with legislation is a mandatory obligation. Equality Impact assessments are undertaken at the time of royal assent for applicable legislation.*
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below) An incident remains which does have significant legal implications for Trust, this case is ongoing and well documented 1. *Legal costs for the Trust*

	2. *Other non-legal costs for the Trust, which could result in;* 3. *Possible non-recovery of costs from the other party*

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?	
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	

Appendix 1 – List of Acronyms

Acronym	Full Title	Acronym	Full Title
CCIO	Chief Clinical Information Officer	CDO	Chief Digital Officer
CEO	Chief Executive Officer	CNIO	Chief Nursing Information Officer
DHCW	Digital Health and Care Wales	DPIA	Data Protection Impact Assessment
DPO	Data Protection Officer	EIR	Environmental Information Regulations
EMB	Executive Management Board	ESR	Electronic Staff Record
FOIA	Freedom of Information Act 2000	GDPR	General Data Protection Regulations
HRA 1998	Human Rights Act 1998	IAO	Information Asset Owner
ICO	Information Commissioners Office	IDTA	International Data Transfer Agreement
IG	Information Governance	IGMAG	Information Governance Management Advisory Group
IM	Independent Member	IQSG	Integrated, Quality and Safety Group
QA	Quality Assurance	ITSM	Information Technology Service Management
QMS	Quality Management System	QSMG	Quality and Safety Management Group
QSP	Quality, Safety and Performance Committee	ROPA	Record of Processing Activity
SACT	Systemic Anti-Cancer Treatment	SAR	Subject Access Request
SIRO	Senior Information Risk Owner	SLT	Senior Leadership Team
SOP	Standard Operating Procedure	TRA	Transfer Risk Assessment
UK/EEA	United Kingdom/European Economic Area	VCC	Velindre Cancer Centre
WBS	Welsh Blood Service	WIGB	Welsh Information Governance Board

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Health & Safety Annual Report

DATE OF MEETING	11th July 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	Steph Williams, Head of Health & Safety
PRESENTED BY	Steph Williams, Head of Health & Safety
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The Health and Safety annual report offers a summary of Health and Safety management at Velindre University NHS Trust from April 1, 2023, to March 31, 2024. The report highlights key achievements, ongoing initiatives and areas for improvement in ensuring a safe working environment for all staff and patients. Throughout the year, the Trust has made significant strides in enhancing safety protocols,

	conducting comprehensive training sessions and implementing advanced risk assessment tools. One of the notable achievements includes a reduction in manual handling incidents, thanks to the proactive measures taken by the dedicated Health and Safety team. In addition to these initiatives, the report also outlines future plans to further bolster Health and Safety standards. This includes the integration of cutting-edge technology to monitor and manage potential hazards, as well as the continuous development of staff training programs to keep everyone informed and prepared. Overall, the Health and Safety annual report underscores Velindre University NHS Trust's unwavering commitment to creating a safe, supportive and thriving workplace environment.
RECOMMENDATION / ACTIONS	The report emphasises the need for strong support from both the board and the committee due to the Trust falling short of its Statutory and Mandatory requirements. Leaders must enhance their visibility among employees by conducting audits across departments. It is crucial to emphasise both occupational and patient safety to yield positive outcomes among our workforce. Engaging with employees through feedback mechanisms is essential to foster a culture of continuous improvement by addressing their concerns and suggestions. Recognising and rewarding teams that excel in maintaining high safety standards can inspire others to do the same. This report is presented to QSP to approve in respect of the current and future work programme to deliver H&S fire initiatives across Velindre University NHS Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMG	(14/06/2024)
Integrated Safety & Quality Group	(19/06/2024)
EMB Run	(25/06/2024)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Approved	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
1	The Health & Safety Annual Report

1. SITUATION

As the newly appointed Health and Safety head for the Trust, Head of H&S analysed the data to create the annual report. Our goal was to pinpoint crucial areas within the Trust where we can develop a roadmap outlining how we will reach our objectives.

2. BACKGROUND

With the position vacant for a period, the team has effectively addressed and resolved various issues and inquiries that have arisen.

Despite the challenges, their collaboration and dedication have fostered a resilient and adaptable work environment. Each team member has stepped up, taking on additional responsibilities and honing new skills.

Appendix 1 provides an update on the Health & Safety Fire delivery over the past year of 2023 - 2024

3. ASSESSMENT

Corporate Objective: The aim is to have senior managers in all divisions finish 85% of mandatory training, with the staff committed to completing assigned training. With 70% of

training administered through an E-learning platform, employees should be able to meet this goal

4. SUMMARY OF MATTERS FOR CONSIDERATION

An assessment conducted last year identified leaders needing the IOSH Managing Safely course, revealing an incomplete rate of 37%. This underscores the need for greater commitment from our senior managers.

This vital training will highlight the responsibilities that are placed on the senior managers. Evidence to support this is also reflected in the lack of recorded evidence for the Fire evacuations. Although we have a Fire Safety Advisor, it is still the responsibility of the building owners to ensure that we meet our obligations by having planned evacuation drills. We haven't recorded any even though we know we have had them. This lack of demonstrable evidence would only go against us in a court of law.

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	We will always be able to improve when it comes to health and safety. The annual report identifies basic points that need to be addressed to get the correct foundation. This will enable us to start developing the Health and Safety Management system in line with occupational health and safety as the focus is very much around quality and patient safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* https://www.gov.wales/socio-economic-duty-overview	Not yet completed (Include further detail below why)
	Not applicable at this point **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Wales of Cohesive Communities - Attractive, viable, safe and well-connected communities.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Potentially yes. The report highlights the Trust Statutory and Mandatory Training requirements. To able us to achieve this objective would require resource.
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 annual report has no effect to the EQIA assessment.

ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Statutory and Mandatory are our legal requirements that are held by the board

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	*All risks are actively managed and recorded in DATIX*
WHAT IS THE CURRENT RISK SCORE	N/A
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	N/A
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	N/A
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	N/A
All risks must be evidenced and consistent with those recorded in Datix	

Health, Safety & Fire

GIG CYMRU NHS WALES

Ymddiriedolaeth GIG Prifysgol Felindre

Velindre University NHS Trust

steph.williams.wales@nhs.uk

Annual Report 2023-2024

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Overview

The Health and Safety annual report offers a summary of Health and Safety management at Velindre University NHS Trust from April 1, 2023 to March 31, 2024.

The report highlights key achievements, ongoing initiatives, and areas for improvement in ensuring a safe working environment for all staff and patients.

Throughout the year, the Trust has made significant strides in enhancing safety protocols, conducting comprehensive training sessions, and implementing advanced risk assessment tools. One of the notable achievements includes a reduction in manual handling incidents, thanks to the proactive measures taken by the dedicated Health and Safety team.

In addition to these initiatives, the report also outlines future plans to further bolster Health and Safety standards. This includes the integration of cutting-edge technology to monitor and manage potential hazards, as well as the continuous development of staff training programs to keep everyone informed and prepared.

Overall, the Health and Safety annual report underscores Velindre University NHS Trust's unwavering commitment to creating a safe, supportive, and thriving workplace environment.

Goals and Objectives

Corporate

- The goal is to ensure that senior managers in corporations complete 85% of mandatory training.
- Identify all managers who require IOSH Managing Safely certification and provide them with the necessary training.
- The goal is to keep the number of accidents under 103 for the year.
- Creating a roadmap for Health and Safety

Velindre Cancer Service

- To reach a compliance rate of 85% in patient manual handling.
- Goal: Decrease injuries by 10% within the upcoming 12 months.
- Promote the Obligatory Response to Violence in healthcare and Anti Violence Collaborative
- H&S workshops / drop in sessions

Welsh Blood Service

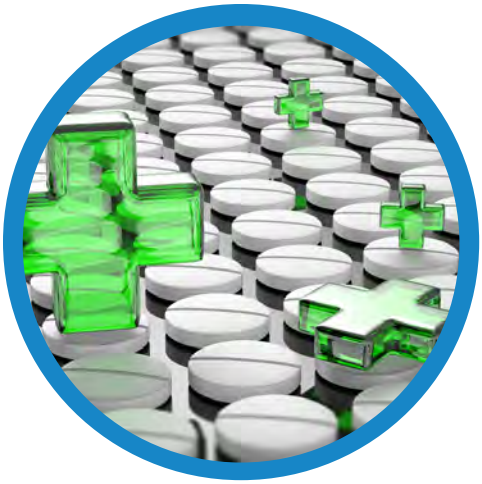
- To reduce incidents by 10% in the next 12 months
- Focus on reducing the leading accident trend
- Reporting accidents directly on Datix without the need for paper forms.

INTRODUCTION

Ensuring the health and safety of employees is a paramount concern for any organisation committed to fostering a productive and secure working environment.

This Health and Safety annual report aims to provide a comprehensive overview of our current practices, policies and procedures designed to safeguard the well-being of all staff members.

Through systematic evaluation and continuous improvement, we strive to mitigate risks, prevent accidents and promote a culture of safety across all levels of our operation.



This report will detail the key findings from recent safety audits, incident investigations, and employee feedback, alongside actionable recommendations to enhance our health and safety protocols.

By prioritising these efforts, we not only comply with regulatory requirements but also demonstrate our unwavering commitment to the welfare of our people, ensuring a safer and healthier workplace for everyone here at Velindre University NHS Trust.

Velindre University NHS Trust

We Provide Your Health & Safety

****

Velindre University NHS Trust provides specialist oncology cancer services across South East Wales and blood services across the whole of Wales. Both of these services are renowned for their quality, safety and good donor/patient experience.

The Trust prides itself on its commitment to excellence, innovation and patient-centred care, continually striving to improve outcomes and enhance the quality of life for those it serves. Through collaboration with various stakeholders, Velindre University NHS Trust remains at the forefront of healthcare advancements, making significant contributions to the well-being of the Welsh population.

Review of Performance 2023 - 2024

- **Number of RIDDOR reportable incidents - 3**
- **Violence and aggression reported incidents - 31%**
- **Number of Improvement notices from the HSE - 2**

PERFORMANCE DATA:

- During 2023 - 2024 we saw a slight increase in our occupational health and safety performance
- The number of RIDDOR injuries reported to the HSE during 2023-2024 was 3 which is a reduction of 1
- The total number of reported injuries was 118
- Total spend in Claims. Fee for intervention and training £6754.85
- Number of Policies requiring review - 1
- Highest reported accident for WBS - Contact with Object / Animal
- Highest reported accident for VCC - Slips, Trips and Falls
- Number of Fire Risk Assessments outstanding - 0

Health & Safety Incidents Trust

Incident Category	2021 -2022	2022 - 2023	2023 -2024
Accident, Injury	116	111	114
Behaviour	46	31	35
Equipment, Devices	21	2	8
Ill Health (work related)	10	2	2
Infrastructure	36	7	14
RIDDOR	2	4	3

Health & Safety Incidents Corporate

Incident Category	2021 -2022	2022 - 2023	2023 -2024
Incidents / Injury	0	6	4
Behaviour	0	0	0
Equipment, Devices	0	0	0
Ill Health (work related)	0	0	0
Infrastructure	0	0	7
RIDDOR	0	0	0

Health & Safety Incidents WBS

Incident Category	2021 -2022	2022 - 2023	2023 -2024
Accident, Injury	83	75	81
Behaviour	22	12	16
Equipment devices	0	0	3
Ill health (work related)	7	1	1
Infrastructure	0	1	0
RIDDOR	0	2	2

Health & Safety Incidents VCC

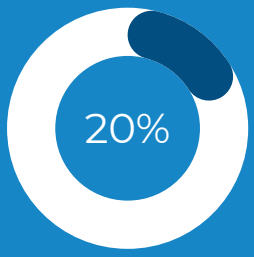
Incident Category	2021 -2022	2022 - 2023	2023 -2024
Accident, Injury	33	30	33
Behaviour	24	19	19
Equipment devices	21	2	5
Ill health (work related)	3	1	1
Infrastructure	36	6	7
RIDDOR	2	2	1

Note - The data above was collected from our datix system June 2021

Violence and Aggression

NHS personnel (Hospital, Ambulance, Community, and Primary Care) are acknowledged to be at high risk of encountering violence and abuse while on duty. There is a significant public concern about holding accountable individuals who intentionally verbally or physically assault NHS staff. At VUNHST, violence and aggression rank as the second most frequently reported problem.

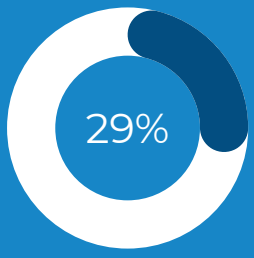
Violence & Aggression



WBS incidents

The second most commonly reported problem is inappropriate behaviour or attitude.

Violence & Aggression

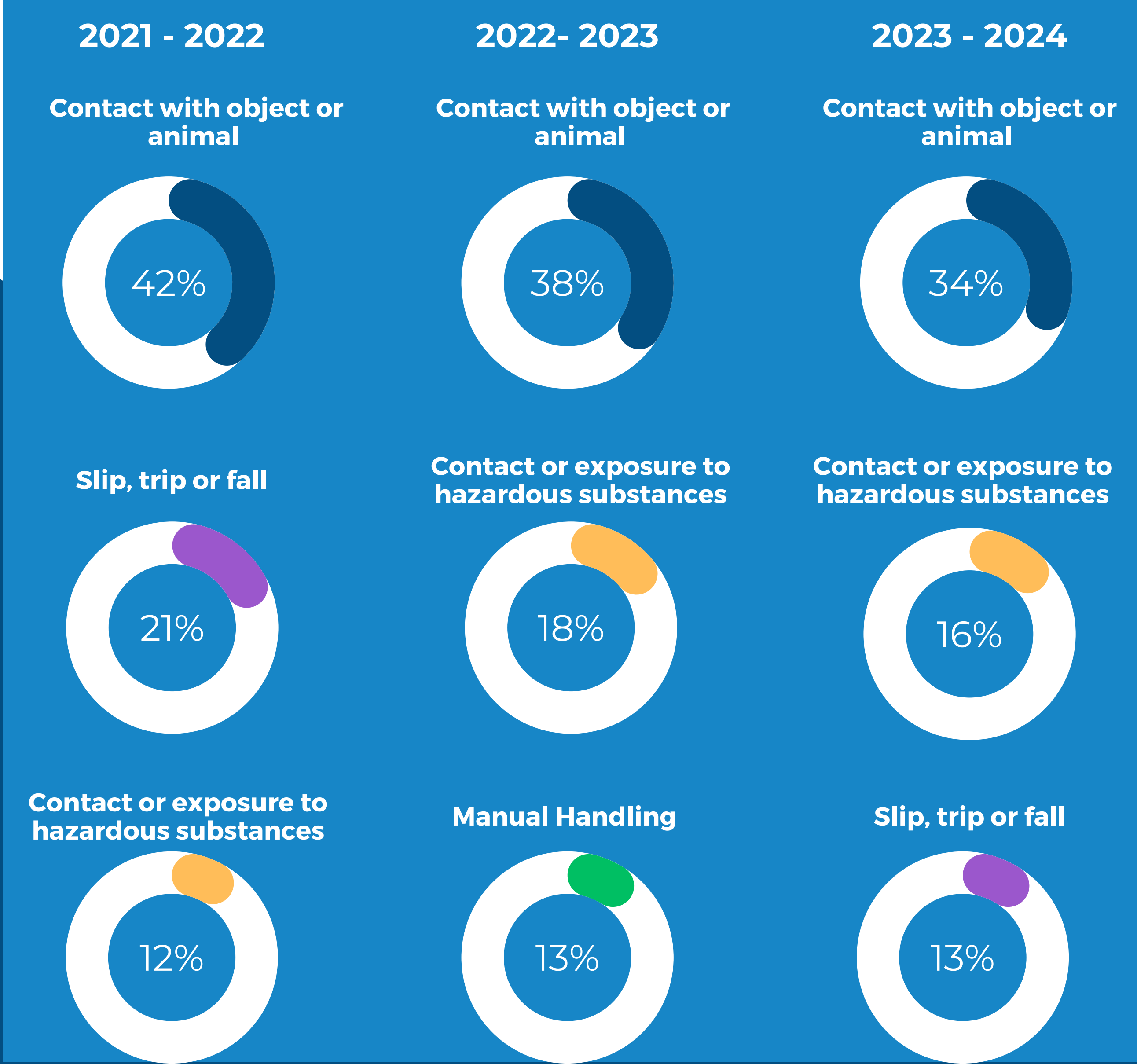


VCC Incidents

The second most commonly reported problem is inappropriate behaviour or attitude.

Note : The 'Obligatory responses to violence in healthcare' agreement sets out the responsibilities of the partners when dealing with violent or aggressive incidents relating to NHS staff. Its focus is on those incidents that need to be addressed by the criminal justice system. There is a future focus to tackle this issue over the next 5 years.

Incident Trend Analysis WBS



As you will be able to see from the graphs above, the past 3 years have shown that we have the same trends. Contact with object / animal remains at the top of the chart for all 3 financial years

This suggests a consistent pattern in incidents reported, indicating areas that require continued focus and preventive measures. It's essential to analyse the underlying causes of these contacts and implement effective strategies to mitigate risks.

Furthermore, the second most common category, "slips, trips, and falls," has also shown a steady presence in our data. This highlights the need for ongoing safety training and awareness programs to ensure our employees are equipped with the knowledge to avoid such hazards.

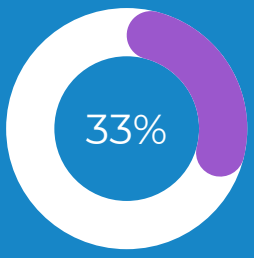
In addition to these, there has been a noticeable decrease in incidents related to "manual handling." This positive trend suggests that our recent initiatives in ergonomic training and proper lifting techniques are yielding results. However, we must not become complacent and should continue to reinforce these practices.

Moving forward, our focus will be on enhancing our reporting systems, encouraging a culture of safety and investing in advanced technologies that can further reduce incident rates. Together, we can ensure that safety remains a top priority and that every employee returns home safely at the end of each day.

Incident Trend Analysis VCC

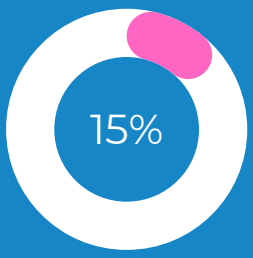
2022- 2023

Slip, trip or fall



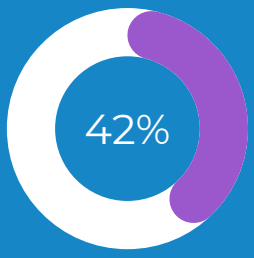
Contact with object or animal

Sharps / needles

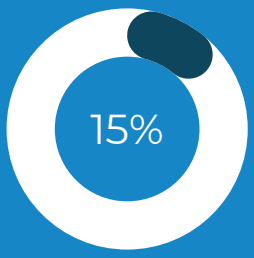


2023 - 2024

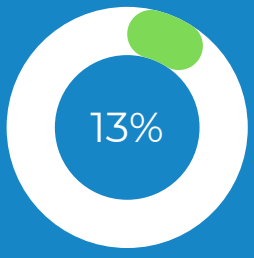
Slip, trip or fall



Contact with object or animal



Manual Handling



The data shows the VCC have slightly different risks to WBS. Slips, trips and falls being the number one offender. Its important to note that they to have the same challenges when reporting issues for contact with object or animal

Additionally, both VCC and WBS share concerns regarding ergonomic injuries, particularly those arising from repetitive motions and improper lifting techniques. It's crucial to implement ongoing training and awareness programs to mitigate these risks.

Moreover, fostering a culture of safety where employees feel encouraged to report hazards without fear of reprisal can significantly enhance workplace safety. Regularly reviewing and updating safety protocols, conducting thorough investigations of incidents, and ensuring that all staff are well-informed about potential risks and prevention strategies are essential steps.

In conclusion, while the specific risks may vary slightly between VCC and WBS, the overarching goal remains the same: to create a safe and healthy work environment for all employees. By addressing these issues proactively and collaboratively, the Trust can reduce accidents and promote a culture of safety and well-being.

HSE Enforcement Action

VCC

Note :

We dont currently have any enforcemts and improvements from HSE for VCC

WBS

Note :

HSE Issued 2 Improvement notices against WBS

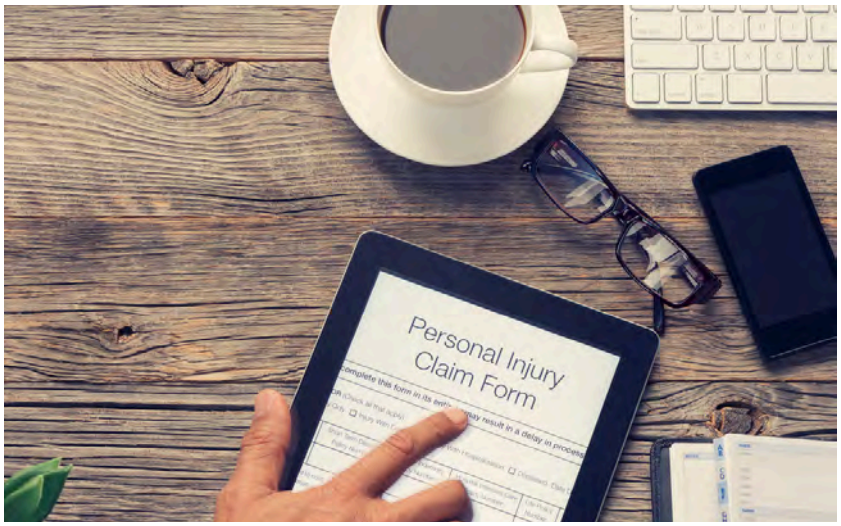
Notices were issued in May 2023. The notices are detailed below:

1 - Contingency plans required for dealing with emergency / exposure of the radiation source / terrorist attack / malleolus attack in relation to the irradiator.

2 - Additional training required. Requirement needed for additional Radiation protection supervisors. General awareness for employees directly involved with the irradiator.

HSE, provided a list of recommendations, which have now been addressed. Lessons learned, will need to be replicated at Velindre Cancer Centre. WBS received a Fee For Intervention at a cost of **£1328** for HSE's time on this case.

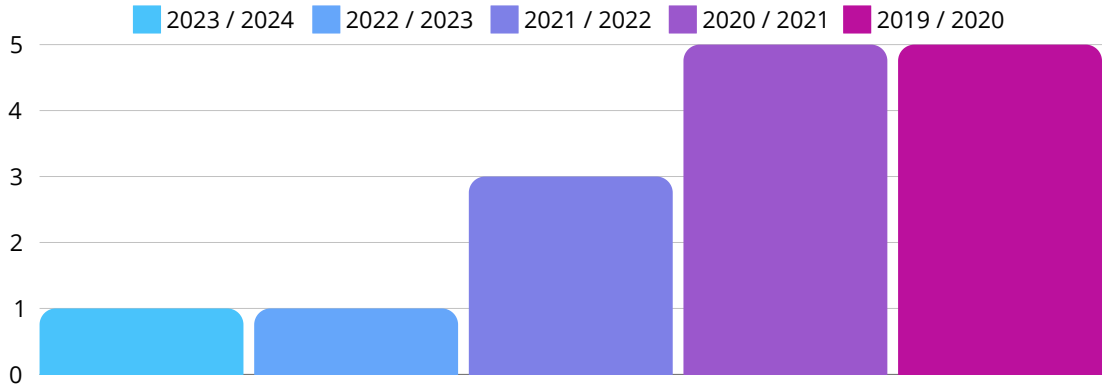
Personal Injury Claims



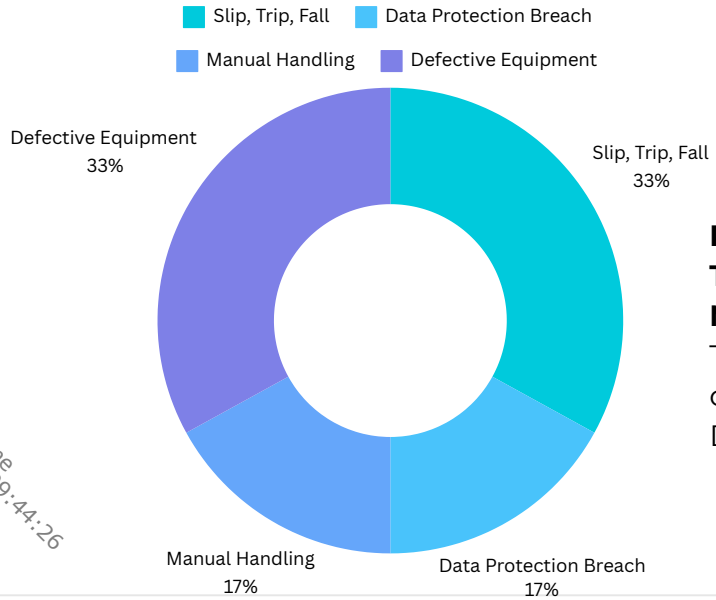
Personal Injury cost

Between April 2023 and March 2024, one claim was received, which remains unsettled. The current estimated cost is around **£1246.85.**

Paying expenses is not optimal when these funds could be more effectively invested in other areas of the Trust.



PERSONAL INJURY CLAIMS RECEIVED PER YEAR

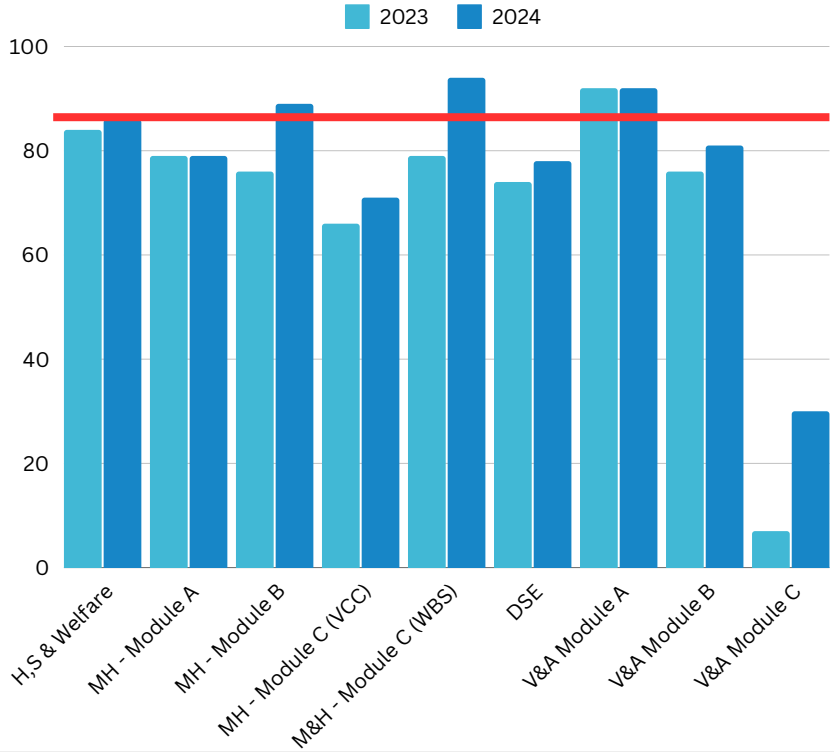


Percentage of personal injury Themes. 1st April 2021 - 31st March 2024.
This demonstrates that **66%** of claims are Slip, Trips and Falls and Defective Equipment.

Education & Development

The statutory and mandatory training at Velindre requires improvement to achieve the 85% target set by the Welsh Government.

The compliance graph below illustrates the Trust's performance. The red line indicates our mandatory compliance level. Despite progress in four areas, meeting our objectives remains our key focus.



Plan, Do, Check, Act

Plan:

★★★★★

Currently, VNHST is positioned within the Planning element of HSG65. No audits were conducted in the previous fiscal year due to a Head of Health and Safety vacancy. The Trust successfully appointed this position early 2024.

Do

★★★★★

Risk profiling - The priority improvement plan in currently under review

Organising - Forward Focus

Implementing the plan - Forward Focus

Check:

★★★★★

Measuring performance - There were no audits carried out in the financial year

Investigating, Accidents, incidents and Near misses - This has continued throughout the year with the use of Datix

Act:

★★★★★

Performance Review: Throughout the year, the Trust's Priority Improvement plan has been the key document used for the advancement and execution of Health and Safety initiatives.

Lessons Learned: Divisional teams are currently addressing and working through the lessons learned.

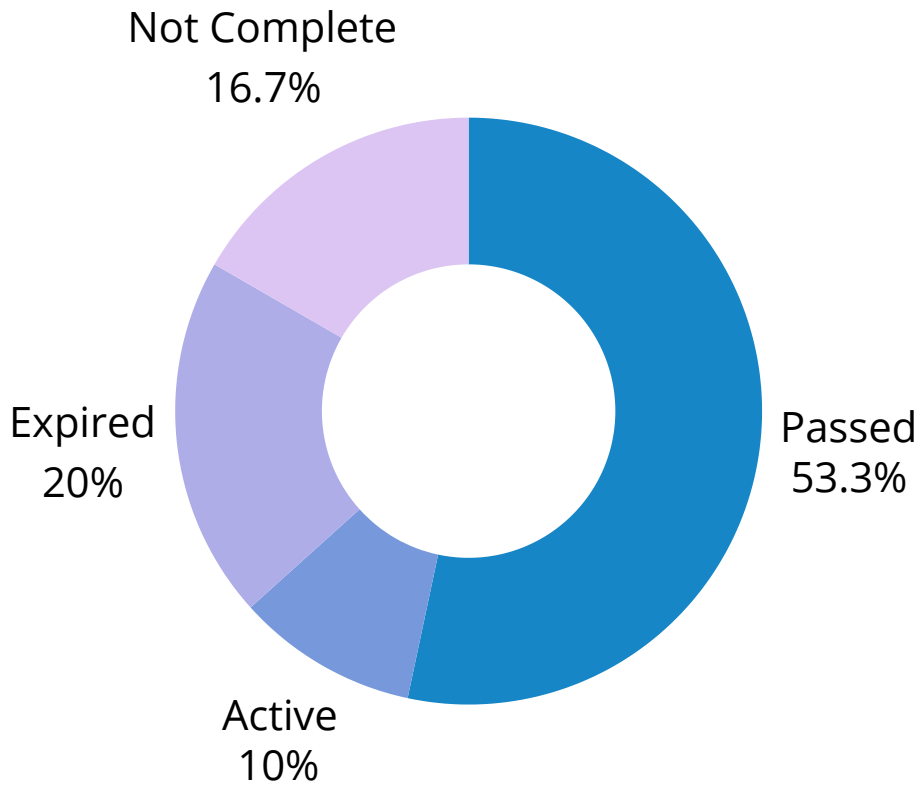
Priority Improvement Plan

In line with last year's objectives, the Trust had planned to provide training for senior managers in the organisation. The outcome reveals a pass rate of 53%. Yet, 37% of the courses were left incomplete or expired due to some individuals not completing the course due to time restraints. This resulted in **£4180** in unused fees.

To address this issue, the Trust has decided to implement a more robust tracking system for course completion. This system will send regular reminders to participants and their responsible management. Additionally, the Trust will explore introducing a policy where incomplete courses must be justified and any future enrolment's will require a commitment to complete.

Furthermore, feedback from participants will be gathered to understand the barriers to completion. Based on this feedback, the Trust aims to make adjustments to the course content and delivery methods, potentially offering more flexible schedules or additional support resources.

By taking these steps, the Trust hopes to improve the completion rates and ensure that the investment in training yields the desired benefits for the organisation and its senior managers. This not only maximises the value of the training programs but also fosters a culture of continuous learning and professional development.



FORWARD FOCUS

The following focus areas will be crucial for achieving a significant impact on the improvement of Health and Safety within the Trust.

First, enhancing training programs for all staff members to ensure they are well-equipped with the latest safety protocols.

Secondly, fostering a culture of openness and communication where staff and patients feel comfortable reporting safety concerns without fear of retribution. Establishing clear channels for feedback and suggestions can help identify potential risks before they escalate.

Thirdly, implementing robust data monitoring systems to track incidents and near-misses. Analysing this data can provide valuable insights into recurring issues and help devise targeted strategies to mitigate them.

Finally, promoting mental health and well-being among staff and patients, recognising that a healthy mind is crucial for maintaining overall safety. Providing access to counselling services, stress management programs and wellness activities can significantly contribute to a safer, healthier environment within the Trust.

Focus 1:

Recruit a new Health and Safety Technician. Approval was granted to add a new team member towards the end of the previous financial year. This additional support will be beneficial to the Trust, enabling progress in other important focus areas.

Focus 2:

Improving and perfecting a successful Health and Safety management system is essential. With audit activity remaining stagnant in the last financial year, it is vital to develop a sustainable system that can be seamlessly integrated within the Trust.

Focus 3:

Striving for the Welsh Government's 85% compliance objective in statutory/mandatory training.
This goal signifies a dedication to providing all staff with essential knowledge and skills for effective and safe job performance. Emphasizing statutory and mandatory training aims to improve service quality, encourage continuous enhancement, and protect the well-being of employees and the public.
To achieve the 85% compliance target, cooperation and dedication across all organisational levels are essential. By fostering a learning-focused environment, the Welsh Government can ensure its workforce is prepared to tackle present and future obstacles.

Fire Safety

Fire Risk assessments

Throughout 2023-2024, the Trust Fire Safety Advisor carried out fire risk assessments as required.

Fire Risk Assessments for the Trust = 39

Number of Fire Risk Assessments in date = 39 No. of Fire Risk Assessments reviewed = 34

The aim of conducting fire risk assessments is to pinpoint potential fire hazards, recommend measures to reduce risks to the lowest practical level and determine fire safety protocols and management strategies to ensure safety in case of a fire incident.

Evacuation Marshals

In the event of a fire or other similar situation, VUNHST have identified staff members which are trained as designated Evacuation Marshals and assigned specific responsibilities. Building complexity and size determine how many marshals are assigned to a location.

Number of formally trained Marshals

The required number of fire marshals is currently under evaluation within different departments to guarantee that the Trust is adequately covered at all times.

Fire Safety Incidents

Incident Category	2020 - 2021	2021 -2022	2022 - 2023	2023 -2024
Number of Fires	2	1	0	2
Unwanted fire signals	7	4	8	8
False Alarms	0	0	0	0
Planned Drills & Exercises	0	0	0	1

Fire Safety Incidents Corporate

Incident Category	2020 - 2021	2021 -2022	2022 - 2023	2023 -2024
Number of Fires	0	0	0	0
Unwanted Fire Signals	0	0	0	0
False Alarms	0	0	0	0
Planned Drills & Exercises	• 0	• 0	• 0	• 0

* Please note - Corporate did not record any scheduled drills and exercises. An action plan will be developed to pick up the key areas of compliance.

Fire Safety Incidents VCC

Incident Category	2020 - 2021	2021 -2022	2022 - 2023	2023 - 2024
Number of Fires	1	1	0	2
Unwanted Fire Signals	7	4	8	8
False Alarms	0	0	0	0
Planned Drills & Exercises	• 0	• 0	• 0	• 0

* Please note - VCC did not record any scheduled drills and exercises. An action plan will be developed to pick up these key areas of compliance

Fire Safety Incidents WBS

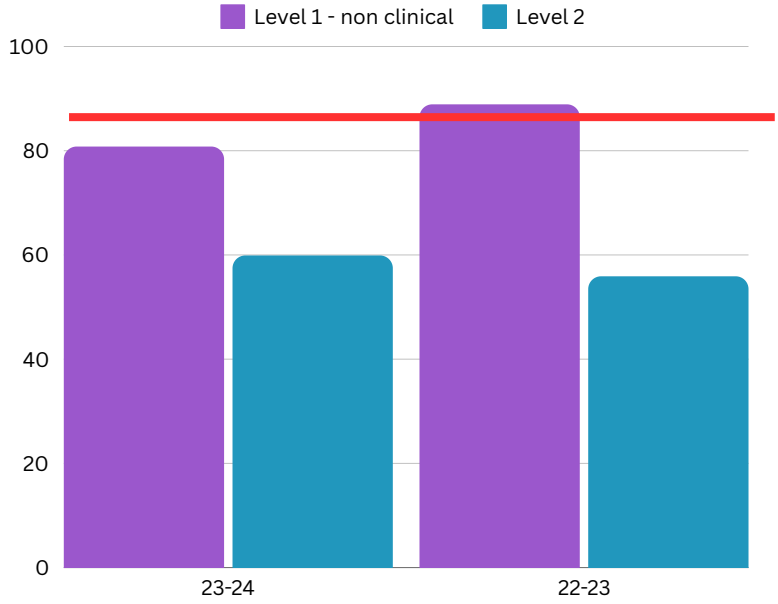
Incident Category	20 - 21	21 -22	22 - 23	23 -24
Number of Fires	1	0	0	0
Unwanted Fire Signals	• 0	• 0	• 0	• 0
False Alarms	0	0	0	0
Drills & Exercises	0	0	0	1

* Please note - WBS did not record any of the unwanted fire signals. An action plan will be developed to pick these up these key areas of compliance.

Fire - Education & Development

To achieve excellence in all VUNHST endeavors, it is crucial to enhance our current and future capabilities by ensuring that our workforce receives training and development of a consistently high quality.
VNHST fosters a supportive learning atmosphere that enables individuals to acquire skills and reach their maximum potential.

The graph illustrates our Statutory and Mandatory training. The current target, set at 85% by the Welsh Government, is displayed below. There has been a decline in level 1 - non-clinical Fire Training, while level 2 has risen to 60%. Despite this progress, further enhancements are needed to reach the target goal.



FORWARD FOCUS

In order to achieve our goals, we have created a plan targeting the following key areas:

- To begin with, our focus will be on enhancing our team's capabilities through extensive training and development programs to foster skill, improvement and innovation.
- Additionally, we will set up training communication channels to promote collaboration among all departments to successfully complete our mandatory requirements

Finally, we will track our progress and adapt our strategies as needed to align with our objectives, ensuring that we not only meet but exceed our goals. Together, we aim to establish a flourishing, forward-thinking organisation that sets a benchmark of excellence in our industry.

Focus 1

To develop supporting documentation (protocols and strategies) to deliver the Fire Safety policy

Focus 2

Highlighting the Importance of ESR Clean-Up.

During our evaluation, we discovered duplicate codes associated with different courses. It is essential to review and archive courses that no longer match our current requirements.

Focus 3:

Assisting departments in creating a lasting program of drills and exercises for the Trust.

This initiative aims to ensure that all departments are well-prepared for any emergencies or unexpected situations. By developing a comprehensive schedule of regular drills and exercises, the Trust can foster a culture of readiness and resilience. These activities will not only test the effectiveness of current emergency plans but also identify areas for improvement.

CONCLUSION

Good progress has been made in a number of important areas during 2023-2024. The rate of improvement has been constrained by the delay in appointing a Trust Health and Safety Manager; who is now in post. The postholder will work with senior leaders to further strengthen systems, processes and training/education. Crucially, the Trust needs to continue to develop a health and safety culture which translates into daily behaviours.

The number of reported occurrences appears to be constant throughout the Trust. Most of whom are seated at WBS. Still, it is evident that the subjects that cause us the greatest pain are also recurring, this is to be expected in this kind of workplace. Prioritising these three areas will be necessary for our Forward Focus in order to guarantee organisational improvements.

For any questions on the content of this review, please contact:

Steph Williams

VUNHST Head of Health & Safety

029 2019 6161

Steph.Williams@wales.nhs.uk

https://velindre.nhs.wales/

Velindre N H S Trust

Velindre University NHS Trust
Unit 2, Charnwood Court,
Heol Billingsey
Parc Nantgarw,
Cardiff
CF15 7QZ

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT REPORT 2023-2024

DATE OF MEETING	11/07/2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sara Walters, Clinical Audit Manager Sarah Owen, Quality and Safety Manager, VCS Edwin Massey, Medical Director WBS Jacinta Abraham, Executive Medical Director
PRESENTED BY	Edwin Massey, Medical Director, WBS Jacinta Abraham, Executive Medical Director
APPROVED BY	Jacinta Abraham, Executive Medical Director
EXECUTIVE SUMMARY	The Velindre University NHS Trust Clinical Audit Annual Report 2023-2024 covers the period 1st April 2023 to 31st March 2024. This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. The key highlights are:

	• The positioning of Clinical Audit within divisional Quality and Safety teams and its central role in the Trust Integrated Quality and Safety Group has been critical in helping the triangulation of clinical outcomes, learning and quality improvement. • A key achievement for the Trust Clinical Audit teams is the wider implementation of a digital system for clinical audit called AMaT: Audit management and tracking, which has streamlined the audit process as well as dissemination of outcomes and tracking of actions. • The report demonstrates the diverse portfolio of high-quality clinical audit undertaken across the Trust and describes how this is impacting on patient and donor care in our local services, as well as national and international platforms.

RECOMMENDATION / ACTIONS	To **ENDORSE** the 2023-2024 Velindre University NHS Trust Clinical Audit Annual Report for Board approval on 30/07/2024.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Cancer Centre Quality Safety Management Group	17/06/2024
Executive Management Board	25/06/2024
Velindre Cancer Centre Senior Leadership Team	04/07/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • Velindre section of the report approved at VCC QSMG • EMB Endorsed for onward approval	

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

APPENDICES	
Appendix 1	Velindre University NHS Trust Clinical Audit Annual Report 2023-2024

1. SITUATION / BACKGROUND

The areas of focus are aligned to the approved Clinical Audit Plan for 2023/2024 which sets out the national and local context, key principles for prioritisation and delivery of Clinical Audit for Velindre University NHS Trust (VUNHST). This annual report provides the outcomes of this programme of work and is seeking endorsement from the Executive Management Board and the Trust Quality and Safety Committee. This Trust Annual Clinical Audit Report will subsequently be approved by the Trust Board.

The recently submitted Trust Clinical Audit plan for the coming year 2024/25, has described our ambition to focus on the learning from clinical audit and more clearly demonstrate how these are leading to improvements in patient and donor care and outcomes. We have a small and highly committed clinical audit team and moving forward will need to build on our success ensuring we have the necessary resource and leadership in place to meet our expectations.

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

The Trust Clinical Audit Annual Report 2023-2024 is attached in ***Appendix 1*** and summarises an overview of the clinical audit activity and clinical effectiveness undertaken at Velindre Cancer Centre and the Welsh Blood Service. The report covers clinical audit activity between 1st April 2023 and 31st March 2024.

The report highlights the successful implementation of a digital system for clinical audit, the diverse portfolio of high-quality clinical audit projects, and the impact on patient and donor care. It also identifies the areas for improvement, such as increasing clinical engagement, patient representation, dissemination, relevance, and governance of audit.

2.1 Velindre Cancer Centre

- Continue to build on the culture of Audit/QI/Patient Safety reporting within Velindre Cancer Centre.
- Improve junior doctor and multi-professional clinical engagement with audit and QI
- Link with the Patient Engagement team to increase patient representation in majority of projects
- Increase opportunities to disseminate and showcase work within hospital.

- Improve the relevance of National Audit data to our local population. This needs to be better understood and articulated.
- Integrate audit into the programme of work regarding horizon scanning and NICE guidance compliance.
- Strengthen the governance surrounding audit to ensure ownership of any actions that arise from the audit.
- Development of the quality and audit dashboards for the Site-Specific Teams.

2.2 Welsh Blood Service

- We need to work with Health Boards, Trusts and Digital Health Care Wales (DHCW) to put in place systems that enable performance monitoring and audit in Wales, this was deemed cost effective by Health Technology Wales in 2022 (https://healthtechnology.wales/reports-guidance/electronic-blood-management-systems/) and was recommended for safety in the Infected Blood Inquiry (IBI) report in 2024. Most obviously through the LIMS2 project (Laboratory Information Management System 2).

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
	Choose a domain/domains.

QUALITY AND SAFETY IMPLICATIONS / IMPACT	Safe ☐ Timely ☐ Effective ☒ Equitable ☐ Efficient ☐ Patient Centred ☐
	Clinical Audit is closely aligned to the Trust Quality and Safety Agenda as it embeds quality and learning and drives a culture of continuous improvement.
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**
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.
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	N/A
All risks must be evidenced and consistent with those recorded in Datix	

Velindre University NHS Trust

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

CLINICAL AUDIT Report 2023/2024

ABBREVIATIONS

AMaT	Audit Management and Tracking
BHNOG	Blood Health National Oversight Group
BHT	Blood Health Team
CAT	Cancer Associated Thrombosis
CNS	Clinical Nurse Specialist
CRM	Circumferential Reserction Margin
CUP	Cancer of Unknown Primary
DHCW	Digital Health Care Wales
GBM	Glioblastoma Multiforme
HEIW	Health Education and Improvement Wales
IBI	Infected Blood Inquiry
IPC	Infection Prevention and Control
IDA	Iron-Deficiency Anaemia
LIMS2	Laboratory Information Management System 2
LCP	Liverpool Care Pathway
MBC	Metastatic Breast Cancer
MDT	Multi-Disciplinary Team
NABCOP	National Audit of Breast Cancer in Older Patients
NACEL	National Audit of Care at the End of Life
NAoPri	National Audit of Primary Breast Cancer
NATCAN	National Cancer Audit Collaborating Centre
NCAPOP	National Clinical Audit and Patients Outcomes Programme
NCA	National Comparative Audit
NCEPOD	National Confidential Enquiry for Patient Outcome and Death

NKCA	National Kidney Cancer Audit
NICE	National Institute for Health and Care Excellence
NLCA	National Lung Cancer Audit
NOGCA	National Oesophago-Gastric Cancer Audit
NPaCA	National Pancreatic Cancer Audit
NOCA	National Ovarian Cancer Audit
NOTCH	National Oncology Trainees Collaborative for Healthcare Research
NACRT	Neo-adjuvant Chemo Radiotherapy
QI	Quality Improvement
PBM	Patient Blood Management
POCT	Point of Care Testing
PROMS	Patient reported Outcome Measures
RCRD	Rapid Cancer Registration Data
RCR	Royal College of Radiographers
SSC	Student Selected Components
SST	Site Specific Team
SACT	Systemic Anti-Cancer Therapy
TxA	Tranexamic Acid
VCC	Velindre Cancer Centre
VUNHST	Velindre University NHS Trust
WBS	Welsh Blood Service
WBMDR	Welsh Bone Marrow Donor Registry
WCN	Welsh Cancer Network
WCP	Welsh Clinical Portal

VELINDRE UNIVERSITY NHS TRUST CLINICAL AUDIT ANNUAL REPORT 2023-2024

1.0 INTRODUCTION

This Annual Clinical Audit Report aims to provide an overview of the clinical audit activity and programme of work on clinical effectiveness, undertaken at Velindre Cancer Centre and the Welsh Blood Service. This report covers clinical audit activity between 1st April 2023 and 31st March 2024. The areas of focus are aligned to the approved Clinical Audit Plan for 2023/2024 which sets out the national and local context, key principles for prioritisation and delivery of Clinical Audit for Velindre University NHS Trust (VUNHST). This annual report provides the outcomes of this programme of work and is seeking endorsement from the Executive Management Board and the Trust Quality and Safety Committee. This Trust Annual Clinical Audit Report will subsequently be approved by the Trust Board.

2.0 EXECUTIVE SUMMARY

2.1 Foreword

In the last 12 months, we have matured in our ambition and capability to deliver Clinical Audit across both divisions. From a position of reasonable assurance following the Internal Audit in January 2023, we have successfully delivered on all the recommendations made which have strengthened our systems further and helped to standardise a Trust approach. The implementation and wide use of the digital AMaT tool has been transformational and has allowed us to maximise the monitoring, measurement and learning from our outcomes.

In line with our organisational strategy and sharp focus on improving the Quality and Safety of care, Clinical Audit continues to play an increasingly important role in helping us to evidence and embed Quality within our systems. The positioning of Clinical Audit within divisional Quality and Safety teams and its central role in the Trust Integrated Quality and Safety Group has been critical in helping the triangulation of clinical outcomes, learning and quality improvement. The value of robust business intelligence to support the clinical audit function as well as reliable data that can be extracted from a central national dataset when needed, is still yet to be fully realised. This remains a priority area for development with our partners including Digital Health Care Wales and the Wales Cancer Network WCN.

This Clinical Audit report is an important source of information with measurements and benchmarking to demonstrate the efficiency of the healthcare services the Trust provides. This report gives you a sense of the breadth of our clinical activity and also the complexity of the services which are continuously changing due to new technologies and treatments. Once again we have managed to meet the expectation of full participation in National Audit, reviews and national registries. The feedback from these links into national improvements for cancer care and shape the UK blood service. At a local level, the clinical audits speak for themselves in continuously testing change, measuring outcomes and informing and changing practice through improvement cycles. In several cases these outcomes have been adopted nationally leading to large scale change and publication. Through our clinical audit activity, we continue to provide an important system leadership role, with several organisations including the NHS Wales National Clinical Audit and Outcome Review Body, Wales Cancer Network, National Institute for Health and Care Excellence, Royal College of Radiology, Health Technology Wales and the Blood Health National Oversight Group

In our recently submitted Trust Clinical Audit plan for the coming year 2024/25, we have described our ambition to focus on the learning from clinical audit and more clearly demonstrate how these are leading to improvements in patient and donor care and outcomes. We also highlighted the development of the Clinical and Scientific Board and Strategy which will inform the priorities for clinical audit moving forward. The establishment of our Value in Health programme which has already been informed by clinical audit, will continue to work in synergy and improve the transparency and learning from outcomes. We have a small and highly committed clinical audit team and moving forward will need to build on our success ensuring we have the necessary resource and leadership in place to meet our expectations.

Jacinta Abraham
Executive Medical Director

3.0 VELINDRE UNIVERSITY NHS TRUST

3.1 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.

AMaT has been instrumental in achieving some of the actions identified within the audit including, facilitation of SMART action planning, identification of re-audits and robust reporting.

3.2 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.

3.3 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.

4.0 VELINDRE CANCER CENTRE ANNUAL REPORT

4.1 Foreword: Velindre Cancer Centre

This report demonstrates that the clinical audit department at Velindre Cancer Centre, has a successful framework in which to support professional groups in completing projects. Our involvement with National Audits not only raises the profile of the hospital but ensures we're contributing and holding ourselves accountable to the national benchmarking of standards. The department has also been actively involved in Site-Specific Team meetings to ensure their priorities and interests are supported. The Introduction of an Audit Management and has supported reporting requirements.

There have been additional challenges and changes for the audit team this year, with the absence of a clinical lead for audit and improvement and the move from Medical Services to the Integrated Care Directorate. Clinical Audit now sits under the Quality and Safety Team which has helped triangulate patient safety, incidents, risks, complaints, quality information and audits offering an encompassing view of safety and quality performance.

We strive to create an environment for continuous learning and mentorship so we can deliver the high-quality healthcare we strive to achieve.

<u>Key points that need addressing</u>

- Continue to build on the culture of Audit/QI/Patient Safety reporting within Velindre Cancer Centre.
- Improve junior doctor engagement with audit and QI
- Link with the Patient Engagement team to increase patient representation in majority of projects
- Increase opportunities to disseminate and showcase work within hospital.
- Improve the relevance of National Audit data to our local population. This needs to be better understood and articulated.
- Integrate audit into the programme of work regarding horizon scanning and NICE guidance compliance.
- Strengthen the governance surrounding audit to ensure ownership of any actions that arise from the audit.
- Development of the quality and audit dashboards for the Site-Specific Teams.

In order to address these key issues, we developed a 3-year plan, the implementation of which has been delayed due to changes in clinical leadership and the review of the SST lead roles, which has now been completed.. The plan aims to embed Quality Improvement and Clinical audit so that they become core values amongst all professional groups. These include:

Departmental Engagement

We propose bi-annual meetings with Site-Specific Teams and professional groups (physics, pharmacy, nursing and radiotherapy) in order to address the following key issues

- Annual key-performance indicators for that year (start with 1-2 a year)
- Patient reported Outcome Measures (PROMS)
- Patient safety (by encouraging a culture of DATIX reporting within SST and teams)
- This will allow important clinical and safety issues to be addressed as well as ensuring that projects are properly planned, completed, supervised and reviewed
- How National Audits are applicable to VCC patient population

Dissemination of Information

In order to display the successful audit work taking place within the cancer centre we propose a six-monthly hospital-wide Audit/QI afternoon. All professional groups will be invited to present completed projects either in oral or poster formats.

In Conclusion

This report demonstrates the substantial audit activity and the hard work of others taking place within Velindre Cancer Centre. It highlights the benefits of the implementation of AMaT for supporting the management of audits and reporting requirements. The progress made in incorporating audit within quality management in the cancer centre particularly around incidents and concerns, and the benefit or this is also clear and will be further strengthened by the development of the quality and audit dashboards. Key pieces of work over the next year is to develop the audit programme of NICE guidance compliance across the cancer centre, as well as to strengthen the governance process around the development and sign off of audit projects.

4.2 Velindre Cancer Centre Summary

The Clinical Audit Department remains an essential pillar within the Clinical Governance structure in Velindre Cancer Centre. The Audit department ensures the Cancer Centre can demonstrate, sustain and improve high quality of care throughout all its departments.

The Clinical Audit team continue to provide and quality assure data for the National Clinical Audit and Outcome Review Plan. Participating in these collaborative projects ensures that we are involved in the dialogue and are continuously improving the quality of care on a national scale. Predetermined performance indicators allow us to benchmark our own practice ensuring we can demonstrate good standards of care within our Site-Specific Teams (SSTs). Greater involvement of the SST's and undergraduate medical students has been a huge success and we will continue to build on this in the coming year.

The Audit team seek to support and facilitate all aspects of audit work within the cancer centre. Key performance indicators are defined through NICE and college guidelines, national audits, safety parameters and patient experience. Throughout the year 2023/2024 a total of 76 projects have been submitted via AMaT, 44 active, 32 completed, and 5 discontinued. There are an additional 4 ongoing continuous monitoring projects not registered via AMaT and are reported via Tendable or the PMF.

The Clinical Audit team also contribute to the reporting of 30-day mortality and this data is reported separately through the Trust Integrated Quality and Safety reports.. The Advance & Future Planning Strategy for Wales, led by Velindre Palliative Care, was published in the British Medical Journal in February 2022 and 2024.

The annual report demonstrates the consistent commitment from healthcare professionals working within Velindre Cancer Centre to fully engage with clinical audit as a driver for change and improve the quality of care for our patients.

4.2.1 Infographic

4.3 CLINICAL AUDIT DEPARTMENT

Clinical Lead for Audit and Improvement	Vacant
Clinical Audit Manager	Sara Walters
Clinical Audit Officer	Rachael Kipling
Clinical Audit Officer	Becky Quinlan
Clinical Audit Support Officer	Janzib Alyas

4.4 National Audit

Velindre participates in the cancer related national audits set out by the National Clinical Audit and Patients Outcomes Programme (NCAPOP), where annual participation is a requirement.

NATCAN The National Cancer Audit Collaborating Centre was established as a new national centre of excellence in October 2022 with the aim of strengthening NHS cancer services by looking at treatments and patient outcomes across the country.

NATCAN will bring national cancer audits together in one place, enabling us to share best practice and clinical excellence as part of the overall strategy of improving healthcare. Each audit will develop explicit goals aiming to improve cancer outcomes and the experience of patients. 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 results from these audits will be published from 2024 onwards – both annually and quarterly.

The Welsh Cancer Network 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.

The clinical audit team have been in contact with the Welsh Cancer Network (WCN), to understand the process for the new national audits and how Velindre data will be captured. 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 organisation's ability to translate information from source systems to Canisc Welsh Clinical Portal (WCP) e-forms 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.

It will be Velindre's responsibility to ensure the data is complete and accurate, there will be an element of validation required.

Other National topic specific audits are set by NCEPOD (National Confidential Enquiry for Patient Outcome and Death), RCR (Royal College of Radiologists audits) and NOTCH (The National Oncology Trainees Collaborative for Healthcare Research.

The team will work closely with the SSTs to ensure key recommendations and areas for learning from National audits are identified and implemented where appropriate. As these National audits are led by the WCN and data submitted from a health board level the recommendations are not always applicable to Velindre services.

4.5 Clinical Audit Activity

The table below demonstrates the current audit activity within Velindre Cancer Centre. The total number of audits reflect the number of projects registered within the system. Total number of open projects is the combination of those projects that are at data collection/analysis stages and therefore open with no results as yet. In addition, there are projects that have been completed but have yet to be signed off as actions plans are being developed, therefore remain open with results. The number of overdue projects (no action plans) relates to the date a lead has anticipated that their projects would be completed or an action plan would be in place. There are sometimes unforeseen delays, however these are followed up by the audit team.

There are some clinical audit projects that require long term data collection over years before results are collected. The figures below exclude the National Clinical Audits set out by NCAPOP but do include those National/multicentre projects that Velindre participate in. There is sometimes a delay in the reporting of these projects, and they are on the system as open with no results, they are tracked as awaiting National reports.

Total number of projects	76	100%
Total number of open projects	44	58%
Number of open projects with no results	32	73%
Number of open projects with results	12	27%
Number of open overdue projects (no action plans)	13	30%
Total number of open projects (with action plans)	2	5%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	32	42%
Number of abandoned projects	5	N/A

4.5.1 Discontinued audits

For transparency the reason for any discontinued audits are published

Discontinued Audit	Reason
National Service Evaluation project, evaluating the "Safety and Efficacy of Atezolizumab in combination with nab-Paclitaxel	Dr Missed national deadline for submission due to Information Governance issues
All Wales Acute Oncology Project – a trainee led service evaluation of acute oncology activity across Wales during the pandemic	No information provided, It was not possible to identify leadership for this study due to competing pandemic priorities
Bevacizumab Induced Hypertension in Gynaecological cancers	No response from lead after several attempts unable to obtain a report. It was not felt to be a priority as Bevacizumab is no longer used widely in this setting (Not NICE approved)
Vaginal dilator use for the management of vaginal stenosis post radiotherapy, a UK scope of current practice	Lead has left the Trust before this was set up. No replacement as yet will follow-up with replacement as to if taking forward in the future.
Management approaches in Grade III (Malignant) Meningioma: a NOTCH UK multi-centre case series	Too few patients with relevant diagnosis were identified

4.6 Clinical Audit Action Plan

Recommendations and subsequent actions are all recorded in AMaT, the audit leads are required to update their actions in a timely manner. A SMART action guide has been developed to assist leads to develop SMART action plans. All audit activity and action plans are discussed within the quarterly meetings and updated accordingly.

4.7 Planned Clinical Audit Programme

The Planned Clinical Audit Programme is a proactive approach to carrying out audit within each SST. The programme is developed before the start of each financial year with the aim of identifying areas for audit including National and local priorities. The programme is predominantly made up of key indicators of practice, NICE guidelines, patient experience, local concern and national audits; these are identified and prioritised within each SST through the implementation of new radiotherapy techniques, the introduction of new drugs with specific toxicities and any serious adverse events.

High level incidents and themes from complaints that have been identified by the Quality & Safety team have been included in the planned programme. These include communication to patients including the management of diabetes and 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.

4.8 Student Selected Components (SSCs) at Velindre Cancer Centre

Cardiff School of Medicine offers a range of opportunities to tailor learning and study specific aspects in depth. As well as intercalating and opportunities to study abroad, there are hundreds of Student Selected Components (SSCs) from which to choose.

For those students with a real interest in oncology this offers an opportunity to work closely with an oncology consultant. There is also the opportunity to work collaboratively with oncologists and clinicians in other hospitals, e.g., surgeons, gastroenterologists, radiologists. Past students have had their work published in scientific journals and have presented their work in International Meetings.

The Clinical Audit Department inducts and supervises the 3rd, 4th and 5th year medical students (SSC) each year. During 2022/23 10 year 3 and 11 year 4 students attended to undertake their SSC at Velindre. These projects make up the majority of the SST's clinical audit programme, the students provide a valuable resource to allow teams to review their service. The results are presented at virtual events which 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 including an independent member of the Board and the winning presenters receive a prize.

The poster below provides and overview of academic year 2023/24.

Canolfan Ganser Felindre Velindre Cancer Centre

CARDIFF UNIVERSITY PRIFYSGOL CAERDYDD

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

VELINDRE SSC 2023

STUDENTS

10 Year 3

11 Year 4

PROJECTS

Year 3

- Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer
- Metastatic non-small cell lung cancer: exploring the role of whole brain radiotherapy in patients with brain metastases in the era of immunotherapy
- A single-centre audit of the neo-adjuvant treatment of localised rectal cancer
- Re-Audit: Immune checkpoint inhibitor immunotherapy related toxicity monitoring and management
- Rectal cancer: ADVANCE Survey on POCT for Neutropenic Sepsis
- A single centre real-world observational study of ipilimumab + nivolumab in advanced renal
- Audit of Surveillance after Treatment of Differentiated Thyroid Cancers
- A service evaluation of the management of cervical cancer during the COVID-19 pandemic

Year 4

- Lynch Testing in Colorectal Cancer – An Audit of The Cardiff And Vale University Health Board Pathway
- Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid-Wales
- Combination immunotherapy (IO) with Ipilimumab and Nivolumab for stage 4 advanced melanoma
- The use of new systematic and/or radiotherapy-based treatments in the treatment of Upper oesophageal cancers
- A critical analysis of the new "The Immunobuddies" podcast series
- Review of National Immuno-oncology Meeting
- PSA PET scan for prostate
- POS-S
- Re-audit of glycaemic control and bone protection in patients with brain tumours taking glucocorticoids

VIRTUAL EVENT

SSC Virtual Presentation Event

Students are invited to a virtual presentation event during the last week of their 6-week block. This provides them with an opportunity to present their work at a multidisciplinary forum and they are provided a certificate for presenting. The presentations are judged by an expert panel and the top 3 presenters received a prize. The prize money has been provided by the FRCR fund and will be given to the project with the highest score from the marking criteria; 1st Prize £100, 2nd Prize £50, 3rd prize £25.

TEACHING SESSIONS

We provide the medical students with the opportunity to attend a number of interesting short virtual sessions on key oncological topics including immunotherapy, radiotherapy and clinical trials. These sessions are provided by the junior doctors and have received excellent feedback from the students.

Session 1

- Careers in Oncology
- Clinical Trials
- Radiotherapy
- Oncological emergencies part 1: Neutropenic Sepsis and SVCO

Session 2

- Genomics
- Oncological emergencies part 2: Cord Comp and Hypercalcemia
- Chemotherapy
- Immunotherapy

FEEDBACK

Overall 100 % positive experience

Chance to explore how to organise and complete our own projects. Lots of help and support when needed

Organised teaching session, very helpful staff and supportive tutor. thank you!

SSC Virtual Presentation Event

91% found presenting at the virtual event extremely beneficial

VCC_SSC_PROJECTS@WALES.NHS.UK

5.0 SITE /SERVICE SPECIFIC TEAMS (SST)

The SST's key roles are to provide a forum for multi-disciplinary service planning, development, audit and research in tumour site and service specific issues, providing recommendations to Velindre Cancer Centre on required service changes and approaches to realising these. They are also required to be accountable for the delivery of excellent, efficient, equitable and safe tumour specific service by VCC and to monitor quality and timeliness of services according to national standards.

5.1 Breast Site Specific Team
5.2 Colorectal Site Specific Team
5.3 Gynaecology Site Specific Team
5.4 Head & Neck Site Specific Team
5.5 Lung Site Specific Team
5.6 Palliative Care Service Specific Team
5.7 UGI Site Specific Team
5.8 Urology Site Specific Team
5.9 Neuro-oncology Site Specific Team
5.10 Melanoma Skin Site Specific Team
5.11 Acute Oncology Service
5.12 Other Sites and Services
5.13 Crosscutting Sites and Services

5.1 BREAST SITE SPECIFIC TEAM

5.1.1 Breast Clinical Audit Activity

Total number of projects	7	100%
Total number of open projects	5	71%
Number of open projects with no results	3	60%
Number of open projects with results	2	40%
Number of open overdue projects (no action plans)	2	40%
Total number of open projects (with action plans)	1	20%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	29%
Number of abandoned projects	1	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.1.2 National Audits and Continuous Monitoring

The NATCAN's programme of work includes two new breast cancer audits. The first audit will look at primary breast cancer, while the second will focus on secondary (metastatic) breast cancer, for women and men of all ages.

5.1.2.1. National Audit of Primary Breast Cancer (NAoPri)

The NAoPri will report on all patients newly diagnosed with primary breast cancer (stages 0 to 3) in NHS hospitals in England and Wales. Building on work previously conducted by the National Audit of Breast Cancer in Older Patients (NABCOP), the NAoPri will report on patients with primary breast cancer of all ages, both female and male, for the first time.

With data on patients diagnosed with cancer in an NHS setting routinely collected as part of their care and treatment, the audit will use these valuable data resources and bring the information all together to provide a comprehensive analysis of all aspects of primary breast cancer care in England and Wales, whilst protecting patient anonymity. This will allow the audit to look at what is being done well, where it's being done well, and what needs to be done much better.

The first Quarterly Report provides an overview of the completeness and quality of key data items provided in the RCRD for people diagnosed with primary breast cancer in England between 01 October 2019 and 30 September 2022; No Welsh data has been published to date.

5.1.2.2 National Audit of Metastatic Breast Cancer

The NAoMe aims to report on all patients diagnosed with metastatic breast cancer (MBC; also known as secondary, advanced or stage 4 breast cancer) in NHS hospitals in England and Wales. This builds on the work of the National Audit of Breast Cancer in Older Patients (NABCOP) and for the first time will include patients of all ages, both male and female, with metastatic disease diagnosed at presentation, as well as those with recurrent metastatic disease.

One of the challenges the audit will face is in identifying those patients with recurrent metastatic breast cancer; previous work from the NABCOP found that although these data are part of routine data collection in both England and Wales, they are often poorly recorded. Focus will therefore firstly be on improving the completeness of key data items, including recording of cancer recurrence, to ensure all patients living with MBC are counted. Initial priorities of the audit will be establishing the baseline from which change in practice and outcomes can be measured and defining a range of outcomes that are important for patients and feasible to measure using national routine data. From this we can look to reduce variation in practice and improve aspects of care and outcomes highlighted as important within the scoping work.

The first Quarterly Report provides an overview of the completeness and quality of key data items provided in the RCRD for people diagnosed with metastatic breast cancer in England between 01 October 2019 and 30 September 2022; No Welsh data has been published to date.

5.1.3 Completed Projects

Counter	Audit code	Active date	Audit title	Forward plan
	BrstSST/CA/2022-23/01	29/09/2022	Clinical Audit of The Potential Impact of Covid-19 On Breast Cancer Stage	✓
2	BrstSST/CA/2021-22/01	06/10/2022	Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)	✓

5.1.3.1 Clinical Audit of The Potential Impact of Covid-19 On Breast Cancer Stage

The immense pressure the NHS faced during the pandemic meant that breast screening, imaging and management was delayed. Services were halted in order to alleviate pressure, to enable staff and PPE to be reallocated so that acutely unwell patients were prioritised, and to reduce the transmission of COVID-19. Long term outcomes from these delays are yet to be determined, and additional research with bigger sample sizes are required to investigate this. However, from this audit we can conclude that this may have had a significant impact on the stage and thus prognosis of breast cancer patients. In the event of another surge in COVID-19 cases, prioritisation of screening programmes and maintaining accessibility to imaging and management warrants consideration as an option for mitigating delayed cancer diagnoses and hence prognosis improvement. Wider capacity for provision of services in order to tackle the backlog should also be considered.

5.1.3.2 Review of Oligometastatic Patients Treated with Stereotactic Ablative Therapy (SABR)

The findings of this audit support conclusions of the CtE evaluation report alongside other larger studies on SABR in Oligometastatic (OM) patients. SABR is an effective treatment for OM patients with improved prognosis compared to standard therapies.

5.1.4 Active projects

Counter	Audit code	Active date	Audit title	Forward plan
1	BrstSST/CA/2023-24/02	30/09/2022	Altra - A national multi-centre audit of long term trastuzumab use in metastatic breast Cancer	✓
2	BrstSST/CA/2023-24/01	03/07/2023	Audit of the Pathway for Adjuvant Bisphosphonates in Early Breast Cancer	✓
3	BrstSST/SE/2021-22/02	07/06/2023	Development of an Intravenous Access Decision tool for breast cancer patients receiving Systemic Anti-Cancer Therapy RELATED AUDITS	✓
4	BrstSST/CA/2022-23/03	30/09/2022	Primrose a national prospective observational study in breast cancer patients with central nervous system involvement in the UK	✓
5	BrstSST/CA/2024-25/01	30/04/2024	Sacituzumab	

5.2 COLORECTAL SITE SPECIFIC TEAM

5.2.1 Colorectal Clinical Audit Activity

Total number of projects	11	100%
Total number of open projects	4	36%
Number of open projects with no results	3	75%
Number of open projects with results	1	25%
Number of open overdue projects (no action plans)	1	25%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	7	64%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.2.2 National Audits and Continuous Monitoring

5.2.2.1 The National Bowel Cancer Audit

The National Bowel Cancer Audit is a collaborative, national clinical audit for bowel cancer, including colon and rectal cancer. It aims to improve the quality of care and survival of patients with bowel cancer; it is now well established and has collected data since 2005. The National Bowel Cancer Audit is designed to provide vital information with regards to diagnosis, treatment, and outcomes; the main focus is to help make sure that people with bowel cancer receive the best care possible.

The most recent report was published in February 2004, the State of the Nation Report Includes people diagnosed between 1 April 2021 and 31 March 2022.

https://www.nboca.org.uk/content/uploads/2024/02/NBOCA-SotN.pdf

5.2.3 Completed Audit

Counter	Audit code	Active date	Audit title
1	CoI/PQ/2023-24/07	31/05/2023	A community-based point of care white cell count device to improve critical care pathways for cancer patients with suspected chemotherapy related neutropenic sepsis: a patient focused questionnaire
2	CoI/CA/2023-24/03	06/06/2023	A retrospective study of the impact of perioperative oncological treatment on clinical outcomes in locally advanced rectal cancer patients
3	CoI/CA/2022-23/01	30/05/2023	A single-centre audit of the treatment of localised rectal cancer in Wales
4	CoI/CA/2021-22/02	13/06/2023	Anal patient survey
5	CoI/CA/2021-22/03	12/06/2023	Colorectal patient survey
6	CoI/SE/2023-24/01	29/05/2023	Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer
7	CoI/CA/2023-24/06	10/07/2023	Lynch Testing in Colorectal Cancer – An Audit of the Cardiff and Vale University Health Board Pathway

5.2.3.1 Community-based point of care white cell count device to improve critical care pathways for cancer patients with suspected chemotherapy related neutropenic sepsis: a patient focused questionnaire

A study evaluating home use of Point of Care Testing (POCT) by cancer patients (23) found that many of the patients were found it difficult to follow the procedural steps required such as using the lancet for blood withdrawal as this was failing to collect enough specimen or resulting in clotted blood. As attractive as the prospect of home testing is, it is evident that more training will be required for domestic use. The SightDx OLO equipment used for this testing is bulky and expensive for home use. However, as investment for POCT devices in the future grows, the reduction in unit price of a device may make home testing a reality.

5.2.3.2 A retrospective study of the impact of perioperative oncological treatment on clinical outcomes in locally advanced rectal cancer patients

In this important retrospective study, patients who achieved a complete clinical response did not need to go on to receive adjuvant chemotherapy. This suggests that neoadjuvant treatment alone followed by surgical resection is sufficient for patients to achieve a complete clinical response without having to undertake additional treatments with side effects that could impact their quality of life. These patients all received a combination of chemotherapy and radiotherapy, suggesting that a combined approach rather than chemotherapy or radiotherapy alone is essential to maximise clinical response.

5.2.3.3 A single-centre audit of the treatment of localised rectal cancer in Wales

To summarise, this audit has supported the application of total neoadjuvant therapy in the treatment of localised rectal cancer, demonstrating patient outcomes which are comparable to the current accepted best practice. Despite this, the outcomes between the two different modalities of total neoadjuvant therapy identified by this audit, chemotherapy alongside chemoradiation and chemotherapy alongside short-course radiotherapy, were considerably different and suggested the latter was equal to or more effective in all patient outcomes.

We have also demonstrated that a proportion of individuals who proceeded directly to surgery could have benefited from receiving neoadjuvant treatment prior to surgery. Furthermore, we have highlighted the potential for overtreatment of individuals who received total neoadjuvant therapy prior to surgical excision and continued to receive adjuvant chemotherapy.

5.2.3.4. Colorectal & Anal Cancer Survey

Many patients felt there were several advantages of having a telephone consultation instead of face-to-face appointments. These advantages included less travelling and reduced waiting times and was also useful for patients who were shielding and helped them feel less anxious. Patients felt more supported at home, when their partner couldn't be present in a clinic room due to being unable to attend with them for F2F in COVID. Pre SACT assessments via telephone also proved popular with patients.

Several patients felt there was an advantage to having a face-to-face appointment as they felt it was a more personal experience especially when needing more support, receiving scan results and for difficult or complex situations.

The offer of video consultations were popular with patients who needed to minimise mixing with others during COVID as it saved travelling and patients appreciated being able to have a family member present on the video call. This method was also more beneficial to hearing aid users. A common theme throughout this project was that the majority of patients generally would have benefitted from more information being provided and steps have been made to ensure this will happen going forward. A re-audit in the future will aim to document that this is the case.

5.2.3.5 Investigating the impact of covid 19 on the management of radiotherapy treatment of locally advanced colorectal cancer

Long course radiotherapy when compared to short course radiotherapy for rectal cancer has...

- Improved outcomes in radiological responses
- Better improvement in Circumferential Reserction Margin (CRM) status
- Higher proportion of patients going on to have excisional surgery
- Superior progression free survival and overall survival

The adjusted care during COVID-19 did not maintain pre covid outcomes. This study also demonstrated :

- Preferential use of Long Course Radiotherapy for more locally advanced cancers in a neoadjuvant setting as opposed to Short Course
- Highlighted some discontinuation in care post-COVID.

5.2.3.6.Lynch Testing in Colorectal Cancer – An Audit of the Cardiff and Vale University Health Board Pathway

The Lynch syndrome testing pathway within Cardiff & Vale UHB aims to ensure all patients with colorectal cancer have their microsatellite stability or MMR genes assessed, in order to initiate further testing to detect cases of Lynch syndrome, which would otherwise remain unknown. Mistakes within the steps of this pathway can lead to cases of Lynch syndrome being missed, affecting both a patient and their family.

Overall, the Lynch syndrome testing pathway is completing its aim for most colorectal cancer patients in Cardiff & Vale. 89.60% of patients audited here received a singular MSI or MMR assessment on the earliest tissue sample diagnosing colorectal cancer. However, 10.40% of patients had incorrect/inefficient testing within the first step of this pathway. Further mistakes were also noted later in the pathway, including duplicate BRAF/MLH1 testing and missed genetics referrals. To prevent these mistakes happening in future, additional safety net mechanisms and standardisation techniques could be implemented. MDT discussions are important for detecting patients with missed Lynch syndrome testing and initiating these tests. It could also ensure test results have been checked and actioned.

5.2.4 Active projects

Counter	Audit code	Active date	Audit title	Forward plan
1	CoI/CA/2023-24/09	19/10/2023	Real world data on BRAF mutated metastatic colorectal cancer patients In South east Wales treated with encorafenib and cetuximab (NICE Licenced 2021)	✓
2	CoI/SE/2023-24/08	26/06/2023	Real-world retrospective Study of total Neoadjuvant Therapy for Rectal Cancer	
3	CoI/CA/2021-22/04	02/08/2023	The incidence of acute onset nausea and vomiting during oxaliplatin infusions	✓
4	CoI/SE/2023-24/04	21/06/2023	The introduction of aspects of the Royal College of Radiologists (RCR) IMRT guidance for national rectal cancer for long course chemo radiotherapy patients	

5.3 GYNAECOLOGY SITE SPECIFIC TEAM

5.3.1 Gynaecology Clinical Audit Activity

Total number of projects	6	100%
Total number of open projects	2	33%
Number of open projects with no results	2	100%
Number of open projects with results	0	0%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	4	67%
Number of abandoned projects	2	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.3.2 National Audits and Continuous Monitoring

5.3.2.1 National Ovarian Cancer Audit (NOCA)

More than 7,000 women in the UK are diagnosed with ovarian cancer every year, however, outcomes vary considerably across the country.

The purpose of the National Ovarian Cancer Audit (NOCA) is to evaluate the patterns of care and outcomes for patients with ovarian cancer in England and Wales, and to support services to improve the quality of care for these patients.

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 assess how we can improve care in England and Wales, and create better results.

This is the first quarterly report provides an overview of the quality of key data items from Rapid Cancer Registration Data (RCRD) for 6,475 patients diagnosed with ovarian cancer in England between 1st October 2022 and 30th September 2023; No Welsh data has been published to date.

5.3.3 Completed Audits

Counter	Audit code	Active date	Audit title
1	Gynae/SE/2023-24/01	16/05/2023	A service evaluation of the management of cervical cancer during the COVID-19 pandemic
2	Gynae/SE/2023-24/02	10/05/2023	Audit of SACT clinic 933
3	Gynae/CA/2023-24/04	04/07/2023	Audit of waiting times for treatment
4	Gynae/PQ/2021-22/01	01/08/2023	Physio-led Prehab Clinic for gynae-oncology patients - Patient Experience

5.3.3.1 A service evaluation of the management of cervical cancer during the COVID-19 pandemic

Stage II patients did not present as frequently during the COVID-19 pandemic. This resulted in increasingly more stage III patients presenting , and 36% more patients overall in March 2021 – February 2022. It is well evidenced that later staging impacts survival, and the delay in treatment was prior to referral, rather than in delays initiating treatment.

Conclusions: Once patients were in the Velindre Cancer service, we adapted to meet treatment targets and ensure as few delays as possible. Some adaptations e.g. treated twice in one day were implemented.

5.3.3.2 Audit of SACT clinic 933

Over four weeks, 55 patients were booked into 933 SACT clinic. 100% were on active treatment. Overall, all patients were appropriately booked into the SACT clinic and it was not appropriate to discharge them back to primary or secondary care at this point.

The results show that clinic 933 is appropriately populated with patients on active treatment. F2F and telephone clinics are used appropriately with the majority of patients (56%) having telephone appointments. In addition, the majority (78%) of patients have bloods done locally.

5.3.3 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Gynae/PQ/2020-21/01	25/07/2023	Late Effects of Radiotherapy Gynae-oncology Clinic – Patient Experience	✓
2	Gynae/SQ/2023-24/03	04/07/2023	Physio-led Prehab Clinic for gynae-oncology patients – Staff Questionnaire	✓

5.4 HEAD & NECK SITE SPECIFIC TEAM

5.4.1 Head & Neck Clinical Audit Activity

Total number of projects	5	100%
Total number of open projects	3	60%
Number of open projects with no results	3	100%
Number of open projects with results	0	0%
Number of open overdue projects (no action plans)	1	33%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	40%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.4.2 National Audits and Continuous Monitoring

There are currently no mandatory national audits within this site.

5.4.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	H&N/CA/2022-23/01	25/07/2023	A retrospective review of Head and Neck neuroendocrine carcinomas treated in Velindre cancer center over the past 10 years	✓
2	H&N/CA/2023-24/01	23/05/2023	Audit of Surveillance following treatment of differentiated thyroid cancer (DTC)	✓

5.4.3.1 A retrospective review of Head and Neck neuroendocrine carcinomas treated in Velindre cancer centre over the past 10 years

This study provides valuable insights into the characteristics and treatment outcomes of this rare and aggressive group of head and neck cancers. The study highlights the clinical

significance of multimodality treatment, particularly with RT with or without concurrent CT, in non-metastatic cases. The reported survival outcomes with multimodality treatment support the importance of aggressive approaches in achieving better patient outcomes. However, the challenges in managing metastatic NEC HN were evident, with limited systemic treatment options and poor survival outcomes. The study's insights into pathology markers and histology provide valuable information for accurate diagnosis. This work also underscores the need for further research to explore novel therapeutic strategies, identify biomarkers for new therapies, and explore immunotherapeutic options. Collaborative efforts among researchers, clinicians, and industry stakeholders are essential in addressing the challenges of managing NEC HN and ultimately improving the prognosis and quality of life for affected patients.

5.4.3.2 Audit of Surveillance following treatment of differentiated thyroid cancer (DTC)

Ultrasonography is non-invasive surveillance method, and within the surveyed period and follow-up it showed good sensitivity and specificity.

The investigated cohort showed 1 extra recurrence detected by USS and 1 missed by USS

5.4.4 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	H&N/SE/2023-24/03	12/09/2023	HEAD AND NECK SQUAMOUS CELL CANCER OF UNKNOWN PRIMARY (HNSCCUP): INVOLVED NECK ONLY (INO) RADIOTHERAPY VS MUCOSAL RADIOTHERAPY (MUC): A NOTCH UK Multi-centre Retrospective Analysis in Collaboration with ENT INTEGRATE	✓
2	H&N/CA/2023-24/02	01/08/2023	Improving patient's understanding of thyroid cancer treatment and follow up through the improvement of educational resources	
3	H&N/CA/2022-23/02	26/07/2023	Retrospective review of the recurrent, progressive, or metastatic head and neck cancers (with positive PDL, CPS >1) treated by first line of systemic treatment (Pembrolizumab/ chemotherapy) in VCC over the past 5 years	✓

5.5. LUNG SITE SPECIFIC TEAM

5.5.1 Lung Clinical Audit Activity

Total number of projects	6	100%
Total number of open projects	4	67%
Number of open projects with no results	2	50%
Number of open projects with results	2	50%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	33%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.5.2 National Audits and Continuous Monitoring

5.5.2.1 The National Lung Cancer Audit (NLCA)

The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit.

The NLCA has previously achieved outstanding levels of NHS participation with data being used to drive improvements in the quality of care for people with lung cancer. The National Lung Cancer Audit (NLCA) evaluates how the care received by people diagnosed with lung cancer in England and Wales compares with recommended practice and provides information that supports healthcare providers, commissioners, and regulators to improve the care for patients. The NLCA reports a set of process and outcome measures that cover important aspects of the care pathway for people diagnosed with lung cancer.

The NLCA State of the Nation report 2024, provides an overview of the patterns of care and outcomes for 36,886 people diagnosed with lung cancer in England in 2022. A separate section provides describes results for 2,211 people diagnosed in Wales in 2022.

The report describes summarises the performance of lung cancer services in 2022 and compares this to the situation in 2019, 2020 and 2021.

https://www.lungcanceraudit.org.uk/wp-content/uploads/2024/04/NLCA-State-of-the-Nation-Report-2024.pdf

https://www.lungcanceraudit.org.uk/reports-publications/summary-of-results-for-patients-diagnosed-in-wales-2022/

5.5.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	LngSST/CA/2023-24/04	12/02/2024	Efficacy of carboplatin-etoposide rechallenge after first-line chemo-immunotherapy in ES-SCLC: An international multicentric analysis	
2	LngSST/SE/2023-24/01	24/05/2023	Management of synchronous brain metastases in patients with metastatic non-small cell lung cancer.	✓

5.5.3.1 Efficacy of carboplatin-etoposide rechallenge after first-line chemo-immunotherapy in ES-SCLC: An international multicentric analysis

A total of 93 pts were included. Sixty-six pts (71%) had PFI between 3 and 6 m. Consolidation thoracic radiotherapy and prophylactic cranial irradiation had been administered in 31 pts (33.3%) and 20 pts (21.5%), respectively. ORR was 59.1%. Median PFS was 5 m (95% CI, 4.3 – 5.7) and median OS was 7 m (95% CI, 5.7 – 8.3). Notably, PFS and OS were not different according to PFI (3-6 m v > 6 m).

Conclusions Rechallenge with carboplatin-etoposide is a valid 2L option in pts diagnosed with ES-SCLC who progress after 1L CT-IO. Our analysis shows similar results compared to

previous studies. Furthermore, outcomes were consistent across pts with different PFIs, confirming its efficacy in pts with PFI > 3 months.

5.5.3.2 Management of synchronous brain metastases in patients with metastatic non-small cell lung cancer

Overall, it appears that WBRT alone does not have a survival benefit for those who have NSCLC with brain metastasis. Some patients do benefit from a combination of WBRT and immunotherapy, particularly those with extensive brain metastasis, however, the use of both treatments together should be used with caution due to the increased toxicity seen when both treatments are used concurrently. SRS has been shown to improve survival and is a better alternative when compared with WBRT, although the amount of patients who can receive SRS is limited by the extent of their brain disease. The majority of patients with metastatic NSCLC benefit from a combination of treatments that have been shown to improve overall survival. It has been shown that immunotherapy remains an important treatment for those with NSCLC and brain metastasis and provided the best survival benefit when compared with WBRT and SRS. In future practice, the use of WBRT alone should be avoided with best supportive care providing the same survival benefit as WBRT without the side effects improving the patient's quality of life and prolonging their survival.

5.5.4 Active Projects

Counter	Audit code	Active date	Audit title	Forward plan
1	LngSST/CA/2023-24/03	08/03/2024	A Service Evaluation of the Liquid Biopsy Service for Lung Cancer Diagnostics in Wales	✓
2	LngSST/CA/2023-24/05	21/05/2024	A single-centre experience of adjuvant Durvalumab in patients with Non-small cell lung cancer (NSCLC) treated with radical concurrent chemo-radiotherapy	✓
3	LngSST/CA/2023-24/02	21/06/2023	Retrospective Data Collection for Lung Cancer Radiotherapy FDG PET Relapse Prediction in NSC Lung Cancer	✓
4	LngSST/CA/2024-25/01	20/05/2024	Stereotactic radiosurgery (SRS) for the treatment of brain metastases: Outcomes for lung cancer patients in South Wales	

5.6 PALLIATIVE CARE SERVICE SPECIFIC TEAM

5.6.1 Palliative care Clinical Audit Activity

Total number of projects	3	100%
Total number of open projects	1	33%
Number of open projects with no results	1	100%
Number of open projects with results	0	0%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	67%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.6.2 National Audits and Continuous Monitoring

5.6.2.1 The National Audit of Care at the End of Life (NACEL) is a UK-wide comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland. NACEL is an annual audit managed by the NHS Benchmarking Network, supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group

Every year, over half a million people die in England and Wales, almost half of these in a hospital setting. Following the Neuberger review, More Care, Less Pathway, 2013, and the phasing out of the Liverpool Care Pathway (LCP), the Leadership Alliance published One Chance To Get It Right, 2014, setting out the Five priorities for care of the dying person. NACEL measures the performance of hospitals against criteria relating to the five priorities, and relevant NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

5.6.2.2 All-Wales Care Decisions for the Last Days of Life Audit was introduced widely across Wales in 2016. Since then, progress in its implementation has been monitored alongside the quality of care being provided in different sectors across Wales. On-going monitoring is undertaken via completed case review sheets. Regular audits are also undertaken for quality control and service evaluation purposes.

5.6.2.3 Palliative Care Outcome Scale (POS –S) audit is an evaluation tool with which we are able to assess the quality of care in palliative care patients. It assesses a patient's physical, psychological and emotional symptoms, as well collecting information about their care and support needs. These measures are uniquely developed so as to be suitable for patients with chronic/life limiting diseases such as cancer, degenerative/neurological disease, respiratory and heart failure. These assessment methods can be used in the clinical environment, in audit, research and in training purposes.
POS-s is an additional assessment tool that focuses on symptom control. This measure is particularly useful when patients have multiple symptoms and is adaptable to all clinical settings; hospital, hospice or home setting. The measures have been shown to be sensitive to changes in a patient's condition over time.

5.6.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Pallcare/SE/2023-24/01	17/07/2023	A service evaluation of symptom control for palliative inpatients at Velindre Cancer Centre RELATED AUDITS	✓
2	Pallcare/CA/2022-23/01	31/07/2023	Cancer Associated Thrombosis (CAT) MDT	

5.6.3.1 A service evaluation of symptom control for palliative inpatients at Velindre Cancer Centre

It is evident from this study that the end-of-life care input at VCC has a significant positive effect on the severity of all 10 common end of life symptoms. Consequently, there are no glaring improvements to be made in terms of specialist palliative care symptom management at VCC. Drowsiness and weakness/lack of energy were the only symptoms to temporarily

worsen between assessments 1 and 2, however this was often due to the nature of the person's illness progressing, rather than any other factors

Should this project be continued on two-yearly basis, for the sake of data reliability, it may be beneficial to continue the consistent POS-S or i-POS scoring technique amongst members of the palliative care team. Another option would be to assign one named individual to perform all three assessments.

Optimum physical symptom management improves patient quality of life and is therefore a crucial component of a holistic palliative care approach.

5.6.3.2 Cancer Associated Thrombosis (CAT) MDT

Of 287 patients reviewed, apixaban was considered appropriate in 100 (35%). Reasons for not using apixaban were cited as either safety reasons (n=106, 37%) or lack of trial evidence/ license (n=81, 28%). Contraindications on the grounds of safety included in-situ primary upper gastro-intestinal or urothelial cancer (n=37, 13%), significant drug-drug interactions (DDI) (n=33, 11%) and recent bleeding or bleeding risk (n=33, 11%). Lack of evidence or lend of life license included non-lower limb venous thrombosis e.g., splanchnic vein or primary / secondary CNS malignancy (n=30, 10%), PICC related thrombosis or superficial vein thrombosis (n=51, 18%).

Our data suggests most patients presenting to a regional CAT service are not being treated with a DOAC due to safety concerns or lack of available evidence for the presenting clinical indication. Some DDIs could be avoided by prescribing edoxaban and it is possible that efficacy data will emerge to support unlicensed indications. However, this will still leave over one third of CAT patients with contraindications to DOACs.

5.6.4 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Pallcare/2024-25/01	15/12/2023	To what extent is the Information in a treatment escalation plan shared	✓

5.7 UGI SITE SPECIFIC TEAM

5.7.1 UGI Clinical Audit Activity

Total number of projects	4	100%
Total number of open projects	3	75%
Number of open projects with no results	1	33%
Number of open projects with results	2	67%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	1	25%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.7.2 National Audits and Continuous Monitoring

5.7.2.1 The National Oesophago-Gastric Cancer Audit (NOGCA)

The National Oesophago-Gastric Cancer Audit (NOGCA) aims to evaluate the quality of care received by people diagnosed with oesophago-gastric (OG) cancer in England and Wales. It describes patterns of care and outcomes, highlights regional variations, and helps NHS cancer services to identify areas where they can improve.

In our first State of the Nation Report, we focus on the care received by patients diagnosed with oesophago-gastric cancer between April 2020 and March 2022 in England and Wales, and the outcomes of treatment. We also evaluate the care pathway followed by patients diagnosed with oesophageal high-grade dysplasia in England.

https://www.nogca.org.uk/content/uploads/2024/02/1a_REF437_NOGCA-SoN-Rep_FINAL.pdf

5.7.2.2 National Pancreatic Cancer Audit

The purpose of the National Pancreatic Cancer Audit (NPaCA) is to evaluate the patterns of care and outcomes for patients with pancreatic cancer in England and Wales, and to support services to improve the quality of care for these patients. The audit will be a really valuable tool, helping to accelerate national efforts to improve the care and treatment of patients diagnosed with pancreatic cancer.

It will gather real world information from databases across England and Wales, allowing better comparisons to be made, and revealing where shortfalls need to be addressed.

Pancreatic cancer is one of the least survivable cancers, with virtually no improvement seen in survival rates in the UK over 40 years from the 1970s.

The first quarterly report published by the NPaCA team provides an overview of the quality of key data items captured in the rapid cancer registration data for people diagnosed in NHS trusts with pancreatic cancer in England between 1st October 2022 and 30th September 2023, at NHS trust and Cancer Alliance levels; No Welsh data has been published to date.

5.7.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	UGISST/CA/2023-24/04	07/08/2023	The use of new systematic and/or radiotherapy-based treatments in the treatment of Upper oesophageal cancers.	✓

5.7.3.1 The use of new systematic and/or radiotherapy-based treatments in the treatment of Upper oesophageal cancers

This study has shown that Neo-adjuvant Chemo Radiotherapy (NACRT) may be a superior treatment regime to at least peri-operative ECX, however, further research with larger sample sizes is required to make the comparison with FLOT.

5.7.4 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	UGISST/PQ/2023-24/02	26/06/2023	An improvement project-Development of a key worker clinic for patients diagnosed with cancer of upper GI origin in the outpatient department	✓
2	UGISST/CA/2023-24/01	25/04/2023	Analysis of the outcomes of Nivolumab and Pembrolizumab in oesophageal cancers and the management of Immunotherapy-related toxicities	✓
3	UGISST/CA/2023-24/03	03/07/2023	Immune checkpoint inhibitor induced liver injury: a multi-centre experience	✓

5.8 UROLOGY SITE SPECIFIC TEAM

5.8.1 Urology Clinical Audit Activity

Total number of projects	5	100%
Total number of open projects	3	60%
Number of open projects with no results	2	67%
Number of open projects with results	1	33%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	40%
Number of abandoned projects	0	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.8.2 National Audits and Continuous Monitoring

5.8.2.1 The National Prostate Cancer Audit (NPCA)

Prostate cancer is the most frequently diagnosed solid cancer (over 40,000 new cases each year) and the second most common cause of cancer-related death in men in the UK. The National Prostate Cancer Audit (NPCA) measures the quality and outcomes of care for patients diagnosed with prostate cancer in NHS hospitals in England and Wales. It supports hospitals in the UK to improve the quality of the care received by patients

National guidelines underpin the management of patients with prostate cancer and the NPCA evaluates current patterns of care against these standards including guidance and quality standards from the National Institute for Health and Care Excellence (NICE).

The NPCA State of the Nation Report was published in January 2024, reports on the impact of and recovery from Covid-19 for prostate cancer services, using the most recently available data in England from the RCRD between 1st January 2022 and 31st January 2023, and in Wales between 1st April 2021 and 31st March 2022.

https://www.npca.org.uk/content/uploads/2024/02/REF433_NPCA-SotN-Report_230124_v2.pdf

5.8.2.2 National Kidney Cancer Audit (NKCA)

Kidney cancer is the seventh most common type of cancer in the UK and there have been some important advances in its treatment over the last few years. But we know there can be further improvements, and the results generated by this new audit will help us to deliver that successfully across the country.

The purpose of the National Kidney Cancer Audit (NKCA) is to evaluate the patterns of care and outcomes for people diagnosed with kidney cancer in England and Wales, and to support services to improve the quality of care for these patients. The audit process will look at diagnosis and treatment, and how patients are managed. Cancer services obviously need to have the right support and expertise in order to provide the best possible care.

The first quarterly report published in April 2024 provides an overview of the quality of key data items for 27,187 people diagnosed with kidney cancer in England between 1st October 2020 and 30th September 2023; No Welsh data has been published to date

5.8.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	URO/SE/2023-24/01	20/06/2023	A single center real-world observational study of ipilimumab + nivolumab (I + N) in advanced renal cell carcinoma.	
2	URO/SQ/2023-24/02	12/07/2023	Evaluating the National Immuno-Oncology Education Forum	✓

5.8.3.1 A single center real-world observational study of ipilimumab + nivolumab (I + N) in advanced renal cell carcinoma

Combination Ipilimumab and Nivolumab continues to improve overall survival and progression free survival, when compared to the general population of mRCC patients and those on targeted therapies. There is some discrepancy between effectiveness seen in Checkmate 214, however it may be attributable to cohort characteristics, study type and Covid-19.

5.8.3.2 Evaluating the National Immuno-Oncology Education Forum

In summary, the findings from this service evaluation demonstrate the success of the National IO Education Forum. The feedback is encouraging and can be reflected on to aid further development. These include advertisement on social media, the circulation of PowerPoint slides, a simple guide to access recordings and a future face to face meeting. A limitation of this project is a low response rate with 25 people responding despite the email list consisting of over 100 people. The number of people in each job role varied significantly and it cannot be determined from the data if this reflects the attendees of the meeting or whether it was due to CNS's being more likely to complete the questionnaire to help guide feedback. It is relevant that a co-study evaluating 'The Immunobuddies' podcast found that the majority of its respondents were also CNS's at 30%. Despite the limitations discussed, the results of this study can be used to help guide future meetings.

5.8.3.3 Disparities in Urothelial Carcinoma (UC) Drug Approval: Contrasting North America and Europe

The US led in drugs approvals for UC, followed by CAN and FRA. Dramatically disparities were observed across Europe, even for drugs with SCB. Additionally, most of indications lacked evidence on OS, QoL, or SCB.

5.8.3.4 Quality-of-Life (QoL) data published by clinical trials supporting drug approvals for Renal Cell Carcinoma (RCC)

Not all the identified approved indications have published QoL data. Of those that have, roughly half have published the data as a secondary endpoint. The 10 QoL scales were used in different combinations in every study, demonstrating no consistency between trials. In future, exploring the parameters each trial used to identify change in QoL status may be useful.

5.8.4 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	URO/SE/2023-24/05	26/07/2023	A Service Evaluation Looking at the Non-Surgical Management of Relapsed Prostate Cancer Following PSMA PET-CT Evaluation	✓
2	URO/CA/2023-24/04	18/07/2023	Clinical Outcomes for bladder preservation treatment at Velindre Cancer Centre	✓
3	URO/CA/2023-24/06	06/09/2023	Standard Radiotherapy prostate 60gy/20# PROMS and outcome	✓

5.9 NEURO-ONCOLOGY SITE SPECIFIC TEAM

5.91 Neuro-Oncology Clinical Audit Activity

Total number of projects	2	100%
Total number of open projects	0	0%
Number of open projects with no results	0	0%
Number of open projects with results	0	0%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	2	100%
Number of abandoned projects	1	N/A

**Figures exclude mandatory national audits and continuous monitoring*

5.9.2 National Audits and Continuous Monitoring

There are currently no national audits within this site.

5.9.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Neuro/CA/2023-24/02	14/08/2023	Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales	✓
2	Neuro/CA/2023-24/01	24/07/2023	Reviewing the implementation of novel guidelines for glycaemic control and bone protection in patients with brain tumours taking glucocorticoids in Velindre Cancer Centre RELATED AUDITS	✓

5.9.3.1 Outcomes in patients undergoing surgery for recurrent/progressive glioblastoma in South and Mid Wales

Glioblastoma Multiforme (GBMs) are aggressive, fast-growing tumours requiring a multi-factorial treatment plan. In the present study, with the cohort of 231 patients, we demonstrated the impact that the COVID-19 pandemic had on the treatment choices for these patients. During the pandemic, many diagnoses were radiological, meaning that the rate of biopsies decreased, and the number of surgical resections declined. This was largely due to staff shortages and a rising demand placed on the surgical teams. Of the patients that were diagnosed during the pandemic, exactly 50% had surgery and 50% did not. However, prior to this 79% of patients received surgery, demonstrating a clear drop in the proportion of patients offered surgical management during the pandemic.

Overall prognosis for patients with a diagnosis of GBM is poor. Our study demonstrated this, revealing a 1-year survival rate (1-YS) of 40% and a 5-year survival rate of just 2.3%. The aggressive nature of this tumour implies a need for aggressive treatment, and our study found that those who received the most aggressive combined treatments had the greatest survival rates.

The project was presented and discussed at the South Wales Neuro Oncology meeting, the data highlighted that during the COVID 19 pandemic not all 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. The data collected for this project has been shared to assist with further studies/projects.

5.9.3.2 Reviewing the implementation of novel guidelines for glycaemic control and bone protection in patients with brain tumours taking glucocorticoids in Velindre Cancer Centre

The average dose and duration of dexamethasone usage increased in comparison to the previous service evaluation carried out in VCC in 2022. (9) There has been a massive improvement in the documentation of dexamethasone dosage which has made it easier for other clinicians to identify and intervene if the dose is too high/low**.**

This project showed that VCC have improved their monitoring and management of neuro oncology patients on dexamethasone. The inclusion of these guidelines has diminished the development of steroid-induced osteoporosis and diabetes.

Adherence to these guidelines need to become consistent which can be improved by placing steroid leaflets in advantageous positions e.g., in follow-up clinic and reminding clinicians and patients with via poster in clinical rooms about steroid monitoring. Moreover, regular reviews

should be conducted to improve adherence and encourage the maintenance of a high standard of care.

5.10 MELANOMA/ SKIN SITE SPECIFIC TEAM

5.10.1 Melanoma/Skin Activity

Total number of projects	1	100%
Total number of open projects	0	0%
Number of open projects with no results	0	0%
Number of open projects with results	0	0%
Number of open overdue projects (no action plans)	0	0%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	1	100%
Number of abandoned projects	0	N/A

5.10.2 National Audits and Continuous Monitoring

There are currently no national audits within this site.

5.10.3 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Skin/CA/2023-24/01	15/08/2023	Combination immunotherapy (IO) with Ipilimumab and Nivolumab for stage 4 advanced melanoma	✓

5.10.3.1Combination immunotherapy (IO) with Ipilimumab and Nivolumab for stage 4 advanced melanoma

This audit looked solely at patients that received the combination immunotherapy. Notably, in comparison to the study by Hodi et al (3) who investigated survival outcomes in metastatic melanoma patients treated with ipilimumab monotherapy, this audit showed a greater overall survival rate. In the former study, the OS at 12 months was 43.6%, whereas this audit showed an OS of 66% at 12 months.

In conclusion, combination immunotherapy with ipilumumab and nivolumab demonstrates clinical efficacy as a therapeutic intervention for patients with stage IV melanoma. Survival outcomes seen in this retrospective audit are similar to that of the Checkmate 067 trial. Adverse events were manageable and there were no treatment-related deaths in this cohort of patients. The incidence of grade 3 or 4 adverse events was lower than reported in the literature, indicating successful management of symptoms before they develop further.

5.11 Acute Oncology Service

5.11.1 Acute Oncology Service Clinical Audit Activity

Total number of projects	8	100%
Total number of open projects	7	88%
Number of open projects with no results	5	71%
Number of open projects with results	2	29%
Number of open overdue projects (no action plans)	6	86%
Total number of open projects (with action plans)	1	14%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	1	13%
Number of abandoned projects	0	N/A

5.11.2 Completed Audits

Counter	Audit code	Active date	Audit title
1	AOS/CA/2023-24/03	22/08/2023	Audit of the 'pre-booked' admissions to the acute oncology assessment unit

5.11.3 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	AOS/CA/2023-24/02	23/06/2023	A Retrospective audit of admissions to first floor and assessment unit at Velindre Cancer Centre during May 2023	✓
2	AOS/SE/2023-24/01	20/06/2023	A retrospective audit of urgent and emergency patient transfers from Velindre Cancer Centre Assessment unit and First floor ward	✓
3	AOS/CA/2023-24/05	05/02/2024	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.	✓
4	AOS/CA/2023-24/04	24/01/2024	An audit to evaluate the compliance with the VCC Autonomic Dysreflexia Guidelines in patients with MSCC, receiving radiotherapy, on the Acute Oncology Assessment Unit. RELATED AUDITS	✓
5	N/A	19/01/2024	Audit of 2222 calls at Velindre Cancer Centre	
6	AOS/CA/2023-24/06	20/03/2024	Burden of Acute Illness	✓
7	N/A	20/03/2024	NEWS Cymru audit	

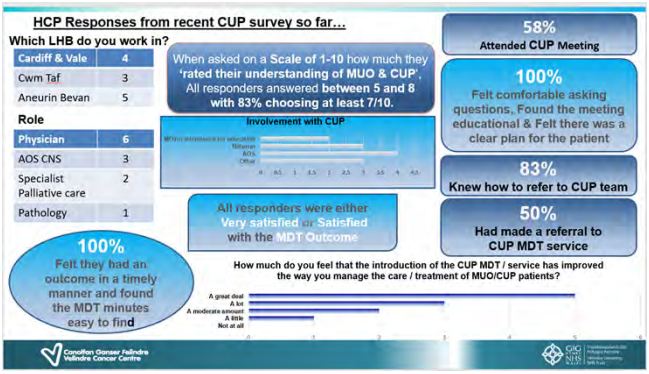
5.12 OTHER SITES AND SERVICES

5.12.1 Other Sites and Service Clinical Audit Activity

Total number of projects	5	100%
Total number of open projects	5	100%
Number of open projects with no results	4	80%
Number of open projects with results	1	20%
Number of open overdue projects (no action plans)	1	20%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	0	0%
Number of abandoned projects	0	N/A

5.12.2 Completed Audits

5.12.2.1 Cancer of Unknown Primary (CUP) Staff Experience Questionnaire



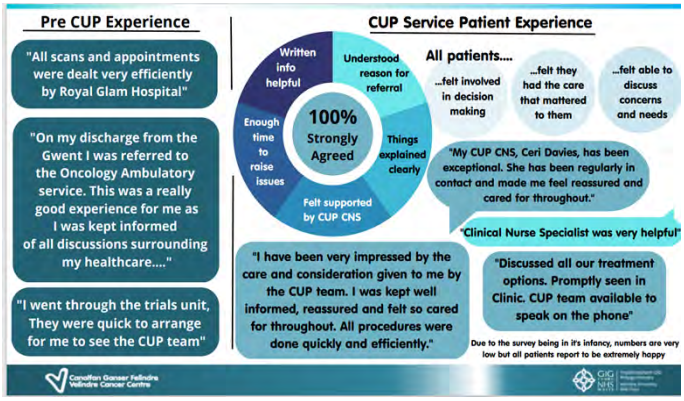
**Figures exclude mandatory national audits and continuous monitoring*

5.12.3 Active

Counter	Audit code	Active date	Audit title	Forward plan
1	Inpt/PQ/2023-24/01	29/06/2023	A patient satisfaction survey to evaluate the launch of V-TV Health and Wellbeing Channel on First Floor ward at Velindre Cancer Centre	✓
2	CUP/PQ/2022-23/01	29/08/2023	Cancer of Unknown Primary (CUP) Patient Experience Questionnaire	✓
3	Inpt/PQ/2023-24/02	14/07/2023	Pilot 2 FFW Joint Occupational Therapy and Clinical Psychology Screen Project	
4	SACT/CA/2023-24/01	18/07/2023	Review of the UKONS Tool Kit on the Assessment of Fever in patient receiving SACT at VCC	✓
5	Inpt/SE/2024-25/01	31/01/2024	VCC TPN patient service evaluation and outcome analysis: An audit of historical cases between January 2021 and January 2024. AIM: Improve TPN provision, patient safety and management in VCC.	✓

5.12.3.1 Cancer of Unknown Primary (CUP) Patient & Staff Experience Questionnaire

Analysis to date completed but due to small number the survey is ongoing.



5.13 CROSSCUTTING SITES AND SERVICES

5.13.1 Crosscutting Sites and Services Activity

Total number of projects	12	100%
Total number of open projects	6	50%
Number of open projects with no results	5	83%
Number of open projects with results	1	17%
Number of open overdue projects (no action plans)	1	17%
Total number of open projects (with action plans)	0	0%
Number of open overdue projects (with action plans)	0	0%
Number of closed projects	6	50%
Number of abandoned projects	1	N/A

5.13.2 Completed Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Other/CA/2023-24/03	18/07/2023	A critical analysis of the new "The Immunobuddies" podcast series.	✓
2	Other/CA/2022-23/01	19/07/2022	Chaperone Audit	✓
3	Other/CA/2023-24/01	05/06/2023	Compliance with completion of Treatment escalation plan forms (TEP) for the new admissions to the First floor wards of Velindre Cancer Centre RELATED AUDITS	
4	Other/SE/2020-21/02	23/08/2023	DPYD Health Technology Assessment Service Evaluation	
5	Other/CA/2022-23/02	21/07/2022	Re-audit of Oral Consent RELATED AUDITS	✓
6	Other/CA/2021-22/02	21/08/2023	Snapshot audit of the use of DPYD in clinical decision making	

5.13.2.1 A critical analysis of the new "The Immunobuddies" podcast series

The accessibility, efficacy and convenience of podcasts have led to a rapid increase in the number of medical podcasts available and discussions regarding their role in medical education. The Immunobuddies podcast has received over 4400 downloads within 5 months and has received extremely positive feedback from its listeners who rate the length, presentation, content and accessibility of the podcast very highly. The results of this survey provide a snapshot into the wider topic of support and demand for medical podcasts from learners, and the success of The Immunobuddies is a testament to this. Whilst there is well-established learner acceptance of podcasts, there are some growing concerns over the limited data on learning outcomes, and a best practice for evaluating the impact of medical podcasts on listeners should be developed. Nevertheless, the feedback of this study and many others evidence that the information age is changing the way we access medical knowledge, and the use of free open access medical education (such as podcasts) is a rapidly growing and exciting field. Therefore, whilst it is unclear exactly to what extent, it is evident that well-respected podcasts such as The Immunobuddies will undoubtedly play a large role in this transforming landscape of medical education.

5.13.2.2 Chaperone Audit

A total number of 275 patients' records were reviewed of which 149 had an intimate examination documented in Canisc.

On review of the notes there was no documentation regarding an offer or acceptance of a chaperone in any of the 275 notes reviewed, however there was mention of a chaperone being present, their job title and patients consent to being examined in some cases.

Although the offer and acceptance/decline of a chaperone was not present in any patients' records, there was documentation to show a chaperone was present in 21% of cases. The audit demonstrates areas for improvement in all the key elements within the good working principles. Re-audit scheduled for next financial year.

5.13.2.3 Compliance with completion of Treatment escalation plan forms (TEP) for the new admissions to the First floor wards of Velindre Cancer Centre

Data collected at VCC First floor ward between 11th Jan 2023 and 29th March 2023. No TEP forms completed for the 21 patients included in the audit.

TEP form need to be completed for all the patients getting admitted to the first-floor wards of the Velindre Cancer Centre. Re-audit scheduled for next financial year.

5.13.2.4 DPYD Health Technology Assessment Service Evaluation

Our analysis suggests that it is cost-effective to routinely screen for DPYD variants prior to prescription of capecitabine or 5-FU for colorectal cancer patients in Wales. Whilst the QALY gain is small (less than one quality-adjusted day), this is in part due to the short time horizon of the model, but also to the unequal distribution of patients who benefit. Mean QALY gains disguise the fact that large benefits accrue in the few patients with DPYD variants who avoid toxicities, whilst wild-type patients will experience no benefit at all. The result was robust to a number of parameter and structural assumptions, with the majority of analyses returning the

result that screening was less costly and more effective. The number needed to screen to prevent one toxicity was 13. Our result is consistent with the results of economic evaluations of DPYD screening in other settings, which suggest that screening reduces costs, and reduces toxicities, resulting in QALY gains. Our analysis has several strengths, firstly, we conducted a cost-utility analysis with the QALY as the outcome measure, which captures both survival and quality of life, and provides evidence to support decisions concerning allocative efficiency, relevant to NHS policymakers. Additionally, our choice of model structure to reflect alternative regimens for poor metabolisers is consistent with clinical practice and guidelines.

5.13.2.4 Re-audit of Oral Consent

The audit demonstrated the standards set out by the UK Chemotherapy Board guidance for SACT consent were not met. However there has been an improvement in the number of consent forms signed and available for review.

The majority (92%) of patients have a scanned copy of written consent within their electronic notes, and of those who did not have a scanned, signed consent form, 3 patients (1.3%) had an annotation in their record to say that consent has been obtained.

There has been an increase in the use of CRUK forms within the cancer centre, however consent form 1 is still being used in 72 (33%) cases**.**

5.13.2.4 Snapshot Audit of the use of DPYD in Clinical Decision Making

The data analysed was similar across the regions and frequency of the four tested DPYD variants (5%) is in line with previous estimates.

This service evaluation identified that a DPYD result was available in 1638/1678 (97.6%;) of cases prior to starting fluoropyrimidine SACT. Broad acceptance of dosing guidance for patients with identified DPYD variants was demonstrated. Notably, for 560/1761 patients, ethnicity data was unknown, limiting observation of statistical correlation with DPYD variants/toxicity.

Toxicity/dosing data fields were optional and not standardised, resulting in small sample sizes and limiting statistical analysis.

5.13.3 Active Audits

Counter	Audit code	Active date	Audit title	Forward plan
1	Other/CA/2023-24/04	11/10/2023	Consent Audit	✓
2	Other/CA/2021-22/01	28/08/2023	Implementation of the 'Antibiotic Review Kit (ARK) Project' into VCC	✓
3	N/A	12/02/2024	National Comparative Audit of Bedside Transfusion Practice 2024 (Re-audit)	
4	Other/CA/2021-22/03	16/08/2023	Record Keeping Audit	✓
5	N/A	16/08/2023	Single Cancer Pathway – Treatment Pathway Review	
6	Other/CA/2023-24/02	02/08/2023	WAASP Quality Audit	✓

6.0 TENDABLE AUDITS

Tendable Quality Assurance Audits have been utilised within Velindre Cancer Centre since November 2021 and WBS November 2022

6.1 VCC Clinical Areas routinely using Tendable:

	First Floor	Outpatient Department	Research & Development	SACT (Rowan ward, CDU, Rhosyn, PCH, Neville Hall)
News & Sepsis	✓	✓	✓	✓
Equipment Checks	✓	✓	✓	✓
Hand Hygiene and PPE	✓	✓	✓	✓
IPC	✓	✓	✓	✓
Patient Centred Care	✓	✓	✓	✓
Quality Assurance Walks	✓	✓	✓	✓
Health, safety, Fire & security	✓	✓	✓	✓
ANTT	✓	✓	✓	✓
Falls	✓			
Nutrition	✓			
Skin Care	✓			
Nursing Document	✓			
Medication Management	✓		✓	✓
Heat Pads			✓	✓

6.2 Validation Audits

In April 2024 Tendable introduced the option to identify who was undertaking the clinical audit:

Self: A member of staff working in the clinical area being audited

Peer: A member of staff that does not work in the clinical area being audited

Expert: A senior member of staff who undertakes a validation audit in the clinical area

IPC team undertake validation hand hygiene & PPE audits in all clinical areas in VCC each month. In addition to the above areas this also extends to: PICC Clinic, Radiotherapy, Radiology and Assessment Unit.

Informatics CNS undertakes validation nursing documentation audit each month

May 2024 validation quality assurance, news & sepsis, patient centred care audits undertaken by Informatics CNS

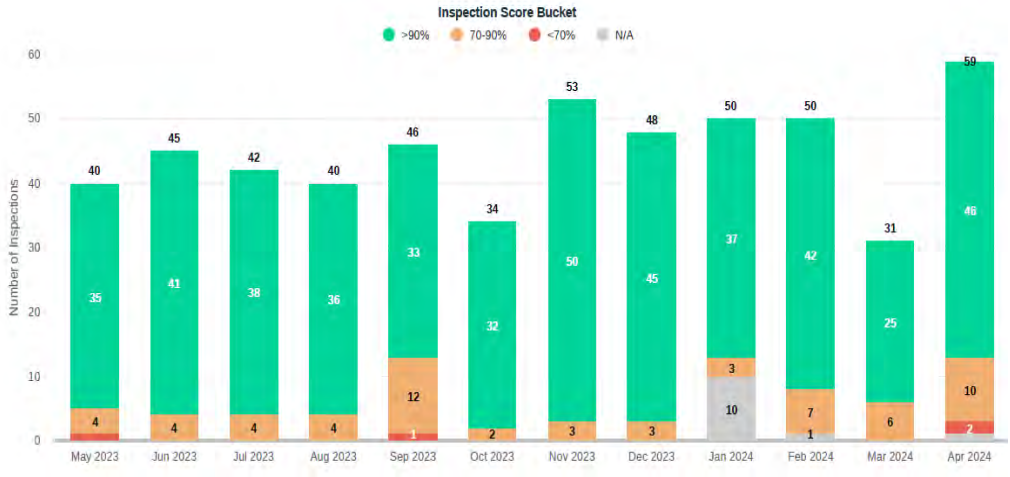
6.2.1 Number of audits undertaken 1st May 2023 – 30th April 2024

The question that scored the most negative answers
'Are the floors clean and in a good state of repair'

This has been an issue for Outpatients and Research and Development Unit – calls logged with estates team

Validation audits have acted as an additional prompt to escalate to estates – flooring repairs are on their work schedule; Monitored by the monthly audits

6.2.2 Other Issues highlighted through monthly audits



6.2.2.1 Change of supplier for disposable clinical aprons. The new aprons came flat as opposed to on a roll which had fitted neatly into the Danicentre dispensers. Due to this desgin aprons were inadvertently pulled out together and were stocked on hand rails instead of in the Danicentres as difficult to get out of the dispenser

Action
Operational Services informed and reverted back to previous supplier so that disposable aprons came on a roll that fitted into the Danicentre dispensers

6.2.2.2 Disposable BP monitoring cuff not available for use with patients with a known infection and being nursed with contact precautions

Action
Discussed with IPC team and following funding being made available disposable BP cuffs were purchaed for use on First Floor Ward

6.2.2.3 Service dates expired on heat pads in SACT

Action
Unit manager informed and escalated to ensure all heat pads within service date

6.2.2.4 Poor documentation of fluid input and output for patients required to have fluid balance monitoring whilst an inpatient in VCC

Action
Ward Manager informed and the importance of accurate fluid balance monitoring reinforced during the 'Big Four' communication method to all staff
Accurate fluid balance monitoring is also captured on the validation documentation audit so issues are highlighted and addressed in an apprpriate timeframe

6.3 Review

Tendable reports with accompanying narrative are presented at Trust Professional Nursing Forum (PNF) meetings bi-monthly. Issues of concerns are highlighted directly to Department leads, Head/Deputy Head of Nursing as appropriate

7.0 BLOOD SERVICE SUMMARY

Gwasanaeth Gwaed Cymru
Welsh Blood Service

7.1 Foreword

The Welsh Blood Service (WBS) provides compatibility testing and other diagnostic services related to blood, cellular therapies and organs. The WBS also collects cells for cellular therapies and blood components, which are provided along with medicines derived from plasma, some drugs and vaccines to the NHS in Wales and also to other countries.

There are many synergies for the two operational divisions of the Trust. Bone marrow and stem cells are predominantly supplied by the WBS for the treatment and cure of cancers. 25-30% of blood components are provided as part of the supportive treatment for patients with cancer. More blood components are transfused in the Velindre Cancer Centre than some general hospitals in Wales. The stem cells for treating cancers and other disorders are collected in the Velindre Cancer Centre site.

The report of the Infected Blood Inquiry (IBI) was published on 20 May 2024 and made positive reference to the Blood Health Plan in Wales. Recommendations were made in the report regarding the education of medical staff on blood safety. So, it is pleasing to see that this is an area we have developed in 2023-24 with good feedback from qualified medical staff and students (Section 7.2.2.8). A Clinical Leadership Fellow has been appointed, partly funded by Health Education and Improvement Wales (HEIW) to focus on developing training for medical staff. He starts with us in August 2024.

We are already auditing areas recommended for performance monitoring in the IBI report such as the use of tranexamic acid and iron (Sections 7.2.1.1 / 7.2.2.1 / 7.2.2.3 / 7.2.2.7) but it is notable that undertaking such performance monitoring / audit is hampered by inadequate information systems in the NHS in Wales. This further reinforces the need for action in Wales on another recommendation of the IBI that IT systems should be in place to provide information on the outcomes of transfusion.

It is also notable that in 2023-24 extensive feedback from donors of blood (7.3.3), stem cells (7.4.2) and a customer satisfaction survey of service users in hospitals have provided a degree of reassuring feedback and demonstrable actions to further improve services. This is particularly true for blood donation. The customer survey is being analysed over the summer so the actions will be presented through our Quality and Safety structure during the year and will feature in next year's annual report.

<u>The key point that needs addressing</u>

We need to work with Health Boards, Trusts and Digital Health Care Wales (DHCW) to put in place systems that enable performance monitoring and audit in Wales, this was deemed cost effective by Health Technology Wales (https://healthtechnology.wales/reports-guidance/electronic-blood-management-systems/) in 2022 and was recommended for safety in the Infected Blood Inquiry (IBI) report in 2024. Most obviously through the LIMS2 project (Laboratory Information Management System 2).

Edwin Massey
Medical Director Welsh Blood Service

7.2 Transfusion and diagnostic support for patients (Blood Health Team and Transfusion Laboratories)

7.2.1 Blood Health key performance indicator monitoring April 1st 2023 - March 31st 2024

The Blood Health National Oversight Group (BHNOG) has developed key performance indicators (KPIs) for a range of transfusion metrics. The data provides an ongoing audit tool of practice from each of the Health Boards (HBs) in Wales. All data is shared across Wales to encourage transparency, learning and discussion of best practice. These have been collated and produced by the WBS on a monthly for local HBs or quarterly basis for BHNOG and other governance groups.

7.2.1.1 Appropriate use of group O D negative (universal blood group) red cells and audit of blood components used in major haemorrhage (MH):

Monthly dashboards provide ongoing audit of:

a) O D negative as a percentage of total red cell issues (KPI ≤12%)
b) O D negative wastage as a percentage of O D negative red cells issued (KPI ≤10%)

Quarterly audits are also completed for all major haemorrhage protocol activations (MHPs) across Wales to promote appropriate use and monitor use of O D positive red cells for males and females who do not have childbearing potential (defined as over 50 years old) thus keeping stocks of O D negative for females of childbearing potential who need them.

This year more sites have implemented the use of O D + blood for suitable recipients and the national KPIs has been met for O D negative demand and wastage as percentages of issues in recent months though the years average remains just above the target. Work is ongoing with the remaining sites to introduce the use of O D + blood for parameter 3. Medical and other staff dealing with haemorrhage to improve sample taking for parameter 4. There are issues with accessing details on tranexamic acid (TXA) use for performance monitoring. A detailed but labour-intensive audit demonstrated good compliance with this parameter (see the specific audit on TXA below). IT connectivity improvements as recommended by the Infected Blood Inquiry would enable performance monitoring for this and other parameters.

Key Performance Indicator	2023-2024
KPI 1: O D Neg issue as a percentage of total red cell issues [KPI target ≤12%]	12.2%
KPI 2: O D Neg wastage as a percentage of O D Neg issues [KPI target ≤10%]	7.6%
KPI 3: O D positive ONLY is used as emergency red cells in adult males for management of major haemorrhage [KPI target ≥80%]	59% (n=204/343)
KPI 4: A pre-transfusion sample is taken, or valid group available prior to administration of the first unit of blood component [KPI target ≥95%]	84% (n=1281/1530)
KPI 5: Tranexamic Acid is given as part of the management of major haemorrhage in Trauma & Obstetrics [KPI target ≥80%]	53% (n=449/843)
KPI 6: Hospital transfusion laboratory team are informed that the major haemorrhage (MHP) was stood down [KPI target ≥95%]	68% (n=1041/1530)

7.2.1.2. Appropriate use of platelets: Monthly dashboards provide ongoing audit of platelet wastage (KPI ≤15%). As performance has been improving there are plans to reduce the KPI for hospital wastage to <12% for 13/17 hospitals in Wales for 2024/2025. The WBS BHT are

directly engaging with the 4 hospitals struggling to achieve the original 15% target. The KPI has been met nationally at 11.8% in the most recent quarterly report below.
Quarterly audits are also completed for platelet wastage within the Welsh Blood Service facilities with a KPI of ≤10%. This KPI was met in 2023-24. Importation of platelets to Wales from other UK nations is also reported and once again the KPI was met this year. These reports are submitted to the BHNOG for scrutiny.

Key Performance Indicator	2023-2024
KPI 1 – % of platelets issued that are manufactured by the WBS [KPI target >99%]	99.95%
KPI 2 – % WBS platelets wastage due to time expiry [KPI target<10%]	9.94%
KPI 3 – Hospital platelet wastage as a percentage of issued (WAPI) [KPI target<15%]	11.42%

7.2.2 Blood Health Audits

7.2.2.1 Pre-operative anaemia audit

Anaemia has been identified as a key work stream for the BHNOG. Following establishment of the anaemia team in March 2023, discussions were held with clinical stakeholders in each of the six health boards providing secondary care. This led to an agreed set of standards being developed:

1a: A standardised pathway across the health board, covering all specialities.
1b: Health board pathway aligns to the All-Wales Pathway.
2: All patients matched to Commissioning for Quality and Innovation (CQUIN) standards should be screened for anaemia prior to surgery.
3: Any patient with Hb <130g/l is assessed for iron status.
4: Any patient identified as iron deficient can be treated prior to surgery.

There is ongoing collaboration with DHCW to develop a data dashboard to support ongoing monitoring and benchmarking of the agreed preoperative anaemia standards. This can evidence a benchmark standard 2 and 3, with ongoing national work to develop a new data stream to capture intravenous iron use and transfusion rates.

Preoperative anaemia standards	2023-2024
Standard 1 - Implementation of standardised preop anaemia HB pathway covering all specialities, aligning with the All-Wales pathway	79%
Standard 2 All adult patients matched to CQUIN standards are screened preoperatively (12 weeks prior to surgery)	87%
Standard 3 - All adult patient with Hb <130g/L are assessed for iron deficiency	69.3%
Standard 4 - any patient identified as iron deficient can be treated before scheduled surgery	No current data

7.2.2.2 Intraoperative Cell Salvage ongoing audit reported annually.

Intraoperative Cell Salvage (ICS) is a technique for collecting and processing blood shed during surgery with a view to reinfusing the red cells back into the patient. This intervention and the resultant autologous transfusion is a blood conservation measure. The All-Wales ICS Network (AWICSN), with clinical leads in each HB, continues to support this, and WBS staff collate and report on ICS usage across Wales. 2189 episodes of ICS usage were reported in 2023-24, a 7.5% increase on 2038 reported episodes in 2022-23.

67% of ICS use (n=1454) was in an elective setting, 30% (n=657) in an emergency setting and in 3% (n=78) neither was specified. The specialty with the highest proportion of ICS use was Obstetric at 33% (n=724), followed by Orthopaedics at 335 (n=716) and Cardiac at 13% (n=272).

The AWICSN plan to develop clear denominator data for surgical activity across the Health Boards have made amendments to the data collection process to improve the quality of data and facilitate the introduction of performance indicators. This will help ensure equitable provision of ICS and improved monitoring of the appropriate use of ICS.

7.2.2.3 NICE Quality Standards: QS138 audit relating to NICE Guidance (NG) 24: Blood Transfusion.

In 2016 the National Institute for Health and Care Excellence (NICE) issued Quality Standard 138 (QS138), to support the implementation of the NICE Guidance NG24, Blood Transfusion. In 2023-24 all acute hospitals in Wales registered with the QS138 Quality Insights Audit Tool; this is an ongoing benchmarking audit scheme hosted by NHS Blood and Transplant, but open to hospitals across the UK..
QS138 is made up of 4 quality statements:

- **People with iron-deficiency anaemia (IDA) who are having surgery are offered iron supplementation before and after surgery**. As part of the preoperative anaemia workstream, the Major Patient Surgery dashboard has been developed in collaboration with DHCW. The dashboard currently captures data for patients undergoing surgery with a high risk of bleeding (estimated blood loss of >500ml). Data so far demonstrates how many of these patients were screened for anaemia prior to surgery, and of those identified as anaemic, how many were assessed for iron status. Work is ongoing with DHCW to create a new data stream to capture IV iron. This data will be linked into the dashboard, evidencing how many patients with iron deficiency anaemia were treated preoperatively.
- **Adults who are having surgery and expected to have moderate blood loss are offered tranexamic acid**. Use of tranexamic acid in elective surgery has now been included in the surgical checklist. This is being reviewed following recommendations made in the infected blood inquiry report. At present it is difficult to performance monitor the use of Tranexamic acid without better system connectivity in hospitals.
- **People are clinically reassessed and have their haemoglobin levels checked after each unit of red blood cells they receive, unless they are bleeding or are on a chronic transfusion program**. An all-Wales strategy has been developed to monitor compliance to this via this QS138 Quality Insights audit tool. Guidance to support the audit process has been developed and circulated. All hospitals will begin auditing this in quarter 1 of 2024-25.
- **People who may need or who have had a transfusion are given verbal and written information about blood transfusion**. As for statement iii. above.

7.2.2.4 BHNOG website analytics

The BHNOG website (https://bhnog.wales.nhs.uk/) is a principal route by which information and guidance relating to patient blood management (PBM) is cascaded out to clinical users. In 2023-24 there were 3136 ‘new’ users recorded as accessing the BHNOG webpages and 752 ‘returning’ users. This demonstrates a good level of engagement with this resource.

7.2.2.5 Where Do O D Negative Red Cells Go? Audit, January-March 2023

The use of group O D negative (O-) red cells in all hospitals in Wales was audited from January to March 2023 to help us understand current usage. 49.6% were transfused to O- patients (non-emergency), 11% to non-O- patients to avoid time expiry (TIMEX), 10.2% were issued for emergency use, 7.8% were wasted (6.6% TIMEX), 12.7% were transferred within the Health Board (HB).

There was variation in this data between hospitals and HBs; individual HB reports were produced and sent out and bespoke follow up discussions took place to identify issues and improve future performance.

7.2.2.6 National Comparative Audit (NCA) of Bedside Transfusion Practice 2024

An audit of patient identification and prescription checks prior to transfusion, and observations being completed and recorded.

All HBs in Wales are participating in this audit, which runs from the beginning of March 2024 to the end of April. Data for Wales will be analysed separately by the WBS Blood Health Team as well as by the four-nation data by the NCA team in England.

7.2.2.7 Audit of use of Tranexamic Acid (TxA) in Major Obstetric Haemorrhage, October 2023:

This was devised to audit whether TxA was given in the management of a post-partum haemorrhage where measured blood loss was ≥1000mL (as indicated in all Wales guidance). 6 of the 9 consultant led obstetric unit in Wales returned data in this audit, showing a 97% rate of compliance with the guidance in the 31 cases audited (see also sections on NICE Quality Standard QS 138 audit O D negative performance monitoring above).

7.2.2.8 Audits of education provided to medical students and postgraduates

a) Senior Student Assistantship (SSA) May 2023: The SSA programme is a well-established educational transfusion programme delivered to all final year medical students across Wales. 424 students went through SSA transfusion training in May 2023.
52% (n=222) completed both the pre- and post- training self-assessment of knowledge, and 61% (n=260) completed the programme evaluation survey.
The surveys showed very positive feedback from students on the workstations delivered, and a positive impact was made across all learning outcomes of the training.

b) Foundation year (F)1/2 PBM/anaemia education
An education programme was developed as part of the pre-op anaemia project, 14 PBM and anaemia focussed education session were delivered to a total of 272 F1/F2 doctors in 2023-24.Participants were surveyed about key aspects of the education session, the results of which are being used to inform both the planned 2024/25 programme for this session, and the future SSA programme. A Clinical Leadership Fellow has been appointed, supported by Health Education and Improvement Wales (HEIW) to further develop this program of medical staff training, a recommendation of the Infected Blood Inquiry.

7.2.3 Customer Satisfaction Survey

The Welsh Blood Service (WBS) Blood Health Team (BHT) and transfusion laboratory services issued a hospital customer satisfaction survey using Snap survey that was open from

19th Feb 2024 to 15th March 2024. The aim of the survey was to gain feedback from customer hospitals to ensure the WBS is providing high quality services and provide insight on opportunities for service improvements. The survey was issued to individual hospitals, and to avoid duplication, the BHT recommended a single response from a health board (HB) be submitted which could capture individual concerns if necessary. This report is the final analysis of the feedback received and written by the BHT.

The findings of the survey will be reviewed with follow up actions and response agreed during the summer of 2024. The actions and outcomes during 2024-25 will be fed back through the Trust Quality and Safety governance route.

7.3 Blood Donor Care Audit

7.3.1 Infection prevention and control (IPC): Effective hand hygiene and adequate skin cleansing practices are critical in ensuring the safety of donors and recipients. Therefore, WBS have implemented a robust monthly audit programme to ensure that required practices and standards are maintained. From 1st April 2023 to 31st March 2024 compliance within all donor facing services across Wales remained high.

Hand Hygiene

Area	Hand Hygiene
Apheresis	100.0
Bangor	99.2
East A	99.9
East B	98.1
East C	99.9
WBMDR	100.0
West	100.0
Wrexham	99.1

Donor Arm Cleansing

Area	Donor Arm Cleansing
Apheresis	100.0
Bangor	100.0
East A	99.9
East B	100.0
East C	99.6
WBMDR	100.0
West	100.0
Wrexham	99.9

7.3.2 Blood Donor Points of Care Audit: To ensure that donors across Wales receive a safe, effective and equitable standard of care and experience the Welsh Blood Service undertakes a monthly evidence-based points of care audit to ensure that key aspects of donor care are delivered effectively, safely and consistency, throughout this reporting period compliance to the required standards across Wales have remained consistently high.

Area	Quarterly Points of Care Principles: Apheresis	Quarterly Points of Care Principles: Whole Blood	Quarterly Points of Care Principles: WBMDR Collection Centre
Apheresis	100.0		
Bangor		100.0	
East A		100.0	
East B		100.0	
East C		99.7	
WBMDR			100.0
West		100.0	
Wrexham		98.9	

7.3.3 Blood Donor Feedback

Feedback is collected from all donors and specifically from donors who have suffered an adverse event or required clinical advice.

Feedback on clinical advice has satisfaction scores 99%

Location	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	
Clinical Support Staff	282	99	100	100	100	100	100	100	99	100
	Overall	99	100	100	100	100	100	100	99	100
	Benchmarks	95	95	95	95	95	95	95	95	

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 Wrexham Team	Compliments and Concerns Bangor Team	Compliments and Concerns Wrexham Team	Compliments and Concerns Bangor Team	Compliments and Concerns Bangor Team	Compliments and Concerns Wrexham Team	Compliments and Concerns. West Team	Compliments and Concerns Bangor Team
Bangor Team	1113	99	100	100	100	100	100	100	100
Donation Clinic (TG)	125	97	100	100	100	100	100	100	100
East A	2406	98	100	100	100	100	100	100	100
East B	2455	97	100	100	100	100	100	100	100
East C	1500	98	100	100	100	100	100	100	100
West Team	3882	99	100	100	100	100	100	100	100
Wrexham Team	2034	98	100	100	100	100	100	100	100
	Overall	98	100	100	100	100	100	100	100
	Benchmarks	95	95	95	95	95	95	95	95

In August 2022, the Welsh Blood Service (WBS) implemented a service user feedback system 'CIVICA' with the aim of improving capture and management of service user feedback through a digitally enabled system. The CIVICA system enables the Welsh Blood Service to gather comprehensive 'real time' service user feedback to inform service provision and to optimise service user satisfaction.

This service user feedback system is key in ensuring high quality service provision, collaboration with service users to inform service development, optimal service user satisfaction and regulatory compliance.

This is a position further reinforced by the requirements of the Health and Social Care Quality and Engagement Act (Wales) 2020 which requires Health and Social Care providers across Wales to place quality at the heart of service provision through adherence to core values;

- Putting Quality and Safety above all else
- Integrating improvement
- Focusing on prevention, health improvement and inequality
- Working in true partnerships
- Investing in staff.

This system will in particular support the Trust in meeting its Duty of Quality obligations under the Act.

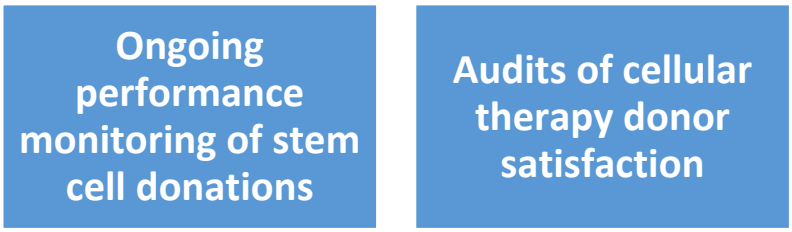
Since implementation of 'CIVICA' the WBS has received some impressive feedback from over 22,600 responses collected. An important part of receiving feedback is to ensure that lessons are learnt from identified failings and that actions are taken to reduce the likelihood of reoccurrence. The WBS have a range of processes in place to share learning, including direct feedback to staff members involved, team meetings, reports, newsletters, and clinical audits. The following spotlight on learning provides examples of how we improved and developed our services following feedback received during the year:

Examples of you said-we did:

YOU SAID	WE DID
➢ Parking facility improvement ➢ Finding parking difficult as very few places ➢ The car park could be bigger for patients but that is all.	Feedback received from service users in relation to parking at the Welsh Blood Service site led to a review carried out by the estates team who worked in collaboration with staff to facilitate the management of appropriate parking on site. Implementing an informative sign to guide and support has allowed Welsh Blood Service visitors to park with ease of access at the front of the building. Since the change has been implemented service users have fed back that Welsh Blood Service have great facilities, easy and accessible parking, and friendly staff. 
➢ Give better directions to clinic. ➢ Improve signage to clinic within venue. ➢ Directional signage within the car park to show where to go. ➢ Needed a sign by the front door to help find the room.	Ongoing Service Improvement Project's (SIP) are underway to look at current venue signage across all the collection teams. This piece of work is concentrating on sourcing and developing new signage that will direct donors at the venue site, from carpark to donation room.

➢ **Milk alternatives for the tea!** ➢ **Offer crisps as a snack.** ➢ **Have gluten/dairy free snacks.** ➢ **Provision of vegan-friendly snacks**	Since the introduction of a variety of vegan and gluten free biscuits, and dairy free milk across the collection teams, the Welsh Blood Service has received less feedback in relation to this theme. Some very positive feedback demonstrates donors continue to enjoy alternative snack options. Donors are also enjoying the Savory snacks introduced as part of feedback received, "I like the mini cheddars, they were a lovely change". Each collection team displays a bilingual poster to advertise the alternative options available for all donors to enjoy. 
➢ **Sadly, the building was very cold.** ➢ **The temperature in the room was on the cold side but otherwise felt the experience was good.** ➢ **It was very cold and could do with more heating.** ➢ **I appreciate it is January, but it was freezing in the hall.** ➢ **I arrived quite cold so it could have been a little warmer.**	Dyson Air Heaters/Coolers have been sourced for each collection team and can be used to cool or heat a room accordingly. Some venues are cold on arrival and take some time to warm up, that said, the room must be at a desired temperature for the integrity of the blood/product collected.
➢ **No dedicated motorcycle parking**	The facilities manager working in collaboration with estates have introduced a designated motor bike parking area at the rear of the Welsh Blood Service building with clearly displayed signage to the area.  

7.4. Audits of support provided by the Trust to transplant recipients and donors.



7.4.1 Ongoing performance monitoring of stem cell donations

Continuous clinical audits are performed of stem cell collection efficiency, CD34+ cell count in stem dell donations. Engraftment data is obtained from recipient centres. Donors are followed up to identify any pre and post donation issues. These are monitored against international standards and the data is reviewed in our own internal clinical governance / Quality and Safety structure and by the regulators. Performance was satisfactory throughout this period.

7.4.2 Audits of cellular therapy donor satisfaction

Welsh Bone Marrow Donor Registry (WBMDR) nursing staff undertook audits to assess the satisfaction of donors with the information and counselling they received prior to donation and with the donation process itself.

The responders all scored 5 / 5 that they were completely satisfied with their care. Positive comments were received about the quantity and quality of the information they were provided in relation to the donation process. All stated that they would recommend donating to others.

7.4.3 Audits of aseptic non touch technique, donning and doffing, hand hygiene and personal protective equipment use by cellular therapy nursing staff undertaking collections in the Velindre Cancer Centre

100% compliance was demonstrated for cellular therapy collection in the Velindre Cancer Centre for all the infection prevention and control measures.

QUALITY, SAFETY & PERFORMANCE COMMITTEE

2023/2024 Trust Annual Putting Things Right Report

DATE OF MEETING	11th July 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Sharon Wilson and Jade Coleman, Quality, Safety and Assurance Managers, Jayne Rabaiotti, Claims, Redress & Inquest Manager and Chris Kelly, Dep. Head of Quality & Safety
PRESENTED BY	Tina Jenkins, Head of Quality, Safety and Asssusrance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Velindre University NHS Trust Putting Things Right 2023-2024 Annual Report covers the period 1st April 2023 to 31st March 2024. The following are the highlights: • 202 concerns were raised, equating to less than 0.06% of patient and donor contacts (335,025). • 73% were successfully resolved via the 'early resolution' process (within 48 hours). • There has been an increase of 20% in Redress matters this is related to the impact of the legislative Duty of Candour requirements, which came into effect on 1st April 2023. • The main themes in concerns related to

	Velindre Cancer Service included communication with patients, and administration processes. • The main themes in concerns related to the Welsh Blood Service were in relation to the donation environment, and appointment and communication issues. • 2059 incidents were reported across the Trust throughout 2023/24. 84% being fully investigated and formally closed within 60 days of the incident being reported. 8 Incidents met the threshold to trigger the Duty of Candour. • There was a 55% reduction in National Reportable Incidents and a 75% reduction in Ombudsman referrals during this reporting period.

RECOMMENDATION / ACTIONS	To **ENDORSE** the 2023-2024 Velindre University NHS Trust Putting Things Right Annual Report prior to submission to Trust Board for approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group (IQ&SG)	22nd May 2024
Executive Management Board (EMB)	25th June 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***IQ&SG:*** That the draft report was condensed. Information was amended to ensure that cases could not be identified. To apply caution, due to low number reporting from an information governance perspective the annual report was amended to reflect comments and endorsed outside of the meeting. ***EMB:*** Endorsed for onward approval.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

APPENDICES	
Appendix 1	Complaints Grading Table

1. BACKGROUND

Regulation 51 of the NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011 (Putting Things Right) provides that each responsible body must prepare an annual report. The report must contain, as a minimum, the number of concerns received, the number of concerns deemed well founded and the number of concerns referred to the Public Service Ombudsman for Wales. In accordance with Regulation 51(1)(d), the annual report should also summarise:

- The nature and number of concerns received.
- Any matters of importance arising out of these concerns, or the way they were handled, including areas of concern within departments, staff groups, treatments or services provided, that is reporting on trends and
- Actions taken to improve services because of concerns being notified.

The report is aimed at providing assurance and evidence to the public, Welsh Government, regulators, and other stakeholders that the body is dealing with and learning from concerns in accordance with Regulations, and that concerns are being *investigated once and investigated well*.

It is important that the Trust say what we have done about concerns received and the lessons learned.

The organisation must ensure that the annual report does not identify individuals or any related sensitive information.

2. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The Trust 2023/24 Putting Things Right Annual Report is attached. The report provides information on how our systems and processes have developed over the reporting period for the effective investigation and engagement with patients/donors and their families, providing comprehensive responses to each concern raised.
The report also provides data on concerns, redress, National Reportable Incidents, Duty of Candour, compliments, and Public Service Ombudsman activity at Velindre University NHS Trust. This is first year that Duty of Candour Information is included since the enactment of the legislation in April 2023.

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
	The Putting Things Right Regulations and the Duty of Candour ensure that, in the interests of justice, there is a requirement to be open and honest and to ensure that adequate provision is made to assist those who are socially disadvantaged when dealing with concerns. As part of the concerns governance processes, there is a need to assess if any equality/social economic issues arise that could potentially have a consequence on the service user or those representing the service user's best interests in relation to a concern. Reducing inequalities prevents social injustice.
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
	Source of Funding: Other (please explain) The report contains details of redress matters against the Trust which give rise to financial impact in addition to potential reputational damage and lack of confidence in the services provided where harm is identified, all of which has the potential for adverse financial consequences. **Type of Funding:** **Revenue**

	Financial impact of the Trust Redress cases is outlined in the Handling Concerns Policy, Welsh Risk Pool Procedures and Welsh Risk Pool Indemnity arrangements. **Scale of Change** Please detail the value of revenue and/or capital impact: The Welsh Risk Pool indemnifies the Trust in respect to a damage's settlement, up to the PTR threshold of £25,000. **Type of Change** **Other (please explain)Other (please explain)** Please explain if 'other' source of funding selected: Not applicable.
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
	Not required for annual reports
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	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.

4. 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.

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust
2023/2024 Putting Things Right Annual Report

Contents

Introduction

Velindre University NHS Trust is a provider of specialist cancer, blood, and transplantation services, bringing together expert staff, high quality cancer care, donor, and transplantation services, excellence in research, development, and innovation. We have built a strong reputation across the United Kingdom and internationally for the services we provide.

The Trust have two main divisions: Velindre Cancer Service (which provides specialist tertiary non-surgical cancer care) and the Welsh Blood Service (which is responsible for the provision of blood and blood products) to NHS Wales.

The effects of harm, when something goes wrong, can be widespread and have devastating emotional and physical consequences, not only for the service users, but also for family members or representatives acting on their behalf.

The Trust places a high value on ensuring that we keep patients and donors at the heart of everything we do, and are grateful for the continued level of assistance, encouragement, and feedback that we get from our patients, donors, staff, and partners.

Whilst we pride ourselves in delivering high quality and safe services, there are occasions when things go wrong. When this happens, we are committed to resolving these matters with transparency and in accordance with legislative and national requirements in particular the NHS (Concerns, Complaints and Redress Arrangements) (Wales) 2011 commonly known as Putting Things Right (PTR).

Velindre University NHS Trust 2023-2024 Putting Things Right Annual Report provides an overview of how the Trust has managed concerns during the period of the 1st of April 2023 to the 31st of March 2024. The report outlines how our systems and processes have developed for the effective investigation and engagement with patients, donors, and their families, providing comprehensive responses. This ensures that changes have been made, lessons have been learned and action outcomes disseminated following the investigations.

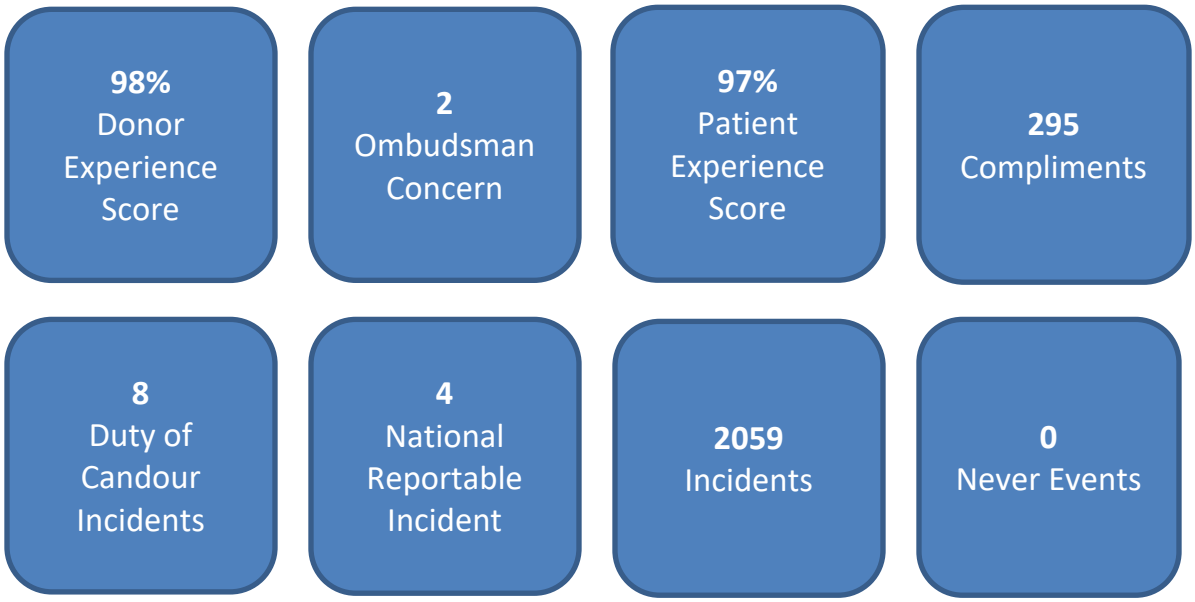
The Putting Things Right Regulations refer to the term “concern” which means any complaint, claim, or reported patient safety incident (about NHS treatment or services). This report sets out the themes in complaints, incidents, and redress cases. In this year’s annual report, we have extracted learning from concerns and redress cases into themes in a section of the

report focused on learning. As an organisation we are committed to learning from concerns to ensure we prevent avoidable harm and improve patient and donor experience.

Executive Summary

2023-24 At a Glance

Number of Concerns Raised	Number managed as Early Resolution	Number managed under Putting Things Right (PTR)	Compliance with PTR timescales
202	147 (73%)	55 (27%)	93%



Did we do what we said we would during 2023/24

In last year's annual report, we set our priorities for 2023-24. How did we do?

- We said we would **continue to listen to our patients, their carers, and our donors, putting things right where things have gone wrong**. The Trust has continued to adhere to the Putting Things Right regulations, reporting and recording concerns, and acting on feedback received, learning from what we find, and putting in place actions to improve.
- We said we would **fully implement and embed the new requirements of the Health and Care Quality Standards**. The Trust has adopted the Standards in full, including the new Duty of Candour. We have put quality at the heart of our processes and decision making and built robust quality governance structure to ensure this continues.

- We said we would **establish a Quality Management System**. The Trust has developed two new frameworks: the Incident Management Framework and the Learning Framework. The frameworks set out how we manage, respond to, and learn from concerns.

- We said we would establish **"Always on" reporting metrics** to aid continual improvement opportunities and real time investigation of concerns that are raised. We have started Always on reporting of patient experience measures, however we need to expand this much further during 2024-25.

- We said we would **implement a revised Complaints, Incident and Claims Policy** in line with current legislation and Welsh Risk Pool protocols. These have been updated and approved.

- We said we would **devise and implement standard operating protocols which will incorporate Learning from Events flowcharts, PTR Panel and Redress flowcharts**. Following appointment to key Quality & Safety positions in the Trust, significant work has been undertaken to review and update our protocols in regard to the above.

- We said we would **review and audit the Once for Wales Datix Cymru system** for all our concerns modules. Regular audits are now taking place and are showing that review arrangements are in place to provide assurance that any errors identified will be rectified.

- We said we would **continue professional development**. As well as undertaking additional complaints and serious incident investigation training, the Quality & Safety teams have engaged staff across both divisions to provide update training and support, as well as feeding back learning after incidents and concerns.

- We said we would **enhance the recording of compliments on the Datix system**. Velindre Cancer Service has taken this action forward and is now utilising a range of methods, including the Datix system, to record and share compliments received for the service.

We also recognised the importance that positive feedback can have on staff wellbeing and developed in collaboration with our Communications Team a **'Wall of Thanks'** to share patient and donors' kind feedback.

"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.

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."

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."

East B

"Fantastic staff as always,

Bangor

"Diolch i'r holl staff am fod mor glên. Hefyd mor braf cael staff Cymraeg i helpu."

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."

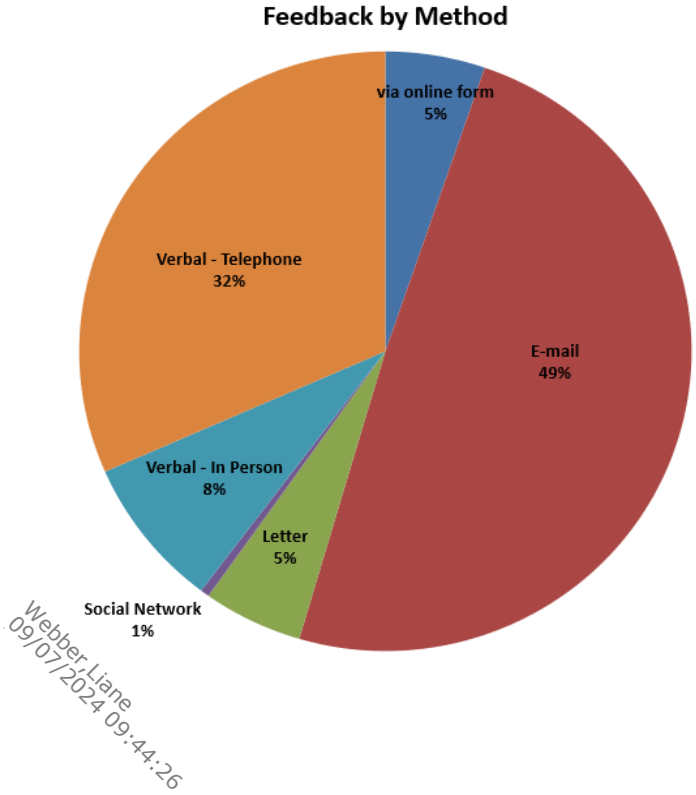
Complaints Management

Raising a concern will be easy and information will be widely accessible. Put the complainant at the centre of the process and provide support for individual requirements.
Listen to concerns and treat everyone with dignity and respect.

Complaints are received via several routes and is evident that e-mail communication remains the preferred method of contacting the Trust, with **49%** of complaints being received in this way. The Trust has seen a 6% reduction in complainants using email to raise concerns, in comparison to the previous year. Velindre Cancer Service have introduced a new online form for complaints, which accounts for the reduction in email contact.

Feedback reporting channels include:

ONLINE | TABLET | EMAIL | PHONE | QR CODES

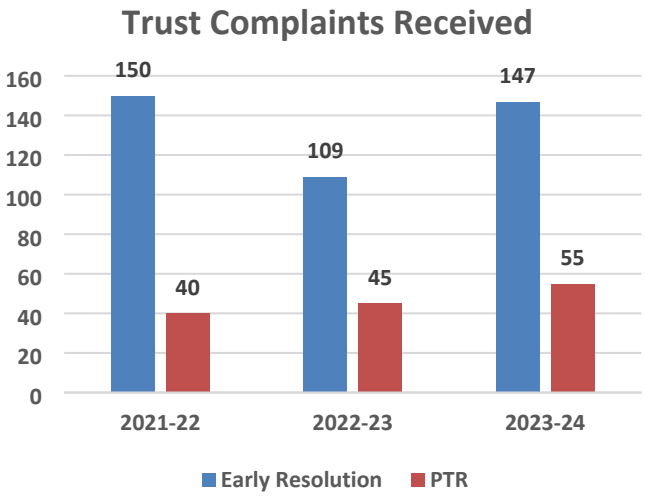


The Trust has positively engaged with Llais by meeting with their Public Engagement Officer and requesting feedback from members of the public on how they would like to see our information presented. We include Llais information and leaflets in all our complaints correspondence to signpost patients, donors, and families to the advocacy services they provide for people who want to raise a concern.

Complaints Received

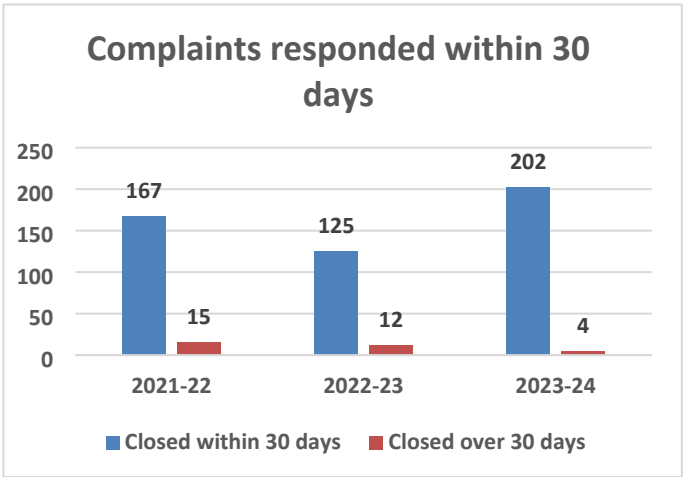
Acknowledge all concerns within 2 working days.
Aim to resolve concerns at source, or by the end of the next working day. Responses required under PTR will be provided within the legislative timescales.

202 complaints were raised, equating to less than **0.06%** of patient and donor contacts. The number of complaints has risen in comparison to previous years (see graph on right), however as a percentage of activity this remains unchanged. When a complaint is investigated under Putting Things Right, an acknowledgment is provided to the complainant within 2 working days of being raised. Welsh Government requires Health Bodies in Wales to thoroughly investigate all complaints received and that 75% of these be resolved within 30 working days of receipt.



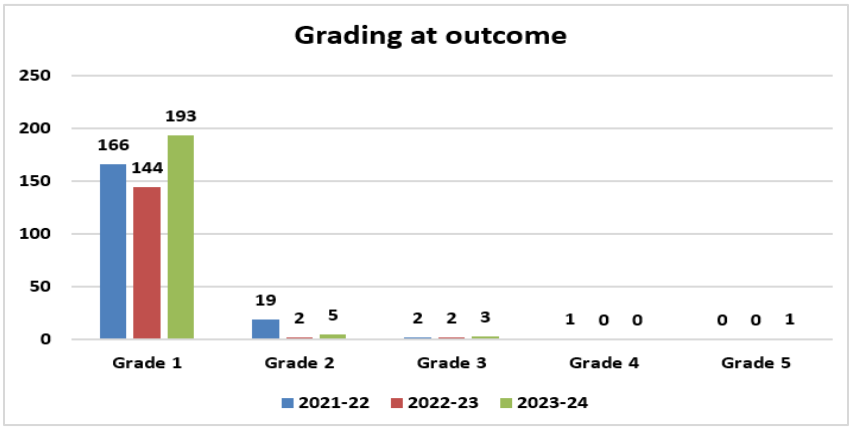
How did we do?

Due to Datix system changes the Trust only has direct comparative data over the last three years. The Trust has continued to respond comprehensively to all complaints during 2023-24, with 93% being investigated, resolved, and closed within 30 working days of receipt (Welsh Government target is at least 75%) and 73% of those received were successfully resolved via the 'early resolution' process.



Complaint Grading

All complaints are graded upon receipt, from 1 (No Harm) to 5 (Catastrophic Harm) in accordance with the All-Wales Grading Framework. This will determine the level of investigation required in dealing with the issue(s) raised. All complaints undergo an assessment of harm to determine the grading and whether there is a possibility that the Trust may have breached its duty of care, to ensure that the appropriate level of investigation is commissioned.



98% of the complaints raised were low level with no or low harm and graded a level 1 or 2, this is an increase of 3% on the previous year.

There were three grade 3 and one grade 5 complaints. These related to issues including:

- Communication throughout treatment
- A delay in chemotherapy
- Pain management
- Staff conduct
- Chemotherapy dosage and discharge planning

Within Velindre Cancer Service, 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 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.

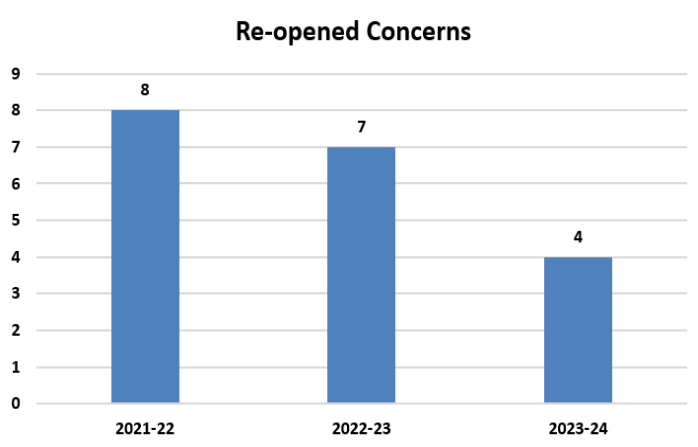
- A recurrent theme around the length of time patients are waiting resulted in the lowest patient satisfaction score to waiting in outpatients dept and radiotherapy. The scoring for "How did you find the waiting time in your recent visit" has been reviewed and adjusted as it was negatively scoring the "about right" response. This has now been made a positive score which has therefore shown an increase in the overall percentage.

Within the Welsh Blood Service, top complaint themes during the reporting period were identified and relate to **appointment & communication** issues which are shared at a divisional level for consideration and to address.

Learning and improvement identified from complaints and incidents can be found on page 19.

Re-opened Complaints

Occasionally a complainant will be dissatisfied with the formal response they have received or require further information and will contact the Trust again. In these instances, the complaint will be re-opened. The number of re-opened complaint can be an indicator of the quality of investigations and responses.



There were **4** complaints re-opened during the year. There has been a steady reduction in re-opened complaints over the last 3 years (see graph right). All 4 of these were promptly reviewed, re-investigated when required and managed, through to final closure.

As part of our complaint response improvement work, we have focused on ensuring the provision of a comprehensive initial response. The 4 cases were re-opened as the complainant raising further queries following the Trust response, seeking clarification on particular elements of the response.

Welsh Language Complaints

The Trust did not receive any complaints relating to the provision of services in the Welsh. There were no complaints in respect of the Welsh Language provision on patient and donor facing internet pages. The Trust Welsh Language Officer continues to update the current internet platform to include content in both the English and Welsh languages. This includes ensuring Welsh versions of Trust policies and procedures are available in line with Welsh Language Standards requirements.

Complaints training and improvement

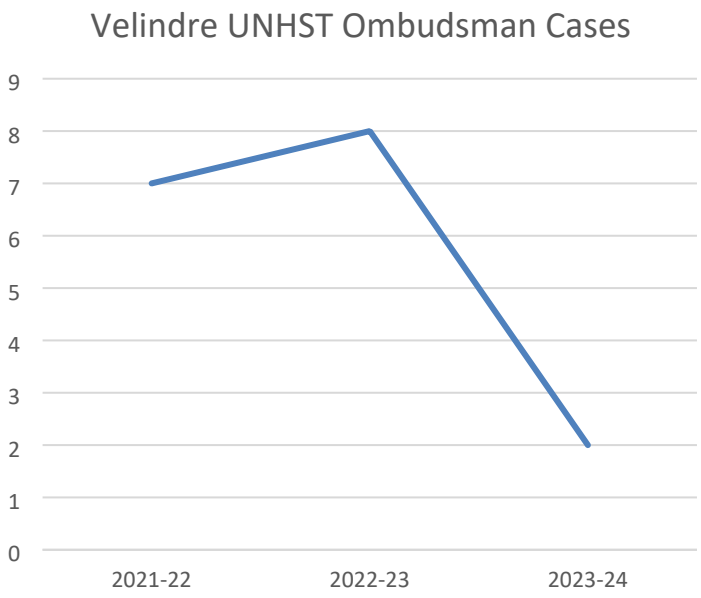
The Trust commissioned training on how to complete effective responses to complaints, that focussed on the principles of good complaint handling and effective writing skills. 13 employees who are involved in the management and investigation of complaints attended this training. Following this training, the complaint template letters were reviewed to ensure they reflect the good practice learned in the session, and that they are accessible for people who require reasonable adjustments.

Public Services Ombudsman for Wales

When a complaint cannot be resolved to the satisfaction of the complainant, they can refer the matter to the Public Service Ombudsman for Wales (PSOW), an independent government body offering free, impartial services to those wishing to raise complaints in relation to public bodies and NHS organisations throughout Wales. The Ombudsman has legal powers to uphold concerns and make recommendations for learning and improvements to prevent similar incidents from happening again. Where an investigation outcome finds that significant injustice has occurred to a complainant, the PSOW can make its findings public. Any public report is shared across NHS Wales.

Despite every effort to provide a comprehensive response to the issues raised, there will, on occasion, be complainants who will remain dissatisfied with a response. To help mitigate against this, the Trust offers the opportunity to meet with relevant personnel to address any unresolved issues in the hope of reaching a resolution to their complaint.

The Trust was referred to the Ombudsman on two occasions. The areas of concern referred to the ombudsman included lack of or poor communication / documentation, delay in referrals / follow up appointments, and delay/failure to treat. These are shown in the graph to the right.



Outcome/Recommendations relating to Velindre University NHS Trust

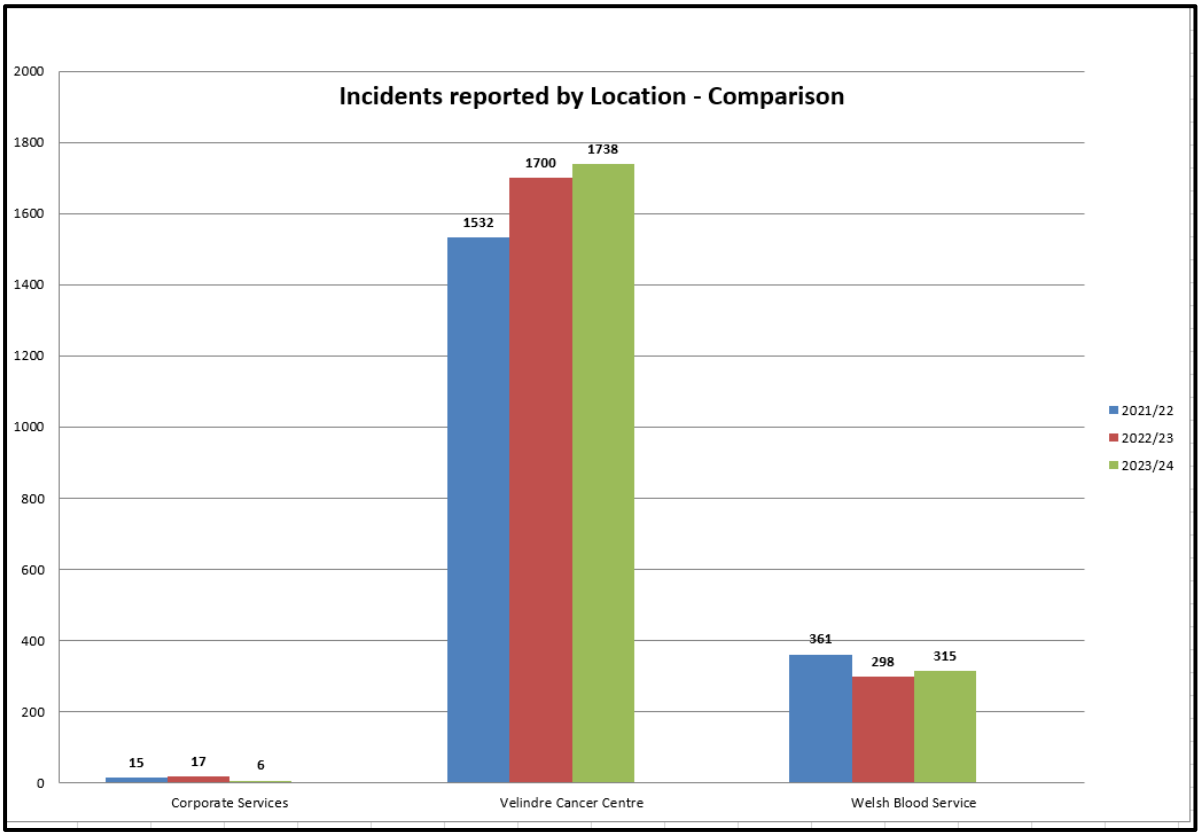
Following an Ombudsman investigation, a final report was issued to the Trust. The Ombudsman felt that the patient should have been offered treatment and that a more balanced explanation involving the risks and benefits should have been discussed and documented. In this regard, the Ombudsman upheld the 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:

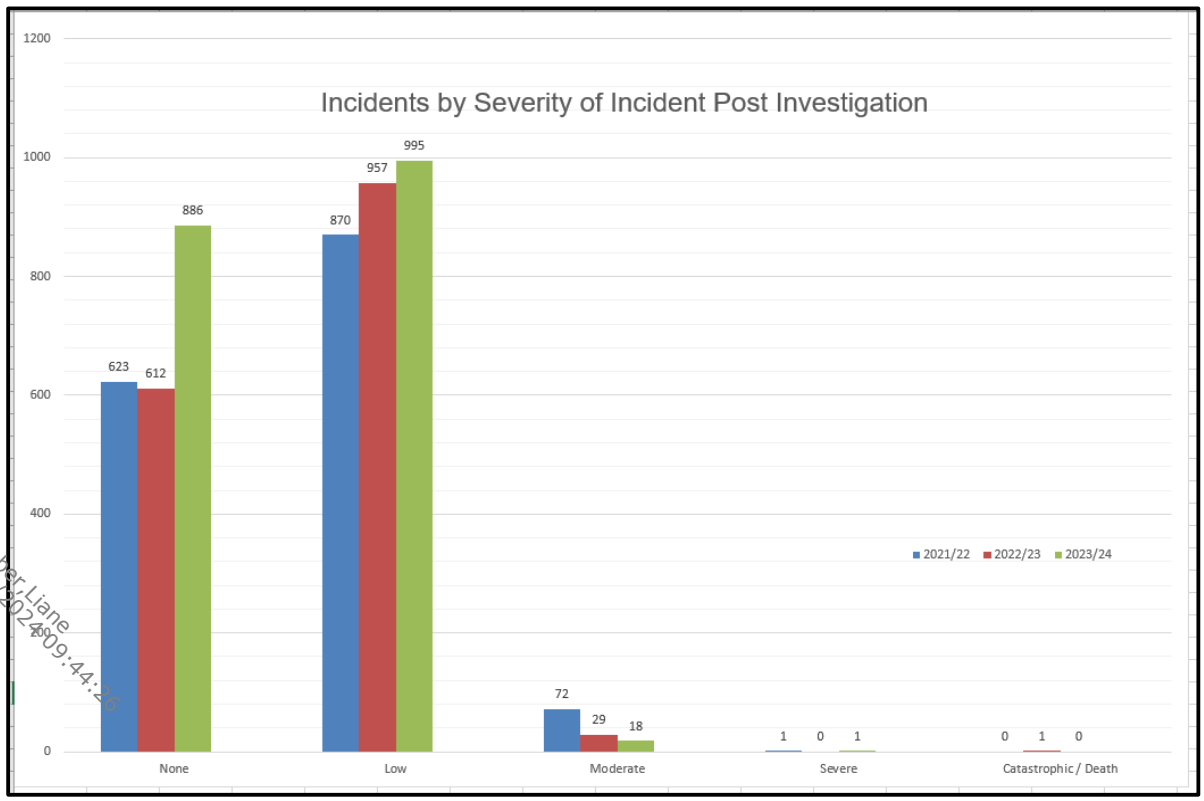
- To apologise for the failings identified in the report and
- To review its documentation and communication relating to the decision taken and for staff to be reminded of relevant national guidelines.

Incidents

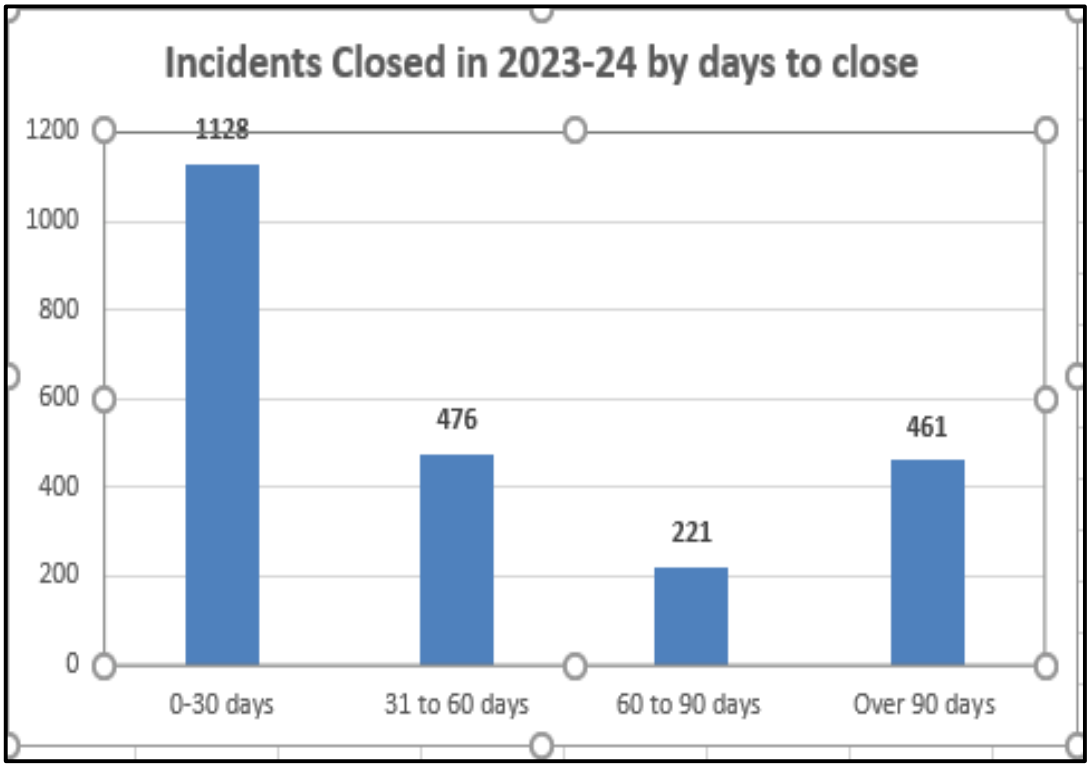
An incident is described as an event or circumstance that resulted in or could have resulted in unintended harm, complaints, loss, or damage to one or more patients/donors or service users. This includes adverse events, near misses and omissions where potential benefits from medical interventions were not provided. The Trust reports all incidents using the DATIX Cymru system.

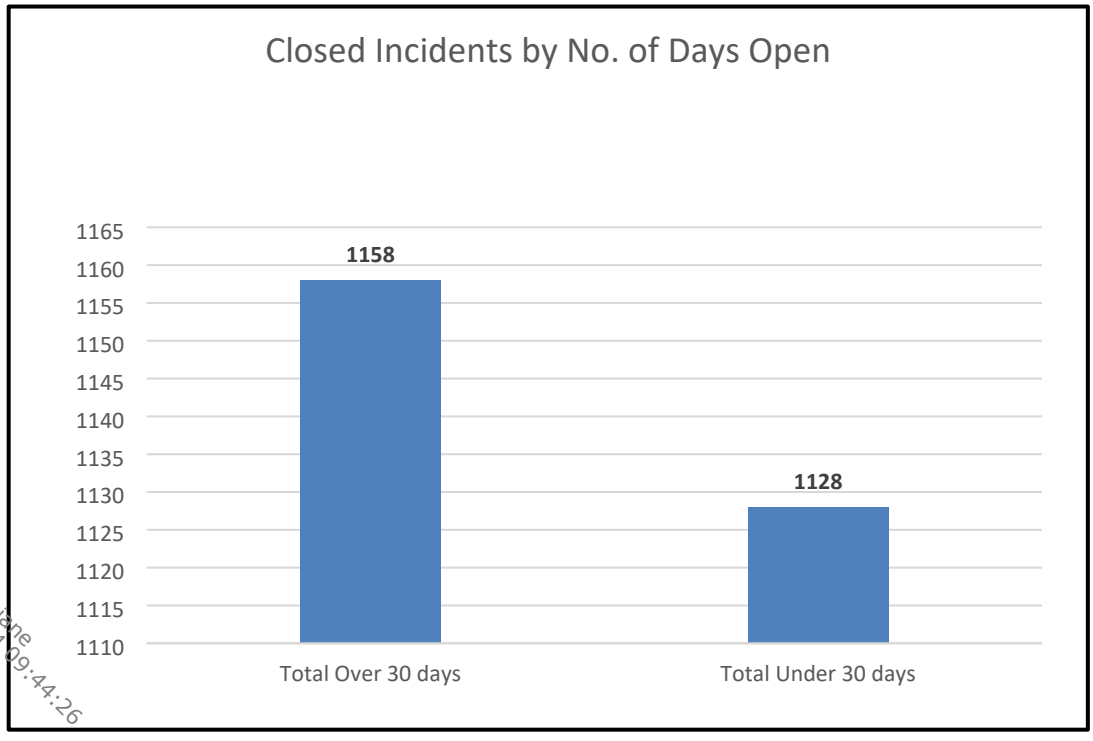
2059 incidents were reported across the Trust throughout 2023/24. The Trust recorded 245,535 patient contacts by Velindre Cancer Service and 89,490 Welsh Blood Service donor attendances, equating to a 0.6% of activity. The graphs below display the number of incidents by each Division and investigated, with the severity confirmed at closure by comparison to previous years.



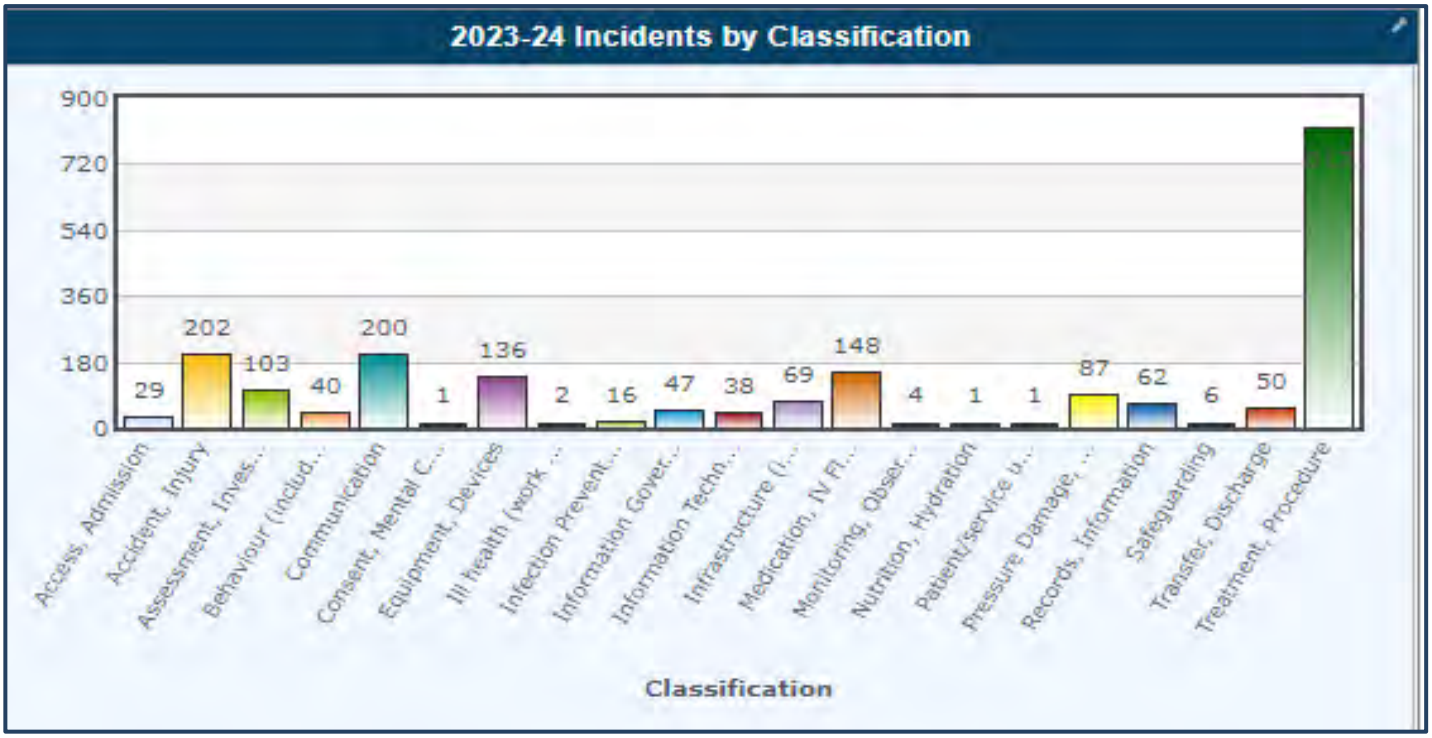


The Trust has improved the time taken for incidents raised via the Datix system to be investigated and concluded. Dashboards have been created within Datix to show all open incidents and for every directorate. These Dashboards have been introduced in the monthly directorate meetings, with focused action taken in service areas where there have been delays. This has resulted in a reduction in incidents open over 30 days from 570 in Quarter 4 2022/23, to 162 in Quarter 4 2023/24.

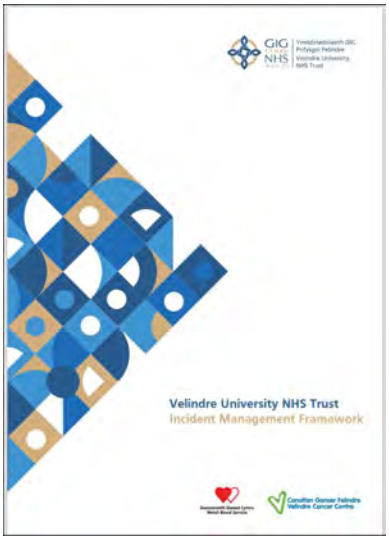




Treatment and Procedure was the highest category of incident reported.



The Trust has revised its Incident Management Framework. The purpose of the Framework is to support colleagues in the management of incidents, guide decision making, establish a standardised approach, and help us learn as an organisation. The emphasis of the Framework is on taking a compassionate approach to incident management. It reinforces proportionate investigations in the spirit of *investigate once, investigate well*. The Framework takes consideration of human factors and psychological safety and promotes SMART action plans. Next steps will include embedding the approach described in the Framework into the culture.



We have also introduced a rapid review /Make It Safe meeting for incidents graded moderate or above, or where there are potential near misses, or themes and trends. This meeting promotes the concept of psychological safety and a 'no blame' learning culture. The meeting allows staff to find risk reduction solutions and identify system improvements using a collaborative approach. Following these meetings, a Terms of Reference for an investigation is agreed and any support for individuals involved in safety incidents is considered.

Duty of Candour Triggers

From 1st April 2023, the Duty of Candour became a legal requirement for all NHS bodies in Wales. It requires organisations to be open and transparent with their patients where harm is caused whilst receiving health care. The Duty of Candour is outlined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and applies if the care we provide has, or may have, contributed to "*unexpected or unintended moderate or severe harm, or death".*

The Trust is required to review incidents to determine whether the procedure has been triggered and follow the Duty of Candour notification processes. An investigation then takes place in line with Putting Things Right Regulations 2011.

The Duty of Candour has led to a closer, more timely, scrutiny of incidents in the Trust. There were 8 incidents that triggered the Duty of Candour. 2 of which remain under investigation.

What do we mean by moderate or severe harm?

Moderate Harm:
A service user experiences a moderate increase in treatment and significant but not permanent harm, and the care provided by the NHS did or may have contributed.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to a significant reaction requiring four or more days in hospital before recovery.

Severe Harm:
A service user experiences a permanent disability or loss of function and the NHS care did or may have contributed.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to brain damage or other permanent organ damage.

Death:
A service user dies and the NHS care did or may have contributed to the death.

For example, they are given medication despite this being documented in their notes as an allergy, and this leads to their death.

What can you expect?

Here is a summary of the Duty of Candour Procedure that the NHS will follow:

On first becoming aware that the duty of candour applies, the NHS must notify the service user or a person acting on their behalf. This contact should be 'in person', which means by telephone, video call or face to face.

The purpose of the 'in person' notification is to offer an apology, provide an explanation of what is known at that time, offer support, explain the next steps and provide point of contact details.

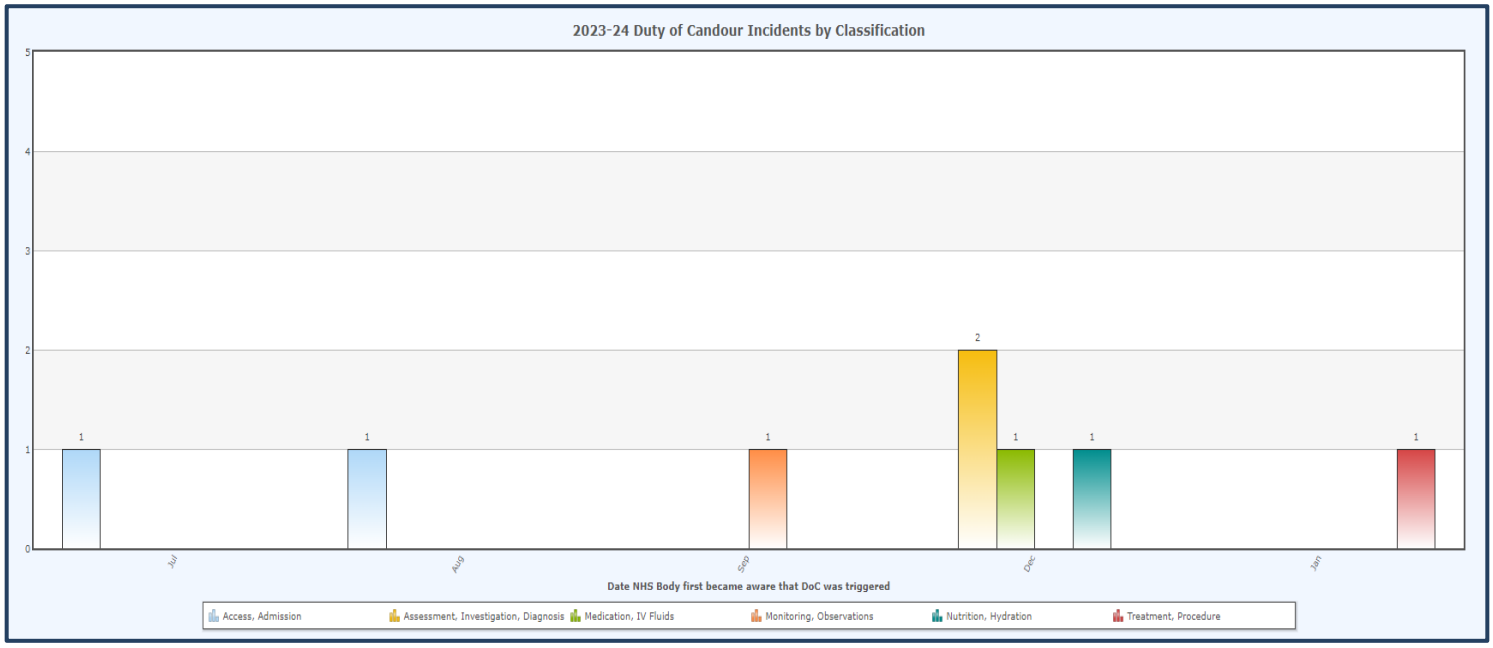
The service user or person acting on their behalf will be sent a letter within five working days, confirming what was said in the 'in person' notification.

The NHS will undertake an investigation to find out what happened and why, and how we can prevent it from happening again.

This will take place according to the NHS Wales 'Putting Things Right' Procedure.

The named point of contact provided as part of the Duty of Candour procedure will give you more information about this process and what happens next.

The table below refers to the incidents that have triggered the act since its inception in April 2023:

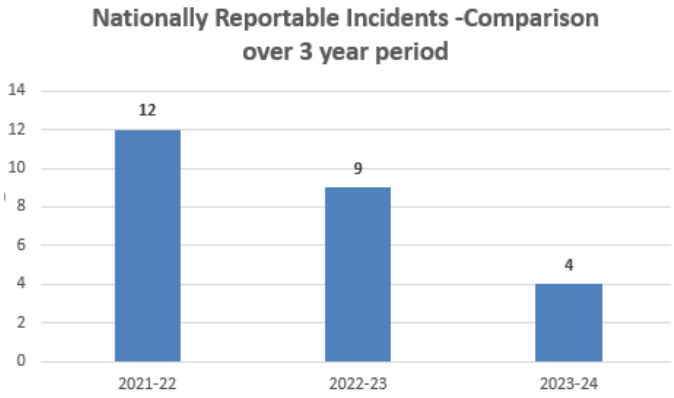


Duty of Candour incidents included delays to treatment, and a theme emerged relating to referral processes at Velindre Cancer Service. These include internal referral management processes, as well as referrals made to other organisations for follow up care. Learning and action taken is described on page 19.

National Reportable Incidents (NRIs)

Any patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare, is nationally reportable. The Trust report all National Reportable Incidents to the NHS Executive.

There were **4** incidents that met the threshold to be reported nationally. A continued steady reduction of NRIs has been seen over the last three years as previous shown in the chart. However, the criteria for NRI changed in 2021, requiring a higher threshold.



The main theme relating to NRIs is lack of robust referral processes at Velindre Cancer Service. Some of the identified issues included:

SUMMARY OF CARE SERVICE DELIVERY ISSUES IDENTIFIED

Issue 1	Velindre Cancer Service lacked a robust referral management system, relying heavily on email and letter correspondence via number of routes (inboxes and recipients). Variation in practice was identified.
Issue 2	Evidence of lack of adherence to policy and procedures.
Issue 3	A lack of support and training for Junior medical staff on the importance of oncology drug prescribing, outpatient follow up, and important actions for the GP during the discharge process.
Issue 4	An overreliance on email as a method of communicating urgent clinical matters within Velindre Cancer Service, leading to delays in treatment
Issue 5	Staff sickness, workload capacity, and supervision.

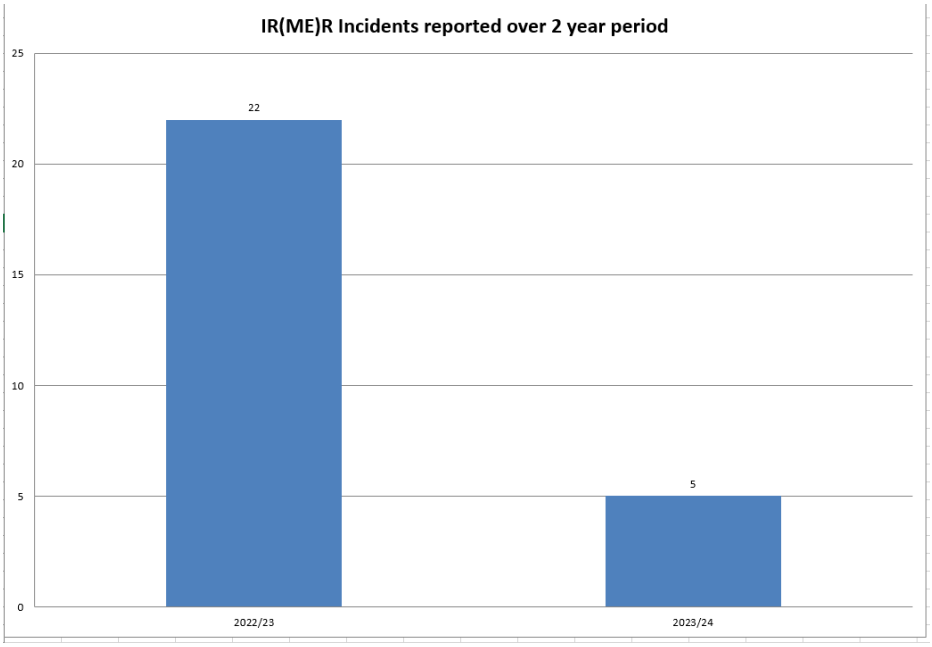
For further details on improvements that have been made, please see the Learning and Improving section on page 19.

A key theme identified last year (2022/23) was avoidable harm attributed to inpatient and outpatient falls. Improvement work has been undertaken to reduce the risk of patient falls at the Cancer Centre, and, as a result, this year there have been no incidents of avoidable harm related to falls. Work undertaken included the development of a new Standard Operating Procedure for the reduction of falls risk, the introduction of a falls scrutiny panel to draw learning where they occur, and the purchase of improved chairs in the outpatient department.

Ionising Radiation (Medical Exposure) Regulation (IR(ME)R) Incidents

When there is an accidental or unintended exposure to ionising radiation, and the **IR**(ME)R employer knows or thinks it is significant or clinically significant, they must investigate the incident and report it to the appropriate UK IR(ME)R enforcing authority (under Regulation 8(4). The Trust reports such incidents to Health Inspectorate Wales (HIW).

The Trust reported **5** Ionising Radiation (Medical Exposure) Regulation (IR(ME)R Incidents to HIW during 2023/24 this shows a marked reduction in the number being reported in the previous year, where 22 IR(ME)R incidents were reported and were mainly attributable to an equipment related issue stemming from a known national manufacturing fault with Elekta Xvi system.

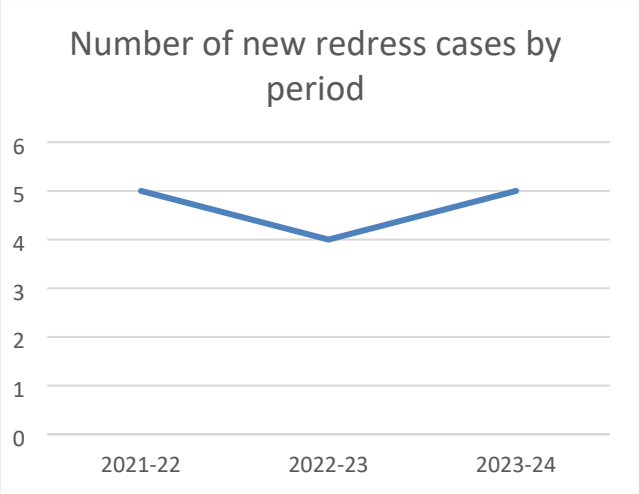


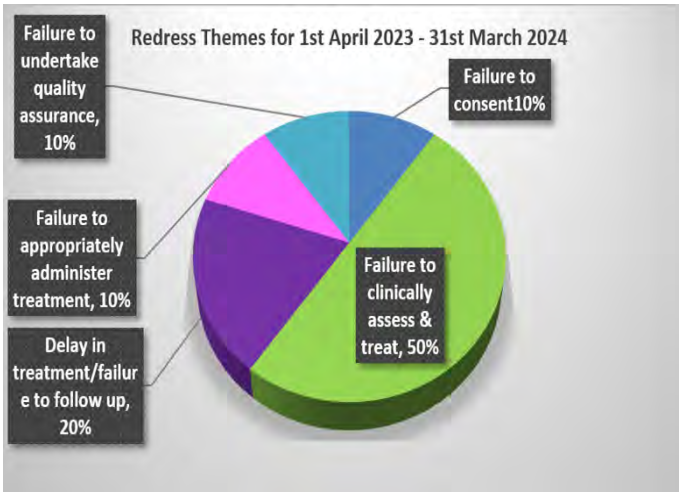
All of the incidents reported in 2023/24 met the criteria for no or low harm but met the reporting classification specifications and were fully investigated with a theme of data recovery errors which have been rectified by Radiotherapy Physics. No concerns were raised by UK Health Security Agency or Health Inspectorate Wales regarding these incidents.

Redress

A case is transferred under the Redress arrangements of the Putting Things Right Regulations (2011), when it is identified that a breach in the duty of care has occurred and a service user has suffered harm, or potential harm, caused by the breach of duty. Where an investigation concludes that a breach of duty and harm has occurred, the case is presented to the Trust's Redress Panel who determine if a qualifying liability exists or may exist.

There have been 5 new redress cases. Please see table below for Redress themes.





The remedies available in relation to the Redress arrangements in accordance with the Putting Things Right Regulations include:

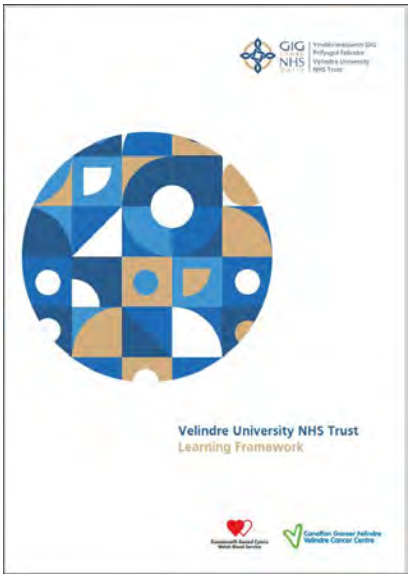
- A full explanation of what happened.
- A written apology
- A report on the action which has been or will be taken to prevent similar cases. arising and/or
- An offer of financial compensation and/or remedial treatment up to £25,000.

There has been an increase in redress matters during this year. This is related to the impact of the legislative Duty of Candour requirements, which came into effect on 1st April 2023 resulting in a notable increase in the number of concerns triggered by the legislative Duty of Candour requirements,

Learning and Improving

Ensuring that we learn and improve when things go wrong to prevent it happening again is of critical importance. Ongoing analysis of complaints and incidents allows the Trust to identify areas that require improvement and highlights systemic issues. Robust investigations are key to this so that the route cause and contributory factors are all identified so we can ensure that the changes that will make the biggest difference are identified. The Trust takes a proactive approach that fosters a culture of continuous improvement. One of the Trust's identified quality priorities for 2023/24 is to create conditions for staff to feel psychologically safe. This promotes a culture focused on learning and improvement, not individual blame.

During this year the Trust has developed a Learning Framework. The Framework sets out 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 Trusts healthcare services.



The Framework shows examples of how learning can be captured and shared, including sharing learning at professional forums, team meetings, Trust-wide communications and using learning and post-reflective events following incidents to bring staff together to learn from each other's perspectives.

The Learning Framework encourages a Just Culture which avoids blaming individuals and looks at issues with the system. This culture encourages managers to treat staff involved in a patient safety incident in a consistent, constructive and fair way.

Velindre Cancer Service – Learning & Improving

Theme: ***Administrative processes including communication***
Issues identified: - A number of patients have reported difficulty in contacting the Cancer Centre by telephone, or not receiving responses to answerphone messages left. - Patients reported that appointment time and location changes were not communicated in a timely manner. - A review of documentation systems identified delays in sending clinical letters to GPs, and that patients were not routinely copied into letters. - Several patients experienced treatment delays due to issues with referral processes.
Learning identified: - There was variation in practice within the Trust's administrative processes - Demand on the Cancer Centre, combined with staffing issues meant that pressure on services was impacting on the ability of staff to complete processes in a timely

manner

- The Cancer Centre telephony system is outdated and requires updating

Action taken:

- A review of telephony systems and arrangements has taken place. Updates were made to answerphone messages to ensure patients have clear instructions for who to contact.
- Several Root Cause Analysis investigations have been undertaken, with recommendations made to the service for improvements. Action plans have been created, and work is underway to strengthen referral processes.

Theme: Monitoring of blood results for Systemic Anti-Cancer Therapy patients

Issues identified:

There was a lack of process to ensure unwell patients' blood results were reviewed in full during the on-call period.

Learning identified:

More robust procedures for the monitoring of Systemic Anti-Cancer Therapy patients' blood results were required, to ensure that these are acted on in a timely fashion.

Action taken:

- Investigations were carried out into the issues with the timely monitoring of blood results.
- Additional blood results have been added to the clinical system used to record chemotherapy care.
- Clinical assessment documentation and escalation pathways have been strengthened.

Theme: Systemic Anti-Cancer Treatment Helpline issues

Issues identified:

- The number of 'out of scope' calls to the Treatment Helpline was affecting the timely response to Systemic Anti-Cancer Therapy patients.
- The triage tool used by Helpline staff was not sufficiently robust and required updating.

Learning identified:

A more robust triage and escalation process for patients is required to ensure patients calling the helpline when unwell are directed to appropriate care as soon as possible.
Action taken: - Enhanced Systemic Anti-Cancer Therapy training for staff will now include assessing and completing the UK Oncology Nurses Society triage tool. - Development of an escalation pathway for patients requiring urgent medical reviews. - An external peer review was commissioned into the Treatment Helpline, with a number of recommendations for improvement made. Areas of good practice were identified. - Work has been undertaken to ensure that patients calling the Cancer Centre are directed to the appropriate department, to reduce the number of 'out of scope' calls to the Treatment Helpline.

Theme: Outpatient waiting times
Issues identified: Patients have fed back to the service that waiting times in outpatient areas are too long
Learning identified: - Ways of working - Environmental factors
Action taken: - Additional room capacity has been made available to increase the number of patients who can be seen at once. - Communication with patients about possible delays have been improved.

Welsh Blood Service – Learning & Improving

Theme: Improvements to the donation environment
Issues identified: Based on feedback from donors, a number of issues were affecting donor comfort at remote venues around Wales.
Learning identified:

- The temperature of the donation venues was not always comfortable for donors, being either too hot or too cold. - The provision of gluten-free and vegan snacks was requested by donors. - The presence of flies was an issue at one venue. - Donors experienced parking issues at some venues.
Action taken: - Fans that can produce hot or cold air have now been provided to blood collection teams. - Gluten-free and vegan snacks are now routinely provided. - Communication about car parking arrangements at venues is now sent to donors in advance of appointments.

Theme: Donor feedback collection
Issues identified: - Following the return of mobile blood collection teams, after the Covid-19 pandemic, no electronic means for donor feedback capture was available. - A lack of connectivity at remote collection sites was affecting the ability of staff to collect donor feedback using devices
Learning identified: Devices and remote connectivity were required for staff to collect donor feedback at remote sites.
Action taken: Teams have been provided with tablets to utilise the CIVICA donor experience system.

Priorities for 2024/2025

The Trust will build on its successes in the 2023/2024 period and continue to learn and improve in line with both feedback from those we serve, and the findings of our own internal work to identify opportunities to improve the quality of our services.

- Our new Learning and Incident Management Frameworks promote a compassionate approach to staff, donors and patients involved in safety incidents. We will work with

colleagues to ensure the frameworks are embedded in our organisational culture, focusing on support, proportionality and a no blame approach.

- When things go wrong, we will conduct proportionate investigations in a timely manner, ensure we learn from what happened and take action to improve our services.
- Utilising the knowledge from our complaints training and ensure that our complaint responses are equitable, and opportunities are taken to identify people who require reasonable adjustments at the earliest opportunity. We aim to ensure our complaints process is accessible to all. Building on the learning from our recent training, we will make our complaints process more accessible at all stages to those who require reasonable adjustments. This includes providing information in a variety of formats, and tailoring our response to the requirements of the person who has raised a complaint.
- To develop a Civica survey to elicit feedback from people who raise concerns to identify areas to improve our complaints handling process.
- To build on the improvements we have made in 2023/24 in the timely managements of safety incidents.
- To develop digital storytelling as a way of capturing feedback and learning to improve our services. Digital story telling involves the development of recorded video and audio pieces to help patients, donors and our staff to share their experiences.
- To further develop ‘Always On’ reporting metrics in line with the Duty of Quality requirement. Always On reporting allows our patients, donors, staff, and the wider public to access key measures of our performance in near real time.

Quality, Safety and Performance Committee

Duty of Quality Annual Report

DATE OF MEETING	11th July 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	ENDORSEMENT FOR ONWARD APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Tina Jenkins, Head of Quality, Safety & Assurance
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director Nursing, AHP & Health Science

EXECUTIVE SUMMARY	This is the first draft of the Trust's first Duty of Quality report that has been developed in line with the Duty of Quality statutory requirement. The report includes the steps the Trust has taken to comply with the duty and improvements that have been made across our services. The Trust reached out to Llais to gather views of the public on how they would like to see information presented. It is recognised that this report will mature in future years. Key messages are. • The Trust has made good progress on the agreed quality priorities for 2023-2024. However further work is required during 2024/25 • The Trust has adopted and implemented the national Quality Impact Assessment process to support quality led strategic decisions. • Further work is required to develop our quality data and always on reporting metrics.

RECOMMENDATION / ACTIONS	To **ENDORSE** for onward approval the first Trust Duty of Quality Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality and Safety Group	22/05/2024
Executive Management Board	25/06/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***Integrated Quality & Safety Group*** - Agreed contents of the report. ***Executive Management Board*** – Endorsed pending further development and additional improvement being added.	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed

1. BACKGROUND

The Welsh Ministers are required to publish an annual quality report on the steps they have taken to comply with the duty to exercise their functions in relation to the health service with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps, and the Welsh Ministers must lay a copy of the report before the Senedd.

Each Local Health Board, NHS Trust and Wales-only Special Health Authority is required to publish an annual quality report on the steps it has taken to comply with the duty to exercise its functions with a view to securing improvement in the quality of health services. The report must include an assessment of the extent of any improvement in outcomes achieved by virtue of those steps.

2. ASSESSMENT

2.1 Duty Of Quality Annual Report Proposal

Quality reporting requirements (Duty of Quality Statutory Guidance 2023)

The annual quality report allows actions taken by NHS bodies and quality improvements to be monitored transparently. The report should describe the progress and challenges on the quality journey to their respective population and stakeholders. Quality reporting needs to be meaningful for NHS bodies, their stakeholders and our population if it is to optimise real time learning, improvement and sharing opportunities. Quality reporting

should reflect the breadth of the Health and Care Quality Standards and quality management system within its structure and content.

A section of the Duty of Quality Statutory Guidance (2023) details the requirements to publish an annual quality report, the evidence to be used in support of an assessment and the conduct of an assessment.

'*NHS bodies may choose to use various qualitative and quantitative data and information to support their quality reporting duty. They should focus on information that will demonstrate the duty of quality in decision-making, action taken following learning, quality improvement and ultimately, improved outcomes for the population. The Health and Care Quality Standards and quality management system components provide a quality report structure. It is recognised that there is already significant work underway across the health system relating to indicators and measures. The intention is that NHS bodies will make use of information and reporting mechanisms already in place wherever possible. They will need to adopt an agile approach to mature their quality report as outcome measures develop, aligned to the Health and Care Quality Standards.*

- T*he annual quality report is intended to summarise and reflect an NHS body's progress to improve the quality of their services and population outcomes. It is anticipated that NHS bodies will sign-post readers to the information provided through the 'Always on' reports that outline learning and improvements that have been made at regular intervals through the year.*
- *The annual quality report should include a look back at what has been achieved, including where things may not have gone well, together with a forward look about the organisation's quality priorities and ambitions for the upcoming year, alongside how progress will be monitored. There should be continuity between annual reports across subsequent years.*
- *The annual quality report will describe what key strategic decisions have been taken by the NHS body, and how the duty of quality has informed these decisions.*
- *The annual quality report should be prepared as soon as practicable after the end of each financial year. To streamline reporting requirements and reduce duplication, it is suggested that NHS bodies align the annual quality report to their Annual Report and Accounts process.*
- *Examples of evidence to be used to assess the duty of quality and the extent of any improvement in outcomes includes:*
- *Existing performance, outcome and delivery indicators and measures from the quality management system*
- *Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)*
- *Mortality data*
- *Information contained within the Once for Wales Concerns Management System such as incidents and concerns.*
- *Patient and staff stories*
- *Strategic decision-making that has been driven by the Health and Care Quality Standards*

- *Reports following external reviews or inspections by inspectorate and licensing bodies.*
- *Consideration of the recommendations and implications of significant national reports, for example, following national inquiries*.

2.2 Planning for our Duty of Quality Annual Report

A meeting was held on the 2nd of February 2024. The meeting was attended by all division's quality representative and support from the NHS Executive Quality team to support in the early planning stage. Key messages from the Duty of Quality Report Meeting:

- A template will not be prescribed or shared from the NHS Executive or Welsh Government.
- The report should be prepared for the reader as a member of the public.
- The Quality Annual Report should have a chair and chief executive summary.
- We should ask our population what they want to know and how they would like information presented.
- Ensure that the report is linked to the organisation's strategic quality priorities.
- Include the Trust priorities for next year.
- Present your report as a story, this is not an assurance report for the organisation.

Two working group sessions have been planned with both divisions to draft the Duty of Quality annual report, the membership will include all divisions including NWSSP.

2.3 What Llais told us in relation to what members of the public want to see in a Duty of Quality Annual Report

- Information should be straight to the point, using everyday language and large print to ensure everyone would be able to read and understand the information. It may be helpful to use colour and images to make the Report more engaging.
- It would be helpful to include information around what the Organisation has done (i.e., events/activities/projects), and how this has had a positive impact and change to the public and/or patients. It comes back to the phrase of 'what does this mean for me'. We know that the public don't always see the strategies or high-level work, they just want to know what it means for them and the care that they receive.
- It would be helpful to include figures such as the number of people engaged with, what communities you have engaged with, as well as any themes coming through – it would be good to include some direct quotes from people you have engaged with.
- As part of the above information, you may also want to include figures around the number of complaints/concerns you have received and again highlight the common themes being picked up.
- Finally, it might be helpful to include a section around what your plans are for the future, so that people can have an idea of what is going on and how this may affect them.

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 ☒
	Provides Quality, Safety and Performance Committee with the details of discussions held and decisions made at both the Integrated Quality and Safety Group and Executive Management Board which impact upon all domains of quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group and Executive Management Board as opposed to service delivery and approach change with a direct impact upon Socio Economic Duty.

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
	This report provides details of discussions and decisions made within Integrated Quality and Safety Group as opposed to service delivery and approaches change that would require an equality assessment.
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

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Duty of Quality Annual Report 2023-2024

Contents

1. Foreword

Velindre University NHS Trust provides specialist non-surgical cancer (Velindre Cancer Service), blood and transplantation services (Welsh Blood Service) and is the host organisation for Health Technology Wales and NHS Wales Shared Services Partnership. As a Trust we are highly motivated and work tirelessly to strive to provide high quality, responsive services to our patients and donors.

We are really pleased to provide you with the Trust's first Duty of Quality Annual Report. We hope that this report provides you with an overview of what we have been doing over the last year to improve the quality oversight and infrastructure across the Trust as well as some of the improvements we have made as we continue to strive to provide the very best care for our patients and donors. We plan to work with LLAIS and the Trust's engagement team to further enhance our report next year by taking feedback on this years' report and asking what, in addition, our patients, donors and public would like to see in future reports.

Our Quality and Safety Vision is for quality, patient / donor safety and experience to be firmly at the heart of everything we do, within every decision we make, enabling the active involvement of both the people who receive care / services and those who provide it, whilst placing a relentless focus on learning and improvement.'

For this vision to be successfully realised, enabling a 'just' safety culture and compassionate leadership approaches are fundamental. This, our first Duty of Quality Annual Report will look back at some of the achievements that we have made to improve the quality of our services. We will look to you joining us on our quality journey.

2. Introduction

This is the first Velindre University NHS Trust ("the Trust") Annual Duty of Quality Report. This Quality report is intended to summarise and reflect the Trust's progress to improve the quality of our services and population outcomes during the last year. We have developed the report based on what members of the public have told us. We reached out to Llais Public Engagement Officer to ask what information they want to know and how they would like to see the information presented.

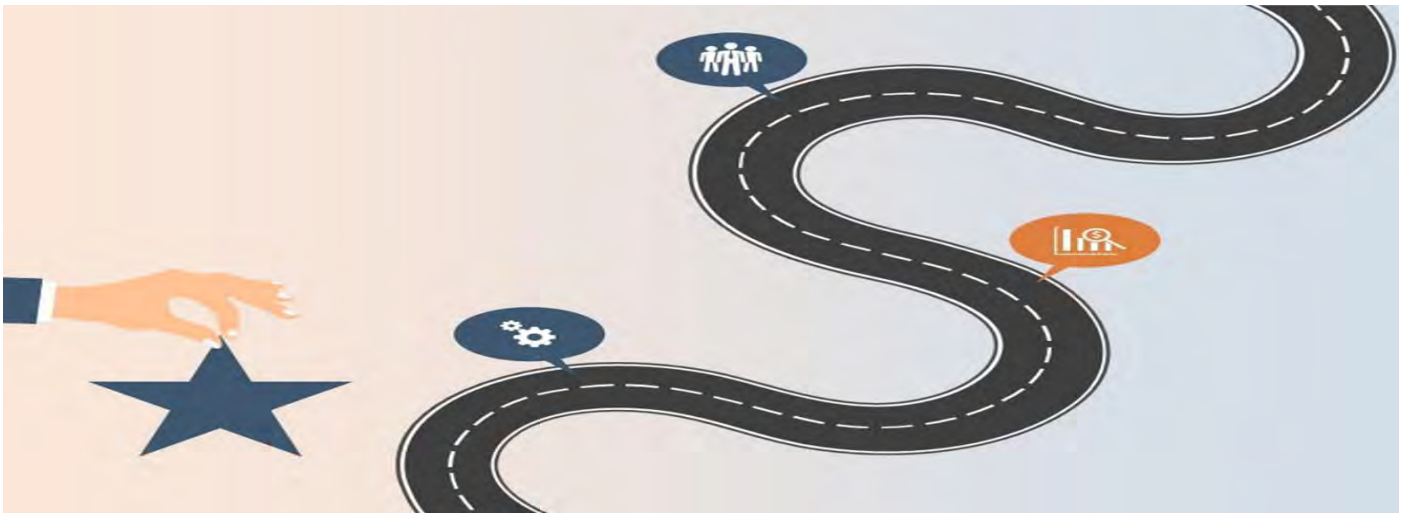
The Duty of Quality applies to all staff in NHS Wales (as well as Ministers), whether they work in clinical roles (such as doctors or nurses) or non-clinical services (such as porters and administrative roles). The Duty aims to:

- Improve the quality of health services,
- Help people in Wales have more years in good health,
- Listen more to people and patients and act on what is shared.

We need to make sure that services are safe and reliable for everyone who uses them by meeting 12 new Health and Care Quality Standards (see below). These standards are part of the Duty of Quality which was brought into effect on 1st April 2023.

The 12 standards are made up of six domains of quality (a domain is a particular area where we want to have good quality health care):

3. Our quality journey so far



Quality is defined as:

'Continuously, reliably and sustainably meeting the needs of the population that we serve'.

The Trust has made changes and developments to meet its legislative requirements in line with the Duty of Quality and has implemented a number of improvements in order to enhance the quality of service that we are able to provide to our patients and donors.

Quality priorities 2023/2024

The Trust's quality priorities for 2023-24 were agreed following identified themes from potentially avoidable harm incidents. There were five improvement areas across the Trust. These priority improvements were selected as improvement projects as part of the Safe Care Collaborative. The Safe Care Collaborative (SCC) brought together health boards and trusts across Wales to accelerate patient safety improvement projects. Over a focused 15-month period, Improvement Cymru and the Institute for Healthcare Improvement (IHI) provided tailored coaching and support to aid the acceleration of existing improvement projects in order to enhance safe and effective care across the country.

More information about the Safe Care Collaborative, is available here.

The Trust's Improvement Priorities

Project 1: Malignant spinal cord compression (MSCC)

Background: MSCC is a rare but serious condition resulting from cancer. MSCC can impair movement, bowel and bladder function, sense of touch and perception of pain and temperature. Radiotherapy is the most common treatment for MSCC and should begin within 24 hours.

Aim: To increase the number of patients treated within 24 hours of diagnosis.

The work focused on several areas:

1. Timely decision making
2. Patient transport
3. Raising awareness and improving communication with health boards.

Progress: This complex project requires work across multiple organisations. Work is ongoing to improve communication and processes. Early changes are being tested, with improvements expected to be seen in the near future.

Project 2: Systemic Anti-Cancer Therapy (SACT) Treatment Helpline

Background: The SACT helpline offers 24-hour support to patients who are unwell as a result of cancer treatment. Approximately 40% of calls are outside of the scope of the helpline. This impacts on response times to unwell patients.

Aim: To ensure that the Treatment Helpline provides timely care for SACT patients.

For more information follow the link below: https://nhswales365.sharepoint.com/sites/VEL_cc_intranet/SitePages/SACT-Treatment-Helpline--purpose-and-scope.aspx?CT=1699369191152&OR=OWA-NT&CID=8e19b851-26f9-6c16-d8cf-f9e2905cddc6

Progress: Improved triage tool and escalation processes are now in place. An external peer review of the helpline was commissioned, with an action plan under development. Some improvements are evident.

Project 3: Donor Adverse Event Reporting (DAER) Project

Background: Adverse events for Welsh Blood Service (WBS) donors can include bruising, pain, fainting, nerve damage or arterial puncture. WBS relies on donors' good will to continue donating, and it is vital that they have a great experience.

Aim: To achieve 100% next day follow up to donors who have suffered and adverse event.

Progress: Welsh Blood Service are piloting digital solutions to ensure DAEs can be reported immediately when blood collection teams are in remote locations. This will speed up follow up calls to donors.

Project 4: Haemochromatosis

Background: Haemochromatosis is an inherited condition where iron levels in the blood build up and harm the body. It is common in Wales and requires blood to be removed several times per year. This blood is often suitable for donation.

Aim: The aims of the project is to identify eligible haemochromatosis patients for regular donation.

Progress: The project team engaged patients to identify barriers to donation. They also worked with WBS staff to raise awareness of Haemochromatosis and put processes in place to ensure regular appointments are available.

There has already been an increase in donations, with further improvements anticipated.

Project 5: Leadership for Patient Safety Improvement

Background: Leaders create the conditions for service improvement.

Aim: To enable Senior Leaders to create the conditions and learning systems that support and enable the culture required for the delivery of Safe, Effective & Reliable care.

Progress: A number of targeted wellbeing support interventions were put in place. The impact of these is under evaluation.

The Trust is collating data from the recent national NHS staff survey, with a view to using this to understand

How staff experienced the Safe Care Collaborative

"Participating in the Safe Care Collaborative has helped us access external data expertise and guidance to gather data to better understand our service and its challenges, which has really helped highlight where we want to focus".

"Being part of the safe care collaborative has allowed us to share the work ongoing developing pathways for patients with genetic haemochromatosis to become blood donors', which improves project reach and will support with the rollout to the health boards across Wales".

"Being part of the safe care collaborative has given us access to training opportunities to upskill the work force in service improvement".

"Being part of the safe care collaborative gained us access to expertise in improvement methodology and robust data for improvement support".

"There has been great engagement from the team throughout the project. They have openly shared their experience of working in the helpline and welcomed others in to challenge and support".

"Being part of the Trust Safe Care Collaborative has strengthened networks across the organisation and enabled the People and OD function, through the lens of Leadership, to be embedded within clinical projects".

"The Leadership Project has helped shine a spotlight on psychological safety within our OD approach and our leadership development plans"

Examples of how we have improved the quality of our services.

Improvements at Velindre Cancer Centre

Immunotherapy Toxicity Service

Immunotherapy drugs, prescribed to treat certain cancers, are associated with adverse reactions resulting from increased immune activity. Reactions may be life-threatening and appear during the treatment course and up to 12 months after the treatment has been completed. Early recognition and appropriate treatment of these side effects is key.

As one of the projects funded by Welsh Government's *Six Goals for Urgent and Emergency Care* programme, the Velindre Immunotherapy Service provides a specialist same-day service for people with cancer who develop toxicity because of their immunotherapy treatment. It also helps avoid repeated emergency admissions to hospital and being admitted to hospital for ongoing care.

When asked about the service, 93% of patients advised that they were promptly assessed and 95% advised that they felt empowered and informed about their treatment complications. There is close teamwork across the whole of Velindre Cancer Centre to safely and collaboratively manage patients who are experiencing immunotherapy toxicities.

A patient at Velindre said, *"They're just fantastic in Velindre. You know when you go there, you're going to get the right treatment and you're not going to be hanging around for hours. I can't praise them enough for what they've done for me."*

Dr Ricky Frazer, Consultant Oncologist and one of the service leads, said: *"Immunotherapy is a hugely effective treatment for patients living with cancer, but in some cases it can cause unpleasant side effects that can become serious if not managed effectively. We have provided educational resources which include the Southeast Wales Immunotherapy Toxicity clinical guidelines, the Immunobuddies podcast and the IO Clinical Network which are available 24hrs a day."*

The Velindre Immunotherapy Toxicity Service has won a national Macmillan 'Innovation Excellence' award earlier this year for the work that the team has done to improve the timely access to high quality specialist care for patients experiencing toxicity from their treatment.

Discharge Improvements at Velindre Cancer Centre

Discharge to Recover then Assess (D2RA) is a pathway that has been introduced to ensure that our patients are enabled to get home as quickly and as safely as possible so that they can continue their recovery in their home environment. Rehabilitation at home empowers patients to be more actively involved in their recovery and enables their actual needs to be more accurately assessed in their own home, rather than in hospital (where it can be difficult for patients to show what they can do for themselves, and what they need support with).

The Velindre Therapies Team has commenced work to improve the provision of post-discharge support to patients, with patients now being reviewed as quickly as possible and by the most appropriate service - this enables a patient's needs upon discharge to be promptly assessed and any required interventions put in place. Ultimately, it ensures that patients can get home quicker and in a safer and more supported manner.

An additional improvement development at the Cancer Centre is that Occupational Therapy, Physiotherapy, Speech and Language Therapy and Dietetic support is now available on a daily basis on the Assessment Unit. This ensures that patients who may be struggling with symptoms from their disease or treatment undergo a multi-professional holistic assessment as quickly as possible. This not only helps to improve the patient's recovery and, in some cases, avoids the requirement for hospital admission, but it also helps to expedite their discharge home.

Some of the great feedback we have had from patients regarding this service is highlighted below:

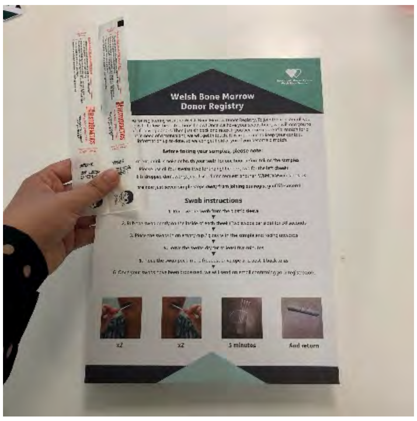
"The Occupational Therapy I received on the ward from the therapist made a massive difference".

"It was the most supportive experience we've had complete wrap around care. Exceptional."

"Discussion was encouraged – giving one confidence, that a sensible and suitable answer is achieved".

Improvements at Welsh Blood Service

The Welsh Blood Service (WBS) has listened to the donor feedback that it received about the location and frequency of its donation clinics. Our donors asked for more opportunities to donate in rural loactions and in response to this, WBS have commenced additional mobile clinics to reach less populated areas.



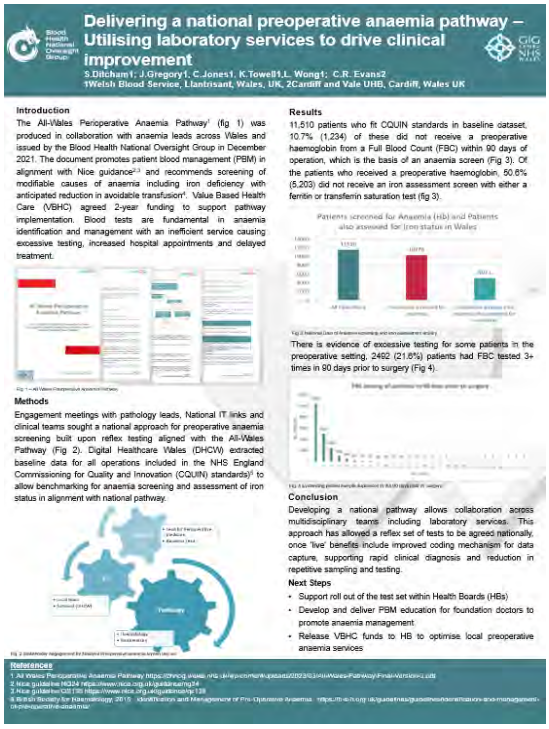
Welsh Blood Service have developed a new way for people to come forward as potential bone marrow donors by providing a swab kit, available online.

Welsh Blood Service have restarted their recognition and donor awards to thank our donors for everything they do and difference they make to patients.

In October 2022 the Welsh Blood Service launched an initiative known as '5 Minute Improvements' as part of its approach to service improvement. 5 Minute Improvements are small, simple improvements that are all about staff fixing the things that bug them or slow them down, making their working day a little bit better and helping establish a culture of

improvement here at the Welsh Blood Service. They are identified by and are completely within the control of staff to deliver and have the added benefit of either directly or indirectly improving the services we offer to our patients and donors. Over 350 of these improvements have been recorded since the launch of the initiative.

All Wales pre-operative Anaemia Pathway



Delivering a national preoperative anaemia pathway – Utilising laboratory services to drive clinical improvement

S.Ditcham1; J.Gregory1, C.Jones1, K.Towell1,L. Wong1; C.R. Evans2
1Welsh Blood Service, Llantrisant, Wales, UK, 2Cardiff and Vale UHB, Cardiff, Wales UK

Introduction

The All-Wales Perioperative Anaemia Pathway[1] (fig 1) was produced in collaboration with anaemia leads across Wales and issued by the Blood Health National Oversight Group in December 2021. The document promotes patient blood management (PBM) in alignment with Nice guidance[2,3] and recommends screening of modifiable causes of anaemia including iron deficiency with anticipated reduction in avoidable transfusion[4]. Value Based Health Care (VBHC) agreed 2-year funding to support pathway implementation. Blood tests are fundamental in anaemia identification and management with an inefficient service causing excessive testing, increased hospital appointments and delayed treatment.

Methods

Engagement meetings with pathology leads, National IT links and clinical teams sought a national approach for preoperative anaemia screening built upon reflex testing aligned with the All-Wales Pathway (Fig 2). Digital Healthcare Wales (DHCW) extracted baseline data for all operations included in the NHS England Commissioning for Quality and Innovation (CQUIN) standards[5] to allow benchmarking for anaemia screening and assessment of iron status in alignment with national pathway.

Results

11,510 patients who fit CQUIN standards in baseline dataset, 10.7% (1,234) of these did not receive a preoperative haemoglobin from a Full Blood Count (FBC) within 90 days of operation, which is the basis of an anaemia screen (Fig 3). Of the patients who received a preoperative haemoglobin, 50.8% (5,203) did not receive an iron assessment screen with either a ferritin or transferrin saturation test (fig 3).

There is evidence of excessive testing for some patients in the preoperative setting, 2462 (21.6%) patients had FBC tested 3+ times in 90 days prior to surgery (Fig 4).

Conclusion

Developing a national pathway allows collaboration across multidisciplinary teams including laboratory services. This approach has allowed a reflex set of tests to be agreed nationally, once 'live' benefits include improved coding mechanism for data capture, supporting rapid clinical diagnosis and reduction in repetitive sampling and testing.

Next Steps

- Support roll out of the test set within Health Boards (HBs)
- Develop and deliver PBM education for foundation doctors to promote anaemia management
- Release VBHC funds to HB to optimise local preoperative anaemia services

References

1. All Wales Perioperative Anaemia Pathway https://
2. Nice guideline NG24 https://www.nice.org.uk/guidance/ng24
3. Nice guideline CG138 https://www.nice.org.uk/guidance/cg138
5. British Society for Haematology. 2015. Identification and Management of Pre-Operative Anaemia. https://

After securing 2 years of funding from the Welsh Government, the Welsh Blood Service has been leading on the development of a national pathway to screen and treat for anaemia in patients before they have planned surgery. Over the past year, great progress has been made in implementing and rolling out this new pathway throughout Wales.

The implementation of this pathway will introduce a number of real benefits to patients, including improved clinical outcomes and recovery post-surgery and a reduction in length of stay in hospital after surgery. Ultimately it is a quality improvement which will also drive an improvement in clinical outcomes for patients throughout Wales.

Further information regarding the All Wales pre-operative anaemia pathway can be found here.

Improving the quality of treatment delivered and clinical outcomes through research

Research is fundamental to driving forwards quality improvements, not only by being able to offer patients the latest and most novel treatment for their disease within the context of clinical trials, but also by improving our delivery of the care that we provide to our patients.

Over the past year much progress has been made in the development of the Cardiff Cancer Research Hub – this is an exciting development for Velindre as it centralises high profile and early phase trials in Cardiff and makes access to new treatment available to the Velindre Cancer Services patients. An example of Velindre's leadership to improve clinical outcomes is highlighted with the FAKTION Trial.

Professor Rob Jones, co-Chief Investigator

"This is a big news story for Cardiff – it all started with the FAKTION trial which was developed at Velindre, sponsored by Velindre, and delivered in collaboration with Cardiff University's Centre for Trials Research.

Truquap™ is an international first-in-class drug for the use in patients with cancer and it's first licence indication.

The global impact of this research is immense – the group of patients who could receive this treatment represent about 75% of patients with metastatic breast cancer.

When a patient has been diagnosed with metastatic cancer, patients are most often concerned about how much time they have left. While we're not able to offer a cure, this new medicine will buy people additional really important time they can spend with their families and friends.

There are still Europe and UK approvals needed before the drug can be used here but the future looks very encouraging for our patients."

Supporting our staff to undertake research also helps us to drive forwards quality improvements in how we can best manage patient care, and our learning is also shared more widely within the UK cancer community.

An example is shown above whereby Velindre-led research into taste changes during radiotherapy treatment has led to improvements in patient education and symptom control. Similarly, during 2023, one of our senior nurses has commenced research to better understand how we can support patients who become unwell during their cancer treatment.

"The idea had been on my mind for a while, years really. As part of the acute oncology team, I have looked after patients who attend their routine clinic or treatment appointments and are quite unwell. They have been suffering symptoms for some time at home but not called the treatment helpline or reached out in any way for support.

This results in them coming in on treatment day not well enough for treatment or sometimes so sick that they have to be transferred to an acute hospital.

I have my own thoughts about patients' help-seeking behaviours. Patients say that they don't want to bother us, or they are hopeful about their treatment so play down their symptoms. However, toxicity from cancer treatment or infections can be life changing – it is far better to recognise, assess and treat problems early.

All this got me thinking – is there anything that we can do differently or modify any interventions for patients to help reduce the incidence of this happening?"

Ceri Stubbs, ANP and Clinical Project Lead Acute Oncology

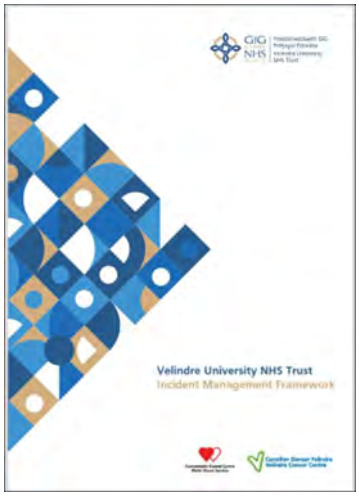
Fran with one of Velindre Cancer Service's new staff nurses, David Longden.

One of our SACT nurses also undertook research to improve the management of adverse allergic reactions to SACT through the use of Simulation training.

Simulation training has now been introduced to support staff training, competence and confidence in managing situations where a patient may experience an allergy to the treatment that they are receiving while on the Chemotherapy Unit. Ultimately, this will improve the quality of care that we provide to our patients, and this is a great example of how our staff are constantly striving to deliver the very highest quality of care in all that we do.

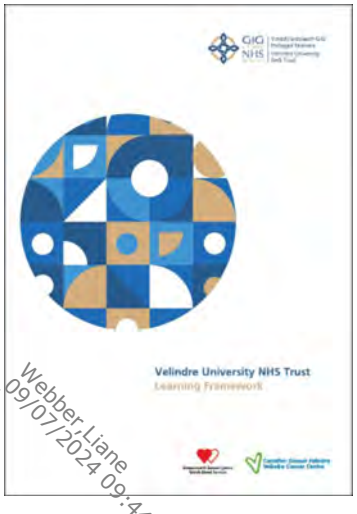
Our Annual Report for Research, Development and Innovation can be accessed here *[link to be added upon approval of report]*.

Trust improvements



The Trust has developed a Learning Framework 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. Learning and improvement is key to providing a high-quality service.

The new Incident framework sets out the expectations for reporting, recording and appropriate investigation of all incidents and near misses. It promotes a continuous improvement in line with the relevant law and our regulatory requirement.

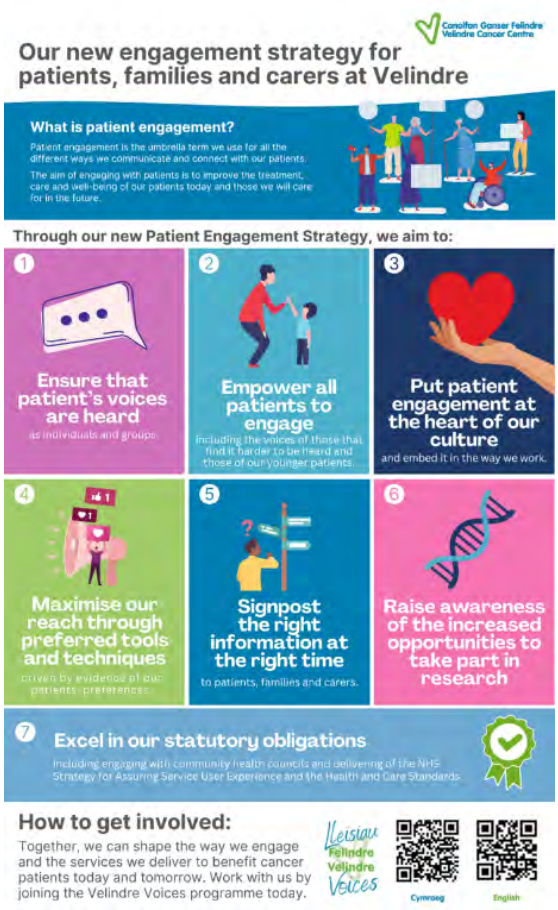


"Our new frameworks will enhance our incident response mechanisms. We will ensure compassionate engagement and involvement for all those affected by safety incidents. This includes our staff, patients, and donors. The learning framework reinforces that learning and improvement is key to a high-quality organisation".

Viv Cooper, Head of Nursing, Quality and Patient Experience

Patient Engagement

Velindre Cancer Centre developed a new patient engagement strategy, co-produced with Cwmpas (formerly Cooperative Centre). The Trust is committed to working in partnership with our patients and donors to shape our services and to provide the care and services that our population is seeking.



Highlights from our engagement over the past year include:

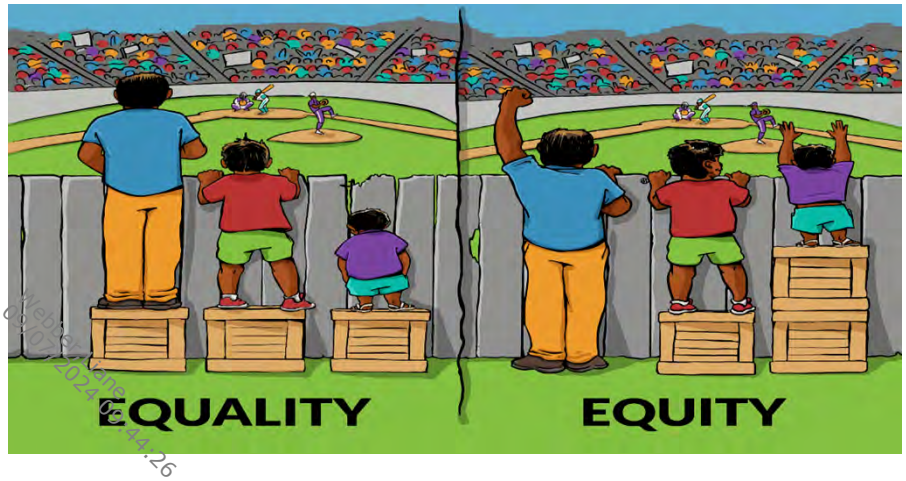
- A new Patient and Carer Partnership Board (PCPB) has been convened. As a voluntary group of patients, carers and family members, the Board supports the Trust to improve by contributing their experiences and ideas.
- A new volunteer recruitment drive has delivered the recruitment of 42 new volunteers.
- Supporting patient engagement and input into the brand new Velindre Cancer Centre design
- Supporting public and patient engagement on the new Clinical and Scientific Strategy
- Developing a new Youth Engagement Framework, to help the service work with young people.

Delivering Equitable Patient and Donor Services

The Trust-wide Vulnerable Groups Forum meets four times per year and has developed a plan of work that includes improvements to the care and support of vulnerable people, including those with dementia and learning disabilities.

The Trust recognises that some patients and donors will require reasonable adjustments in order to have equal access to the services we provide.

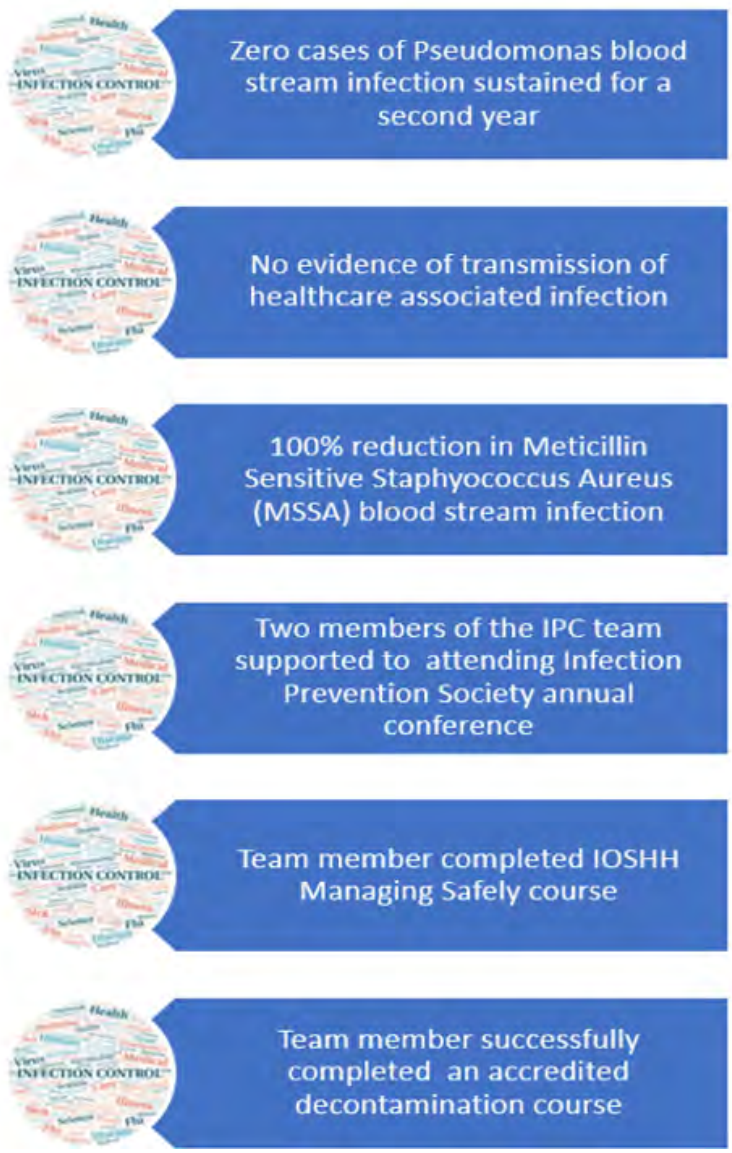
We are committed to doing everything we can to break down barriers to people accessing our services. The Vulnerable Groups Forum supports the Trust in achieving this goal.



Our 2023/34 Safeguarding and Vulnerable Persons Annual Report can be accessed via this link *[link to be added upon approval of report]*

Infection Prevention and Control

The Trust's Infection Control Team work alongside our clinical and management teams to ensure that we do all we can to prevent healthcare associated infections and antimicrobial resistance. This includes ensuring that our staff are appropriately trained, that they have the correct equipment to keep patients and donors safe, and that our core services such as our water supply and antibiotic usage are safe and optimised. Some of the things we have done to reduce harm through healthcare associated infections are:



Our 2023/24 Infection Prevention and Control Annual Report can be accessed here *[link to be added upon approval of report].*

Learning from our patients and donors over the past year

A key element of our quality improvement work is ensuring that we listen to and learn from what our patients and donors tell us through the feedback that they provide to us. Quality improvement work is also informed by ensuring that we learn from any incidents that may have occurred.

Capturing Concern Data at a glance.

2059 Incidents	**202** Complaints	**334** Compliments in writing	**2** New Claims	**4** Nationally Reportable Incidents
8 Duty of Candour Incidents	**0** Never Events	**2** Ombudsman Concerns	**5** New Redress Cases	**97%** Patient & Donor Experience Score

Further information relating our reporting themes and learning can be found in the Putting Things Right Annual Report 2024/25 here (link) and the Patient Experience Annual Report 2024/25 here (link). *[links to be added upon approval of report].*

Duty of Candour

The Duty of Candour is a legal requirement for NHS Organisations in Wales to be open and honest with service users receiving care and treatment.
It applies if the care we provide has, or may have, contributed to unexpected or unintended moderate or severe harm, or death.

Our aim

In the NHS, we strive to provide high-quality, safe, and compassionate care to all our service users. However, even when we do our best, people may sometimes experience harm. That's why we have the Duty of Candour.

Our goal is to create a culture of trust and openness, so that patients and donors can feel confident in the care they receive from us.

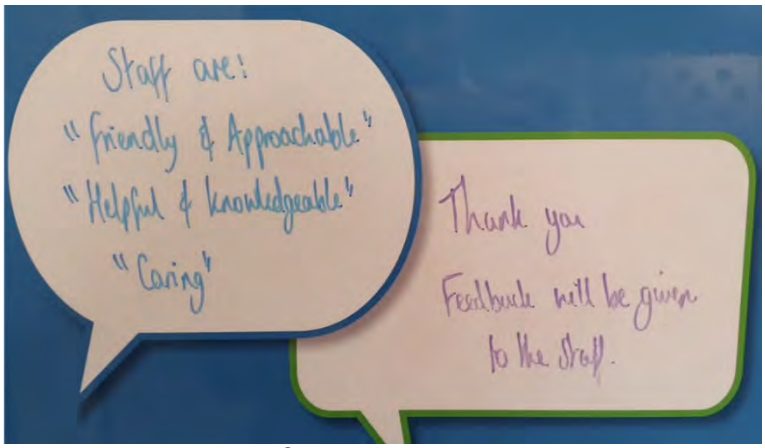
"The introduction of the Duty of Candour in April 2023 has strengthened our incident review process. We have complied with all elements of the Duty of Candour process in the Trust and taken a compassionate approach when we have identified that we may have caused avoidable harm."

Tina Jenkins, Head of Quality & Assurance

More information about our Duty of Candour triggers can be found in our Putting Things Right annual report *[link to be added upon approval of report]*.

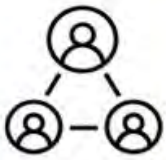
Patient and donor experience

Receiving real-time feedback from our patients and donors, whether good or bad, helps us continually improve our services and make service decisions based upon your thoughts and experiences.



The All-Wales Patient Experience survey includes a suite of standard experience survey questions, including the Friends and Family Test. The Trust is also able to generate more in-depth surveys to gain feedback within particular service areas and projects. This allows for an adaptable approach to gathering information on performance.

What Experience did Velindre Cancer Service Patients Have?

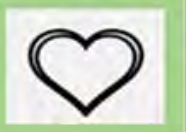
A total of 1434 surveys returned. (1st April 2023 to 31st March 2024)			
	97.4% scored their experience as 'Excellent' (5 and above).		99.8% stated they felt cared for.
	99.5% felt they were listened to.		95.7% said their time either shorter than expected or about right.
	99.8% felt they had assistance when they needed it.		99.5% understood what was happening with their care.
	99.8% said explanations were given in a way they could understand.		99% felt they were involved as much as they wanted to be in decisions about their care.

You Said	We did
The food could be improved including more vegan options on the menu.	New menus have been introduced and catering have facilitated this.
There is not enough appointment availability outside core hours within the Therapies Clinicians.	An evening clinic has been introduced.
Waiting room seating areas feel crowded.	Chairs repositioned to make better use of the available space.
When there are long waiting times for appointments, refreshments would be nice.	A water fountain is available, and Velindre Cancer Centre is looking at the return of the Royal Voluntary Service.
Lack of communication regarding delays and waiting times within clinics	A digital system displays expected daily clinic delays.

Waiting area floor looking aged.	The area has now been painted and a new floor laid.
Electronic display or Tanoy for calling patients.	New Tanoy system being installed and investigating an appropriate electronic display system.
Waiting times for blood tests is an issue in Outpatients.	An additional blood collect chair has been added to the outpatient department to increase capacity.

What Experience did Welsh Blood Service Donors have?

A total of 12,188 surveys were returned during the 1st April 2023 to 31st March 2024

	98% of donors scored their experience as completely satisfied with their overall experience		100% of donors found a good standard of hygiene and cleanliness
	100% of donors found staff welcoming and friendly		100% of donors found staff helpful and knowledgeable
	100% of donors felt they were treated with dignity and respect.		100% of donors said they felt safe
	100% of donors felt they were offered quality of care		100% of donors found staff compassionate and caring
	100% of donors were provided with enough information about the donation process		100% of donors felt they received adequate emotional and physical support

YOU SAID	WE DID
➢ **Parking facility improvement** ➢ **Finding parking difficult as very few places** ➢ **The car park could be bigger for patients but that is all.**	Feedback received from service users in relation to parking at the Welsh Blood Service site led to a review carried out by the estates team who worked in collaboration with staff to facilitate the management of appropriate parking on site. Implementing an informative sign to guide and support has allowed Welsh Blood Service visitors to park with ease of access at the front of the building. Since the change has been implemented service users have fed back that Welsh Blood Service have great facilities, easy and accessible parking, and friendly staff. 
➢ **Give better directions to clinic.** ➢ **Improve signage to clinic within venue.** ➢ **Directional signage within the car park to show where to go.** ➢ **Needed a sign by the front door to help find the room.**	Ongoing Service Improvement Project's (SIP) are underway to look at current venue signage across all the collection teams. This piece of work is concentrating on sourcing and developing new signage that will direct donors at the venue site, from carpark to donation room.

➢ **Milk alternatives for the tea!** ➢ **Offer crisps as a snack.** ➢ **Have gluten/dairy free snacks.** ➢ **Provision of vegan-friendly snacks**	Since the introduction of a variety of vegan and gluten free biscuits, and dairy free milk across the collection teams, the Welsh Blood Service has received less feedback in relation to this theme. Some very positive feedback demonstrates donors continue to enjoy alternative snack options. Donors are also enjoying the Savory snacks introduced as part of feedback received, “I like the mini cheddars, they were a lovely change”. Each collection team displays a bilingual poster to advertise the alternative options available for all donors to enjoy. 
➢ **Sadly, the building was very cold.** ➢ **The temperature in the room was on the cold side but otherwise felt the experience was good.** ➢ **It was very cold and could do with more heating.** ➢ **I appreciate it is January, but it was freezing in the hall.** ➢ **I arrived quite cold so it could have been a little warmer.**	Dyson Air Heaters/Coolers have been sourced for each collection team and can be used to cool or heat a room accordingly. Some venues are cold on arrival and take some time to warm up, that said, the room must be at a desired temperature for the integrity of the blood/product collected.

➢ **No dedicated motorcycle parking**	The facilities manager working in collaboration with estates have introduced a designated motor bike parking area at the rear of the Welsh Blood Service building with clearly displayed signage to the area.  

Mortality

Mortality data measures the number of deaths in a particular population. The Cancer Centre reviews all deaths where a patient has died in the hospital. There is also a requirement to review the cases of patients who have died within 30 days of Systemic Anti-Cancer Treatment (SACT) and identify appropriateness of treatment decisions.

Monitoring this data and undertaking reviews on the care provided ensures that we are delivering a high-quality service, that we are prescribing SACT and radiotherapy appropriately, effectively managing cancer treatment toxicities and unwell patients, and undertaking advanced care decisions discussion with patients and providing palliative care in a timely manner.

Death within 30 days of Curative SACT 1st April 2023 to 31st March 2024

The illustration below demonstrates the average number of deaths, the average number of patients receiving SACT per month and the average percentage for the financial year.

Death within 30 days of Palliative SACT for November 2023

The illustration below demonstrates the average number of deaths, the average number of patients receiving SACT per month and the average percentage for the financial year.

The only benchmarking data currently available in Wales is the overall SACT target of 2% overall mortality rate. An action was taken to benchmark mortality rates across other cancer centres so that VCC's position in this can be determined.

The death following radiotherapy data is still being validated and requires further digital support.

A key element of this continual cycle of quality improvement is the analysis and understanding of mortality information.

Velindre Cancer Centre has been committed to improving its mortality data and review process over the last year and it is one of our key Quality Priorities for next year.

The Medical Examiners Service provide an independent scrutiny of all inpatient deaths. They will ensure that an accurate cause of death of recorded, identify any concerns surrounding the death itself which can then be further investigated by the care provider or coroner if required, and take the views of the bereaved into consideration. We have reviewed **47** deaths In April 2023 – March 2024.

"Within the last year VCC has established a robust process for reviewing all cases where patients have died within 30 days of SACT, death within 30 days palliative radiotherapy, and 90 days curative radiotherapy and are currently rolling this out throughout all the cancer site teams. Again, this provides assurance around appropriate decision making and management of side effects and toxicities with a focus on learning."

Sarah Owen, Quality & Safety Manager at Velindre Cancer Centre

Recommendations from external reviews and inspections

Health Inspectorate Wales (HIW) is the independent inspectorate and regulator of all health care in Wales. We had one HIW review during this reporting period. They conducted an inspection of Velindre Cancer Service Radiotherapy Department in May 2023, and published the findings in August 2023.

The inspection team found that *"patients provided positive feedback about their experiences of attending"*, and *"We identified good compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) 2017, with few areas for improvement".*

Improvement was needed to provide greater protection of patients' privacy and dignity in the Brachytherapy treatment area.

Staff provided "mixed feedback about working for the organisation", and action was required to address some of the less favourable staff comments.

In response to the recommendations, changes to the Brachytherapy treatment area have been made to limit access and improve patient privacy and dignity. Work is ongoing with staff to address concerns about the working environment.

External Peer Reviews

The Trust commissioned two external peer reviews to provide an expert opinion on our services and identify strengths and opportunities for improvement.

Treatment Helpline Peer Review

Telephone helplines have a vital role in the delivery of safe care to unwell Systemic Anti-Cancer Therapy (SACT) patients. To ensure the highest standards of care are being provided, an external Acute Oncology Nurse Consultant was invited to complete a peer review of the Velindre Cancer Service SACT Helpline.

The peer review found that:

- The Cancer Centre is a welcoming and friendly site.
- Staff are happy and friendly, understand their roles, and feel supported by senior colleagues.
- Clinical pathways are robust.
- Good information is provided to patients about the helpline.
- The helpline staff management structure and alignment with the wider service was unclear and requires a review.
- The role of the helpline in the wider Cancer Service is not fully understood by staff.
- Improvements are required to ensure staffing is consistent across day and night, including the availability of senior support.
- The physical working environment for helpline staff requires improvement.
- Many calls to the helpline would be better directed to other departments, and this impacts on the delivery of the service.

- The clinical triage tool used by helpline staff requires strengthening.
- Improvements have been made, with further changes also underway including:
  - A relocation of the helpline team to a more appropriate environment has already taken place.
  - Changes have been made to the clinical triage tool to bring in line with national standards.
  - A workforce modelling exercise is underway to address staffing issues and the availability of senior support.

Intravenous Access Service Peer Review

The Intravenous Access Service at Velindre Cancer Centre provides Peripherally Inserted Central Catheters (PICCs) for patients requiring treatment intravenously. An external Lead Intravenous (IV) Access Practitioner was invited to conduct a peer review of the Velindre IV access service in June 2023.

The peer review found that:

- The quality, safety and governance of the service was good, however required the development of a programme of regular audit.
- The service was under considerable demand, and a review of capacity was needed to ensure timely access for patients.
- Aftercare for patients was responsive and included access to the Velindre Treatment Helpline.
- The system for booking appointments was overly complex and relied on manual processes.
- A number of service improvements could be made to increase capacity without additional staff being required.

The IV Access Service has accepted the report and several improvements are underway. A programme of clinical audit has been developed and will be carried out quarterly. A process mapping exercise was undertaken to identify opportunities to improve the booking system. Alternative methods of PICC placement are under review, with a view to reducing the time taken for each procedure, therefore increasing the service capacity without additional staffing.

Trust Regulatory and Assurance Tracker

To support the management of recommendations and improvements from investigations and reviews, the Trust has adopted the use of a Regulatory Quality and Safety Tracker. See image below:

"It is vital that the Trust has robust processes in place to capture learning opportunities following inspections, investigations audits and peer reviews. The new system has made a significant difference as all plans are in one place and staff are sent reminders to complete their actions. This improves the quality oversight and governance."

Chris Kelly, Deputy Head of Quality and Assurance

National inquiries

The Speaking up Safely Framework was circulated to NHS Wales Chief Executives at the end of August. This was to support their reflection on their quality and safety systems in light of recent events (the case of Lucy Letby), which have served as a stark reminder of how vital it is that everyone working in the NHS feel safe and confident to speak up about anything that gets in the way of delivering safe, high-quality care.

The Trust established a working group to undertake a self-assessment based on the Trust's current processes to support staff to speak up. The actions and outcomes of the action group are listed below.

Speaking up Safely: what is the Trust doing?

1. Getting Feedback from staff by:
   - Running a series of listening exercises to speak to staff and understanding what is concerning them. These sessions will run until December and will help the organisation and leaders understand how staff feel working at Velinde.
   - The Trust values have been refreshed following wide consultation with staff.

2. Prioritising Speaking up Safely by:
   - We've set up a specific Task and Finish Group to look at the staff feedback and ensure we are addressing any gaps raised. The work of the group is reported to the Trust's Executive Board.

- The Task and Finish Group is being run in partnership, together with our trade union partners.
- An Independent Member of our Board has been selected as a Speaking Up Safely Champion.

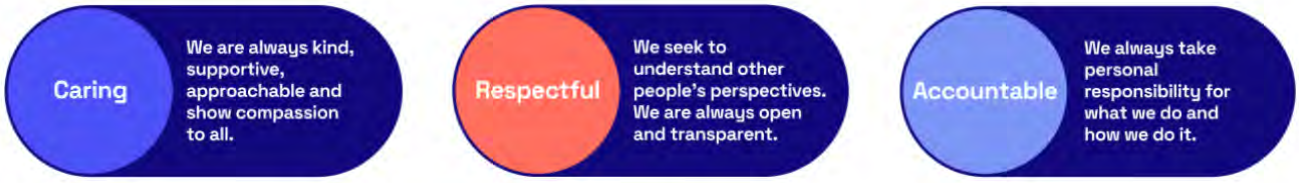
Investing in our staff and our culture to improve the quality of our services

It is well-documented and frequently reported in the media the extent of workforce pressures in the NHS and how this can impact on staff retention and wellbeing.

A positive culture is characterised by a sense of collaboration, open communication, and a focus on employee well-being. It's not just about implementing policies; it's about fostering a mind-set that values individuals, promotes equality, collaboration, and empowers our people to contribute their best to the organisation's success. It contributes to both the well-being of employees and the overall success of the organisation.

What we have achieved

Trust Values



After wide consultation we developed and launched our new Trust-wide values which capture what's important to us and how we should all behave. Everyone has a stake in them because they were developed by you, for you.

We felt it was time to review our values because we're always evolving as individuals and as an organisation. Over the past 18 months we have held wide-ranging consultations with staff and members of the public.

Working Together

We wanted to start a conversation across the organisation about improving the way we connect and support each other in delivering for our patients and donors.

The sessions we've held throughout the year, both in person and virtually, have seen a high number of staff share their honest thoughts and experiences about what it's like to work for the Trust, in addition to many worthwhile ideas for us to consider.

This has engaged our healthcare staff to design and implement improvement based on what matters to them.

Velindre Oncology Academy

The Velindre Oncology Academy aims to establish a national standard-setting oncology academy at the Velindre Cancer Service, providing accredited non-surgical education, training, and upskilling to the workforce across Wales.

Education via the Academy will build upon existing education and knowledge by providing courses, educational sessions, skills training, and upskilling both internally and externally.

The Academy's offer will vary from short, one-hour courses and study days to full Masters programmes and will include face-to-face and virtual learning.

Employee Excellence Awards

The Employee Excellence Awards saw a total of 16 awards presented to staff from various parts of the organisation for their amazing achievements.

The hybrid ceremony took place both in-person and online, with nominees invited to attend either at the Welsh Blood Service headquarters or at Velindre Cancer Centre, with the rest of our staff invited to join via Teams.

We received 153 staff nominations and 30 public nominations, which demonstrates the depth of amazing achievements taking place across the Trust.

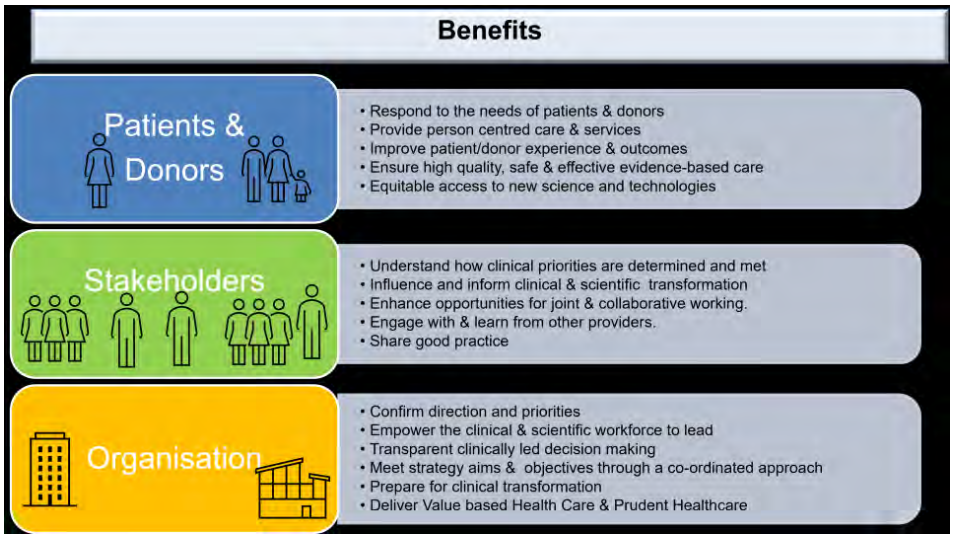
Nursing Strategy launch

On International Nurses' Day, Velindre University NHS Trust hosted its first ever Nursing Conference. It provided Registered Nurses, Health Care Support Workers and Clinic Collection Assistants from across the Trust with an opportunity to come together to celebrate our past successes and get excited about our future achievements. It was also an opportunity to launch the Trust-wide Nursing Strategy 2023-26 which was developed in consultation with our nursing workforce and will empower nurses to lead compassionately and deliver the best care to our patients and donors.

The Trust is very proud of our nurses, both registered and unregistered, who provide the most amazing care and services to our patients and donors.

Clinical & Scientific Strategy

Since October 2023, the Trust has been on an exciting journey to develop the Trust-wide Clinical and Scientific Strategy.



An important part of this work involves listening to the views of staff and stakeholders to determine the Trust's clinical and scientific priorities over the next five years.

We have asked people to share their views through an online questionnaire, listening sessions and engagement events and the Clinical and Scientific Strategy Lead has attended meetings and forums.

Over 850 people have responded and shared their views on what they think should be our clinical and scientific priorities.

Leading Patient Safety Programme 2023/2024

In August 2023 three Velindre employees were successful in securing a place on the second cohort of the Leading Patient Safety Programme. They joined 30 other leaders in patient safety from across the NHS Wales system, focusing on building a system of safety for their organisations. At the end of the programme, they will join the Leading Patient Safety network to build over 60 patient safety leaders across Wales.

"The Trust now has a patient safety leader within each quality hub. Together and through collaborative working and reporting, they are committed to ensuring patient safety and learning is a key driver for improvement across both divisions."

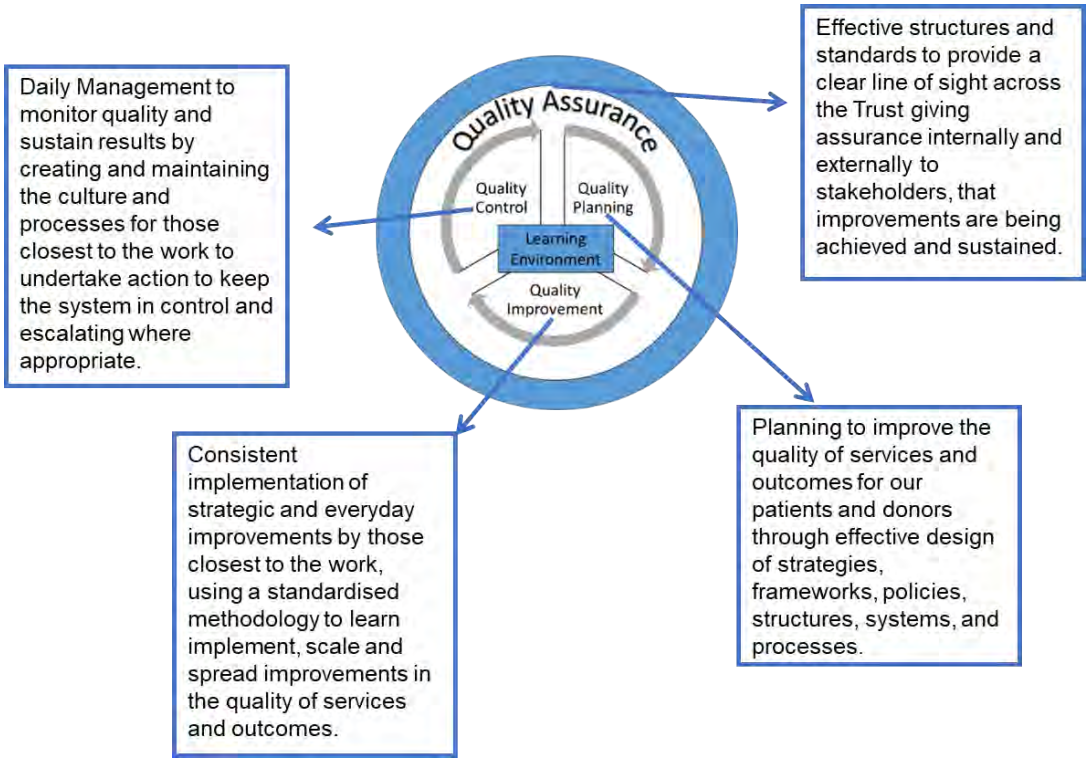
Peter Richardson, Head of Quality & Safety at the Welsh Blood Service

Quality Management System

To achieve our Quality and Safety vision and meet our Duty of Quality legislative requirements in line with the Duty of Quality we need to take a system-wide approach that actively involves patients, donors, colleagues and other key stakeholders. To achieve this, we have developed and implemented a robust Quality Management System. A Quality Management System enables us as an organisation to focus upon understanding what a quality service looks like, knowing whether we are delivering the services that our population needs and ensuring a strong focus continuous learning and improvement.

The key to the success of our Quality Management System is ensuring and enabling everyone across the Trust to be engaged and dynamic in ensuring quality is at the heart of everything we do:

Every Quality Management System is based upon the continuous Quality Cycle which consists of 4 parts: **Quality Planning: Quality Control: Quality Assurance: and Quality Improvement**, which are all underpinned by provision of a **learning** environment.



Through the development of our Quality Management System, we aim to:

- Enable a positive, psychologically safe, and Just quality culture through the provision of compassionate leadership.
- Enable a shared responsibility and voice for Quality to ensure the provision of safe, timely, effective, efficient, equitable and person-centred care.
- Embed Quality Driven Decision Making at all levels of the Trust.
- Demonstrate a quality approach based upon learning and continuous improvement.

Quality Driven Strategic Decision Making


Quality-driven decision-making

Quality Impact Assessment

A Quality Impact Assessment (QIA) is a tool for considering and capturing the impact of proposals / decisions on the quality of our healthcare system, to inform strategic decision-making. Key to the success of the implementation of the Quality Impact Assessment across healthcare in Wales is that it must be proportionate, have clinical sign-off, and feed into existing corporate processes rather than creating new ones. Organisations must be able to evidence that their strategic decisions have been made through a Quality lens.

The proposal / decision considered the impacts on each of the Health and Care Quality Standards: What specific risks have been identified? What mitigation will you implement to manage adverse impact? What measures and evidence will you use to monitor the impact. The outcome of these was that it would have a positive impact and improve the overall quality of our services.

"The quality impact assessments inform strategic quality-driven decision-making, it helps us at the Trust to identify and assess the effect or influence of a proposal on the quality and safety of our healthcare system, in line with the Health and Care Quality Standards. It also provides assurance of quality-driven decision-making, together with an audit trail and promotes good governance."

Dr Jacinta Abraham, Medical Director

The Quality Impact Assessment was utilised to support the following strategic decisions since September 2023:

New Velindre Cancer Centre (nVCC) Full Business Case (FBC)

It was proposed that the existing Velindre Cancer Centre is replaced with a new Velindre Cancer Centre (nVCC) that will deliver most tertiary non-surgical oncology services for the population of south-east Wales, contributing to the regional Clinical Operating Model for cancer services. This will include the provision of new equipment where it is not possible or economically viable to transfer from the existing Velindre Cancer Centre. A quality impact assessment was undertaken as part of the approval process that detailed the overall positive impact on quality of the nVCC proposal.

Welsh Blood Service – National External Quality Assessment Service

A QIA was undertaken in relation to the proposed re-procurement of a digital solution to support the National External Quality Assessment Service (NEQAS) for Histocompatibility and Immunogenetics within the Welsh Blood Service. Due to the specialist nature of the Welsh Blood Service a bespoke IT solution was required to be created as there was not an 'off the shelf' suitable commercial software product available. An External Quality Assessment IT System (EQAITS) was subsequently created and procured from a third party provider. However, the contract with this supplier expires in 2025. We are therefore required to re-tender for a new digital solution which will enable the continuation of this service. This Quality Impact Assessment therefore relates to the procurement of this digital solution that detailed the overall positive impact on quality of the proposed re-procurement.

West Nile Virus Testing

West Nile Virus Testing is an arthropod-borne flavivirus, widely distributed in Africa, Western Asia, Europe, and Australia. Current national guidelines state, travel to a West Nile Virus risk area provokes a 28-day deferral if the donor is not symptomatic or six months if the donor has any suggestive symptoms at or upon arrival to the UK. Other UK blood services (NHSBT and SNBTS) carry out Nucleic Acid Amplification (NAT) tests on these donors. A negative test result allows the donor to continue donating. The QIA demonstrated an overall positive impact of implementing West Nile Virus Testing.

Welsh Blood Service - Nucleic Acid Testing

This QIA was in relation to the re-procurement and implementation of Nucleic Acid Testing for the Welsh Blood Service. The requirement, and benefits, of Nucleic Acid Testing had previously been clinically recommended by the Welsh Blood Service and approved by the

Velindre University NHS Trust Board. Nucleic Acid Testing is also mandated by Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC). This proposal relates to the procurement of a new solution ion to support the safe and timely Nucleic Acid Testing for Welsh Blood Service Donors. The QIA demonstrated an overall positive impact of this procurement.

Velindre University NHS Trust was required to submit a financially balanced and Trust Board approved Integrated Medium Term Plan (IMTP) to the Welsh Government by 28th March 2024. The core principle in developing our IMTP is our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety, and experience; and continual learning and improving.

The IMTP covers:

- Decisions / actions already approved by the Trust Board
- Strategic developments which have been endorsed by the Trust Board, but the preferred option(s) for implementation is yet to be agreed
- Clinical developments which have been proposed but have not yet been approved by the Trust Board

Each proposal, prior to implementation, was subject to a Quality Impact Assessment to be completed prior to implementation and a QIA was undertaken in respect of the plan.

Integrated Quality and Safety Group

The Trust Integrated Quality and Safety Group provides operational oversight to support the Trust in meeting its Quality and Safety legislative and national requirements in relation to all areas of Quality and Safety, and the 'Duty of Quality', ensuring quality is at the centre of all decision making across the Trust. To achieve this, the Group is responsible for reviewing, analysing and triangulating information, outcomes, and metrics from across a broad range of Quality, Safety and Experience functions to identify themes, trends, areas for improvement, audit, and escalation and producing a quarterly assurance / escalation report for the Executive Management Board and Quality, Safety & Performance Committee.

Improved governance reporting

Make sure the Board supports work to improve quality. They must be willing to invest time and money into work to improve services. They need to make sure they stick to the Duty of Quality when they make decisions. In order to achieve this, our Trust report templates were revised, an impact assessment was included that is aligned to the six domains of quality. This will ensure that the Duty of Quality is included in decision-making by the Board.

The Board sets the overall aims and goals for a service.

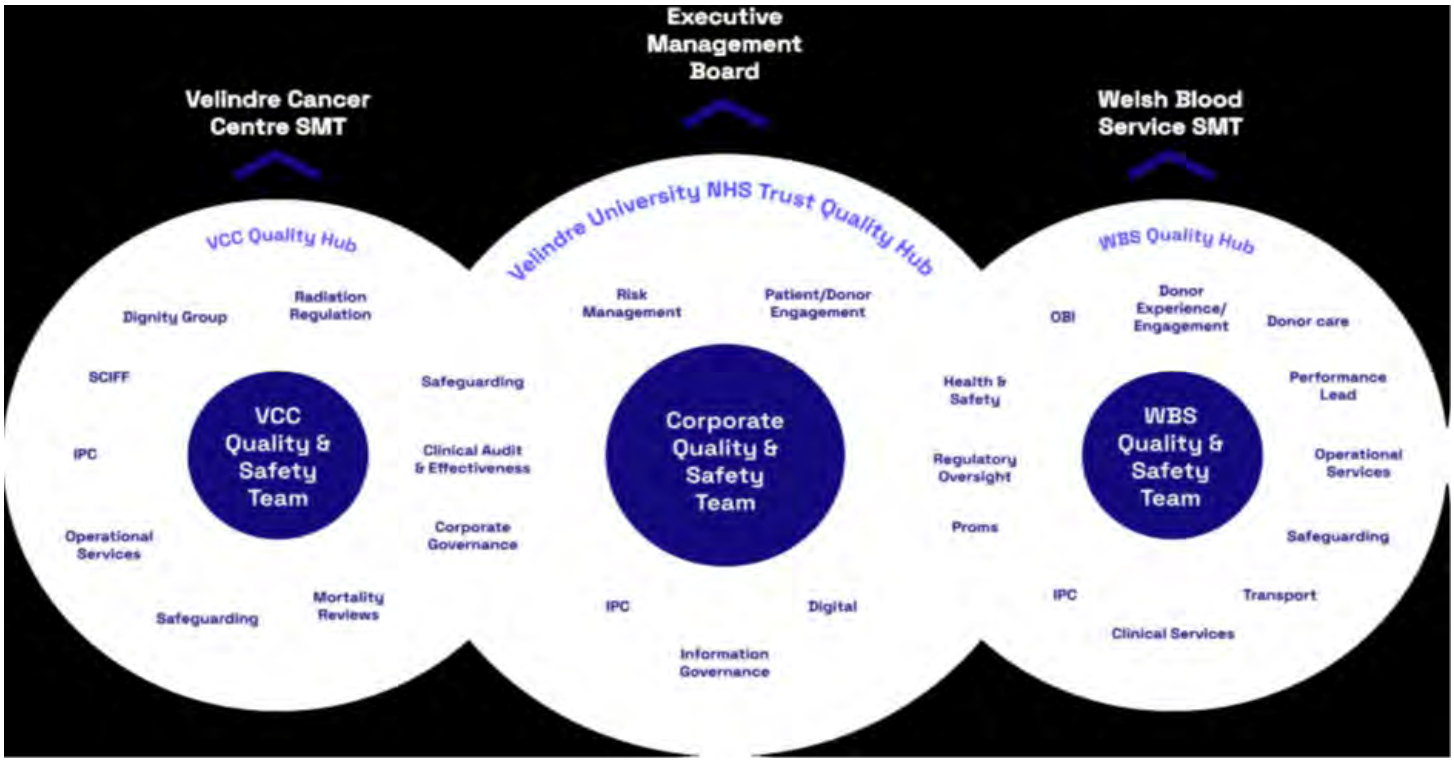
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should 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].* Click or tap here to enter text

"It is vital that the Board ensure that quality is at the centre of strategic decision making. Good leadership means better care".

Nicola Williams, Executive Director of Nursing, AHP & Health Science

Quality Hub Developments

Each Division has a Quality & Safety hub that meets every month and is responsible for the oversight of quality, safety, and experience reporting and assurance**.**



Looking Ahead, Trust Quality Priorities 2024-2025

For quality priorities to be achieved and deliverable it is important that they reflect identified issues within the organisation's quality management system. It is essential to work collaboratively to identify shared priorities. Giving everyone a voice and bringing together staff and patient, donor feedback to design our services and drive improvements is essential. Each division decided on their annual priorities, they have been approved and will be monitored through the Trust governance routes. They have also been included in the Trust Integrated Medium Term Plan. This plan sets out the organisation priorities and how they will be achieved.

Conclusion / Summary

Velindre University NHS Trust is committed to striving to provide the very highest levels of quality of care to our patients and donors. This can only be achieved through continuously developing and improving our services. Much has been achieved over the past year, and there is a plan in place to ensure that we continue to improve the quality of our services and the outcomes and experiences for our patients and donors. We will achieve this through the continued determination and dedication of our staff, by ensuring we learn when things go wrong and by working in partnership with our patients and donors and our Health Board partners. We look forward to providing another report in a years' time documenting our ongoing quality improvement journey and achievements.

2024-2025 Quality Priorities

2024/25 Quality Priorities:	What we expect to see:
To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.	A reduction in patient concerns/incidents related to administration of communication issues. An improvement in patient experience. An improved referral processes.
. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.	100% compliance with the VCS agreed process in line with best practice guidance. Increased opportunity for early detection learning that can be rapidly share.
To Integrate Clinical Audit within Velindre Cancer Centre Quality and Safety function	An audit plan that reflects themes and trends identified from concerns/incidents.
Development of robust Site-Specific Quality Metrics	Publish the Quality Matrix. Medical Lead identified
.	

2024-2025 Quality Priorities

2024/25 Quality Priorities:	What we expect to see:
To Improve incident and risk management.	Improved quality of incident investigation. Proportionate investigations depending on incident grade. Improved compliance with incidents closed with 30 days.
. Continue to review and update the WBS Quality Management Framework, including the deployment of a new electronic Quality Management System	A Trust wide quality management system. A management system that is compliant with current ISO standards and medical devices legislation. A repository of all registration and current accreditation.
To Successfully Introduce West Nile Virus testing within Welsh Blood Service.	Availability of WNV testing for high-risk donors.
Introduce leucodepletion filters, Hepatitis A and Parvovirus B19 testing to support the national Plasma for medicines programme and improve supply chain resilience for plasma-derived medicines.	Introduction of: Leucodepletion filters Hepatitis A testing Parvovirus testing
. Review and improvement of donor selection and screening processes	Revised UK screening guidance Development and implementation of revised donor

2024-2025 Quality Priorities

2024/25 Quality Priorities:	What we expect to see:
Introduction of all Wales foetal D Screening for RhD negative pregnant women	Testing platforms operationalised. Foetal RHD screening undertaken
. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT, which will reduce risk of manual transcription of results.	System operationalised. Reduced errors in transcription
Achieve Joint Accreditation Committee ISCT – Europe (JACIE) accreditation for the Welsh Bone Marrow Donor Registry	JACIE Accreditation in place
Commencing rollout of live connectivity of the BECS at community-based donation clinics,	Live connectivity is operationalised. Reduced transcription errors Improved donor experience
. Enablement of DATIX, QPULSE connectivity on community-based clinics for incident, risk and concerns recording at point of contact.	Live connectivity is operationalised. Improved incident and concern response times Improved standard of donor care follow up.

2024-2025 Quality Priorities

2024/25 Quality Priorities	What we expect to see:
*TBC % increase in staff psychological safety scores within Trust Staff Survey results.	🕐 Increased staff concerns being raised. 🕐 Increased staff suggestions for improvement 🕐 Improved staff survey results. 🕐 Increased staff innovations.
The Trust will utilise the NHS Wales Digital Stories Toolkit to expand the range of methods we have for collecting patient stories. Patient & Donor stories allow us, with consent, to listen to individual journeys and improve our services.	Further development of staff and patient stories shared across the Trust.
To further develop 'Always On' reporting metrics in line with the Duty of Quality requirement.	A developed quality dashboard to use information. Always on reporting will makes sure that we make information about our services readily available to our population.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Velindre University NHS Trust – Annual Performance Report 2023 - 2024

DATE OF MEETING	11th July 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO
PREPARED BY	Phil Hodson, Deputy Director of Planning & Performance
PRESENTED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
EXECUTIVE SUMMARY	Velindre University NHS Trust is required to publish, as a single (unified) document, a three-part Annual Report and Accounts which includes the: • Performance Report; • Accountability Report; and • Financial Statements

RECOMMENDATION / ACTIONS	The Velindre University NHS Trust Quality, Safety and Performance Committee is ask to endorse the Velindre University NHS Trust Annual Performance Report (2023 – 2024).

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre University NHS Trust Executive Management Board	25th June
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS: The Velindre University NHS Trust Performance Management Report was endorsed by the Velindre University NHS Trust Executive Management Board.	

APPENDICES	
Appendix 1	Velindre University NHS Trust Annual Performance Report – 2023 / 2024 (Draft – awaiting formal feedback from Audit Wales)

1. SITUATION

1.1 Velindre University NHS Trust is required to publish, as a single (unified) document, a three-part Annual Report and Accounts which includes the:

- Performance Report;
- Accountability Report; and
- Financial Statements

1.2 The Performance Report will form part of the suite of Annual Report Documents and is intended for public publication. It provides information in an honest and transparent way about the performance of services provided by Velindre University NHS Trust.

2. BACKGROUND

2.1 The guidance provided by the Welsh Government advises that the Performance Reporting needs to include a breakdown of the Annual Performance Report content requirements as set out in **NHS Manual for Accounts**.

2.2 Welsh Government has advised that the focus of the guidance is on ensuring that bodies show how they have performed against the Annual targets set for 2023 - 2024.

2.3 The draft document has been endorsed by the Executive Management Board subject to any agreed amendments following formal feedback from Audit Wales.

3. ASSESSMENT

3.1 The Velindre University NHS Trust Annual Performance Report (2023 / 2024) is based upon data reported to the Velindre University NHS Trust Board through the Performance Management Framework.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The purpose of this paper is to ask the Velindre University NHS Trust Quality, Safety and Performance Committee to endorse the Annual Performance 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*	10 - Governance

QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
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 yet completed - Include further detail below why
	The Velindre University NHS Trust Annual Performance Report is a factual report against performance over the last 12 months.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	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

Velindre University NHS Trust

Performance Report

2023 - 2024

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

Canolfan Ganser Felindre
Velindre Cancer Centre

Gwasanaeth Gwaed Cymru
Welsh Blood Service

INTRODUCTION AND CEO STATEMENT

This Annual Performance Report, describes how we delivered services from 1st April 2023 to 31st March 2024. It also provides assurance that we continued to deliver excellent patient and donor care over the last year with our commitment to Quality, Care and Excellence being our guiding principle.

During 2023 / 2024 I am proud that our patients, donors and families have continued to benefit from the highest standards of care, innovation and professionalism across the range of services we deliver. We successfully maintained the delivery of transplant services and the supply of blood and blood products to the whole of NHS Wales whilst also delivering essential tertiary cancer services to the South East Wales population. We believe the strong foundations and clinical operating models that we have established will stand us in good stead, as we enter 2024 / 2025.

The NHS Wales Annual Planning Framework Guidance required the production of a three year Integrated Medium Term Plan (IMTP), covering the period 2024 / 2025 – 2026 / 2027. In line with this guidance we submitted our plan to the Welsh Government on the 28th March 2024, following approval by the Velindre University NHS Trust Board on the 26th March 2024. Our IMTP builds upon the excellent work undertaken by teams from across the Trust, working with our many partners, to develop a set of ambitious organisational priorities, which build on our strengths and which will result in people who use our services receiving excellent care, service and support. Our plans are outlined in four distinct areas.

Firstly, the plan sets out our commitment to ensuring that we have firm foundations to support the delivery of high quality, safe and effective services which provide an excellent experience to all of our service users.

We then provide an overview of the Trust's strategic intent. This not only covers the scope of our core services but also identifies wider opportunities where we believe we can contribute across the health and social care system so that we can further support our partners in achieving outcomes and benefits for the populations we serve. It outlines our key strategic priorities and objectives and describes the programmes of work we have established to ensure that these will be delivered.

Thirdly, the plan identifies our priorities related to the implementation of enhanced models and integrated pathways of care and services for blood and cancer services. This will see donors and patients being able to access services as close to home as possible, being able to receive a wider range of information services digitally, and having access to clinical trials and other services. To support this ambition we are also actively progressing a number of key infrastructure programmes. These infrastructure improvements, together with our clinical and sustainability plans, will provide us with the

opportunity to deliver a carbon net-zero organisation and a range of wider benefits to support the development services across Wales.

Finally, we have included a detailed financial plan which sets out how we will deliver our key actions whilst remaining within our assumed financial allocation, both for revenue and capital.

The plan we have set out demonstrates the challenging, but exciting times, ahead for the Trust. We look forward to working with our commissioners, staff, patients, donors and partners to deliver the changes set out within the plan and continue our transformation into the future.

Mr Steve Ham, Chief Executive Officer

CONTENTS

ANNUAL PLANNING FRAMEWORK AND DELIVERY FRAMEWORK CONTEXT

Our Integrated Medium Term Pan (IMTP) for 2024 / 2025 – 2026 / 2027 was approved by the Trust Board, on 26th March 2024, as part of the Trusts' statutory duty under the Finance (Wales) Act 2014. Our IMTP was developed in line with the requirements of the Welsh Government NHS Wales Planning Framework.

Our plan builds upon our approved plan for 2023 /2024 – 2025 / 2026 and is and output of the excellent work undertaken by teams from across the Trust and strong engagement with our many stakeholders. We have set ourselves a set of ambitious priorities, which build upon our strengths, and which will result in the people who use our services receiving excellent and person-centred care.

Our plan is framed within the Trusts' ambition for the future, following the Boards' approval of the Trust strategy '*Destination 2033*' and brings together the immediate, medium and long-term ambitions of the organisation. The core principle in developing our plan has been our commitment to quality and safety. Our plan will ensure that we put our patients and donors at the centre of everything we do; working towards optimum quality, safety and experience; and continual learning and improving. This is the '*golden thread*' throughout our organisation.

Our strategic goals will be achieved by ensuring that all of our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to learn and improve. These priorities, as set out within our IMTP, have been discussed and agreed with our commissioners and reflects their service needs.

Our IMTP for 2024 /2025 – 2026 / 2027 will be subject to internal performance management arrangements and will be reported to various external stakeholders, including the Welsh Government.

DUTY OF QUALITY

The Duty of Quality came into legal force in April 2023, in line with the Health and Social Care (Quality and Engagement) (Wales) Act 2020. The Trust has ensured that all reporting requirements are in place in line with the statutory requirements and these are reported through the Trust Public Quality, Performance and Safety Committee.

Our Commitment to Quality and Safety:

Our Trust strategy (*Destination 2023*) sets out our commitment to quality and safety:

Strategic Goal 1: Outstanding for quality, safety and experience

Strategic Goal 2: An international renowned provider of exceptional clinical services that always meet, and routinely, exceed expectations

Quality and safety is at the heart of everything we do. We will ensure we will continue to put our patients and donors at the centre of everything we do, working towards optimum quality, safety and experience and continual learning and improving.

Our strategic goals will be achieved by ensuring that we meet in full the requirements of the Duty of Quality (Health and Social Care Quality and Engagement (Wales) Act 2020) and by ensuring that quality improvement is driving all strategic decision making. We will also ensure that our services are developed and delivered in collaboration with the patients and donors who use them, continually reviewing outcomes and experience and using these to continually learn and improve.

We will continue to actively engage and participate with Improvement Cymru, the Safe Care Collaborative and national improvement work Programmes. Our quality Improvement Goals are being progressed through the collaborative.

During 2023 / 2024 we have continued to ensure that 'q*uality is at the heart of what we do*' to deliver and improve the quality of services we provide and to drive further improvements in care.

- Continued embedding of the Trust Quality & Safety Framework - Quality, Safety, Outcomes is everyone's business

- Duty of Quality & Duty of candour requirements implemented
- All service developments are now required to be subject to a quality impact assessment prior to approval by the Trust Board
- Integrated Quality & Safety Group working effectively and ensuring enhanced triangulation & assurance across the Trust
- Quality governance assurance mechanisms implemented with training for all department, divisional, executive and Board leaders

The Trust continually drives hard to ensure that quality, safety, experience and value are fundamental in the delivery of both the Velindre Cancer Service and the Welsh Blood Service.

OUR APPROACH TO THE PLANNING AND DELIVERY OF SAFE, EFFECTIVE AND QUALITY SERVICES

Destination 2033: Developing our Strategy:

Over the last twelve months we have worked closely with our workforce, patients, donors and other key stakeholders to develop our revised Trust strategy (*'Destination 2023'*) which was approved during the reporting year. In developing this strategy we considered the following in relation to the services which we deliver as well as the wider requirements across the health and care system.

Our Guiding Principles: The Well-Being of Future Generations Act (2015):

Everything we do will make a contribution to developing:

A Prosperous Wales

A Resilient Wales

A More Equal Wales

A Heathier Wales

A Wales of Cohesive Communities

A Wales of Vibrant Culture and Welsh Language

A Globally Responsible Wales

How we will Work:

Long-term

Integration

Involvement

Collaboration

Partnership

Destination 2033: Our View of the Future:

Our Purpose: To Improve Lives

Our Vision: Excellent Care, Inspirational Learning, Healthier People

Our Trust Values

Our 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 training for all

5 – A sustainable organisation that plays its part in creating a better future for people

PERFORMANCE ANALYSIS

During 2023/24 our Performance Management framework has continued to evolve with an enhanced range of measures which are routinely used to monitor the quality and performance of our core services.

Our Performance Management Framework:

This Annual Report provides an overview of the performance our Trust for the financial year 2023/24 against a range of national targets, best practice standards and locally identified outcome measures for our cancer and blood and transplant services, as well as incorporating measures of patient and donor satisfaction, staff wellbeing and sustainability.

The performance report format adopts a 'balanced scorecard' approach which seeks to 'triangulate' the interplay between operational delivery, service quality and safety, our people and physical/finance resources, and is based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.

Each Key Performance Indicator (KPI) is supported by analysis that explains the current performance, using wherever possible Statistical Process Control (SPC) Charts, to enable the distinction to be made between 'natural variations' in activity, and trends or performance requiring investigation.

The continued process of enhancing the Performance Management Framework has involved extensive engagement and discussion with Independent Members, Executive Directors, patient and donor representatives plus detailed work with Directorate Leads and all staff.

The Trust performance reports are received by the Trust Board and these papers are available on the Trust's internet site via the following **link.**

Velindre University NHS Trust Performance for 2023/24

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2023/24		
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	86%
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0
	Number Healthcare acquired Infections (HAIs) MRSA Bacteraemia	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) MSSA Bacteraemia	National	Monthly	0	0	1
	Number Healthcare acquired Infections (HAIs) P. aeruginosa Bacteraemia	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) Klebsiella spp Bacteraemia	National	Monthly	0	0	1
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) E Coli Bacteraemia	National	Monthly	0	0	0
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	1
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	0
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	99%
	Number of National VCS Reportable Incidents recorded with Welsh Government	National	Monthly	0	0	0
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	2
	Number of Health and safety incidents recorded	Local	Monthly	15	0	14
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7C/m3 Dec	137.4C/m3 Dec
Effect	Number of Pathway of Care Delays	National	Monthly	1	0	1

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2023/24		
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	94%
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	121%
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	10%
	Number of Stem Cell Collections per month	Local	Monthly	6	7	5
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.17%
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	72%
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	95%	96% 94%
	% Donor Satisfaction	Local	Monthly	95%	95%	97%
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	90%	N/A
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	17% 94%
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 85%
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	94% 100%
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	100% 100%
	% Patients Beginning Non-Emergency SACT within 21 days **February position**	National	Monthly	98%	98%	79%
	% Patients Beginning Emergency SACT within 5 days **February position**	National	Monthly	100%	98%	100%
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	97%
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	97%
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.030 m
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£31.005m	£31.002 m

QSF Domain	Trust-wide Performance Management Framework Scorecard			Average Monthly Performance for 2023/24		
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.543m	£0.775 m
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£1.8m	£1.8m
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	98%
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	TBA	TBA
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	TBA	5.96%
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	TBA	5.74%
	% of Workforce not declared Welsh Language Listening/Speaking capability	National	Quarterly	11.63%	0%	7.50%

VELINDRE CANCER CENTRE (VCS)

Overview:
Performance during 2023/24 was of a high standard and reflected our on-going ambition to deliver the best possible services. Areas not meeting set levels have been and are subject to continued scrutiny and actions are being taken forward to improve. Below, we examine our performance in 2023/24 in more detail.

WAITING TIMES AND ACCESS TO SERVICES

During the year we saw high demand for the radiotherapy and chemotherapy services provided at the Velindre Cancer Centre. Our staff worked hard to meet this demand and we continue to explore new ways of working which will reduce waiting times and improve patient access to our services.

Demand for cancer services is driven by the need to deliver care for patients newly diagnosed with cancer but, also by the requirement to make available new cycles of treatment to existing patients, e.g. patients with metastatic disease who are prescribed further cycles of therapy. Demand is also influenced by the availability of new treatment regimens, i.e. newly approved treatment agents, such as certain immunotherapies and targeted treatments, which are presenting entirely new treatment options or are influencing dramatic changes to treatment pathways.

Demand for non-surgical cancer services at VCS has been increasing steadily in recent years. The demand forecast for 2024/25 is informed by data derived from a major exercise we have led in conjunction with our health board partners, the Wales Cancer Network, Improvement Cymru and the NHS Executive's Delivery Unit.

The demand modelling initially focused on historic flows of patients from primary care to diagnosis and on to treatment. This approach was used to develop a predictive model which could forecast external demand driven by new patient referrals. We have used this model to quantify capacity requirements for 2024/25 and beyond. We will continue to use this model to review demand in the future.

The table below provides a summary of the planning assumptions that underpin the capacity and delivery plan for 2024/25:

Forecast Growth in Demand for our Services in 2024/25:

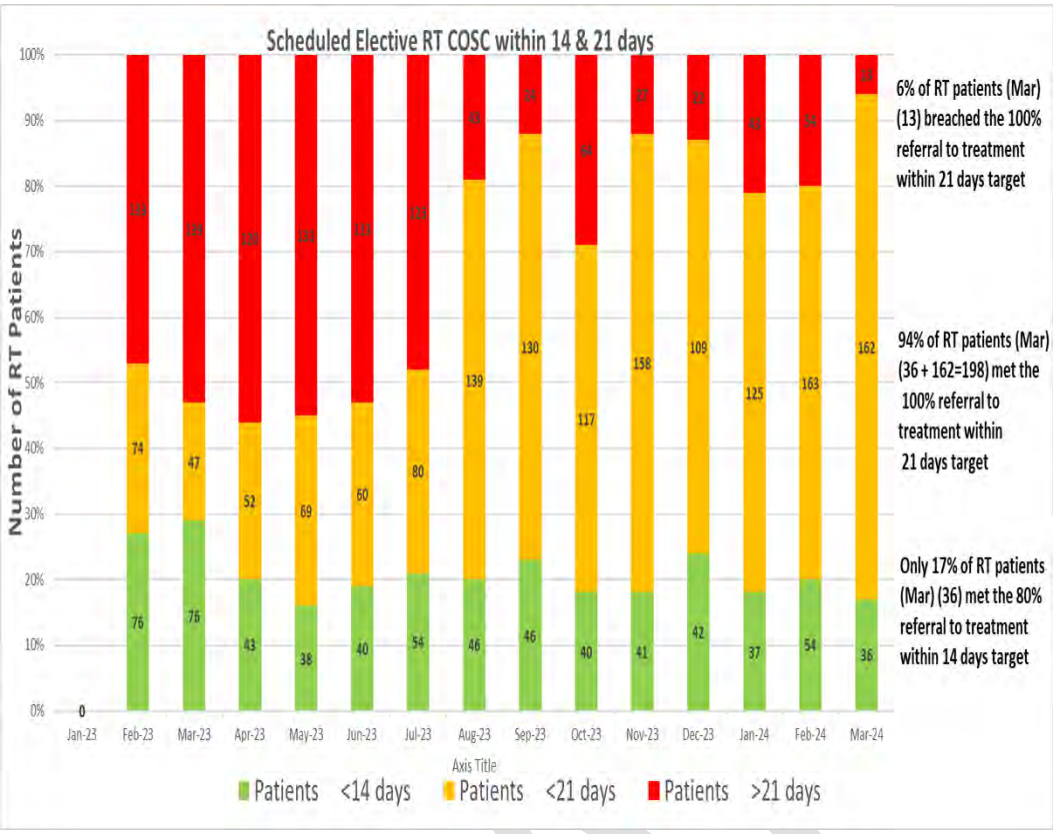
Service	2024/25
Radiotherapy	6%
Nuclear Medicine	2%
Radiology Imaging	10%
Preparation and Delivery for Systematic Anti-Cancer Therapy	10%
Ambulatory Care Services	2%
Outpatient Services	10%
Inpatient Admitted Care	2%

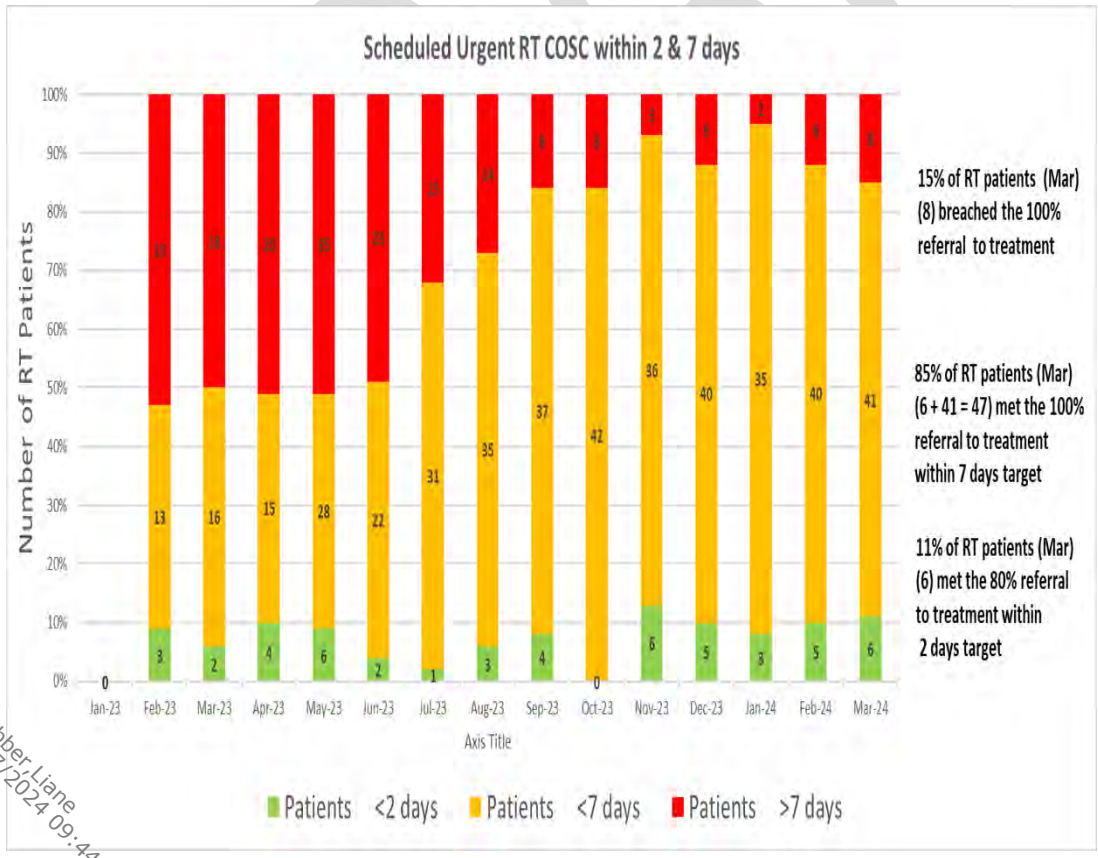
To accommodate the forecast increases in demand for anticipated in 2024/25 will require changes to clinical practice and service delivery. The increased utilisation of virtual outpatient attendances, the mix of oral and IV infusion SACT delivery, the expanded use of hypofractionation in administering radiotherapy treatments to certain patient groups and the delivery of patient care in outreach settings will all need to be explored. This work is ongoing alongside activity to identify efficiencies and developments across all treatment pathways.

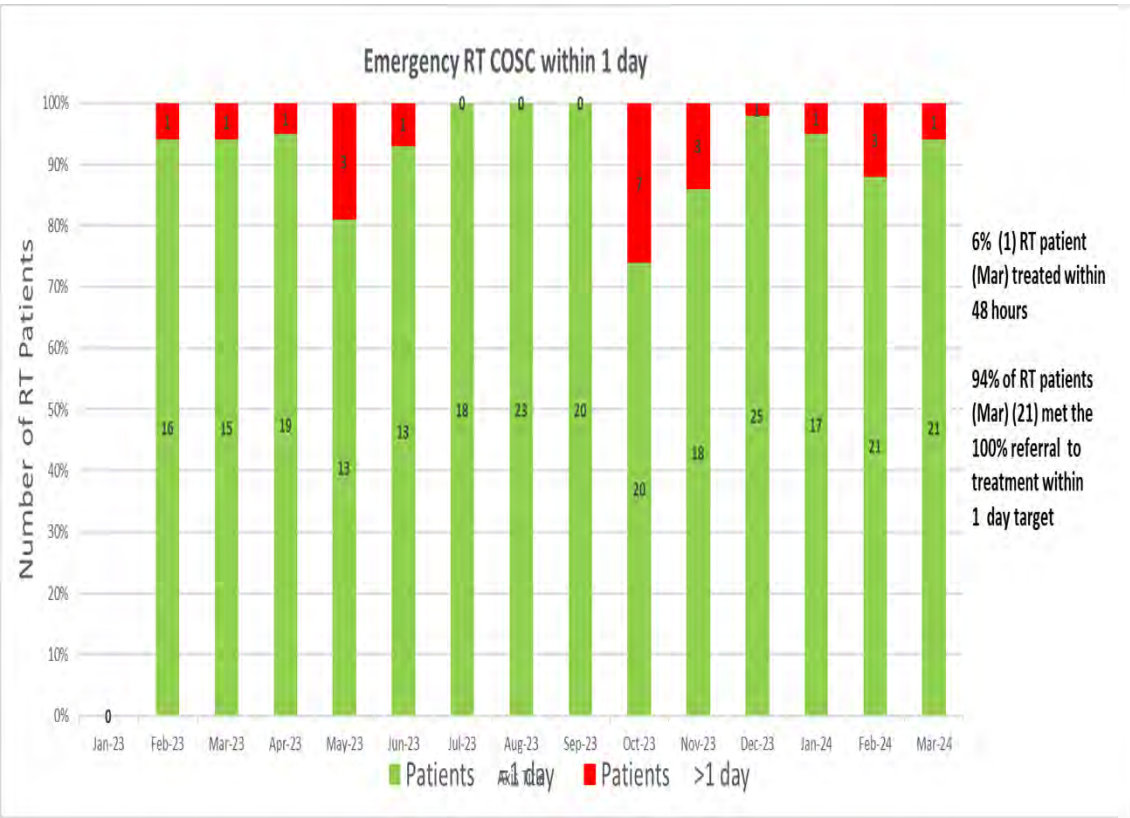
PROGRESS AGAINST: RADIOTHERAPY

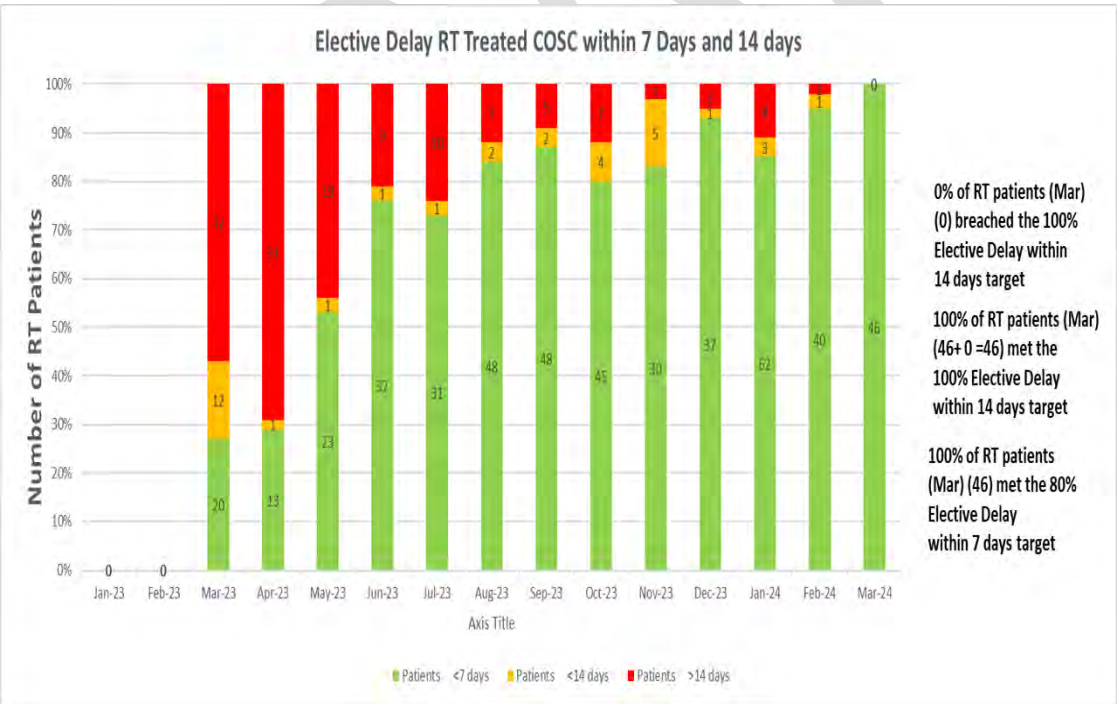
In 2023/24, we experienced an increase in demand for radiotherapy services. Our performance improved across the year and by March 2024:

- 94% of radiotherapy patients met the referral to treatment target (21 day target)
- 85% of radiotherapy patients met the referral to treatment target (7 day target)
- 94% of radiotherapy patients met the referral to treatment target (1 day target)
- 100% of radiotherapy patients met the elective day target (14 day target)





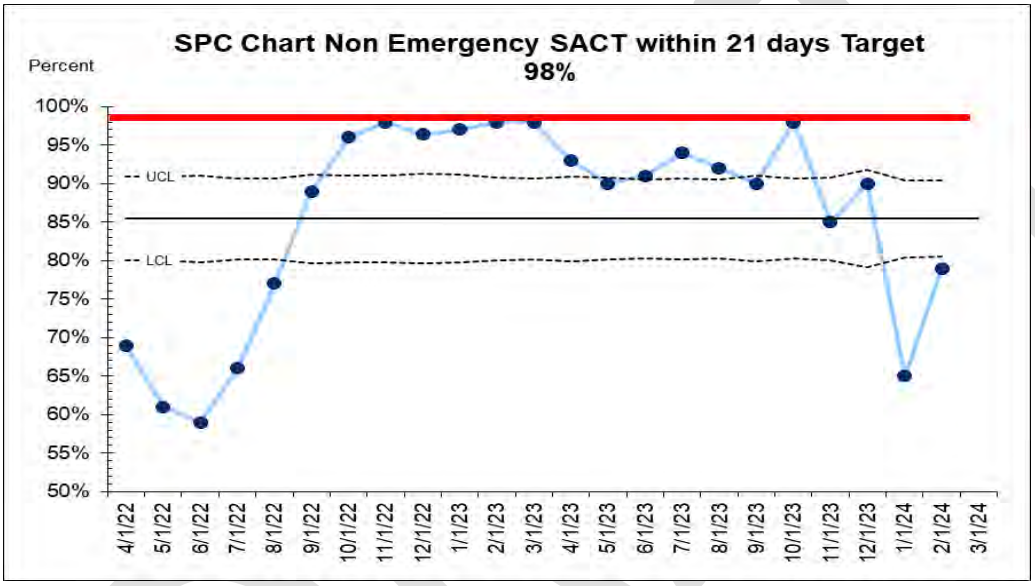


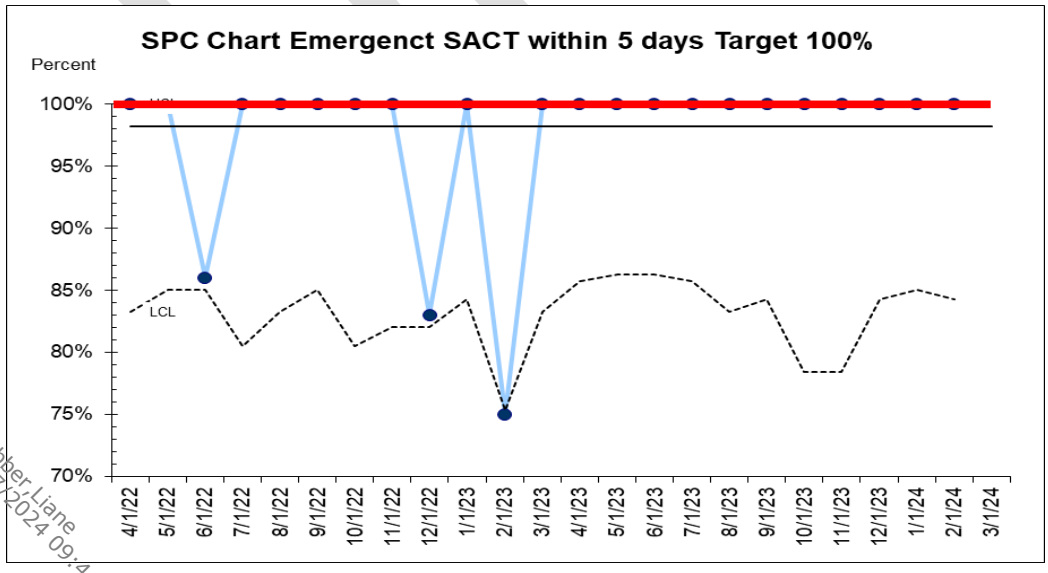


PROGRESS AGAINST: SACT

In 2023/24, we experienced an increase in demand (circa 12%) for SACT services. This resulted in a significant in-year challenges in being able to deliver sufficient capacity to meet demand. A major contributing factor was a continued reduction on the provision of outreach services across our Health Board partners as well as constrained pharmacy capacity. However, we are pleased to report that performance improved significantly towards the end of the year and by March 2024:

- 100% of emergency patients were treated within target (5 days)
- 91% of non-emergency patients treated within target (21 days)





PROGRESS AGAINST: ACCESS TO THERAPY SERVICES

Performance throughout 2023/24 was excellent overall, but we recognise that the small number of therapies staff means that staff absence can have a disproportionate effect on overall performance. Every effort is made to manage such situations effectively.

VCC	Jan 23	Feb 23	Mar 23	Apr 23	My 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Marc h 24
Percentage of Therapies Referrals (Inpatients) Seen Within 2 Working Days															
Dietetics	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
OT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
SLT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Percentage of Urgent Therapies Referrals (Outpatients) Seen Within 2 Weeks															
Dietetics	91	100	98	84	100	97	95	93	97	100	100	100	100	100	100
Physio	100	100	100	100	100	100	100	100	100	100	100	100	100	na	100
OT	100	100	100	100	100	100	100	67	100	64	100	100	100	100	100
SLT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Percentage of Routine Therapies (Outpatients) Seen Within 6 Weeks															
Dietetics	100	100	100	96	94	100	100	100	100	100	100	100	100	100	100
Physio	100	100	100	100	100	100	94	94	81	100	100	100	100	70	73
OT	96	100	96	100	100	100	100	100	93	100	100	100	100	100	100
SLT	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

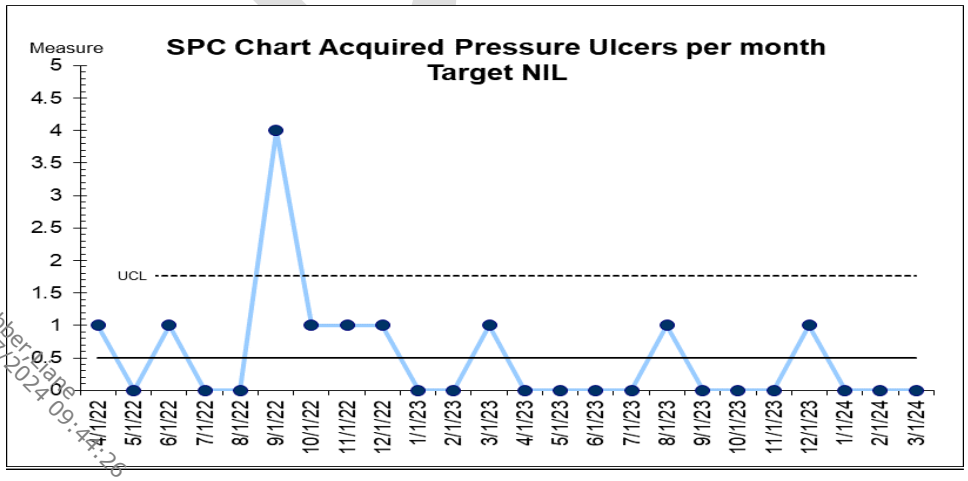
PROGRESS AGAINST: SAFE AND RELIABLE SERVICES TARGET

Hospital Acquired Infections: We have continued to maintain our low rates of hospital acquired infections. We have zero tolerance with respect to hospital acquired infections, such as MRSA. This means that our aim is to see no such infections in our inpatients over the course of any year. However, we also recognise that our inpatients can be particularly

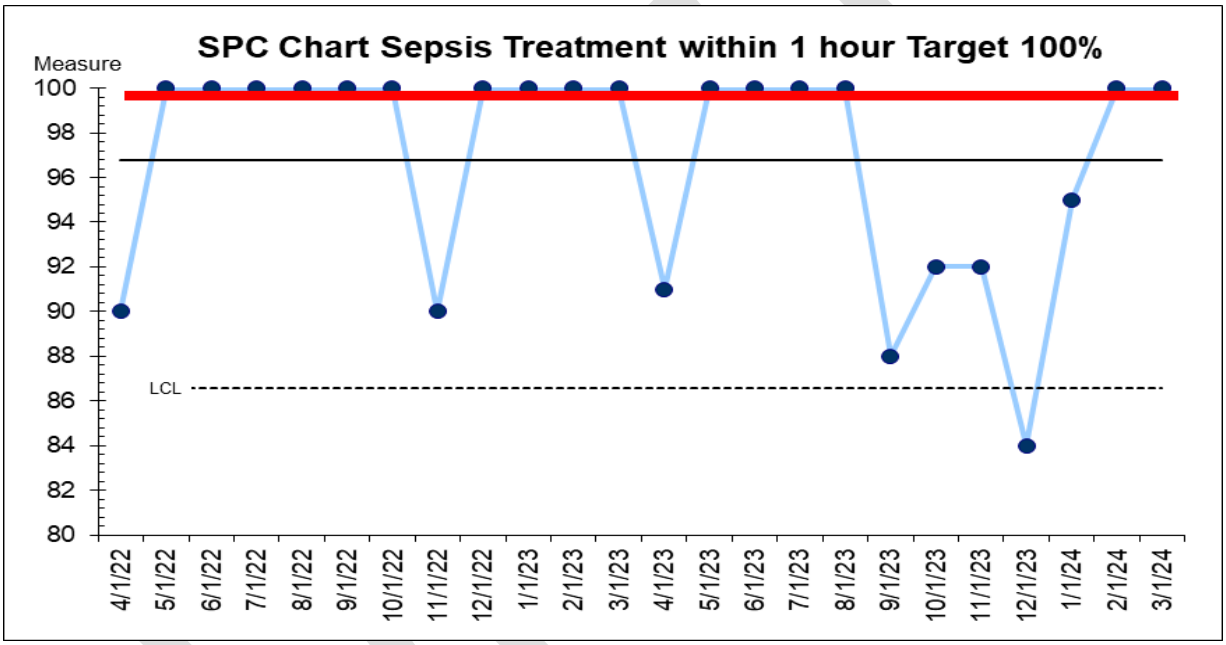
susceptible to infection because of the nature of the treatments that they undergo and their physical condition.

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

Pressure Ulcers: We also have zero tolerance with respect to tissue damage and pressure ulcers. Again, our inpatients can be particularly susceptible to this sort of damage. Compliance with our Skin Care bundle, which has been developed to reduce the risk of skin and tissue damage for our inpatients, showed full compliance with the aviodable pressure ulcer target all year.



National Early Warning Score (NEWS): NEWS was originally developed by the Royal College of Physicians and is intended to help reduce the number of patients whose conditions deteriorate whilst they are in hospital. When a patient is assessed using NEWS, a score equal to, or greater than 3, indicates that they may be at an increased risk of developing complications. At VCS, we use NEWS to determine whether our patients are at an increased risk of complications related to neutropenic sepsis. Those patients that are deemed to be at greater risk have the 'Sepsis Six' bundle (a combination of 3 different treatments and 3 tests) administered to them within a set time. The graph below shows that we consistently achived or narrowly miseed our target of treating 100% of Sepsis patients within one hour.



PROGRESS AGAINST: FIRST CLASS PATIENT EXPERIENCE TARGET

Our patient feedback is largely positive. The Trust has worked to improve the way it collects and receives feedback from those who use our services. Work to understand how best to collate feedback, identify themes and to use this information to aid improvement is crucial. There are 2 surveys used in VCS – 'Would you recommend us?' and 'Your Velindre Experience' The Your Velindre experience uses 0-10 in the question about rating VCS, whereas 'Would you recommend us?' used Very good, good etc.

Patients at Velindre Cancer Centre consistently rated their own experience as being very good, scoring an average in the 96% for 'would you recommend us?' to an 86% average for 'your Velindre experience'. The importance of learning from patient feedback remains paramount in the development of our services.

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

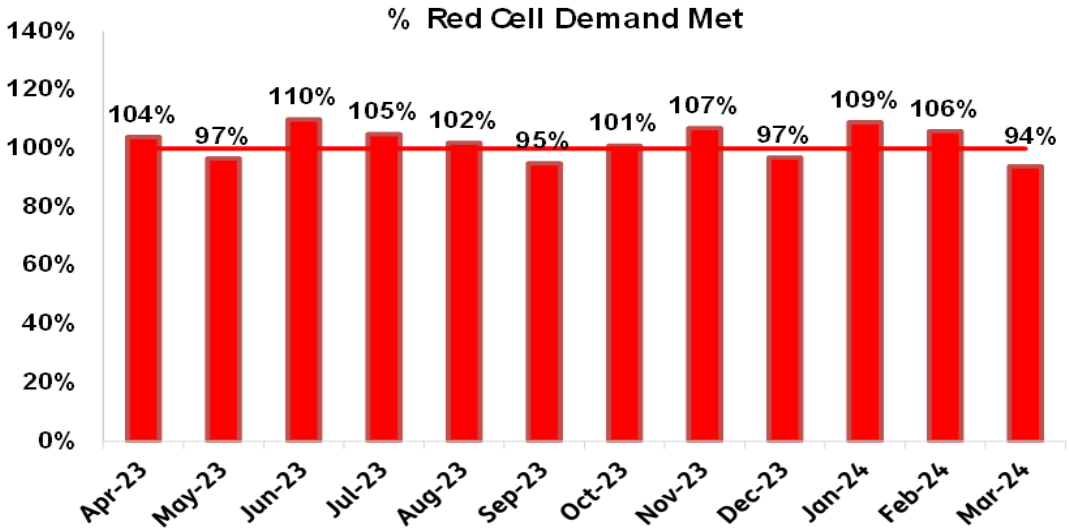
WELSH BLOOD AND TRANSPLANT SERVICE (WBS)

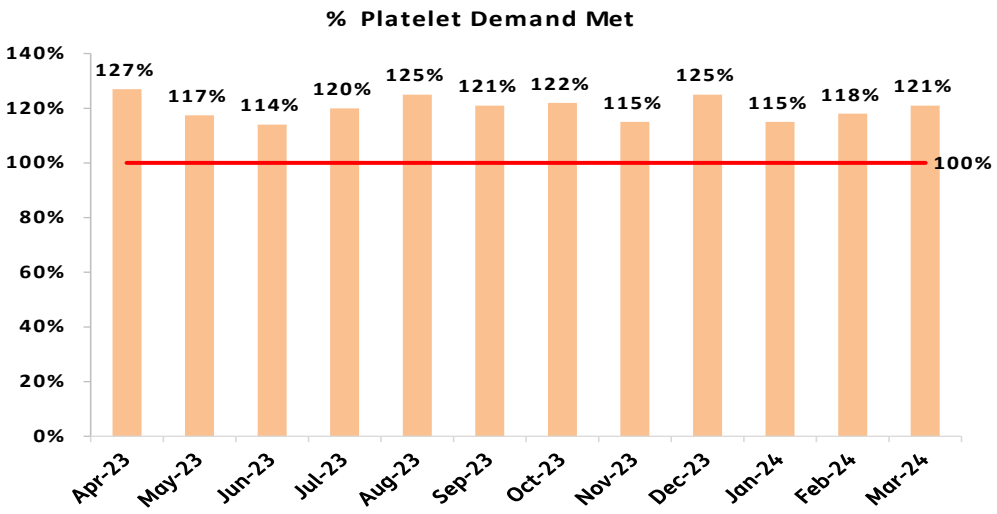
Overview:

Performance during 2023/24 was of a high standard and reflected our on-going ambition to deliver the best possible services. Areas not meeting set levels have been and are subject to continued scrutiny and actions are being taken forward to improve. Below, we examine our performance in 20232/24 in more detail.

PROGRESS AGAINST: MEETING CLINICAL DEMAND FOR RED BLOOD CELLS AND PLATELETS

Throughout 2023/24, the Welsh Blood Service successfully met all clinical demand for Red Blood Cells (RBC) and Platelets for our customer hospitals across NHS Wales. This is the result of established daily communications between the Collections and Laboratory teams enabling agile responses to variations of stock levels and service needs and working closely with our customer hospitals.



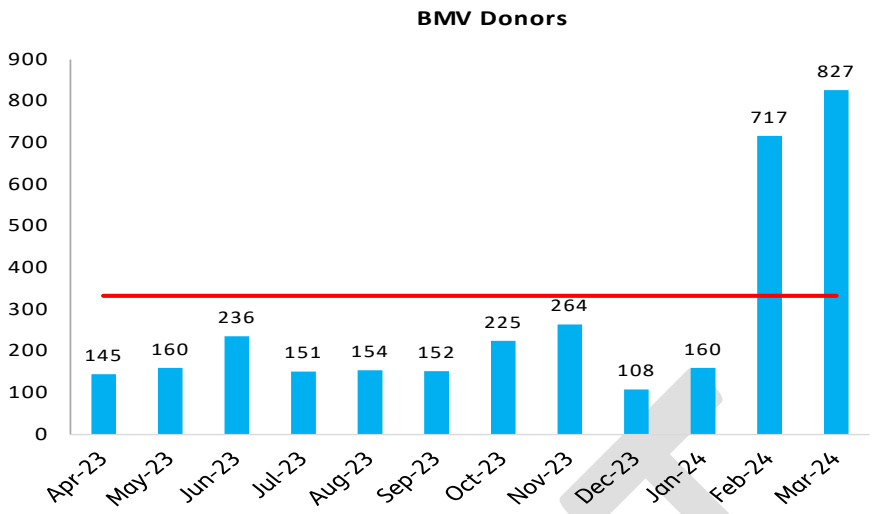


PROGRESS AGAINST: GROWING OUR BONE MARROW REGISTRY

The Welsh Bone Marrow Donor Registry (WBMDR) provides a panel of volunteer donors recruited from the blood donor panel willing to donate stem cells for use as cellular therapy. A donor attends a blood donor session and if aged between 17 and 30 is asked if they would like to join the panel. Donors stay on the panel until their 61st birthday.

Our registry currently includes more than 70,000 volunteers who were recruited via a blood donor session. The target recruitment is 4,000 per annum which was not met in 2023/2024 (actual – 3,341). However, we continue to focus on our five-year service strategy with the aim to address this shortfall.

Current Bone Marrow Volunteer (BMV) recruitment involves a combination of recruitment of blood donors aged 17-30 at blood donor sessions and the recruitment of non-blood donors using buccal swabs. This age group is preferred as young donors have longevity as a potential donor and because they provide a more clinically effective transplant. Recruitment via blood donor sessions is becoming increasingly difficult to sustain as the strategy of aligning blood supply to demand going forward, will require increased focus on returning blood donors whose demographic is not necessarily aligned to the target BMV age group. This has resulted in the requirement to increase our focus on recruitment of bone marrow volunteers via buccal swabs



There are 114 registries in the global network and in total there are approximately 41 million donors on the global panel. The panel grows at around 7% each year. In the UK, there are 4 registries with a total of just over 2 million donors. The Welsh Bone Marrow Donor Registry represents 3% - 4 % of the total donors in the UK. The WBMDR has the highest collection index of the 4 UK registries and consistently scores high in international collection and efficiency indexes and trend reports such as the WMDA Global Trends Report and the National Marrow Donor Program (NMDP-USA) Global Registry Report. The WBMDR has recently passed inspection by the Human Tissue Authority (HTA) and the World Marrow Donor Program (WMDA) and maintains its status as a donor centre for the NMDP.

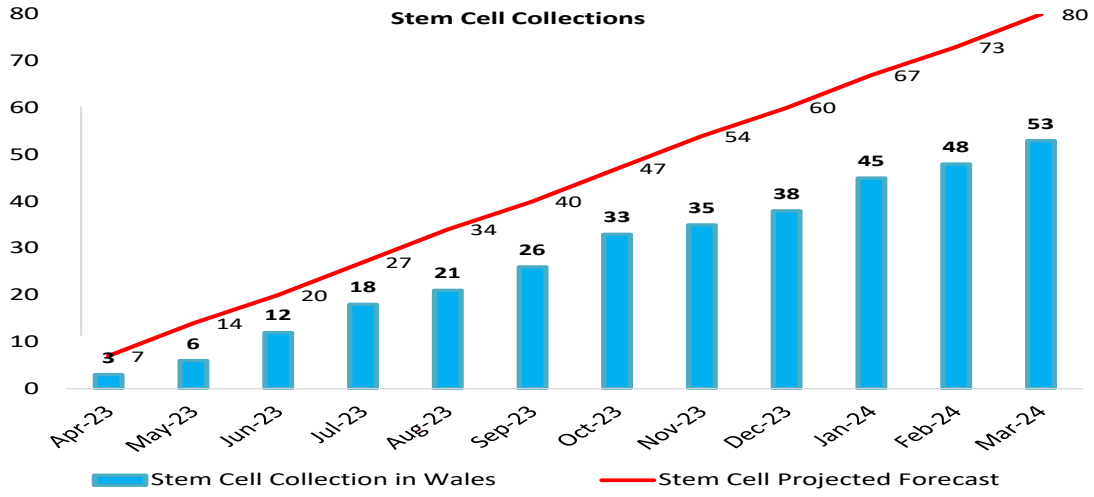
PROGRESS AGAINST: MEETING TRANSPLANT SERVICES REQUESTS

Our annual target for the number of stem cell collections that we would anticipate in any 12-month period is set at the beginning of the year.

There are a high number of variable factors that influence the number of stem cell collections that are undertaken in any one calendar month. There is an initial confirmatory test, which is, then sent back to the requesting transplant centre who then make a decision on which donor will be taken forward for their particular patient. From the basic genetic match of our donors, availability and willingness of our donors to participate and donate, the wellbeing of the recipient patient, and their treatment pathway, all contribute to the final number of collections that will be undertaken in any one calendar month.

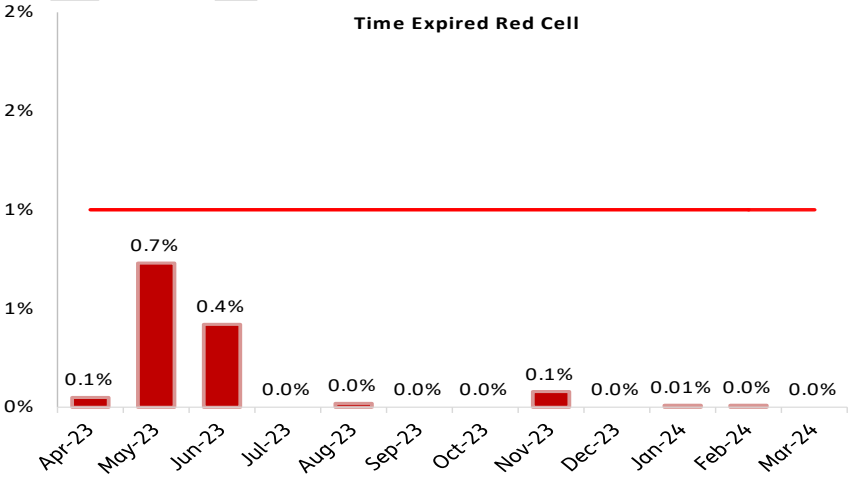
During 2023/24, the Welsh Bone Marrow Donor Registry fell short of its annual target. The Welsh Bone Marrow Donor Registry five-year strategy, re-appraising the existing

collection model and its ambition, is being developed to support the ongoing development of the service. This is part of the Welsh Blood Service Futures programme and as part of this 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.



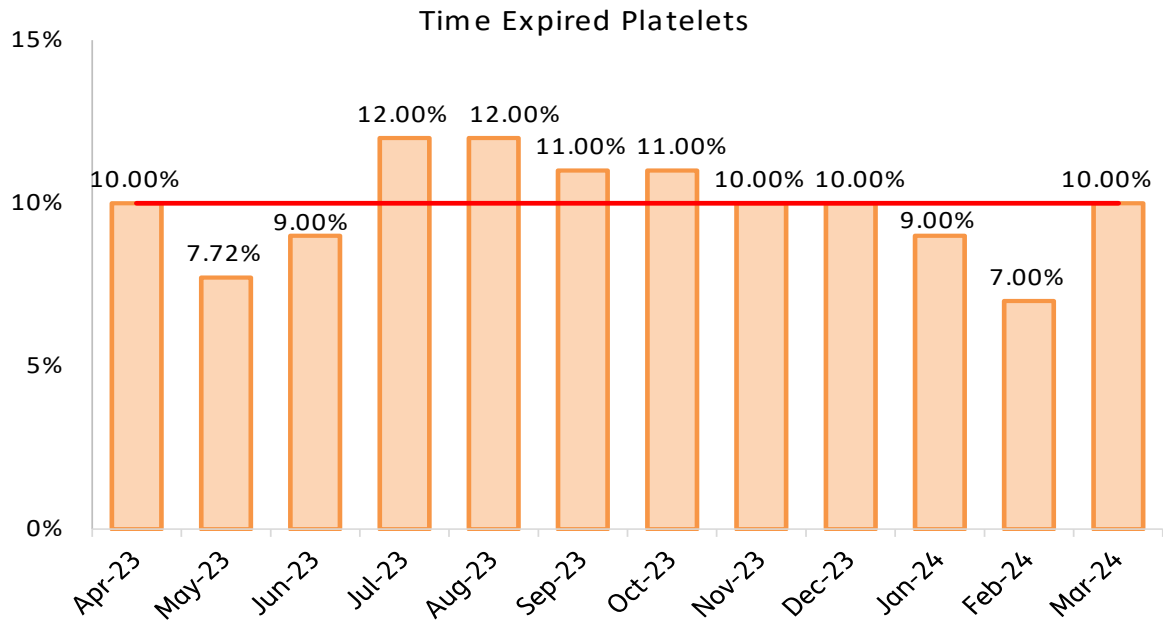
PROGRESS AGAINST: MINIMISING WASTE TIME EXPIRED RED CELLS AND PLATELETS

Aligning the supply of blood components, which have limited shelf life, to the varying demand of hospitals is highly complex and multifaceted. Currently, the WBS has set itself a target of no more than 1% of Red Blood Cells (RBC) time expiring each month where they exceed their 35-day 'shelf-life' and a 10% target for platelets (7 days shelf life). During 2023/24, the levels of time expired red cells remained consistently below the 1% target, this was attributed to the active and agile management of the supply chain and demonstrates the excellent performance of the service.



Time expiry of platelets was largely within our target tolerance during the reporting year. However, there were four months where we exceeded the target tolerance threshold. We therefore continue to focus on service delivery and have developed the following actions to ensure that we continue to improve the service and reduce wastage.

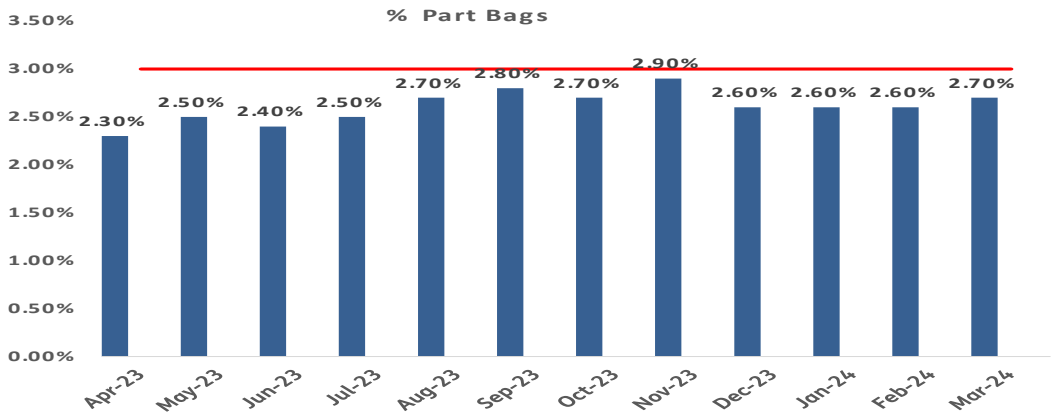
- Daily monitoring of the '*age of stock*' as part of the 'Resilience' meetings.
- A Welsh Blood Service Platelet Strategy is being developed. This will be managed through the Wels Blood Service Futures Programme - Lab Services Modernisation Programme.
- We are developing a forecasting tool to inform decisions around pooled platelet manufacture.



PROGRESS AGAINST: COMPLETE WHOLE BLOOD DONATIONS

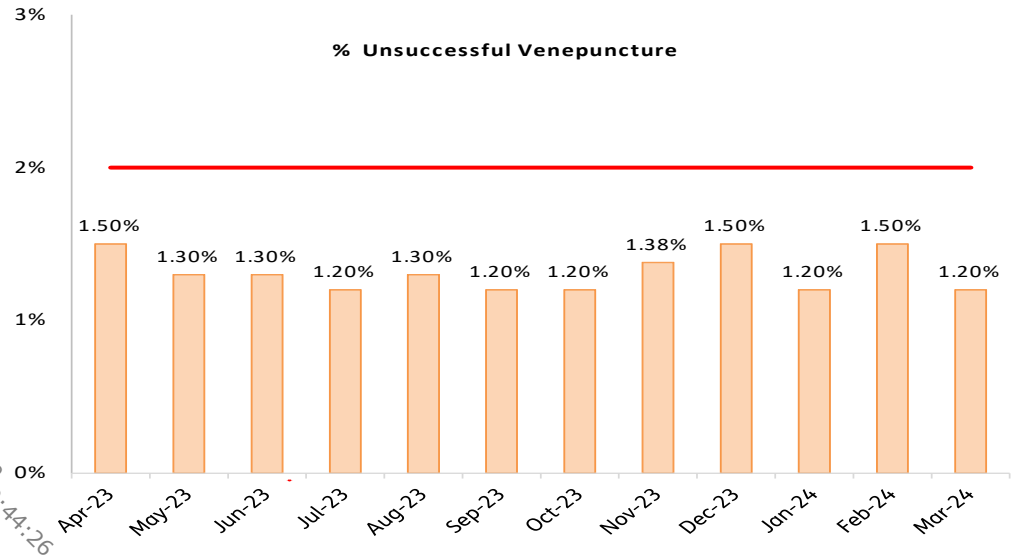
Part bag is the term we use to describe a whole blood donation of less than 420ml of blood and which is therefore not viable for clinical use and disregarded. There are various reasons why a donation may need to be stopped before the required volume of blood has been collected. These reasons include venepuncture technique, donors feeling unwell or equipment failure. Our current target is to ensure that we collect less than a maximum of 3% part bag blood donations and during 2023/24 we are pleased to report that we achieved this target every month. However, and despite this excellent performance, the

Welsh Blood Service will continue to modernise our service and strive to reduce the numbers of part bags wherever possible.



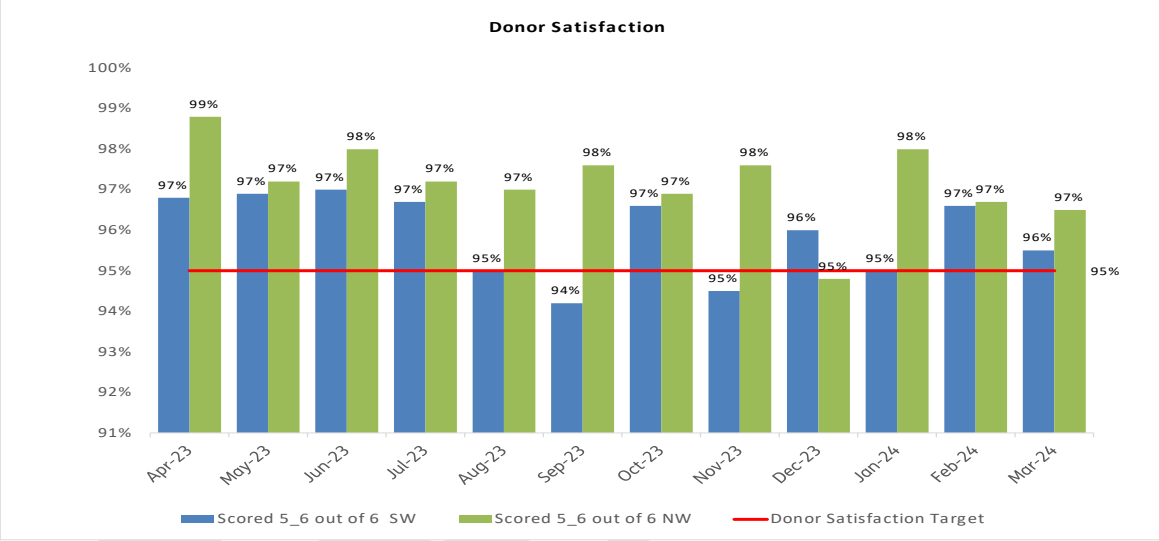
PROGRESS AGAINST: UNSUCCESSFUL VENEPUNCTURE

Unsuccessful venepuncture refers to donors who have reached the donation chair but despite an attempt to venepuncture the donor, no blood enters the bag. There are various reasons why this can happen, typically this might be a result of inaccessible donor veins, poor venepuncture technique or equipment failure. Our current tolerance threshold is no more than 2% of all donors where a blood donation is initiated to result in a failed venepuncture attempt. Performance during 2023/24 was excellent and consistently within target tolerance levels. Despite strong performance in this area the WBS will continue to modernise our service and strive to reduce the number of unsuccessful venepunctures wherever possible.



PROGRESS AGAINST: FIRST CLASS DONOR EXPERIENCE TARGET

The importance of learning from donor feedback remains paramount in the ongoing development of our services. During 2023/24, the Welsh Blood Service has continued to work hard to improve systems and processes relating to concerns management to ensure that donor and service user feedback is consistently managed in a timely and effective manner, whilst ensuring lessons are learnt and identified service improvements are introduced. This has resulted in excellent donor feedback which has consistently met our target.



RISKS AND CHALLENGES

VELINDRE CANCER CENTRE – RISKS AND CHALLENGES

Velindre Cancer Centre, currently, faces a number of key challenges. Additional detail on how we will address these can be found in our three year plan, but it is important to recognise that these issues effect the design of our services and our performance.

CANCER INCIDENCE IS INCREASING

The incidence of cancer in Wales is forecast to increase by 2% per annum to 2031. However we are forecasting actual that demand for the majority of services that we deliver will increase by the following.

Forecast Growth in Demand for our Services in 2024/25

Service	2024/25
Radiotherapy	6%
Nuclear Medicine	2%
Radiology Imaging	10%
Preparation and Delivery for Systematic Anti-Cancer Therapy	10%
Ambulatory Care Services	2%
Outpatient Services	10%
Inpatient Admitted Care	2%

THERE CONTINUES TO BE VARIATION IN OUTCOMES THROUGHOUT WALES

While survival rates have improved, there continues to be significant variation in survival rates between the least and most deprived in south-east Wales. We need to work with our partners to reduce inequalities, improve prevention, improve the rates of earlier detection and diagnosis and patient access and take up of treatment.

THERE IS A GAP BETWEEN FORECAST DEMAND AND SUPPLY WHICH WE NEED TO CLOSE

The increasing incidence of cancer, increasing survival rates of people with cancer and the increasing complexity in treatments will create a significant pressure on our ability to deliver the required level of services in the future. It is crucial that the healthcare system responds to this increasing and changing demand if it is to continue to deliver services and maintain current performance.

TREATMENTS ARE BECOMING MORE COMPLEX

The pace of innovation, clinical and technological change in cancer services is rapid. We know that on the immediate horizon are new advances in radiotherapy along with personalised medicine. Similarly, within SACT services, there is a growing list of cancer types for which immunotherapy has shown promising results and, consequently, we are introducing ever more immunotherapy treatments. These treatments are often used in addition to existing therapies or, in some cases, are providing entirely new options for patients. This is an exciting and dynamic area. We recognise that the use of these novel treatments introduce new levels of complexity and are sometimes delivered over extended periods. We must ensure that the appropriate support and infrastructure is in place to allow us to continue to offer these treatments in a timely, safe fashion in order to optimise outcomes for our patients.

MORE PEOPLE ARE LIVING WITH AND BEYOND CANCER

As treatments have improved survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation, and to ensure patients are able to maximise their potential and enjoy the highest quality of life.

There is a need to develop a broader range of services which support individuals and helps them engage fully in society, including employment, following their recovery. We need to ensure that we can continue to offer robust, high quality Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

SUPPLY OF WORKFORCE

Survival in the UK has doubled over the last 40 years. A new approach to longer term care is therefore required to support individuals with ongoing treatment and rehabilitation and to ensure patients are able to maximise their potential and enjoy the highest quality of life. There is a need to develop a broader range of services which support individuals to engage fully in society, including employment, following their recovery. We need to ensure that we can continue to offer robust Therapies and Clinical Psychology services. This will require a change in relationship between patient and clinician, with patients taking an equal role in designing and co-producing care.

Maintaining an engaged healthy donor panel:
The challenge of ensuring we have enough donors of the right group to meet our demand is one that is being experienced by blood services globally with an aging population, increased travel to countries where donors may be susceptible to blood donor disease and people having busy lives.

Meeting demand and service development:
Aligning varying hospital demand to the supply of blood components, especially those with limited shelf life, is a challenge.

Increasing use of immunotherapy and improved compliance with national guidelines increase the demand for highly specialised reference blood testing provided by WBS Red Cell Immunohaematology (RCI) laboratory. This service need continues to grow and is not sustainable under the current commissioning arrangement which needs to be revised.

Demand for stem cell donation and transplant immunology services is also expected to increase through presumed consent legislation across the UK and increased use of stem cell treatments. The Welsh Blood Service is also exploring the opportunity for expansion of its stem cell collection services for partner organisations.

Continuing to meet stringent blood selection guidelines and regulatory requirements:
Changes in science, technology and ways of working provide a continually evolving service and developing regulatory requirements for blood services.

In addition there are regular changes in Donor Selection Guidelines (DSGs) and the Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC) guidelines for the Blood Transfusion Services in the United Kingdom (Red Book).

Finally the service will receive the outputs and recommendations from the Infected Blood inquiry in 2024 and will re required to respond to these within agree timielines.

Changing science and technology:
Advances in both scientific and medical understanding of the origin and management of disease, as well as broader supporting technological developments, provide

opportunities for step changes in operational workflows, efficiencies and services provided by WBS. This includes Next Generation Sequencing (NGS) and Advanced Therapy Medicinal Products (ATMPs).

During 2023/24, WBS continued to 'horizon scan' and support the Welsh Government and NHS Wales on developing strategies to facilitate the adoption of these new ATMP therapies. Through Advanced Therapies Wales, WBS worked closely with NHS Wales organisations, private and third sector to make recommendations on prioritised activities required for such a roll out.

Automated technology is rapidly evolving within the field of blood component manufacturing and testing and WBS are exploring the potential of these technologies including red cell genotyping.

Advances, such as artificial intelligence driven data analysis and implementation of augmented reality enhanced routine procedures, that increase throughput and quality, eliminate errors and identify issues earlier in a cost-effective manner are emerging. Adoption of these techniques will enable further developments in efficiency and quality of our services.

Workforce:
WBS has to respond to these advances in terms of its own workforce but also in the role it plays in the training of the current and future scientific workforce for NHS Wales through its support for undergraduate provision and its informal and formal outreach to support NHS colleagues. Consideration also needs to be given to the throughput of entry level scientific staff and their career progression within the NHS which already creates some pressure within WBS. In addition, competition for scientists with the commercial sector will increase the current difficulties in recruitment / retention, meaning that we will have to develop and maintain attractive roles and opportunities. Education strategies that support succession planning and develop a work force that is flexible and responsive to the transformation are being developed as well as those which support the new and emerging skills requirements.

DELIVERING IN PARTNERSHIP

The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector. Our primary health partners are set out below:

Organisation	Relationship
Aneurin Bevan University Health Board	Commissioner
Betsi Cadwaladr University Health Board	Commissioner
Cardiff and Vale University Health Board	Commissioner
Cwm Taf Morgannwg University Health Board	Commissioner
Hywel Dda University Health Board	Commissioner
Powys University Health Board	Commissioner
Swansea Bay University Health Board	Commissioner
Welsh Ambulance Service NHS Trust	Provider
Public Health Wales NHS Trust	Provider
Health Education and Improvement Wales	Provider
NHS Wales Shared Services Partnership	Provider of services
Digital Healthcare Wales (DHCW)	Provider of services
Welsh Health Specialist Services Committee	Specialist Commissioner

Effective planning and commissioning of services is fundamental to achieving the best outcomes for the people we serve across Wales and the cultural shift required to reduce health inequalities, improve population health and well-being and achieving excellence across Wales.

The Trust has worked in close partnership with our Local Health Board partners to ensure that our key strategies are aligned, that there are a clear set of shared priorities and to ensure that we can provide sufficient capacity and capability to deliver commissioned services of the highest quality.

Engagement with people who use our services to design them in partnership:

Effective and ongoing engagement is vital in the development of our services and we strive to make it as easy as possible for patients and donors to share feedback following their care.

Trust Values

During 2023 / 2024 we have engaged extensively in relation to our Trust values. The outcome of this engagement process has been a refresh of our previous Trust values. Our new Trust values are listed below. These will underpin how we plan all service developments across the Trust.

Caring	Respectful	Accountable
We are always kind, supportive, approachable and show compassion to all.	We seek to understand other people's perspectives. We are always open and transparent.	We always take personal responsibility for what we do and how we do it.

We value our staff and recognise that they are a key priority to the successful delivery of high quality services. Our aims, therefore, are to continue to develop our workforce by:

- Supporting career pathways
- Developing the leadership skills of our staff
- Providing our staff with the knowledge and skills that they need now and in the future
- Supporting the well-being of our staff
- Recognising and valuing the diversity of our staff as part of a bi-lingual culture and ensuring all staff are able to be themselves and work in an environment that supports and values difference.

Our strategic ambitions build upon our strong foundation as a good employer and is essential to the delivery of our service plans for VCS and WBS.

Our Workforce Vision: To Become an Employer of Choice:

Skilled and Developed People: an employer of choice for staff already employed by us, starting their career in the NHS or looking for a role that will fulfil their professional ambitions and meet their personal aspirations.

Planned and Sustained People: having the right people with the right values, behaviours, knowledge, skills and confidence to deliver evidence based care and support patient and donor wellbeing.

Healthy and Engaged People: within a culture of true inclusivity, fairness and equity across the workforce. A workforce that is reflective of the Welsh population's diversity, Welsh language and cultural identity.

Over the past 12 months, key deliverables include:

- 86% compliance with statutory and mandatory training
- Continued to work closely with HEIW, including maintaining provision of the Trust Inspire Management Programme.
- Working with colleagues to develop the School of Oncology and the Collaborative Centre for Learning Training and Innovation
- Development of a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement.
- Devlopment of an Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge
- Initiation of a new Trust Strategic Equality Plan that supports the implementation of our Anti-Racist Action Plan and other aligned anti-discriminatory practices
- Continued development of our talent management process that supports career pathways
- Implementation of our welsh culture plan targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce
- Continued to work closely with our partners, both in academia and nationally, to ensure the best leadership and management offers are provided for staff including coaching, mentoring and provision of masterclasses
- Health and Wellbeing infrastructure embedded and enhanced across the Trust to support staff physical, mental and financial wellbeing
- Further embedded our workforce planning process and toolkit
- Ongoing management and development of Apprenticeships, Graduate trainees

Looking forward to 2023/24:

With the successful implementation of the core themes outlined within our Trust workforce strategy we will be able to facilitate the transition of people across all of our key deliverable areas. This will help us create and sustain a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce.

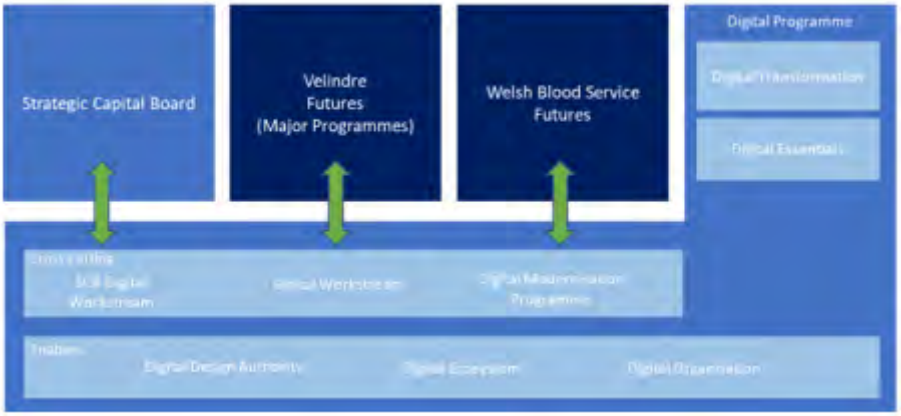
DIGITAL TRANSFORMATION

The Trust, in June 2023, published a new Digital Strategy – '*Digital Excellence | 2023 to 2033*' – to complement the new Trust strategy, '*Destination 2033*'. It describes our vision for how digital services will be used to enhance patient and donor services, enable wider access through work on digital inclusion, secure and protect our data and how we will use data collected from all over NHS Wales to inform decision making and plan our services for the future.

The Trust's Digital Strategy sets out our strategic themes and in the next sections we have used these to show coverage across the Digital IMTP. This highlights that we have a balanced plan in support of our vision.

Theme 1:	**Ensuring our Foundations**
Theme 2:	**Digital Inclusion**
Theme 3:	**Insight Driven**
Theme 4:	**Safe and Secure Systems**
Theme 5:	**A Digital Organisation**
Theme 6:	**Working in Partnership**

To successfully deliver our digital strategy we have established a Digital Programme, which will co-ordinate the digital transformation. The rationale for bringing this work together into a programme is to recognise the importance that Digital plays in supporting the services of the Trust, the interconnected nature of Digital services and to better focus our Digital resources on patients, donors and staff. This will allow us to be more efficient with our resource, increase staff confidence and capability with Digital, and better manage our Digital risk. The components of the Digital Programme are shown below.



Digital Programme Scope

Over the past 12 months, key deliverables include:

- Further upgrades to the national Welsh Patient Administration System (WPAS) and the Welsh Clinical Portal (WCP) to better support the clinical and operational workflows across the VCS and to further improve the mobility and visibility of patient data across organisational boundaries.
- The Digital Service Desk – established in March 2021 – continues to effectively manage calls for IT support with a relatively high percentage of calls immediately resolved by the team.
- Continued upgrades to some of the key operational and clinical applications across the Trust.
- The Digital Services team continue to play a central role in the design of the new Velindre Cancer Centre (nVCS) – due to open in 2027 – and the Radiotherapy Satellite Centre in Nevill Hall, Abergavenny – due to open in 2025. Digital is at the forefront of the design for the nVCS, with the intention to use a variety of new and innovative digital solutions to enhance the patient experience and improve the working conditions of staff who work in the new hospital.
- Delivered the IT infrastructure services and equipment to support the first the implementation of the Trust Integrated Radiotherapy Solution (IRS) programme.
- Continued development our local cyber security systems and procedures, and participation in national approaches to help secure patient and donor data and protect critical Trust IT services.
- Establishment of the Trust Digital Programme, to oversee delivery of the digital transformation agenda across the Trust.
- Enhanced focus on digital inclusion for staff and patients who use and access our services. This will be a key focus for all our digital projects and programmes over the coming years.

SUSTAINABILITY STRATEGY 2023/2024

WELLBEING OF FUTURE GENERATIONS ACT / CREATING A SUSTAINABLE ORGANISATION

Our Approach to the Well-Being of Future Generations Act:

We have a commitment to transform the Trust and to create a sustainable organisation. The Trust Strategy: Destination 2033, together with associated strategies for specialist Cancer and Blood and Transplantation Services for 2023 – 2034 have been approved. These strategies have a strong focus on sustainability and set out the actions that we will take over the coming years to achieve the excellence we are committed to.

These strategies have been developed within the context of the Well-Being of Future Generations Act ('*the Act'*) as we seek to implement the principles of the Act within the Trust to ensure that they become the central organising principle of each and every action that our staff take on a daily basis. This will take time, but we are committed to ensuring we translate the intentions and spirit of the Act into tangible and sustainable benefits for the people of our region.

The Act requires public-sector organisations in Wales to focus on delivering long-term well-being goals in a sustainable manner. Whilst we have made progress in embedding the Act across the organisation we know that we have much more to do. The pioneering Act and the 2016 Environment (Wales) Act 2016 provides Wales with an exciting opportunity to lead the way internationally and outlines our sustainability aims and enables real action to create positive and significant change. Therefore, we are really excited to be able to set out our journey to sustainability and the benefits it will realise over the coming years.

As an anchor organisation in Wales, we are committed to embedding sustainability within our own organisation and become an exemplar for others to come and learn with, and from. We are committed to placing sustainability at the heart of everything we do and to maximise the benefits we can provide for people across Wales.

The Trust's Sustainability Strategy: Sustainability Excellence, has created a roadmap for us to contribute to our communities and mitigate our impact on the planet whilst continuing to deliver world class services for our donors, patients and carers. Our Sustainability Strategy outlines 10 Key Themes which we will focus on to deliver our ambitions:

- Theme 1 – Creating Wider Value: Our organisation approach
- Theme 2 – Sustainable Care Models

- Theme 3 – Carbon Zero
- Theme 4 – Sustainable Infrastructure
- Theme 5 – Transition to a Future of Renewables
- Theme 6 – Sustainable Use of Resources
- Theme 7 – Connecting with Nature
- Theme 8 – Greening Our Transport & Travel
- Theme 9 – Adapting to Climate Change
- Theme 10 – Our People as Agents for Change

Achieving our ambitions will only be possible if we enhance our existing infrastructure, and educate and empower our workforce. Every individual and team should have the ability to act sustainably and have the knowledge and confidence to make environmentally conscious decisions.

This will require an increased focus on sustainability and well-being over the next three years as we attempt to embed the Sustainable Development (SD) principles still further to make it a 'normal' part of everything that we do. The journey we are on will see us implement a new approach to planning and delivery across the Trust and the development of a different organisation that is more involved across the breadth of health, social care and public services. This collaborative way of working will see us working across the region with a range of partners to ensure the five ways of working are embedded within everything we collectively do and that we are actively contributing to the seven well-being goals.

Leadership will be fundamental to effective change. Our Chair is committed to leading the Trust to function as an exemplar Public Sector body in relation to the five ways of working and the embedding of the sustainability principle in all we do as an organisation. We have worked with our Health Board partners to facilitate the establishment of the South East Wales Collaborative Cancer Leadership Group (and this regional collaborative work also embraces the Act as a central principle).

During the next five years we recognise that there are opportunities for us to do more to advance our and the wider community's, well-being and sustainable development agenda. Within our major capital schemes in the new Velindre Cancer Centre and Talbot Green Infrastructure Upgrade Project, are developing ambitious and inclusive community benefits. We will seek to evolve existing partnerships to a much greater extent, and also to develop new relationships within the health sector and beyond in order to maximise our contribution and to support others in doing the same.

Our Well-Being Objectives:

The Trust, recognised under the Act as a national body, was required to develop and publish a set of its own well-being objectives. These objectives were developed in 2015 and were designed to focus the Trust's contribution to the realisation of the national Well-Being Goals outlined in the Act.

The Trust's Well-Being Objectives have undergone a refresh following extensive engagement both internally and externally, to better align them with the needs of our staff and patients, and our refreshed Trust Strategies. Following engagement and

consultation, there is a greater focus on staff well-being and job creation in Wales, in our Well-Being Objectives.

Delivery Arrangements:

Our approach is built upon the personal support and leadership from the Chair and our Board. At Executive level, the Director of Transformation, Strategy and Digital holds the responsibility for sustainability within their portfolio and discharges this through a range of Offices which are co-ordinated and led by the Director of Commercial and Strategic Partnerships. The Trust has established a Sustainability Community Group to facilitate and support work across the Trust and the Sustainability Manager plays a key role in this process.

However, it is important to emphasise that our approach is to expect all of our workforce, suppliers and service providers to contribute to the well-being goals and to embody the five ways of working in their day-to-day actions and behaviours. The Act is viewed as adopting a 'way of being' rather than simply demonstrating compliance to standards. In this regard, at its heart, it is viewed as whole system organisational development and emphasis is being placed on induction, education and training, relationship management, communication and workforce health and well-being.

The workforce, and the processes they utilise to function, will be supported and enhanced respectively so that they: clearly reflect what 'long-term' means, identify the root causes of problems through system wide perspectives, support work across organisational boundaries to maximise value, establish shared processes and ways of working. Importantly, our actions will be framed and facilitated by our strategic approach.

Progress against Delivery:

There are a number of actions that we are progressing:

Whilst recognising we have much more to do, it is important to acknowledge the achievements of the organisation to date and the strengths it can draw on as we grow together as a sustainable community.

The Welsh Blood Service is currently developing ambitious Business Case to reduce the carbon footprint of the Talbot Green site. A key and ambitious objective of this Programme is to transition to a carbon neutral footprint for the building. This will be achieved through an increased focus on the use of renewable technologies, solar photovoltaic arrays, ground source and air source heat pumps and bio- mass boilers.

We have also focused considerable efforts on ensuring that the TCS Programme has embedded the requirements of the Act. The new Velindre Cancer Centre project is championing sustainable developments, such as integrating sustainable transport into the design of the new VCS, and encouraging the use of sustainable travel. We have identified several proposals for community benefits in the design of the new VCS. In this regard, a number of fundamental deliverables can be evidenced. The project aims to the

We have applied, and continue to apply, the Sustainable Development Principle when designing and developing the TCS Programme clinical service model and supporting infrastructure. The new TCS Programme clinical service model has a clear preventative focus and there are opportunities to educate patients and the wider community on healthier lifestyles to help prevent cancer. The TCS Programme clinical service model and supporting infrastructure also has a strong long-term focus based on a sophisticated understanding of current and future needs.

We have worked in an integrated way to design and develop the TCS Programme and supporting infrastructure and have considered how it can deliver wider benefits as the programme progresses to ensure it has a positive impact on social, economic, environmental and cultural well-being. We are also collaborating with partner organisations across South East Wales to develop and improve cancer services.

In addition, we have a range of strategic and operational examples of good practice in implementing the Act that also align with our Trust Sustainability Strategy Key Themes. A number of these are shared below.

THEME 1 – TRUST SUSTAINABILITY STRATEGY

The Trust's approved Sustainability Strategy seeks to ensure we contribute to a better world for future generations. In short, acting today for a more sustainable tomorrow. To achieve this vision, we set out what we want to achieve together with ten core themes which we will focus on to deliver our ambitions. These are driven by the United Nations Sustainable Development Goals and the Well-Being of Future Generations Act.

THEME 1 – ARTS IN HEALTH COORDINATOR APPOINTMENT

The Trust has appointed an Arts in Health Coordinator to provide a vibrant creative programme that embeds the arts across Velindre Cancer Centre and Welsh Blood Service. Arts in health is any art project, intervention or commission where the intention is to improve health and well-being.

A comprehensive plan has been developed for an Arts in Health Programme with a view to launch the programme in June 2024. The Programme has been divided into three priority work areas:

- Patient experience
- Health Inequality
- Staff Well-being

THEME 6 – WALKING AIDS RECYCLING PROJECT AT VCC

A new scheme has been launched by Velindre Cancer Centre to recycle hundreds of walking aids a year.

There are over 1.5 million people in the Welsh population supported by Velindre Cancer Centre and it welcomed 9,000 new patient referrals through its doors in 2023.

Many of these patients need walking aids – such as walking sticks, crutches and Zimmer frames – during different times of their cancer journey.

The new scheme aims to recycle as many walking aids as possible. It's calling on patients and their loved ones to return the walking aids they no longer need so they can be refurbished for future patients.

Not only will the scheme help to save costs and protect resources, it will also help to reduce waste by preventing walking aids being disposed of in landfill. Reusing a walking aid is on average 98% lower in carbon emissions than ordering new.

Walters UK, a partner in the enabling works for the new Velindre Cancer Centre, donated the materials used to build the shed to the Men's Sheds community group, a national charity.

THEME 2 – ISO14001:2015 EXTERNAL SURVEILLANCE AUDIT

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard, an environmental management system.

The Trust underwent an external surveillance audit in November 2023. The audit was successful with no non-conformities raised. The Auditor was complimentary of the work that the Trust is doing to promote sustainability and effective environmental management.

The Trust will undergo a full ISO14001:2015 Recertification Audit in November 2024.

THEME 10 – SUSTAINABILITY IMPLEMENTATION PLANS

The Trust has commissioned work to develop site-based Sustainability Implementation Plans (SIP's) which will pull together sustainability targets, specific actions and action owners for each of our sites.

The SIP's are broad and encompass all aspects of sustainability including arts in health, waste, energy and decarbonisation. These plans will enable the Trust to track its progress alongside a set of specific measures towards meeting national targets for decarbonisation and internal KPI's for aspects such as energy usage.

THEME 10 – TRUST WELL-BEING OBJECTIVES REFRESH

The Trust, recognised under the Act as a national body, was required to develop and publish a set of its own well-being objectives. These objectives were developed in 2015 and were designed to focus the Trust's contribution to the realisation of the national Well-Being Goals outlined in the Act.

The Trust's Well-Being Objectives have undergone a refresh following extensive engagement both internally and externally, to better align them with the needs of our staff and patients, and our refreshed Trust Strategies. Following engagement and consultation, there is a greater focus on staff well-being and job creation in Wales, in our Well-Being Objectives.

Following this update, the Trust will now work to engage with staff across the Trust to raise awareness of our Well-Being Objectives and why they are important. Furthermore, the Trust will work to embed the Objectives and key principles of the Act more strongly in the work that our staff do daily; particularly in decision making forums.

THEME 7 – SUSTAINABLE JAMBORI'S

Throughout the year, a series 'Sustainable Jambori's' were held in the Cancer Centre for staff, patients, families and the local community. The Jambori's take the form of mini festivals - engaging with patients, families, staff and communities through arts and crafts to demonstrate the benefits of undertaking creative activities in a green space and to educate on sustainability and biodiversity matters.

The Trust Sustainability Team, together with the new Velindre Cancer Centre project team, have held several events during Winter, Autumn and Spring, for patient and community engagement.

There was a breadth of different activities, linking the broad themes of sustainability, well-being and art. Notable events include an 'Active Travel' week for staff and biodiversity themed days for staff and our local community.

WELSH LANGUAGE REGULATIONS AND COMPLIANCE

Introduction:

This will be the Trust's fifth annual report dedicated to the delivery, promotion and monitoring of the Welsh Language Standards. The Trust's focus is strongly embedded in the cultural promotion of the Welsh Language and within this we are committed to comply with the legal requirements of the language as a provider of services for Patients and Donors.

Our delivery of the Welsh Language Standards and the '*More than Just Words*' framework continues to be the driver for us to ensure compliance and we now have strong governance processes to monitor our performance.

It is our ambition to ensure our patients and donors are aware of their Welsh Language rights and our response to this awareness becomes even more proactive, providing bilingual services as a matter of course rather than request is our ultimate aim.

Celebrating Welsh Culture:

The Trust continues to actively seek ways in which to engage its staff in the culture of Wales as well as its language. We recognise the need to comply with our legal obligations but we aim to do more than is needed as this celebrates the diversity of our staff and services.

This reporting year we have initiated our Cultural Plan that aims to strengthen our engagement with staff around the language and Culture of Wales and promote a value of inclusion that encompasses all that we believe. The Executive Management Board have have responsibility for certain aspects of the Equality and Diversity agenda and this includes an Ambassador role responsible for the Welsh language.

The Trust's draft Cultural plan aims to be as inclusive as possible and the Welsh language Ambasador will drive the ethos of this plan throughout the work of the Executive Management Board.

Welsh language Standards Compliance:

Governance structure

We continue to work with our divisions to ensure a local approach to the achievement of the Standards. The divisional groups report frequently into the Trust-wide Welsh Language Group and information is fed directly to the Executive team and the Trust Board.

It has proved to be an extremely successful way to ensure information is shared and it informs the Trust Board of any regulatory changes that need discussion at Board level.

Our Board Welsh Language Champion continues to support and challenge our Welsh Language compliance.

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%**

Workforce planning

We continue to work diligently on ensuring a Trust wide compliance with the Welsh Language standards whilst promoting and suppporting the ethos of 'more than just words...'

Our Governance structure is embedded successfully and our document used to monitor compliance, demonstrates a strengthened compliance level. As a Trust we continue to use this as a benchmark for the delivery of our Welsh Language services.

As part of the Supply and Shape activity, we have undertaken an assessment of our workforce. Part of this assessment was to help the Trust better understand the current capability of colleagues to speak, read and write in Welsh and, in response to develop a set of actions which will ensure that our workforce reflects the local population average, as well as enhancing the capability levels of future colleagues (i.e., students currently enrolled on commissioned courses).

Translation

Our increase in investment over the last two years has meant we have been able to increase our translation capacity. In 2023-24 we will have a team of three dedicated translators as well as utilising a Service level agreement with NWSSP.

Job descriptions and recruitment

Translation has supported the time the Trust has given to strengthening its assessment of language needs whilst recruiting. Workforce planning is critical in order to ensure the Trust supports its patients and donors and is proactive with its recruitment priorities.

This year we have continued to focuss heavily on ensuring recruitment managers are aware of the Welsh language recruitment process.

Contractual obligations at Velindre Cancer Centre

Integrating our bilingual obligations into all that we do is essential to '*normalising*' the use of the langauge and an understanding of our commitment to the development and

promotion of the Welsh language Standards. As we plan our services we have ensured that our obligations are highlighted in all that we do.

At the Cancer Centre a revision of service level agreements has encouraged us to ensure the Welsh language is considered by our suppliers as well as our internal services. A simple yet effective way to ensure our compliance and encourage discussions with providers. It highlights our expectations of the provider and supports a discussion previously not considered:

Welsh Language Obligations

The Provider warrants and undertakes that it will not discharge its obligations under the Agreement in such a way as to render the Commissioner in breach of its obligations in respect of the Welsh language including, but not limited to, the Welsh Language Act 1993, the Government of Wales Act 1993, the Welsh Language (Wales) Measure 2011 and the Welsh Language Standards (No. 7) Regulations 2018.

Clinical consultations

We continue to implement and monitor our clinical consultation plan. The plan highlights the struggles of providing bilingual consultations for patients and donors but it also recogises the need to ensure a clear understanding of what skills are needed and where. The divisional groups have been charged with monitoring the action plan and will inform the Trust development group of any concerns.

We will continue to work with the divisional groups to ensure our plan is revised and is informed by the language needs of our services.

Welsh language calls are around 4% of the calls.

Calls to Velindre Cancer Centre and the Trust headquaters are not measured, however specific actions for staff directly working on the telephone have been communciated. A specific question and answer session was also held to ensure staff understand their duties.

Promotion

We continue to highlight important events in the Welsh language calendar. This means an additional opportunity for staff to engage with the culture of Wales as well as the language.

This year the Trust has participated in a number of awareness raising days. Information on these events run alongside our regular communications, where we promote Welsh language traning, on line and face to face.

Our social media accounts have been incredibly busy this year with both divisions taking part in events. We are now offering bilingual approaches to all our promotional videos.

Concerns and Complaints

The Trust welcomes feedback on its services. Concerns or complaints are used to ensure we continue to understand the needs of our patients and donors. Welsh language users are becoming increasingly aware of their rights to use the language and it is our duty to ensure we can provide those services to the best of our ability.

Overall, the number of concerns and complaints around the provision of Welsh language services are small, however, we are aware of the need to continuously monitor our provision and have this year updated our Concerns policy to reflect Welsh language provision.

NHS Wales Shared Services Partnership

The Welsh Language Unit at NHS Wales Shared Services Partnership has continued to support NWSSP divisions and services with advice on compliance and service delivery to our customers through the medium of Welsh and have supported the organisation and other NHS Organisations with translation support during 2023/24.

Compliance with Standard 106A

NHS Wales Shared Services categorises vacant or newly created posts as either Welsh essential or Welsh desirable, and we have introduced a matrix to determine which skill category is most relevant to each vacancy.

We have devised a protocol and a system whereby all advertisements are translated and published on the TRAC recruitment system and NHS Jobs in both Welsh and English since June 2022. We regularly review the system to capture any issues that arise in the creating vacancy advert process.

Easy-read Patient Information Leaflets

We continue to review our easy-read leaflets and new leaflets, and have ensured that the translation of these leaflets is suitable for the audience for which they are intended.

Workforce Reporting System

This site provides a Web Portal for Primary Care Data accessible to GP practice staff, Clusters and Health Boards of NHS Wales and other approved stakeholder organisations. This site is only available to registered users. However, we have ensured that the system is bilingual.

Duty of Candour Public Video

This animated video, providing information about the duty of candour is available in both Welsh and English.

Counter Fraud Awareness Course and App

The Counter Fraud Awareness Course for all Wales NHS Staff is available in Welsh, as is the application for NHS Staff to report fraud or suspicion of fraud in NHS Wales.

All Wales GDPR Awareness Course

We have been supporting the production of the All Wales GDPR Awareness Course through the medium of Welsh.

All Wales Occupational Health System for NHS Wales Staff

This system includes the ability to interface and any correspondence/messages and mail tips through the medium of Welsh as well as English. Further work on this system has continued in 2023/24.

Assessment of compliance across our services

We have continued to undertake local assessments across our services in order to identify areas of best practice, identify areas of risk. Local improvement and action plans are established in order to strengthen our Welsh language services offer across all NWSSP services and programmes.

CONCLUSION AND FORWARD LOOK

We have produced our Integrated Medium Term Plan for 202425 – 2026/27 (insert link) which sets out how we will deliver services from 1st April 2024 to 31st March 2027. It describes what services we will provide, where they will be provided from and how we will continue to ensure patient, donor and staff safety. It also outlines the arrangements we have in place for managing our capacity so that we can meet the expected increase in demand for our services.

The next three years will undoubtedly continue to provide both challenge and opportunity in equal measure. Our intention is to see the challenges as opportunities to place quality, safety and experience at the heart of everything we do. We are committed to working with patients, donors and our health and public service partners to understand, design and deliver services which are truly person focused and deliver the experience and outcomes that people value most.

Annex - Glossary of Terms

IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality and Planning Delivery
IPC	Infection Prevention Control
Linac	Linear Accelerator
RT	Radiotherapy
SACT	Systemic Anti-Cancer Therapy
VCS	Velindre Cancer Centre
WBS	Welsh Blood Service
CCLG	Collaborative Cancer Leadership Group
nVCS	New Velndre Cancer Centre
WCP	Welsh Clinical Portal
WRP	Welsh Risk Pool
LfER	Learning from Events Report
EAP	Employee Assistance Programme
TCS	Transforming Cancer Services
CDPS	Centre for Digital Public Services
DCW	Digital Communities Wales
WPAS	Welsh Patient Administration System
DHCW	Digital Healthcare Record
WTAIL	Welsh Transplantation & Immunogenetics Laboratory
BECS	Blood Establishment Computer System
WNCR	Welsh Nursing Care Record
NWSSP	NHS Wales Shared Services Partnership
HTW	Health Technology Wales
ESR	Electronic Staff Record

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Surgical Materials Testing Laboratory (SMTL) 2023-24 Briefing

DATE OF MEETING	11/07/2024
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	GAVIN HUGHES (DIRECTOR, SMTL) JAMES EVANS (R&D MANAGER, SMTL)
PRESENTED BY	Ruth Alcolado (Medical Director, NWSSP)
APPROVED BY	Choose an item
EXECUTIVE SUMMARY	This paper provides an overview of the SMTL's achievements and quality and governance arrangements for the period 2023/24. Key areas to note are: • Expansion of UKAS ISO 17025 accreditation for medical device testing from Imperial Park 5 (IP5) satellite laboratory and addition of new test methods onto scope. • Attaining Customer Service Excellence (CSE) accreditation.

	• Meeting financial commitments and performance measurements.

RECOMMENDATION / ACTIONS	Note the contents of the report

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS N/A	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
1	2023 UKAS Inspection Report for SMTL
2	2023 UKAS Schedule of Accreditation for SMTL

1. SITUATION & BACKGROUND

The Surgical Materials Testing Laboratory (SMTL) is part of NHS Wales Shared Services Partnership (NWSSP). SMTL's core service is to provide medical device testing and technical services to the Welsh NHS. As part of this service SMTL performs medical device defect and incident investigative work for NHS Wales as recognised in the Welsh NHS notice MDA/2004/054 (Wales). To meet financial commitments, SMTL also provides commercial testing and technical assurance services to the UK Health Service and the international medical device industry.

This paper provides an overview of the SMTL's achievements and quality & governance for the period 2023/24 and supplements the overview of SMTL service paper previously submitted to the group in September 2023.

2. ASSESSMENT

This has been another successful year for SMTL during which we have balanced our financial commitments and continue to meet and exceed performance measurements.

2.1 Performance Measures

2.1.1 Key Performance Indicators (KPIs)

SMTL provides monthly KPI reports to NWSSP Planning Performance and Informatics division. In addition, SMTL reports to senior colleagues via Quarterly Performance reviews.

In 2023/24 SMTL met all reportable targets (Table 1). If KPI targets have been breached, SMTL generates KPI exception reports that detail the reason for the underachievement and how, and when, performance is expected to improve.

SMTL is reviewing current performance measures so that they remain relevant and meaningful, in line with any new IMTP objectives and delivery of the service. We intend to modify our Medical Device Adverse Incident (MDAI) reporting process and our 2024/25 KPIs will be amended in line with the new reporting structure.

Table 1: SMTL reportable Key Performance Indicators

Key Focus Area	Description of Key Performance Indicator	Responsibility	Frequency	Target	2023/24
Customers/Excellence	% of medical device incident reports sent to regulatory authority within 50 days of receipt	NWSSP	Monthly	90%	100%
Customers/Excellence	% delivery of audited reports on time (Commercial)	NWSSP	Monthly	90%	99%
Customers/Excellence	% delivery of audited reports on time (NHS)	NWSSP	Monthly	90%	100%
Excellence	Annual UKAS accreditation	NWSSP	Annual	Attained	ATTAINED
Excellence	UKAS findings addressed on time (Annual)	NWSSP	Annual	Completed	COMPLETED
Excellence	Completion of Internal Audits on schedule	NWSSP	Annual	Completed	COMPLETED
Value for Money	Production of Evidence Reviews	NWSSP	Annual	5	5
Customers/Excellence	% delivery of Technical Assurance evaluations on time	NWSSP	Monthly	89%	100%
-	Sickness & Absence	NWSSP	Monthly	3.30%	2.06%
-	88% PADRs delivered on time	NWSSP	Monthly	88%	98%
-	85% Statutory & Mandatory Training Compliance	NWSSP	Monthly	85%	99%

2.1.2 Integrated Medium Term Plan (IMTP)

SMTL successfully delivered 7 out of the 11 objectives outlined in the 2023/24 IMTP. Four objectives were delayed due to external factors and have been carried over to the 2024/25 IMTP.

2.1.3 Laboratory Performance

In 2023/24 the laboratory undertook 195 projects, with 97 projects performed for NHS Wales, producing 639 test reports and processing 2954 samples.

The laboratory performed 89 adverse incident investigations relating to medical devices in 2023/24. This figure remains lower than pre-COVID pandemic figures. It is recognised that the current WG guidance MDA/2004/054 is outdated. It is envisaged that redrafting this guidance with Welsh Government (WG) will educate NHS Wales staff and promote adverse incident reporting. SMTL has identified this as a key project in the IMTP.

The staff numbers remained consistent with 21 permanent staff, 3 fixed-term positions and 2 bank staff that are utilised when required. SMTL was invited to present at 4 conferences and produced 5 evidence reviews, 3 of which were for the Evidence Based Procurement Board.

SMTL was able to meet its financial commitments and commercial income was comparable with pre-COVID pandemic income figures. SMTL collaborates closely with several Welsh employers which generated approximately 20% of the laboratory income.

SMTL forwards customer questionnaires to clients following each project using a 5-point Likert scale for 8 specific questions. Client feedback continues to be very positive with average scores indicating clients are very satisfied with SMTL's service.

2.2 SMTL Quality Assurance

2.2.1 Internal audits

SMTL has a programme of quality system audits that are performed on a rolling basis over the year. All 15 internal audits were completed on time, no major anomalies identified and all corrective actions completed within expected time scales.

2.2.2 Quality System Review (QSR)

The Laboratory Director chairs an annual QSR to establish what changes, if any, are necessary to ensure that quality arrangements for the laboratory continue to meet both the laboratory's needs and UKAS requirements.

The annual QSR review was undertaken on 27th October 2023 with 3 action improvements identified, all relating to IT changes that SMTL is currently implementing. SMTL did not receive any formal complaints during 2023/24.

2.2.3 Risk Register

SMTL has 3 current risks identified which are related to IT resilience, facilities and budget. Following mitigated actions, the risks are deemed to be moderate in nature.

2.3 UKAS Audit 2023

A full re-certification and extension to scope inspection took place 25th to 27th September 2023. This visit was complicated by additions to scope from our Biological and Physical Testing Departments and an extension to scope for our Quality Assurance (QA) Department. This was also the first assessment of biological testing activities from our IP-5 satellite laboratory in Newport. The submission of findings was completed on the 10th November 2023.

Following the audit, SMTL became the first laboratory to offer accredited testing to the European Standard *EN 13726:2023 Test Methods for Wound Dressings - Aspects of absorption, moisture vapour transmission, waterproofness and extensibility*.

The UKAS 2023 Accreditation Report and Schedule of Accreditation are presented in Appendix 1 and 2 respectively.

2.4 CSE Audit

In 2023 SMTL attained accreditation with the Customer Service Excellence (CSE) Standard. This was the first time SMTL has been audited against the CSE criteria that assesses organisations and measures customer focused areas that research has identified as a priority to customers.

2.5 ISO 14001 Audit

External audits took place in March 2024 and SMTL~~'s~~ maintained its ISO 14001 accreditation with only 2 improvements recorded for the whole of NWSSP.

2.6 Client Audits

Creo Medical (www.creomedical.com) audited SMTL on 26th October 2023: The audit was very positive with no observations or non-conformances raised.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The committee is asked to note the governance arrangements of SMTL and 2023/24 review document.

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
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below** Safe ☒ Timely ☐ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☐ 1. SAFE: SMTL services ensure user and patient safety is of paramount importance when centrally procuring medical devices for NHS Wales; 2. EFFECTIVE: SMTL use prudent evidence-based principals to ensure high value care for our patients; 3. EQUITABLE: SMTL is an independent All-Wales service which is available to all NHS Wales Health Boards and Trusts:
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	**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.
	Source of Funding: Other (please explain) Please explain if 'other' source of funding selected: SMTL receive core funding from WG via NWSSP. To achieve a balanced budget SMTL also provides commercial testing and technical assurance services to the UK Health Service and the international medical device industry. **Type of Funding:** **Revenue** **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	**Choose an item**

For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	*[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].*
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

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
WHAT IS THE RISK?	
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	

ASSESSMENT REPORT

Name & Address of Organisation	NHS Wales Shared Services Partnership trading as Surgical Materials Testing Laboratory Princess of Wales Hospital Bridgend CF31 1RQ	**Type of Assessment**	Reassessment
		UKAS Reference Number	5527
		Date(s) of Assessment	25th – 27th September 2023
Assessment Location(s)	As above and also : - IP5 Newport	**Project References**	232240-03-01
Assessment Standard / Criteria	ISO/IEC 17025:2017	**Schedule Issue No(s)**	032
Name & Role of UKAS Assessment Team	Chris Arthur – Assessment Manager / Lead Assessor Helen Cini – Technical Assessor	**Date(s) of Assessment Plan**	16TH August 2023
		No. of (M) Findings: Action Mandatory	8
Name of Organisation Representative(s)	Paul Edwards	**No. of (M) Findings: Require Evidence to UKAS**	7
Report Issued By	Chris Arthur	**No. of (R) Findings: Action Recommended**	1
Report Issued Date	13th October 2023	**Method of Reviewing Evidence**	Remote
Report Acknowledged By	Paul Edwards	**Quote for Reviewing Evidence**	0.5 Days Quote to follow
Report Acknowledged Date	As per email	**Agreed Action Completion Date**	10th November 2023
Report Acknowledged Method	email	Please return evidence using the portal as discussed.	

AREAS SAMPLED AT ASSESSMENT (*marked as 'X'*)			
ORGANISATION		*IMPARTIALITY & INTEGRITY*	
Legal Status	X	Independence, Impartiality & Integrity	X
Liability Cover (CB / IB only)	NA	Confidentiality	X
Management of Finances (CB/IB only)	NA	**EVALUATION PROCESSES**	
Resources	X	Design & Development of Methods / Schemes	X
Organisation Structure	X	Enquiries, Tenders, Contracts	X
Responsibility & Authority	X	Planning & Resource Allocation	X
MANAGEMENT		Testing/ Calibration/ Inspection/ Audit *	X
Management System Including Documented Policies & Procedures	X	Reports & Certificates	X
Roles & Responsibilities for Quality	X	Decisions/ Opinions	X
Control of Documents and Records	X	Certification & Maintenance of Certification (CB only)	NA
Management of Sub Contractors and Purchases	X	**TECHNICAL COMPETENCE**	
Service to Clients (Test / Cal only)	X	Personnel	X
Handling of Complaints / Appeals / Disputes	X	Methods / Schemes	X
Control of Nonconforming Items Dealing with Corrective & Preventive Actions and Improvements	X	Facilities / Equipment (Test/Cal/IB only) / Environmental conditions (Test/Cal only)	X
Internal Audit and Management Review	X	Assurance of Quality of test / calibration Cooperation (IB only)	X
Supervision & Monitoring of Staff	X	Witnessed Activities	X
Conditions for Granting & Maintaining Certification (CB only)	NA	***OTHER (specify)**	

*Delete as applicable

Summary and Recommendation:

Executive Summary

This report details the reassessment of Surgical Materials Testing Laboratory located at the both the Princess of Wales Hospital and IP5 location (Newport) to assess the organisations ongoing ability to provide accredited test services, as defined in the relevant UKAS schedules for the lab in accordance with ISO/IEC 17025:2017. The scope of the visit is as described in the plan which can be found below: -

2023 RA SMTL Assessment Plan

There were 8 mandatory findings (7 of which requiring evidence to close out) mostly the findings raised were minor in nature and nothing found has an impact on the tests undertaken .

Improvements are required where the areas of the findings raised relate to following areas: -

- *Some minor issues relating to calibration suitability of equipment (non-accredited calibrations and detail on traceability).*
- *Sample transportation detail could be more informative (Bio).*
- *Humidity control of CEL room in IP5.*

Strengths of the lab were as follows: -

- *Competent well trained staff in all areas of the business as encountered.*
- *Well detailed methods, processes and procedures which were up to date and relevant.*
- *Strong auditing of every project performed in place to give a good level of scrutiny to work being done.*
- *Good use of PT work and ILC seen with good analysis of results.*
- *Improvements continuously being made to IT infrastructure being introduced in a controlled and methodical manner.*

Appropriate system in place for managing NCRs which measure impact and gauge actions based on risk.

Lack of customer complaints and largely positive feedback seen point to a good level of service being offered and as always all staff encountered were professional and knowledgeable in their respective areas and were a pleasure to assess.

As seen in recent years the lab continues to understand what level of work is required to ensure a largely compliant system is in place to meet the requirements of ISO/IEC 17025:2017

Recommendation

It is recommended that accreditation should be renewed for the current schedule of accreditation, noting that the changes from this process (and the associated Extension To Scope which was performed at the same time under project Number 319741-01-01) takes the schedule to issue 033 (see draft schedule at the end of this report)

This is subject to the satisfactory clearance of all mandatory improvement actions and by submitting evidence for those requiring it by the agreed date. It is worth noting as this is a reassessment/ETS that this is subject to further scrutiny if required for the decision-making process to approve this recommendation.

Next Steps
The next step of the assessment process is the evaluation of the evidence submitted to clear the findings identified at this visit. Please submit these using the portal as discussed.

Where findings require mandatory action and no evidence is required by UKAS, it is expected that such actions will be undertaken by the laboratory as agreed. This should be within the same timescale, and completion should be confirmed as part of the submitted evidence. Lab will still need to undertake root cause analysis and impact for all actions raised. The recommendations provided by the Assessors are not mandatory and are proposed for consideration.

Organisation and scope of accreditation *(ISO 17025 clause 5)*

The lab sent an updated documented detailing changes since the last assessment as can be seen below : -

UKAS - SMTL
Update-Staff Changes

This was discussed during the opening meeting as was the required ETS which was run concurrently with the reassessment but reported separately under its project number (319741-01-01).

None of the changes have a significant impact on the current ability to deliver the testing as defined on the current schedule.

The legal entity of SMTL is defined as being part of the NHS Wales shared services partnership (independent mutual organisation) which is founded by the Welsh assembly government and Website check (22/09/2023) states lab are 17025 accredited and links to current schedule of accreditation (032). The website also carries a disclaimer that not everything SMTL does is accredited.

Quality Manual Figure 1 shows the labs reporting structure and its place in the wider organisation with reports lines into NHS Wales and the shared services section.

The quality manual used during the assessment was version 3.38 as updated July 6 2023.

Impartiality & Confidentiality (ISO 17025 clauses 4.1.& 4.2)

QMS section 3.1 & 3.2

The lab have a section on impartiality and includes the need for all staff to complete an 'employee interest form – SOP139' . Section 3 states risks to impartiality are identified on an on-going basis. Looked at a recent correspondence where there was a requirement to declare any interests in other sectors or within healthcare sector or other potential conflicts of interest. Looked at the example for Paul Edwards from 2022 where declaration of his wife working in a Cwm Taf Morgannwg but has no impact on impartiality.

Also looked an example of SOP139 for Imogen dated 10/01/2022 which stated she had no interests which could impact on her role in the lab.

Confidentiality describes the labs policies on redaction (patient information) and the guide to good practice and also makes reference to policies such as sub-contracting and safe guarding of other people's information via NDAs. No issues identified.

Resource Requirements

Personnel, competence and training (ISO 17025 clause 6.2)

Lab QMS Reference 5.2

The lab states the required qualifications and experience in Table 1 of the QM and the lab also have Job descriptions for all roles.

Looked at an example of key targets are managed, month by month for personnel.

Looked at SOP160 which is the labs training procedure which covers how training and authorisation is managed.

The manual describes that the trainee shall carry out the test or techniques under observation until the Quality or Technical Manager.

For on-going competence the lab staff must perform some PT work every 12 months as a minimum. As an example looked at the PT sheets for Heath in relation to TM-302 and TM-303 as performed 18th September2023.

The lab quality department check each project against the method for the current competence capability as an example looked at TM-297 for the determination of volume (Urine Bags) which listed Paul Fram as 'Currently Active'. No Issues.

Facilities and environmental conditions (ISO 17025 clause 6.3)

Lab QMS Reference 6.1

Fixed facilities and requirements for both Bridgend (POWH) and Newport (IP5).

All test rooms are listed and the conditions required for each area.

Access and housekeeping are also explained for the both sites.

Looked at the Logging system in the CEL room which has adequate Temperature and Humidity control in place for Bridgend but IP5 CEL room has some humidity issues as raised (see CA notes for more information).

Equipment and Traceability (ISO 17025 clause 6.4 & 6.5)

Lab QMS Reference 6.2

Looked at how the lab manage the internal calibration declaration (F166) and all items are listed for both sites but lab need to be on the new format document.
FINDING RAISED : NC-1433157

Example of internal calibration was seen for the internal calibration of the Vaisala (SOP-397 Rev 0.39) which is calibrated for humidity using salt pots provide by Vaisala (FINAS) 11% and 75% rh.

Looked at the process for SOP-36 Equipment admin procedures. This details the management of equipment.

Also, looked at how the RT (Request Tracker) system is used and an example record in the database for TinyTag 637 with the comprehensive history of the items including the calibrations done, acceptance criteria, offsets and considerations and the ranges required.
This system is described in the procedure SOP-394.

There were a couple of issues raised in the area of accredited calibrations (see CA notes for more information).

Externally provided products and services (ISO 17025 clause 6.6)

Lab QMS Reference 6.3

This section refers to a number of SOPs and include SOP196, this process is for the ordering and procurement of goods and services. States UKAS accredited providers for calibration should be used where available (unless there are exceptional circumstances).

The Lab uses subcontractors of tests (ALS) for bio tests. Looked at the list of approved suppliers and ALS who are accredited for water sampling. Looked at their current schedule of accreditation for this area Organic carbon : Total. No Issues.

Suppliers are evaluated regularly and suppliers lists are relevant and up to date.

Process Requirements

Review of requests, tenders and contracts (ISO 17025 clause 7.1)

Lab QMS Reference Section 7.1

Section refers to SOP-81 (lab admin procedures) discusses use of Request for Work for commercial work (RFW) section also discusses how statements of conformance (decision rules are agreed) and Non-commercial projects are handled. Also describes are deviations / additions are handled (when applicable).

Looked at an example of what is issued to a commercial customer (RFW 6841) for some chemical testing for total viable count for TM-372 (UKAS accredited) and includes reference to non-accredited parts which are suitably disclaimed. Section of the quotes discusses the Uncertainty and the taking into account on the probability of the results.
No Issues.

Methods (selection, verification & validation) *(ISO 17025 clause 7.2)*

Lab QMS Reference Section 7.2

All methods seen and used during the witnessed assessments were up to date and relevant with good detail allowing the reader to repeatably action the testing being performed.

Sampling *(ISO 17025 clause 7.3)*

Lab QMS Reference Section 7.2.5.

Discussed what actual sampling is being undertaken and when being done is in accordance with standards/methods as appropriate for areas such as air cleanliness.

Handling of items to be tested / calibrated *(ISO 17025 clause 7.4)*

Lab QMS Reference Section 7.3

Examples seen in accordance with procedures and also looked at the process in place with the rooms being used for storage at both sites. Hele Cini raised 1 action relating to the sample information held (see HC notes for further information).

Technical records *(ISO 17025 clauses 7.5)*

Lab QMS Reference Section 7.4

Records seen being kept for more than the retentions times seen , with original observations made during tests and internal calibrations kept as prt of the project files. Helen raised an issue with Environmental monitoring sheets (see HC Notes for more information).

Evaluation of measurement uncertainty *(ISO 17025 clauses 7.6)*

Lab QMS Reference Section 7.5

Looked at a couple of examples of how uncertainties are calculated and managed. For example Uncertainty for flow rate was defined as 10% taking into account repeatability and calibration information and appears a reasonable estimate for the process undertaken, no issues.

Ensuring the validity of results*(ISO 17025 clauses 7.7)*

Lab QMS Reference Section 7.6

Looked at some examples of QA/QC and inter-comparisons and PT work.

Looked at an example for filling flow rate test using TM-295 with comparisons between Laura, Rhianon, Heath and Paul F.

Lab regularly participate in interlab scheme with Enersol and participated in the last one was conducted May 2023. For the physical testing Laura, Heath, Paul F and Rhiannon took part for waterproofness. Dimensional and force of break (including others) initial internal indications are good and lab are awaiting official feedback.

Last year's results were seen and were positive.

Helen did raise one issue with regards to membrane filtration (see HC notes for further information).

Reporting the results *(ISO 17025 clauses 7.8)*

Lab QMS Reference Section 7.7

Process (SOP 44) and section is in line with the requirements listed in ISO 17025 for test reports.

Looked at example report for project number 6892 for medical gloves testing as reported on the 29th June 2023. The authoriser of the report was electronically signed as Gavin Hughes.

New version symbol and ILAC mark included, test location defined as POWH, date of testing defined, product information and method used TM-342 Force at break and extractable protein TM-230 in accordance with BS EN 455 Part 2 & 3 . 13 samples were tested and the statement of conformance was presented with the probability of result included as the decision rule that the force of break was determined to be more than 9.2 N to give 100% probability of result being correct. All correct format statements were included.

Statements of conformance and the associated decision rules is covered in good detail.

Complaints *(ISO 17025 clauses 7.9)*

Lab QMS Reference Section 7.8

Procedure referenced (SOP-434) includes independence aspect

Looked at an example complaint (self-raised) classified as a testing delay (ID 59676). The inflated lead times were due to equipment issues. The main outcome was decided that the delays should have been better communicated to the customer. Outcome was staff awareness required and recurrence has been classified as unlikely to reoccur due to infrequent of the type of test. (Not UKAS accredited work).

Total number of complaints on record were 2 neither of which were actually complaints made by customers. No Issues raised.

Non-conformances *(ISO 17025 clauses 7.10)*

Lab QMS Reference Section 7.9

Non audit findings are classed as anomalies. One typical anomaly was for ID 58832 which was in relation to an issue with the autoclave not unlocking after a cycle. Engineer door lock failure was identified and repaired considered a low occurrence rate issue.

Procedure SOP-434 is the process which includes responsibility and authorities for managing NCR, actions based on risks, impact evaluation, acceptability.
All actions were dealt using appropriate corrective actions.

Control of data and information management *(ISO 17025 clauses 7.11)*

Lab QMS Reference Section 7.10

Information management systems are being improved in all areas in a controlled manner with the old Linux systems being updated to give greater flexibility and modernisation to the way data and information is being managed.
Good control in place with continuous backing up of data evident.

Management System Requirements

Options

Lab are option A

Management system documentation (ISO 17025 clause 8.2 Option A)

Lab QMS Reference Section 8.1

All documentation, processes, systems, records, related to the fulfilment of the requirements of this document shall be included in, referenced from, or linked to the management system with management providing evidence of continuous improvement being driven from the system in place.

Control of management system documents (ISO 17025 clause 8.3 Option A)

Lab QMS Reference Section 8.2

Section describes that the WIKI system is used for the control of system documents, as seen for TM030 which moved from Rev 0.32 to 0.41. This rev number increments each time it is checked out and back in to avoid any clash of revisions being missed for change. Documents include a change history and reason for change. Date and time of last revision are recorded and all documents are paginated.

Are documents reviewed periodically (as a backstop of 2 years).

The management of obsolete documents is performed by use of offline system and accessing via the terminal function and was seen that the staff can find old version documents as required. No issues.

Control of records (ISO 17025 clause 8.4 Option A)

Lab QMS Reference Section 8.3

SOP-41 includes times on retention which depends on record types such as project files kept for 10 years from the date that the project is closed. The QMS documents are 6 years.
In reality nearly all records are kept indefinitely (electronically) as seen with records stretching back to 2006. No Issues.

Action to address risks and opportunities (ISO 17025 clause 8.5 Option A)

Lab QMS Reference Section 8.4

Risks are identified and mitigated for and recorded in the risk register including budgetary impact from the loss of customers (no longer planning on trading). Facilities (as identified June 203) in terms of leaks and lapsed maintenance at POWH. Risks are given a grading based on likelihood and Impact. Risks are mitigated against and review dates are set. No Issues.

Improvement (ISO 17025 clause 8.6 Option A)

Lab QMS Reference Section 8.5

Feedback is harvested by means of a customer questionnaire with process related questions based on scores between 1 and 5 and are sent out with every project completed.

Examples seen were generally very good with one exception seen which were for expectation on timescales being marked as a score of 1. This was followed up with an e-mail communicating with the customer and repeat work has been completed with the same customer.

All scores are discussed during the monthly meetings and improvements identified fed back into the system. No Issues.

Corrective Actions (ISO 17025 clause 8.7 Option A)

Lab QMS Reference Section 8.6

Covered during NCR section, actions being taken are being checked for effectiveness and are based on impact and risk.

Internal audits and management reviews (ISO 17025 clause 8.8 & 8.9 Option A)

Lab QMS Reference Section 8.7 & 8.8

Audits are planned using SMTL Quality system audit schedule 2023 which list audits against Audit RT numbers covering both IP5 and POWH. Areas covered include areas such as staff and training, equipment and IAO17025 reviews. As an example looked at an audit for accommodation and environment and the IP5 for physical and bio lab which found no NCs the one for POWH raised 2 NC s for Bio one was seen for a monitoring sheet not being signed off. Appropriate root cause and action taken appropriate with the level of risk and impact of the action found.

Lab audit every single project which has been undertaken accredited or not as per SOP-37 (Rev 0.46) any actions raised are looked at for systemic issues or not for any trends identifiable.

Witnessing schedule seen from records from 2006 up until 2023 looked at random example RT60133 as performed and witness by Lindsay. On Rev number 0.49 of TM 303. No major issues identified but some procedural changes such as location of testing added to result sheets. Lindsay has been deemed competent to perform auditing against SOP-457 which is the witnessing process.

Comprehensive auditing in place giving a good level of scrutiny to the management system and activities performed.

Last full management review was 20th October 2022 and all managerial staff were present.

The management reviews minutes were seen to be in line with the agenda requirements of 17025.

Areas covered included resources (staff and equipment), project audit results, complaints and feedback and Review of previous actions and progress.

QA/QC section covers the ILC with LGC for bio and Med gloves with Enersol in accordance with BS EN 455.
No Issues.

Technical Assessors Reports

2023 SMTL Notes CA

2023 SMTL Notes HC

Appendices (if applicable)

SMTL Findings RA only.csv

1492Testing_Multiple_033_Draft

Please visit www.ukas.com for latest technical publication and guidance documents.

END OF ASSESSMENT REPORT

Schedule of Accreditation

issued by

United Kingdom Accreditation Service

2 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3HR, UK

UKAS TESTING **1492** **Accredited to ISO/IEC 17025:2017**	**NHS Wales Shared Services Partnership** **trading as Surgical Materials Testing Laboratory** **Issue No:** 033 **Issue date:** 27 November 2023	
	Princess of Wales Hospital **Coity Road** **Bridgend** **South Wales** **CF31 1RQ**	**Contact: Dr G Hughes** **Tel: +44 (0)1656 752820** **Fax: +44 (0)1656 752830** **E-Mail: info@smtl.co.uk** **Website: www.smtl.co.uk/**
Testing performed by the Organisation at the locations specified		

Locations covered by the organisation and their relevant activities

Laboratory locations:

Location details		Activity	Location code
Address Princess of Wales Hospital Coity Road Bridgend Mid Glamorgan CF31 1RQ	**Local contact** Dr G Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: info@smtl.co.uk Website: www.smtl.co.uk/	Surgical Materials & Medical Devices: Physical Mechanical Safety Health and Hygiene	B
Address IP5 Imperial Park Celtic Way Newport NP10 8BE	**Local contact** Dr G Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: info@smtl.co.uk Website: www.smtl.co.uk	Surgical Materials & Medical Devices: Physical Health and Hygiene	N

Site activities performed away from the locations listed above:

Location details		Activity	Location code
Controlled Clean Rooms	**Local contact** Dr G Hughes Tel: +44 (0)1656 752820 Fax: +44 (0)1656 752830 Email: info@smtl.co.uk Website: www.smtl.co.uk/	Classification of Air Cleanliness Active Air and Surface Microbiological Monitoring	S1

DETAIL OF ACCREDITATION

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
EXTENSIBLE BANDAGES	Physical Testing		
	Elastic properties	BS 7505:1995 (on unwashed samples) TM-393	B, N
MEDICAL SPECIMEN CONTAINERS FOR MICROBIOLOGY	Safety Testing		
	Leak testing	BS EN ISO 6717:2021 Annex C TM-18	B
COMPRESSION HOSIERY	Physical Testing		
	Graduated Compression Hosiery, Anti-Embolism Hosiery and Graduated Support Hosiery – Compression, durability and stiffness	BS 661210:2018 +a1:2022 TM-487	B, N
MEDICAL DEVICES (GENERAL)	Safety testing		
	Endotoxin testing by quantitative kinetic turbidimetric method	British & European Pharmacopoeia Bacterial Endotoxin Test USP Transfusion and Infusion Assemblies and Similar Medical Devices TM-254 including RO water	B
	Health and Hygiene		
Samples types including Gowns	Estimation of bioburden	BS EN ISO 11737-1:2018 TM-345	B , N
VAGINAL SPECULUMS	Speculum Break Testing	Documented In-House Method TM-334	B

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
MEDICAL GLOVES			
	<u>Biological Testing</u>		
	Extractable Protein	BS EN 455-3:2015 Annx A TM-230	B
	Determination of Removable Surface Powder	BS EN 455-3:2015 Section 5.2	B
		BS EN ISO 21171:2006 TM-391	B
	Endotoxins	BS EN 455-3:2015 Section 5.1	B
		European Pharmacopoeia TM-254	B
	Physical Testing		
	Dimensions	BS EN 455-2: 2015 TM-343	B, N
	Labelling	BS EN 455-2: 2015 & BS EN 455-3:2015 TM-392	B, N
	Perforations	BS EN 455-1:2020 TM-22	B , N
	Force at Break	BS EN 455-2:2015 TM-342	B , N

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS	Physical Testing		
	Free swell absorptive capacity	BS EN 13726:2023 Annex B TM-507	B
	Fluid retention capacity	BS EN 13726:2023 Annex C TM-507	B
	Absorption under compression	BS EN 13726:2023 Annex D TM-508	B
	Fluid Handling Capacity	BS EN 13726:2023 Annex E & N TM-509	B
	Fluid donation of amorphous hydrogel dressings	BS EN 13726:2023 Annex F TM-510	B
	Dispersion characteristics of gelling dressings	BS EN 13726:2023 Annex G TM-511	B
	Moisture vapour transmission rate of a wound dressing when in contact with vapour	BS EN 13726:2023 Annex H TM-512	B
	Moisture vapour transmission rate of a wound dressing when in contact with liquid	BS EN 13726:2023 Annex I TM-512	B
	Waterproofness	BS EN 13726:2023 Annex J TM-513	B, N
	Extensibility and permanent set	BS EN 13726:2023 Annex K TM-514	B

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS (Cont.)	Air Expulsion for Fluid Handling Capacity Testing	BS EN 13726:2023 Annex O TM-500	B
	Adhesiveness	BP 1993, Vol 2, App XX H, Test 1	B
		BP 1993, Addendum1996, App XX H, Test 1 TM-186	B
		BP 1993, Vol 2, App XX H, Test 2 TM-175	B
	Dispersion characteristics	BS EN 13726-1:2002 Section 3.6 TM-112	B
	Dispersion/solubility of hydrogel dressings	BS EN 13726-1:2002 Section 3.7 TM-116	B
	Free swell absorptive capacity	BS EN 13726-1:2002 Section 3.2 TM-101	B
	Fluid handling capacity	BS EN 13726-1:2002 Section 3.3 TM-390	B
	Absorbency and fluid retention	Documented In-House Method TM-404	B
	Absorbency under compression	Documented In-House Method TM-414	B
	Fluid affinity of amorphous hydrogels	BS EN 13726-1:2002 Section 3.4 TM-238	B
	Conformability for primary wound dressings	BS EN 13726-4:2003 TM-396	B

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
WOUND DRESSINGS (Cont.)	Moisture vapour transmission of Permeable Film Dressings	BS EN 13726-2: 2002 TM-394	B
	Waterproofness	BS EN 13726-3: 2003 TM-395	B, N
	<u>Biological</u>		
	Test for Bacterial Penetration of Film Dressings	Documented In-House Method TM-43	B , N
URETHRAL CATHETERS	<u>Health and Hygiene</u>		
	Surface finish	BS EN ISO 20696:2018 Section 5.4 TM-309	B
	Dimensions	BS EN ISO 20696:2018 Section 5.5 TM-300	B
	Strength	BS EN ISO 20696:2018 Section 6.1 Annex A TM-301	B
	Connector security	BS EN ISO 20696:2018 Section 6.2 Annex B TM-302	B
	Occlusion of drainage eyes and leakage from balloons	BS EN ISO 20696:2018 Section 6.3 Annex C TM-303	B
	Balloon recovery volume	BS EN ISO 20696:2018 Sections 6.4.2 Annex D TM-304	B
	Flow rate	BS EN ISO 20696:2018 Section 6.5 Annex E TM-305	B
	Symbols and labelling	BS EN ISO 20696:2018 Sections 5.5, 7.2, 7.3 TM-308	B

1492 **Accredited to ISO/IEC 17025:2017**	**Schedule of Accreditation** **issued by** **United Kingdom Accreditation Service** 2 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3HR, UK **NHS Wales Shared Services Partnership** **trading as Surgical Materials Testing Laboratory** **Issue No:** 033 **Issue date:** 27 November 2023

Testing performed by the Organisation at the locations specified

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
URINE COLLECTION BAGS	<u>Health and Hygiene</u>		
	Physical, mechanical: Rated and test Volume	BS EN ISO 8669-2:1997: Section 6.1 TM-286 & TM-297	B
	Freedom from leakage without load	BS EN ISO 8669-2:1997: Section 6.2 TM-287	B
	Freedom from leakage under load	BS EN ISO 8669-2:1997: Section 6.3 TM-288	B
	Freedom from leakage under impact	BS EN ISO 8669-2:1997: Section 6.4 TM-289	B
	Non-return valve	BS EN ISO 8669-2:1997: Section 6.5 TM-290	B
	Strength of attachment systems of bags provided with cutouts	BS EN ISO 8669-2:1997: Section 6.6 TM-291	B
	Strength of attachment systems of bags provided with button and buttonhole systems	BS EN ISO 8669-2:1997: Section 6.7 TM-292	B
	Strength of integral suspensory systems	BS EN ISO 8669-2:1997: Section 6.8 TM-293	B
	Strength of attachment of the inlet tubing	BS EN ISO 8669-2:1997: Section 6.9 TM-294	B
	Pressure/time required to initiate flow into the bags and filling rate	BS EN ISO 8669-2:1997: Section 6.10 TM-295	B
	Dimensions	BS EN ISO 8669-2:1997: Annex A TM-296	B

UKAS TESTING 1492 **Accredited to ISO/IEC 17025:2017**	**Schedule of Accreditation** **issued by** **United Kingdom Accreditation Service** 2 Pine Trees, Chertsey Lane, Staines-upon-Thames, TW18 3HR, UK **NHS Wales Shared Services Partnership** **trading as Surgical Materials Testing Laboratory** **Issue No:** 033 **Issue date:** 27 November 2023

Testing performed by the Organisation at the locations specified

Materials/Products tested	Type of test/Properties measured/Range of measurement	Standard specifications/ Equipment/Techniques used	Location Code
CONTROLLED CLEAN ROOMS	<u>Physical Testing</u>		
	Classification of air cleanliness	BS EN ISO 14644-1:2015 and current GMP guidance TM-266	S1
	<u>Health and Hygiene</u>		
	Active air and surface microbiological monitoring	Documented In-House Method, TM-354, based on current GMP guidance	S1
FLUIDS	Total Viable Count by filtration or spread plate method of Fluid Samples (potable and process water, aqueous solutions and liquids or powders reconstituted in water or aqueous diluents only)	Documented In-House Method, TM-372	B , N
END			

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Medical Examiner Service Annual Report 2023/24

DATE OF MEETING	11/07/2024
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 (NWSSP)
PRESENTED BY	Dr Ruth Alcolado
APPROVED BY	Choose an item
EXECUTIVE SUMMARY	This report provides assurance that the implementation of the Medical Examiner Service for Wales is meeting current non-statutory requirements and is on course to be able to meet future regulatory requirements from 9th September 2024.
RECOMMENDATION / ACTIONS	To note the MES Annual Report 2023/2024

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	
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** *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 – N/A

1. SITUATION

In line with the Coroner and Justice Act 2009, specific Regulations were laid in England and Wales in April 2024 to establish the legal framework for a statutory, unified system of scrutiny by independent Medical Examiners (ME) for all deaths which are not investigated by a coroner. **These Regulations will come into force on 9th September 2024.**

2. BACKGROUND

The new statutory ME roles – and the new procedures – are expected to have a positive impact for families and for health services in Wales as follows:

- The cause of death recorded on medical certificates of the cause of death (MCCDs) by doctors will be scrutinised by an ME. This will help to identify patterns and trends and, in turn, help to detect any poor practice or even criminal activity.

- MCCDs will provide more accurate information about the causes of death leading to better planning of health services.
- Improved information for clinical governance and health monitoring will support learning and improvement, which will help to make health services safer.
- The death certification process will be easier for bereaved families to understand, open and transparent, and provide opportunities for loved ones to raise concerns with an independent ME about the standard of care leading up to a death. There will also be opportunities for MEs to provide reassurance that the cause of death has been correctly established by the doctor.
- Appropriate referrals to the coroner service.

The Medical Examiner (Wales) Regulations 2024 form part of the wider death certification reforms being introduced in England and Wales through statutory **Regulations** being laid by the UK Government's Department of Health and Social Care. These include:

- The Medical Certificate of Cause of Death Regulations 2024
- The Medical Examiners Regulations 2024
- The National Medical Examiner (Additional Functions) Regulations 2024

The reforms to the death certification process and the introduction of the statutory role of MEs aim to ensure that the system for certifying all non-coronial deaths provides adequate scrutiny to identify and deter criminal activity or poor practice.

In Wales it is expected that the Service, which is provided directly by NHS Wales Shared Services Partnership (NWSSP), will scrutinise around 34,850 deaths per year when fully operational in the statutory environment, equating to an average of 2,904 deaths per month. To meet this demand, the agreed staffing model includes a core of 12.4 WTE medical examiners supported by 38 WTE medical examiner officers, in line with National Medical Examiner guidance.

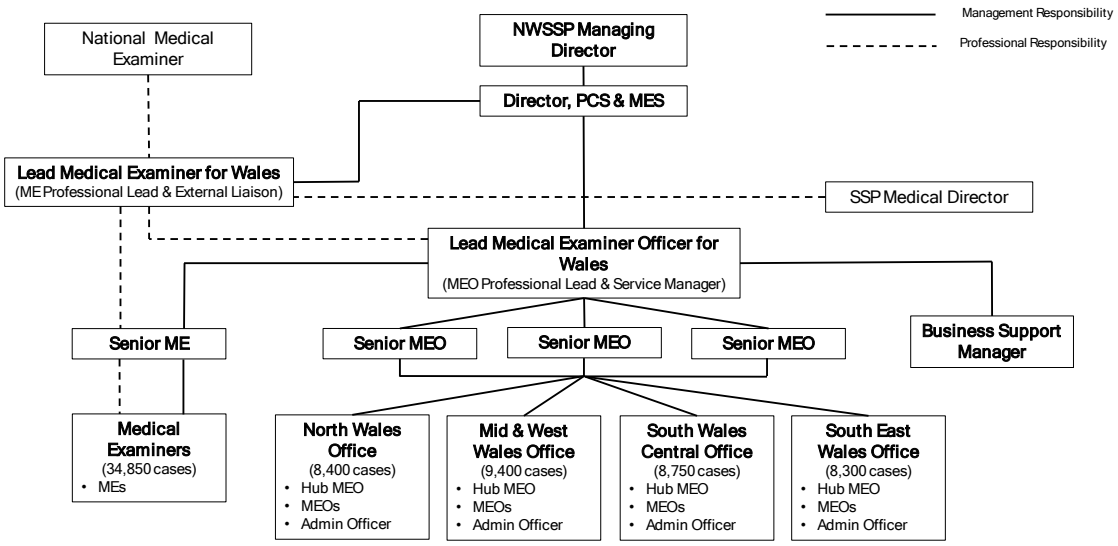
3. ASSESSMENT

The original expectation was that the legislation for statutory medical examiner scrutiny of deaths would be enacted in 2023, with an effective implementation date of April 2024. Based on this, the Medical Examiner Service in Wales has, during the financial year 2023/24, been ensuring that its structures, systems and processes are in place to meet this requirement. Progress can be seen below:

3.1 Structure

The following sets out the full structure of the service. It should be noted that this includes a management infrastructure to support service delivery:

MES Operational Management Structure 2024



As NWSSP employ all Medical Examiners and Medical Examiner Officers directly it can ensure full independence from care providers. It is also able to ensure that all staff employed comply with the professional standards set out by the National Medical Examiner for England and Wales (e.g. in terms of qualifications and experience) and can also monitor ongoing performance against relevant competence frameworks (e.g. Medical Examiner and Medical Examiner Officer).

3.2 Systems and processes

During the year the Service has reviewed, and amended as required, its systems and processes. The Medical Examiner Module within the DATIX system continues to operate as our case management system and work to refine its reporting capabilities is ongoing with both the Once for Wales team and Datix personnel.

All performance frameworks have been reviewed and refined as appropriate, as have all Standard Operating Procedures. This ensures that all deaths, no matter where they occur, or who they are scrutinised by, receive the same standardised approach with outcomes recorded and reported in a standardised fashion.

It should be noted that, while undertaking scrutiny of the cause of death and circumstances surrounding it, the Medical Examiner Service for Wales does not have a regulatory or investigative function. As such, any potential issues regarding patient safety or clinical quality identified via the three-stage scrutiny process will be forwarded on to the care provider concerned for further consideration/investigation as required, in line with the Once for Wales Concerns Management System processes.

For deaths that occur in an NHS hospital environment, issues identified will be notified via the Medical Director, or nominated alternative, of the care organisation involved. For deaths that occur in the community, issues identified will be notified to the Senior Partner of the relevant GP Practice or a nominated individual, with the relevant health board nominee, as the commissioner of primary care services, also informed that a notification has been sent to the practice. For non-NHS Wales organisations, such as Hospices or Trusts in England, referral will be via a direct notification mechanism in line with the National Medical Examiners Good Practice Guidance.

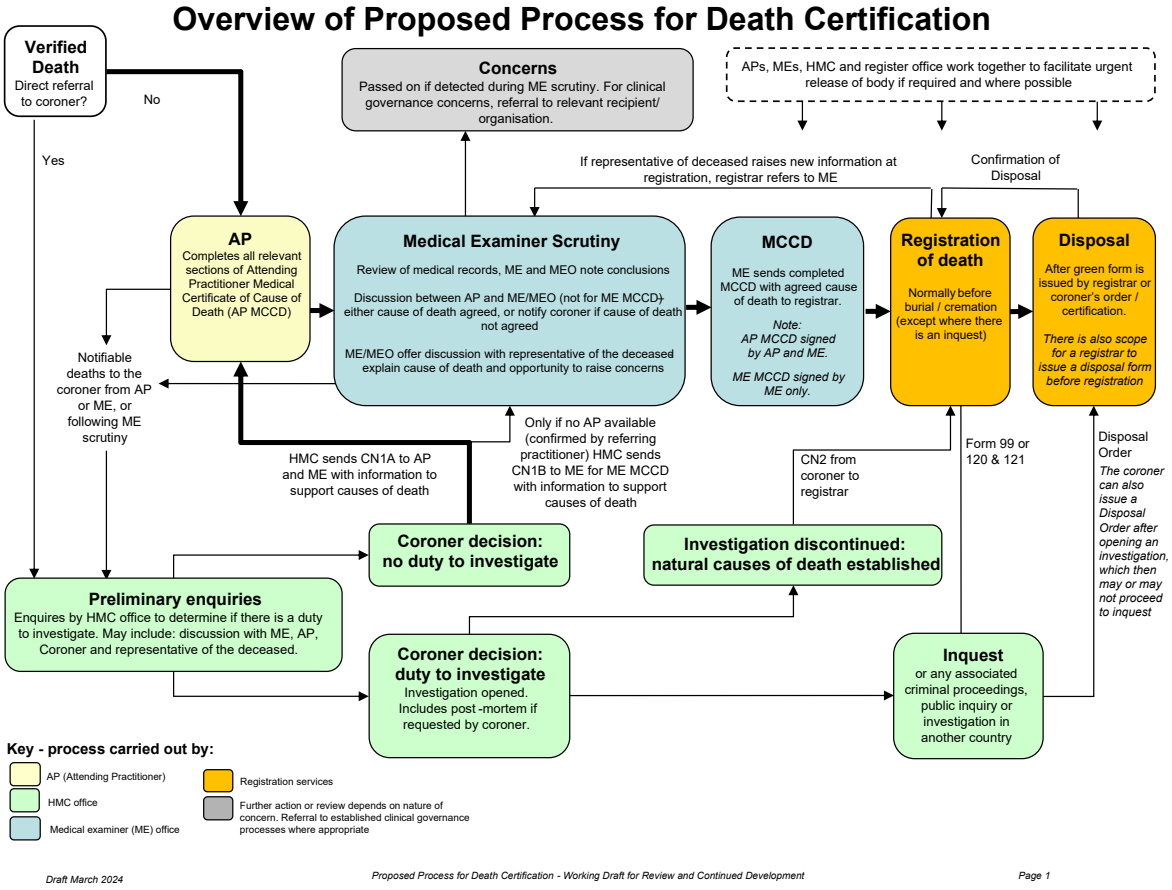
The feedback mechanism to care providers has been developed in line with the Healthcare Quality Standards, standardising notification categories and allowing improved comparison capabilities.

It should be noted that the Medical Examiner Service cannot direct further investigation by the care provider, nor determine the level of an investigation if undertaken. This remains the responsibility of the care provider and is consistent with the Putting Things Right process where a concern is identified and then evaluated within the care provider to determine the appropriate next steps.

In addition, in recognition of the unique database and insight that the Medical Examiner Service for Wales has on patient safety and clinical governance concerns across Wales, the Service produces quarterly Thematic & Trends Reports for care providers and Welsh Government.

Each Regional Hub Office receives notes scanned by health boards and emailed directly to the office or uploaded into the Clinical Portal for review. For deaths that occur in the community, the Regional Office will access GP records directly via the GP system or, where not feasible, a summary record can be emailed to the Regional Hub Office. Access to these records is covered by Data Sharing Agreements with each Practice. The Medical Examiner Service's scrutiny process will sit within a wider death certification system, as shown in Diagram 1 below. This is subject to national agreement and refinement.

Diagram 1



3.3 Activity

As noted earlier the Service, when fully staffed, has the capacity to scrutinise up to 34,850 deaths per year (2,904 per month on average, evenly split between those that take place in acute care settings and those in community settings).

During the year the number of deaths scrutinised has increased from 1,204 in April 2023 to 1,676 in March 2024, representing 58% of all expected deaths.

Given the original expectation that the statutory date for implementation would be April 2024, the Medical Examiner Service aimed to be able to scrutinise 100% of available deaths from that point. That meant ensuring that the capacity was in place to manage all potential deaths, however, given the changed implementation date to September 2024, the requirement for all deaths to be scrutinised did not happen, despite the capacity being largely in place. As a result, deaths scrutinised during the year were largely limited to those that occurred in acute care settings.

In general, GPs have been clear that they will not use the service until it becomes a statutory requirement, although their engagement with the service generally has been good and we have been able to test and refine systems and processes in advance of the statutory introduction.

4. SUMMARY OF MATTERS FOR CONSIDERATION

As of 31st March 2024, the Medical Examiner Service for Wales has been in a position to scrutinise all deaths that occur in Wales in accordance with regulatory requirements and in line with the National Medical Examiner's Good Practice Guidance. Capacity is in place and systems and processes have been tested and refined to ensure that there is an independent and equitable provision across Wales, using a single, all Wales, service model. This allows capacity to be flexed to meet demand changes from geographical areas as they occur, and the skills and knowledge that exist in the workforce can be deployed as required across the whole of Wales.

The Service has demonstrated the added value of an all-Wales approach in identifying issues across providers and locations and is increasingly being seen as an important part of provider organisations clinical quality and patient safety systems.

Work has been undertaken, and will continue, to ensure that the impact of the wider death certification reforms being driven by UK Government are understood, and that we, and our partners and stakeholders in this wider system, ensure that the bereaved are supported and re-assured throughout the process.

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 ☒
	[Please include narrative to explain the selected domain in no more than 3 succinct points].
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	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**: 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
	[In this section, explain in no more than 3 succinct points what the equality impact of this matter is or not (as applicable)].
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)].

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
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	

NHS WALES SHARED SERVICES PARTNERSHIP

Duty of Quality Annual Review
2023-2024

Introduction from Chair and Managing Director of NWSSP

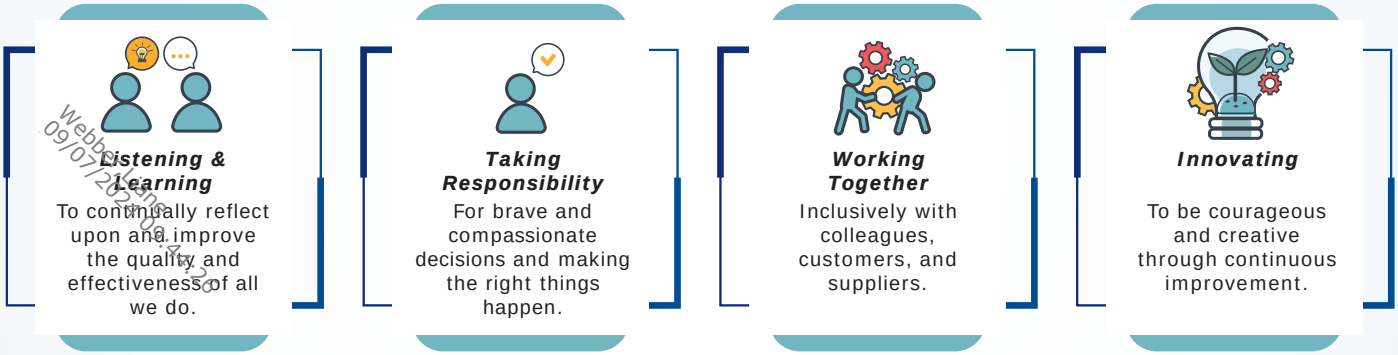
We take immense pride in presenting our inaugural annual report on the implementation of the Duty of Quality within NWSSP.

The Duty of Quality came into force on 1st April 2023. For the first time a duty was placed on NHS bodies to ensure improvements in the quality of both clinical and non-clinical services, which reflects the ambition of NHS Wales to achieve ever increasing standards of service provision to the population of Wales.

NHS Wales Shared Services Partnership provides an extensive portfolio of services, and over the course of the past 13 years has broadened the remit of its service provision on an All-Wales basis to include services ranging from Legal to Laundry, from Procurement to Pharmacy, from Accounts Payable to Audit, from Payroll to Primary Care Services, Specialist Estates and Surgical Materials Testing Laboratories and so much more.

Assuring and improving quality over such a wide range of services has been a core part of our culture as evidenced by our core values and strategic objectives which were refreshed in 2022/23.

Our Values



Our strategic objectives reflect Our people, Our Services (including improving quality), Our Value.

This annual report outlines the work we have done to assure our public that we have quality at the heart of all that we do.

The report shares with you details of how our quality management systems, comprising quality planning, quality improvement, quality control and quality assurance, function in a variety of settings within NWSSP.

There are links to recordings made as part of our 'always on' reporting which will continue to be updated on a regular basis on our intranet site and the NWSSP YouTube site so that we can build up and continuously update the NWSSP quality story for you to view at your leisure.

We hope that reading this report will give you the confidence that, as an organisation, delivering a quality service and constantly improving the quality of the services we provide is top of our agenda.

Tracy Myhill OBE,

Chair

Neil Frow OBE,

Managing Director

Medical Directors Report

Quality is defined in the Health and Social Care (Quality and Engagement) (Wales) Act 2020 as ***"Continuously, reliably and sustainably meeting the needs of the population that we serve."***

Centuries ago, Aristotle stated that ***'Quality is not an action, it is a habit',*** this philosophy is what we have tried to embed in NWSSP, even before the Duty of Quality was established, but the Duty of Quality has helped us to focus on:

- What quality means for our non-clinical as well as clinical services.
- How we communicate what quality means.
- How we use quality to inform our planning and decision making.
- How we measure and report on quality.
- How we make sure that quality is everyone's responsibility.

The Duty of Quality came into force on 1st April 2023. It places upon all NHS bodies a statutory duty to consider quality in the execution of both our clinical and non-clinical services. The overarching aim of the duty is to improve the quality of health services and to improve health outcomes for the people of Wales.

NWSSP provides a variety of clinical and non-clinical services through a divisional structure. The services in NWSSP include:

Our Services

- Audit and Assurance Services
- Accounts Payable
- Counter Fraud Wales
- Central E Business Team
- Digital Workforce Solutions
- Employment Services
- e-Enablement
- Finance Academy (hosted)
- Health Courier Service
- Laundry Services
- Lead Employer for medical, dental & pharmacy trainees
- Legal and Risk Services
- Medical Examiner
- Primary Care Services
- Procurement and Supply Chain Services
- Pharmacy Services
- Specialist Estates Services
- Finance and Corporate Services
- Planning, Performance and Informatics
- People and Organisational Development
- Surgical Materials Testing Laboratory
- Salary Sacrifice
- Student Awards Services
- Welsh Risk Pool
- Wales Infected Blood Support Scheme

Key achievements in year 1

Awareness raising: Early work included:

- A practical session in informal Senior Leadership Group, considering what quality means to each division and the impact of the Duty on our day-to-day work.
- An on-line coffee morning to engage with staff about the new duty and to encourage staff to consider how they play their part in delivering quality services.
- A session at the partnership board development day to consider what the duty means to NWSSP both for our services but also how we can support the NHS Wales system in provision of information to enable HBs to consider their Duty of Quality, in particular relating to non-clinical services.
- The establishment of an implementation team comprising champions and leads from each division in NWSSP where we can share our practical expertise in embedding quality into our services.

Quality Planning and Decision Making:

As an integral part of our 2024-27 IMTP production we challenged divisions to keep quality at the heart of their future plans and were able to highlight the key quality statements in the IMTP and attribute them to one or more of the 12 health and care standards (Appendix 1).

Quality Driven Reporting:

reporting in NWSSP includes always on reporting on the NWSSP intranet site and the provision of reports to Health Boards in a variety of contexts:

Always on reporting was established, in which each month divisions recorded a presentation or video to outline the quality management system used in their division and to highlight some of the quality driven projects they are working on. We currently have 7 presentation videos online (Service Submissions sharepoint.com)) which can help our public know more about the quality agenda in NWSSP.

- Leadership and Culture
- Performance
- Recruitment
- Procurement
- Digital and Workforce Productivity
- Pharmacy Division
- Audit and Assurance

The above videos are only currently available via NWSSP intranet or via the direct link. It is proposed that over the next months as part of always on reporting that these will be made publicly available for assurance for our communities.

Quality Driven reporting into Health Boards and Trusts:

The Medical Examiners service was set up in response to the Francis enquiry as part of an England and Wales service to provide:

- Advice on the accurate and registerable medical cause of death.
- Proportionate scrutiny of the management of patients who have died in Wales independent of the Health Board/Trust where the patient died.

The service provides a report back to the responsible Health Board/Trust/GP practice to highlight any areas where the Health Board/Trust/GP practice may want to look for opportunities for improvement in patient care. These reports have been re-structured against the 12 domains and enablers in order to support learning and provision of Quality Services.

The Audit and Assurance Division of NWSSP provide audit services across NHS Wales and are in the process of structuring the reports they provide back to services to focus on the 12 health and care standards – as part of always on reporting this will inform the development of next year's annual report.

Quality control and using data for quality improvement:

Quality control and quality assurance is undertaken through divisional quarterly reviews.

Holding divisions to account for Key Performance Indicators (KPIs) which are based on the safe, timely, effective, efficient, and person-centred quality domains is a key mechanism that NWSSP has long established to ensure quality is central to our service delivery.

Quality assurance is gained by using the KPIs to inform quality improvement projects which feed into improved quality measures and give the senior leadership team and the partnership board assurance. KPI reports serve to inform the Integrated Medium Term Plan (IMTP) which is submitted to Welsh Government on a yearly rolling basis and supports the principles of delivering Value, Innovation and Excellence through Partnership. This in turn is underpinned by the innovative approach to the Duty of Quality in NWSSP.

Each division is held accountable to a set of unique measures, applicable to them. These include internal and external measures, including sickness, time to hire (see below) and statutory and mandatory training compliance.

Below we outline 3 projects which demonstrate how quality control data is used to inform quality improvement:

- Time to Hire: Using data from Trac we can determine where there are delays in the recruitment journey. In discussion with HBs, we have removed 'non-value-added steps' and worked to close long open recruitment timelines. There has been a significant reduction in time to hire following data and thematic analysis, with a reduction of around 20% when the newly agreed process is followed.

- Overpayments: A member of the Employment Services team developed an app for Digital Overpayments Solutions which is able to be used across Wales. This involved use of data to identify the issue, and cross division working to roll this out at no additional cost to NWSSP or the Health Boards across Wales.

- Data has also been used to co-produce a Thematic Review Learning Report with the Health Boards and Welsh Government to improve the quality of Do Not Attempt CPR documentation. The Medical Examiner Service has used their review process to feedback to the Health Boards to inform quality improvement work and have done this by utilising the enablers and domains outlined in the Duty. The review presents findings and identifies opportunities for quality improvement to ensure equitable application of decision making.

External Quality Reviews and Awards:

Customer Service Excellence Accreditation

As a partnership organisation, providing services to our partners and customers across NHS Wales, one of our key actions in this first year of Duty of Quality being applied to non-clinical as well as clinical services was to ensure that our customers were at the heart of all that we do.

In order to assure ourselves that all divisions in NWSSP were customer focussed, we sought for an external, accredited view of our 'customer-centeredness'.

This was our first attempt to gain Customer Service Excellence (CSE) accreditation for the whole organisation, a few divisions having achieved this stringent accreditation in previous years, so we were delighted to be granted CSE accreditation in 2023. Importantly we are also using the CSE review and its recommendations to ensure continued improvement in the experience of our customers and partners.

CSE and the Duty have been linked on the NWSSP SharePoint site to demonstrate the inherent linkage between these crucial pieces of work to demonstrate the quality and value of customer experience to NWSSP and those we work with.

Moving forward we will work to respond to those recommendations identified by the CSE assessors to further improve. Again, this will be reflected in the always on reporting processes and will ensure that we work consistently to reflect on what the Duty means to NWSSP and our stakeholders.

Below are some examples of the External Quality Reviews and awards achieved by NWSSP over the last year.

Customer Service Excellence

Awards and Achievements

Staff and divisional awards, both internal and external, demonstrate the quality of the services provided in NWSSP.

To evidence this, the infographic below includes links (ctrl and click) to the 2023 staff awards and other external awards and nominations recognising excellence.

Explore some of our Awards and Achievements in depth by clicking the boxes.

Staff Awards

CSE Accreditation

Decarbonisation team shortlisted for SSF Sustainability Future Vision Award

PROMPT Wales team awarded RCM excellence in midwifery education and learning May 2023

Scan Safety (S4S) Team awarded the Evolution Award at the Future Vision Awards Ceremony.

Staff Voices

The 12 health and care standards which comprise the 6 measures of quality and the 6 key enablers laid out in the Duty of Quality are shown in the inner ring and outer ring respectively on the wheel below.

The 6 measures of quality are:

Safe **-** This focuses on avoiding preventable harm, getting processes and care right, and learning from incidents and concerns to prevent repetition.
Timely

Timely – This is described as providing high quality care in the right timeframe.

Effective – This reflects utilisation of evidence-based practice including prevention as well as treatment.

Efficient – a values-based approach to improve outcomes for people.

Equitable – providing equality of opportunity and human rights.

Person Centred – meeting people's needs.

The 6 enablers are:

Workforce – Ensuring that the workforce is skilled and available to provide care and support to those providing care.

Leadership – clear vision with governance and accountability embedded in the organisation.

Culture – Quality systems and safety in a supportive way enabling sharing new ideas and learning from mistakes.

Information – Using data and knowledge to inform service quality and development.

Learning and Improvement – Quality improvement to deliver quality services and outcomes.

Whole system approach – Improving quality across the health care system to improve population outcomes.

These can be further explored by clicking on the following:

[Duty of Quality Statutory Guidance (gov.wales)]

Explore the wheel below (by clicking on each section) to hear staff in NWSSP explaining how quality is key to their work on behalf of NHS Wales and what it means to them, or to see links explaining how quality is demonstrated in NWSSP. This will evolve over time to reflect on current developments and link to future plans for a monthly blog.

Leadership – Leadership Cohort 2

This video describes the current Leadership programme and places it in the context of quality and value to the organisation. It also describes how the leadership programme is designed to provide the skills necessary to future leaders with the skills necessary to implement a quality management system within their workplace.

Person centred – Welsh Infected Blood Support Scheme (WIBSS)

This is hosted by NWSSP within the Planning, Performance and Informatics Division on behalf of Welsh Government. It demonstrates the transparency and quality of the service and its responsiveness to concerns and queries raised by those affected by the scandal. The service holds Accredited Quality Status (AQS) for its welfare rights advice.

Equitable – Medical Examiner Service, DNACPR, an All-Wales Thematic Review Scheme

The Medical Examiner Service has significantly contributed to the development of the All-Wales Learning from Mortality Review Framework (2022). Following from this and acknowledging the support which the MES gives to families of the deceased in allowing them to raise concerns regarding care during their loved one's final illness, a thematic review was completed on an All-Wales basis. This is authored and owned by the NHS Wales Executive Quality and Safety Team and includes and acknowledges the work done by the MES in identifying issues with DNACPR documentation and the linking of these to the themes in the Duty of Quality to demonstrate an equitable approach. Including this has been agreed with the Executive and we will be able to link to the document when it has been published, which is expected in the next weeks.

Timely – Time to Hire

The reduction of time to hire has been a priority for recruitment services and they have produced videos and training materials for recruiting managers to support them with this. Focusing on this process and working with recruiting HBs we have ensured the time to hire is falling, ensuring availability of skilled staff and reduced reliance on temporary/high-cost agency staff.

Information – Planning, Performance and Informatics presentation

The PPI team has developed a video/animated slide deck which discusses the role of information in assuring the quality of performance in NWSSP.

Workforce

This video clip from a YouTube video available on SharePoint explains the role of the International Recruitment team, Digital workforce and Productivity solutions and the whole system approach to strategic workforce planning and a Once for Wales operating model.

Effective

Medicines in secondary care procurement demonstrates the effectiveness of assessment of medicines ensuring quality in terms of patient information and technical data. It also looks at stability of medication and uses a list of criteria including patient acceptability.

Culture

This video clip from a YouTube video available on SharePoint demonstrates how the implementation of Scan for Safety has significantly contributed to a culture of patient safety across NHS Wales.

Whole systems approach – Decarbonisation Newsletter

The decarbonisation team have developed a whole systems approach to decarbonisation across NWSSP and the NHS in Wales. A link will be provided to their most recent newsletter and videos which will clearly demonstrate their achievements and ambitions in this area.

Learning, Improvement and Research presentation

This video clip from a YouTube video available on SharePoint demonstrates how identifying an issue, researching potential solutions, learning and implementing improvements has increased the quality of the service provided in decontamination.

Safe

This video clip discusses the implementation of a system for identifying and contracting for purchasing pH strips for gastric aspirate testing. This follows on from a National Patient Safety Alert in 2011, and work done since then has resulted in purchasing of a strip that is safe for patients and staff to use. This ensures public and patient confidence.

Efficient

This video clip from a YouTube video available on SharePoint describes the provision of an end to end service of providing wound care products to patients.

Future

Quality in healthcare is not a state of being, as we are reminded by Dr Tedros Adhanom Ghebreyesus, World Health Organisation, Director General:

"Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring".

In NWSSP we intend to continue our quality journey and in the next year we will look to:

- Continue our 'always-on' reporting by allowing each division to share their quality management systems with the rest of the organisation so that we continue to learn.
- Add to our 'always-on' reporting to ensure that we provide details of ongoing quality achievements.
- Gain re-accreditation for our Customer Service Excellence certification by demonstrating how we have used the recommendations of the first pan-organisation award.
- Continue to raise awareness amongst our staff and promote the use of the e-learning tool on Duty of Quality.
- Review our KPIs to ensure stretching targets which reflect quality measures as well as continuing work to maintain good performance in areas where improvement work has been carried out this year.
- Review the mechanism for ensuring quality driven planning and decision making, in particular to review the way the quality lens is shone on the IMTP process.

We are committed to ensuring that our reporting against the Duty is kept as a live document, reflecting the work done by all the Divisions within NWSSP and the reporting processes we utilise.

Linking into the IMTP (See Appendix 1) also demonstrates the commitment and effectiveness of the cohesive Quality Planning approach taken by NWSSP (Planning final DoQ slides PPI.mp4 (sharepoint.com)).

Appendix 1

Duty of Quality:

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau Shared Services Partnership

This appendix demonstrates further alignment to our commitment to the Duty of Quality. Throughout our IMTP we have mapped the relevant Health and Care Standard logos to identify associated work streams.

Audit and Assurance: Development of a staff pipeline programme, inclusive of new trainees and apprentices. Ensuring there are quality candidates, who are ready to meet the future needs of the service.

Specialist Estates Services: Continued recruitment and training development programme for Network 75 students. This will improve the quality of team capacity and resilience.

Procurement Services: Develop workforce capabilities and capacity to meet the changing needs of the organisation. The team are looking at the workforce approaching retirement age and may pose skills gaps. It will ensure that there is capable and experienced workforce.

People and Organisational Development: Launching and embedding a workforce planning strategy and accompanying toolkit. This will ensure the learning needs of staff across the organisation are met and that we are developing a capable workforce.

Digital Workforce Solutions: All-Wales Recruitment Programme. This will continue to deliver an ethical, sustainable supply of healthcare professionals into the NHS Wales workforce.

Audit and Assurance: Embed training strategy within the division, including alignment of Personal Appraisal and Development Reviews – The PADR will identify additional and common training needs to improve competency of workforce.

Digital Workforce Solutions: Support the National Medical Workforce and Productivity agenda – Using the National Medical Workforce Group to review strategic objectives that can improve the workforce.

Employment Services: Support staff with new digital skills and compassionate management – As roles are being redesigned and more digital support offered, this will reflect on how the workforce progresses and enables staff to feel more confident and skilled to deliver effective work.

Pharmacy Services: Increase the skills and resilience within the Welsh Technical Services Workforce. The training programmes intends to upskill existing workforce and allow them to carry out further tasks and projects.

Single Lead Employer: Provide support and assistance to trainees with protected characteristics. This will ensure every individual is treated fairly and they are not disadvantaged due to their characteristic, which will enable them to progress and develop their careers in Wales.

People and Organisational Development: Develop a programme of activity that offers opportunities to under-represented groups in NWSSP to support an inclusive culture. Through providing a positive working environment for all staff will enable employees to thrive as a healthy and engaged workforce.

People and Organisational Development: Continue to create a positive culture across NWSSP, that embeds healthy working relationships, collective and compassionate leadership approaches to enable staff to show compassion; to speak up; to continuously improve; and to learn.

Specialist Estates Services: Promote a mentoring service to Health Boards and Trusts to support development of estates and professionals – Indicates further a collaborative culture, emphasising NWSSP value of working together to increase confidence in staff, which subsequently shapes customer/patient experience.

Legal and Risk: Develop a travel app to monitor expenses and carbon footprint. The data gathered from this app will support the divisions in reducing costs in travel expenses and carbon footprint.

Legal and Risk: Develop further methods of data sharing with the client health bodies to better support improved decision making. The information provided will identify pressure areas, allowing the service to allocate resources appropriately.

Pharmacy Services: Quantify volume and complexity of medicines shortages and supply chain issues within primary and secondary care. Consolidated data will facilitate NWSSP support to Health Boards in the management of supply chain issues and understand local capacity impact when managing these challenges.

NHS Counter Fraud Services: Maintain focus on data analysis – This objective aims to identify new service streams in Primary Care that are suitable for data analysis. The division is also seeking to liaise with data analytical team in Primary Care Services, to retrieve crucial information on optical claims.

Audit and Assurance: Duty of quality thematic piece.

Central Team eBusiness Service: Business Intelligence review of all systems, tools, and reports. The reports utilise information to identify any gaps or duplication in the tools being used.

Digital Workforce Solutions: Improve the quality of workforce data in line with National Workforce Datasets. This will provide workforce data quality to enable improved workforce reporting, workforce planning and establishment control.

Single Lead Employer: Assessing trainee experience by using surveys from February/March 2024 during the onboarding Process. The learning from these surveys will highlight any arising issues for improvement in time for August and September onboarding.

Legal and Risk: Work with NHS bodies to embed a culture of improved learning –how to prioritise improved learning as a long-term outlook and ways this this can be applied within an All-Wales approach.

Digital Workforce Solutions: Implementing a Digital Workforce Quality Improvement Programme. The information gathered will encourage the sharing of innovative solutions, as well as improvements and developments implemented where possible.

Accounts Payable: Support and implement any Procure 2 Pay initiatives that emerge from the action plan – utilising and learning new initiatives to support various actions such as reducing number of invoices going into dispute.

Central Team eBusiness Service: Continually auditing its service. The information is used to gain accreditation and service improvements.

Employment Services: Evaluate the Recruitment Modernisation Programme, to identify further streamlining opportunities and ways to reduce the time to hire. This will provide an efficient recruitment service that meets the needs of customers.

Digital Workforce Solutions: Continue to maintain the continued supply of Agency Nurses to NHS Wales organisations via the provision of an All-Wales Nursing Agency Contract.

Employment Services: Evaluate the payroll/recruitment Modernisation Programme to identify further streamlining opportunities. This will provide a modern and efficient payroll service that meets the needs of customers.

Central Team eBusiness Service: Developing a new Financial Management System (FMS) Service Recharge Model. This model will be the best fit for NHS Wales.

Specialist Estates Services: Deliver enhanced services to Welsh Government and NHS health organisations to support decarbonisation agendas – Collaborating and reviewing progress with Welsh Government to support the Action Plan.

Service Improvement: Achieving the Customer Service Excellence Accreditation across the whole of NWSSP. This provides assurance to our customers that we provide excellent quality of service.

People and Organisational Development: Implement a Learning and Development Strategy to address the learning needs of staff across the organisation. Focusing on growing our leadership and people management capabilities.

People and Organisational Development: Run a Leading for Excellence and Innovation Programme. The programme welcomes all leaders to develop their knowledge and skills to be confident, effective and inspiring leader within NWSSP.

Digital Workforce Solutions: Lead the development and Implementation of the People Portal Transformation Programme – This division is taking the lead on this programme, showcasing leadership in creating a flexible and agile system.

Diogel Safe

Pharmacy Services: Maintain regulatory and professional licences and registrations. This will provide a safe high quality regulated medicines service across NWSSP.

Specialist Estates Services: Complete the Fire Safety Improvement Programme. This will provide a modern and reliable fire safety platform.

Surgical Materials Testing Laboratory: Review Development of new products from the NWSSP Medicines Unit – Supporting partner Health Boards with safe local aseptic, cancer and critical care services.

Amserol Timely

Digital Workforce Solutions: Support continued implementation of Establishment Control – Implementation of Establishment Control will be carried out according to needs of each organisation in a timely manner, ensuring to work in accordance with local priorities.

Employment Services: Evaluation of Recruitment Modernisation Programme, streamlining opportunities and ways to reduce hire time – By reviewing the technology used in recruitment programmes, this will identify how best to reduce the time to hire, and reduce prolonging recruitment processes unnecessarily.

Single Lead Employer: Ensure Trainees are onboarded correctly, and contracts are issues on or before commencement date – Ensures that trainees are correctly remunerated in their first month of employment, and there are no untimely delays.

Central Team eBusiness Service: Continue to roll out and develop the All-Wales QlikView replacement reporting tool. This will reduce time spent reworking financial figures for multiple reporting purposes

Procurement Services: Modernising National Distribution Centre warehousing, hospital inventory management and Transport and Logistics Model for NHS Wales which will support. This will reduce the risk to patient services from potential shortages in critical products.

Procurement Services: Improving Supply Chain, Logistics and Transport operations and infrastructure at all sites to reduce carbon emissions. This will contribute towards the NHS Wales Decarbonisation strategy measures.

Procurement Services: The service held a session in November 2023 on refreshed Standard Operation Procedures, to standardise practice across Wales.

Legal and Risk and Welsh Risk Pool: Long term document and case management solution in prioritised phases – Creating a more effective way to provide customers with a secure, effective, and efficient legal service.

Central Team eBusiness Service: Free up resources by applying automated technology. Focuses on optimising use of resources, including staff time to achieve better outcomes without compromising quality.

Pharmacy Services: Identify unlicensed medicines routinely used across Wales and specifications of medicines that are routinely being purchased and are suitable to be outsourced. This will be efficient in reducing variation in spend of medicines across Wales.

All-Wales Laundry Service: Rolling out an energy efficiency dashboard, which will look at wastewater heat recovery systems and steam recovery systems. This will increase efficiency across the service.

Digital Workforce Solutions: Lead the development and Implementation of the People Portal Transformation Programme – enhance the way work is carried out in the NHS by ensuring organisational readiness, by tracking progress against local action plans.

Employment Services: Advance service efficiency through digital automation – by utilising new digital resources, and automating processes, this can support staff in completing tasks more efficiently and in a smoother manner.

Teg
Equitable

Single Lead Employer: Provide dedicated tailored support to overseas trainees new to the United Kingdom to assist them to settle into their post in Wales. This ensures that all trainees have the required support so that they have an equal opportunity within their new roles.

Medical Examiner Services: Meet all legislative requirements, i.e., 100% of deaths not referred directly to coroner, scrutinised in a timely manner – By implementing this scrutiny process, it acknowledges that there are contrasting religious requirements for burials, thus making the process fairer.

Single Lead Employer: Provide Trainees with protected characteristics the required support – Ensures that all Trainees are treated in a fair and impartial manner, and no individuals are disadvantaged. Ensures that all trainees experience a positive and encouraging work environment.

All-Wales Laundry Service: Develop multilingual training – Contributing to making the division an equitable workspace, by acknowledging how there are a wide range of nationalities in Laundries, and addressing how to better support them in training, and provide more ease of accessibility.

Person ganolog
Person centred

Employment Services: Advancing workforce sustainability/transformation strategies, by providing more understanding of the roles of staff working in the community – As these influences directly how care is delivered in the community, this objective is centred around people, and how to support decision making between staff in how best to prioritise patient care and needs.

People and Organisational Development: Embed a new approach to employee relations whereby our people are at the centre of everything we do, aiming to reduce harm caused to staff, witnesses and investigators when dealing with employee investigations.

We hope that this report has been informative and has given an insight into our drive to continually demonstrate, assure, and improve quality in the services provided by NWSSP.

For any questions on the content of this review, please contact:

Shelley Jones
Business Manager to the Medical Director

02921 500500

shelley.jones2@wales.nhs.uk

www.nwssp.wales.nhs.uk

@nwssp

NHS Wales Shared Services Partnership

NHS Wales Shared Services Partnership,
4-5 Charnwood Court,
Hoel Billingsley,
Nantgarw,
CF15 7QZ

This document was designed by the NWSSP Communications Team.
nwssp.communications@wales.nhs.uk

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Estates Annual Report 2023-24

DATE OF MEETING	11/07/2024

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	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
PRESENTED BY	Jonathan Fear, Interim Assistant Director Estates Capital & Environment
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The attached report outlines the latest position regarding Estates service delivery for the period April 1st, 2023 - March 31st, 2024. The report covers the following areas: • Statutory Compliance • Utilities • Staffing • Capital • Strategy • Leases

	• Professional Support

RECOMMENDATION / ACTIONS	No actions required – this report is presented to the QSP for Approval in respect of the current & ongoing delivery of the Estates work programme across Velindre University NHS Trust.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Estates Monthly Group Meeting	14/06/2024
Executive Management Group – Run	25/06/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Feedback from WBS Director to add in some information under RAAC section in annual report regarding assurance works being undertaken on Donor sites where the blood collection teams visit.
This has been added to the 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	N/A

APPENDICES	
Appendix 1	Estates Annual Report 2023-24

1. SITUATION

The Estates Annual Report, attached as Appendix 1, sets out progress against the 2023/24 Estates objectives set out in the Trust Integration Medium Term Plan and strategy.

It is presented to the QSP for Approval.

2. BACKGROUND

Appendix 1 provides an update on the Estates delivery plan over the financial year of 2023-24.

3. ASSESSMENT

Good progress continues to be made against the wide range Estates objectives.

For full details please refer to the full report in Appendix 1.

4. SUMMARY OF MATTERS FOR CONSIDERATION

No immediate matters for consideration / action.

The report is presented to the Quality, Safety and performance Committee to provide assurance for the delivery of Estates services across the Trust.

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☒
	High performing Estates services are key to maintain the safe, effective and efficient delivery of all Trust clinical and operational services.

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
	A Resilient Wales A Globally Responsible Wales
	The Trust Well-being goals being impacted by the matters outlined in Annual Report
	A Globally Responsible Wales
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
	This paper provides and update last year's progress in terms of the delivery of the Trust Estates programme and associated objectives - themes. There are no aspects of the update that change or introduce changes that impact upon equality.
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?	All Estates risks are actively managed and recorded in DATIX.
WHAT IS THE CURRENT RISK SCORE	n/a

HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	n/a
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	n/a
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	n/a
All risks must be evidenced and consistent with those recorded in Datix	

ESTATES ANNUAL REPORT

2023-24

Ymddiriedolaeth GIG
Prifysgol Felindre

Velindre University
NHS Trust

Jonathan.Fear@wales.nhs.uk

TABLE OF CONTENTS

INTRODUCTION

An exciting Year for VUNHST Estates Department

Within the last year the Estates Department has successfully completed a number objectives , in line with the strategic direction of the Trust.

These are focused on several key areas:

Compliance

Statutory Compliance: The department has addressed critical areas of compliance, ensuring that all facilities meet the latest regulatory standards in-line with WHTM requirements and undergo regular audits with NWSSP-SES (Specialist Estates Services).

Development of New Velindre Cancer Centre (nVCC) a Talbot Green Infrastructure (TGI)

nVCC Development: Significant contributions have been made towards the strategic direction of the estate. This state-of-the-art facility is designed to provide cutting-edge cancer care and support, reflecting the Trust's commitment to improving patient outcomes and experiences.

TGI Project: The Talbot Green Infrastructure project has made steady progress; the future plans aim to enhance the operational capabilities and infrastructure within the Talbot Green premises.

Energy Management

Decarbonisation Targets: In alignment with Welsh Government decarbonisation targets, the Estates Department has implemented advanced energy management strategies. Including upgrading to more energy-efficient systems, incorporating supplier renewable energy sources and optimising energy usage across all facilities.

Structural Safety Assessments

Safety Evaluations: Rigorous structural safety assessments relating to RAAC have been conducted to ensure the integrity and safety of the Trust's buildings. These evaluations help identify and mitigate potential risks, providing a secure environment for all occupants.

Recruitment and Appointments

The department has successfully recruited into key positions, focusing on compliance and essential roles for the continued growth and development of the Trust. These appointments bring in new expertise and leadership, driving forward the Trust's strategy.
The targeted recruitment efforts have strengthened the department, ensuring that all areas are well-supported by skilled and dedicated professionals.

Targeted Capital Investments

Targeted investments have been made to support services across the Trust.
These investments have taken place in the following areas:

- First Floor Ward Ventilation
- Pharmacy (dispensary capacity)
- Linac 3 Upgrade
- VCC canteen facility (environmental improvements)
- Outpatients department (additional clinic space)
- Radiotherapy (reception desk)

Our Vision :
Excellent Care,
Inspirational Learning,
Healthier People

STRATEGY

Our purpose :
To Improve Lives

Destination 2033

The Trust has published a long term strategy to support the delivery of destination 2033 - achieving excellence.

As part of the strategy, we have formulated four themes to guide our efforts in delivering the best possible estate.

Theme 1:
A safe and high-quality estate which provides a great experience

Theme 2:
Healthy buildings and healthier people

Theme 3:
Minimising our impact

Theme 4:
Using our estate to deliver the maximum benefit and social value to the community

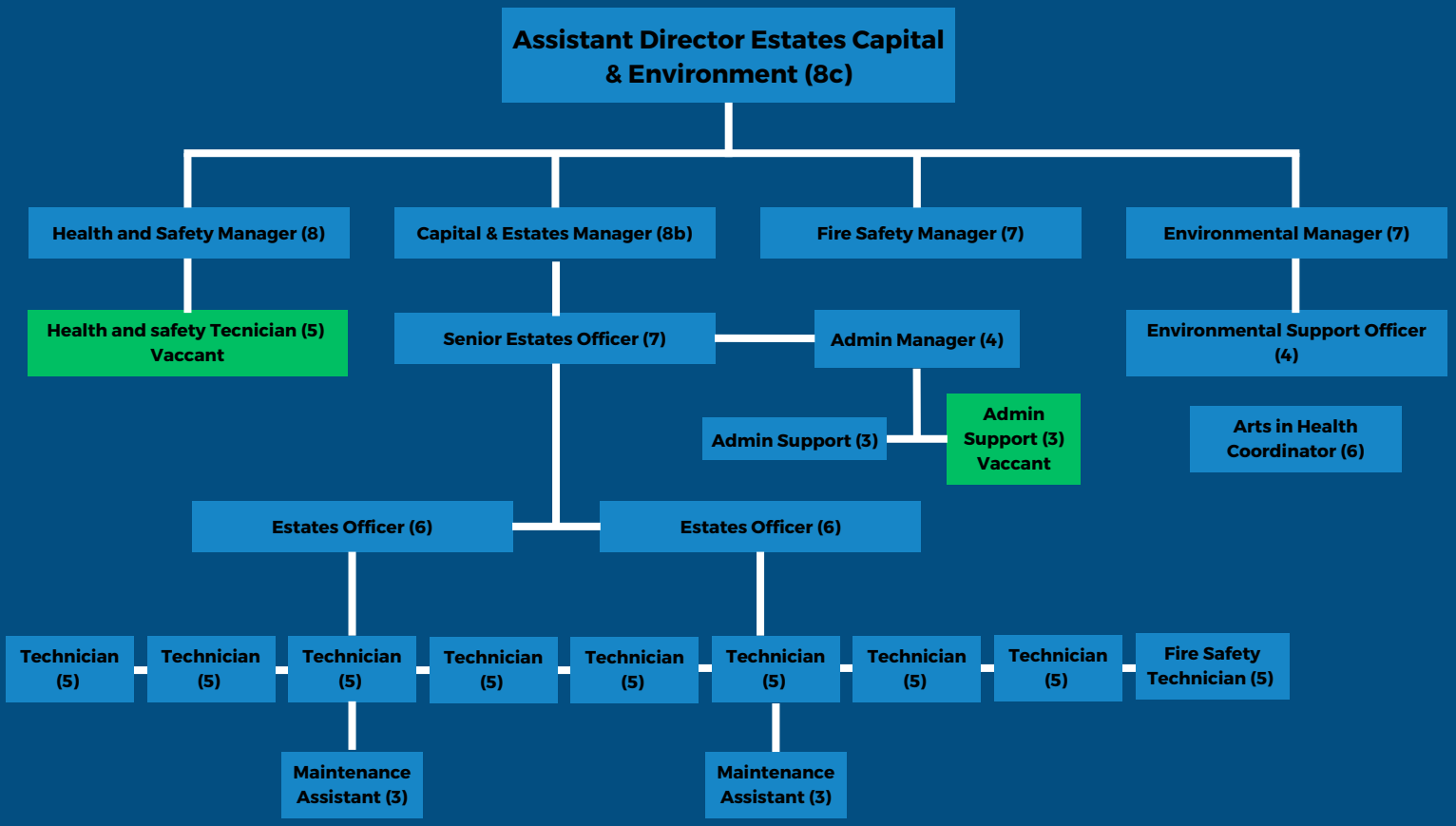
Our objectives are to:

- Enable High-Quality Clinical Services: Provide an estate that enables the delivery of high-quality clinical services.
- Ensure Safety and Quality: Maintain a safe and high-quality estate that provides patients, donors, staff, and partners a high quality experience.
- Support Well-Being: Provide healthy buildings that support and enhance individual well-being.
- Minimise Environmental Impact: Minimise the impact of our estate on the environment.
- Maximise Social Value: Maximise the benefit and social value our estate can provide to our staff, patients, donors, and the communities we serve.

We will achieve these by:

- Engaging with Teams: Ensuring that the Estate provides the required facilities by engaging with teams in all areas of the Trust.
- Investing in the Estate: Addressing backlog maintenance and maintaining category B status through continued investment.
- Implementing Strategies: Executing estates, digital, and sustainability strategies to enhance our operations.
- Promoting Alternative Travel: Providing accessible alternative methods of travel, including walking, cycling, public transport and electric vehicles.
- Optimising Space Utilisation: Identifying facilities through space utilisation studies and sharing spaces with other public bodies.
- Delivering Major Capital Programs: Implementing major capital programs with sustainability at the heart of the design.
- Community Engagement: Working with the community and partners to open up our buildings, facilities, and land for community benefits.
- Refurbishing the Welsh Blood Service Building: Completing the refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025.
- Opening the New Velindre Cancer Centre: Launching the new Velindre Cancer Centre by 2025.
- Expanding SACT Facilities: Providing additional Systemic Anti-Cancer Therapy (SACT) outreach facilities by 2024-25.
- Opening the Satellite Radiotherapy Centre: Opening the Satellite Radiotherapy Centre (SRU) early in 2025.

STAFFING ARRANGEMENTS



A key focus during 2023-24 has been the recruitment and retention of staff, Despite some challenges, we have continued to advertise and recruit for key positions in Estates, Environment and Health and Safety.
We have also added two new positions to the team: Environmental Support Officer and Arts in Health Coordinator.

The staffing strategy has continued to support the future service provision for the new Velindre Cancer Centre (nVCC) and Welsh Blood Service Blood Service (WBS).

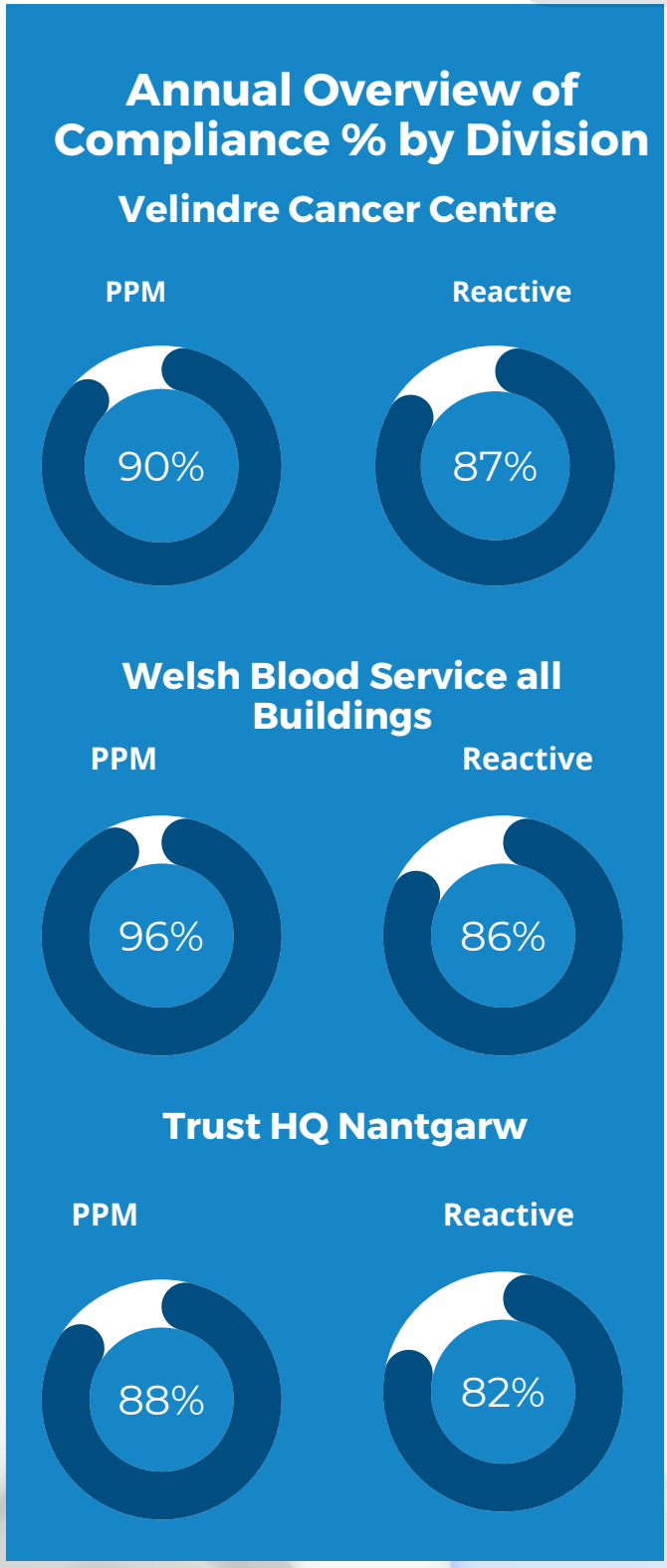
TRUST ESTATES POLICIES

During 2023-24, all Trust Policies listed below have been reviewed and updated. Each policy has also undertaken equality impact assessments against the nine protected characteristics to ensure they do not discriminate against individuals applying to work in or are currently employed by the Trust. All Trust Policies are accessible via the VUNHST website.

- The Asbestos Policy
- Business Continuity Management Policy
- Control of Contractors
- Environmental Policy
- Fire Safety Policy
- Fire Prevention Arson Prevention Protocol
- Medical Gas Piped systems Policy
- Protocol for Dealing with Suspect Packages and Bomb Threats
- Security Policy (currently being reviewed)
- Waste Management Policy
- Water Safety Policy
- Health and Safety Policy
- High Voltage Contractor as AP
- Operational Policy for High Voltage
- Low Voltage Electrical
- Ventilation

Compliance 2023-24

At VUNHST, we are dedicated to providing a compliant estate that ensures a safe, high-quality environment for our staff, patients and donors. Our key objectives are centred on maintaining and continuously improving compliance.



Commitment to Improvement

The Estates department remains committed to working towards meeting the 95% benchmark in 2024-25.

Strategies will be implemented to enhance performance, including addressing staffing issues, optimising preventive maintenance schedules and improving operational efficiency align to new CAFM System

ses.info@wales.nhs.uk

Specialist Estates Services Audits

WHTM 01-01 Decontamination Limited Assurance
The Trust continues outsourcing this facility through a Service Level Agreement (SLA) with CTMUHB. However, an action plan has been developed to improve areas of assurance in Decontamination.

WHTM 03-01
Reasonable Assurance
The Trust has maintained reasonable assurance with governance in place and suitably trained Authorised Persons (APs) and Competent Persons (CPs) to work on the system. Additionally, the Trust has supported areas of compliance by conducting annual verifications on critical plant across Velindre Cancer Centre (VCC) and the Welsh Blood Service (WBS).

WHTM 05-01 Fire
Assurance and Compliance:
Limited Assurance:
- Non-conformities related to fire compartmentation have been addressed across both divisions.
- The Trust has implemented additional planned preventive maintenance (PPM) requirements.
- Fire safety technicians have been successfully trained to BMTRADA standards.
- Introduced permits, such as permits to drill, to ensure that compartmentation is not jeopardised.

The Trust has developed an action plan to address in 2024.

WHTM 06-02 Electrical Low Voltage
Limited Assurance
The Trust received Limited Assurance in March 2023, indicating improvements compared to previous years' audits. Following this assessment, the Trust gathered audit actions and developed an action plan. Currently, the Trust is on target to complete all actions in 2024.

WHTM 02-01 Medical Gas
Assurance and Compliance:
Reasonable Assurance:
- The Trust has continued to maintain reasonable assurance for its medical gas systems.
- Governance structures are in place, and suitably trained Authorised Persons (APs) and Competent Persons (CPs) are available to work on the system.

The Trust's governance and training efforts ensure the ongoing safe management of medical gas systems.

WHTM 04-01 Safe Water in Healthcare
Assurance and Compliance:
Substantial Assurance:
- The Trust has received substantial assurance for maintaining water services to a very high standard.
- The Trust remains committed to monitoring compliance and sustaining this level of assurance.

The Trust's consistent high standards in water services reflect their ongoing commitment to safety and quality in healthcare.

WHTM 06-03 High Voltage Systems
Assurance and Compliance:
Reasonable Assurance:
- The Trust has maintained reasonable assurance for its high voltage systems.
- Recently reviewed the High Voltage (HV) contractor appointment.
- The contractor will be appointed as a High Voltage Authorised Person (HV AP).
- Conducted formal training for staff to manage access to HV substations.

These steps ensure that the Trust's high voltage systems are managed safely and effectively.

ESTATES TRAINING 2023-24

The Trust invested £33,248.00 in training during 2023-24.
Estates staff successfully completed Authorised Person (AP) and Competent Person (CP) training courses at the Eastwood Park training facility, tailored for healthcare engineering systems. Following this, the Trust implemented a nomination process for staff to be externally assessed by NWSSP-SES (NHS Wales Shared Services Partnership - Specialist Estates Services) and appointed through a thorough technical assessment.

Authorised Training (AP's)

Medical Gas AP	Water Safety AP
Low Voltage AP	Ventilation AP

Competent Persons (CP's)

Medical Gas	Water Safety
Low Voltage	Ventilation

Other Training Course's attended by Estates Staff

- Ladder Safety
- Asbestos Awareness
- Confined Spaces
- Legionella Awareness
- IOSH Managing Safely
- First Aid Training
- CAFM System Training
- Fire Control Systems Training
- Fire Safety for Managers

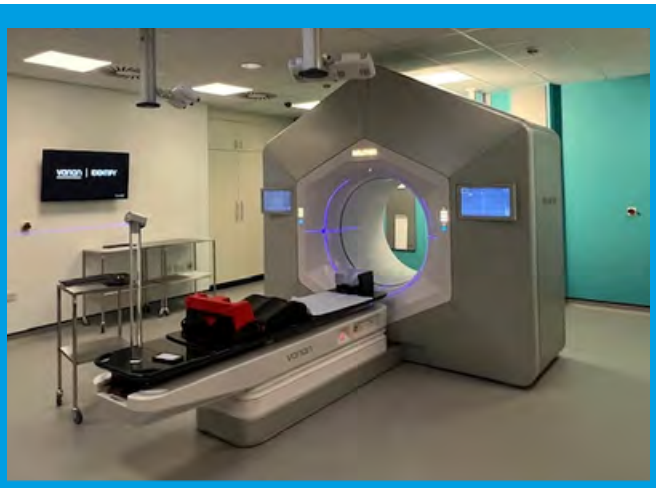
Capital Works Programme 2023-24

The Trust's annual capital programme has been an integral part of our strategy to provide a safe, high-quality and fit-for-purpose estate for our staff, patients and donors. Providing investment in the necessary infrastructure and facilities to ensure the delivery of excellent healthcare services.

Velindre Inpatients Facility Ventialtion Works

The First Floor Inpatient facility recently upgraded its ventilation system by installing a steel structure on the main inpatients roof to house two Air Handling Units. This upgrade ensures that staff and patients have a high quality environment throughout the year. The capital scheme was completed within a period of 16 weeks, adhering to both budget and program.

Linac 6 Varian Halcyon Upgrade



In 2023 -2024 The Linear accelerator at the Velindre Radiotherapy suite reached its operational term. This was replaced with a Varian Halcyon Linac. The upgrade not only continues to deliver safe, efficient and effective radiotherapy services to the population of Southeast Wales, but supports the move to nVCC, to relocate the new Linac in a transfer program and conforms with our decarbonisation strategy, achieving a 40% reduction in operational energy usage compared to the previous Linac. As part of these works, we fully refurbished the bunker, control bay and associated plant and equipment.

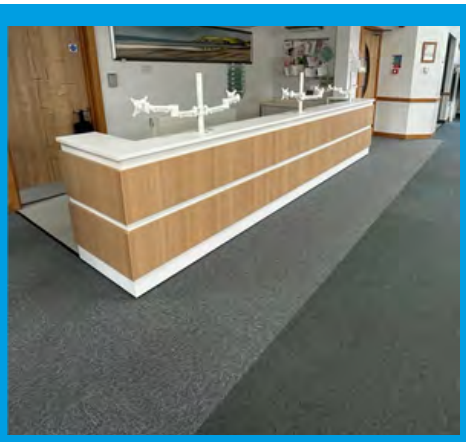
Asbestos Removal - Water Infrastructure Works

The Velindre Cancer Centre Chemotherapy Inpatients Unit recently refurbished a critical part of its infrastructure, replacing assets that were beyond economical repair. The unit housing the boiler plant had known asbestos contamination, which had been safely contained over several years. During this upgrade, asbestos-containing material was safely removed through a licensable task completed over a three-week program. A temporary boiler was provided during the works. The hot water boilers were replaced with more efficient options and the heating systems were integrated into the main hospital site. This new system is now more efficient and resilient, ensuring the safe delivery of hot water services for staff, patients and donors at VCC.

Capital Works Program 2023-24

Operational Improvements VCC

Estates Staff & supporting contractors successfully replaced the Radiotherapy reception desk over a bank holiday weekend to increase staff numbers that serve patients in the RT department. This caused minimal disruption and provides an overall better patient experience when attending for scheduled treatments.



Pharmacy Aseptic Dispensary Works

The Pharmacy aseptic services recently had an annual audit in line with the DGM(97)5 guidance on quality and Good Manufacturing Practice (GMP). During the latest audit, several high-risk deficiencies were identified, including issues with the facilities, particularly the final release room. This room is crucial for final checks on products prepared in the aseptic unit as well as outsourced products.
To address these recommendations, the room was repurposed from an existing office to accommodate dispensary equipment and comfort cooling. This scheme was executed amidst busy day-to-day activities in the Pharmacy department, adhering to both budget and schedule constraints.

Trust Estates Discretionary Capital

The estates team has been allocated a discretionary budget of £75,000 throughout the financial year. This funding has been allocated to several schemes listed below.:

- Building Management System Upgrades to support our decarbonisation strategy.
- Installation of new Low Voltage Switch room doors to enhance security in critical spaces.
- Replacement of operating lighting in the Theatre Suite.
- Flooring repairs throughout the site to maintain safety and aesthetics.
- Replacement of essential Cold Water Boosting Pumps to ensure reliable water supply.
- Procurement of critical asset spares to ensure business continuity in case of emergency failures.
- Installation of air purifying systems to promote clean air environments for staff, patients, and donors.
- These investments contribute to the overall safety, efficiency, and quality of the estate, ultimately benefiting staff, patients and donors.

Leases Land and Acquisition

The Department is responsible for developing, maintaining, and accessing the Trust's Property Management Portfolio database, known as e-PIMS (Electronic Property Information Mapping Service). This database includes all premises under the Trust's control and records key dates and actions necessary for the operational management requirements of the Trust.

With the assistance of NWSSP (NHS Wales Shared Services Partnership), the Trust ensures that all necessary leases and agreements for its properties are completed and approved by a Trust Board Member. The list of properties owned or hosted by the Trust has been updated throughout 2023-24.

Dafen WBS
Situated in Llanelli this is the primary base for our collection teams in West Wales the building occupies a footprint of 356m2 and houses all consumables required to support collections. This building is leased until 2025

Bangor WBS
This is the primary base for our collection teams in North Wales. The building occupies a footprint of 520m2 and houses all consumables required to support collections. This building is leased until 2024.

Wrexham (Pembroke House) WBS
Pembroke House occupies a floor area of 465m2 in size and is leased until 2025. The main purpose of this building is to act as a stock holding unit providing North Wales hospitals with blood products. It is also the main base of operations for the collections team in the North East region of Wales. We also provide services from various buildings across Wales which are owned by a range of partners to support our 'hub and spoke' model of service delivery. These include buildings within local communities and at local hospital sites.

Trust Headquarters HQ
The Trust headquarters building, located in Nantgarw, Cardiff, houses the executive and corporate function of the organisation. Lease has been extended until 2025.

Environmental Management

ISO14001:2015

Welsh Government sets a requirement for all NHS bodies to be accredited by the ISO14001:2015 standard; an Environmental Management System (EMS). The Trust has successfully obtained the ISO 14001:2015 standard for the last seven years for all sites.

In November 2023, the Trust underwent a surveillance audit facilitated by BM Trada. Each year, a different selection of sites are chosen to be reviewed. The following sites were under review -

- Velindre NHS Trust Headquarters (1 day)
- Velindre Cancer Centre (2 days)
- Welsh Blood Service, Talbot Green (1 days)
- Welsh Blood Service, Pembroke House & Bangor (1/2 day)

The Trust successfully obtained recertification and received zero non conformities. The External Auditor noted:

'The EMS showcased a dedication to environmental stewardship in service delivery, highlighted by measures to reduce environmental hazards and ongoing efforts to prevent pollution. This demonstrated compliance with the audit Standard's requirements and provided a robust framework to support the implementation and maintenance of the Management System.'

The ISO14001:2015 Management Group continues to to oversee all elements of the Environment Management System (EMS) across the Trust. The group consists of key divisional colleagues who input into the Trust EMS. The purpose of the group is to ensure sufficient and effective monitoring of the EMS. Members meet once a month and the agenda aligning with the Management Review timetable. All members are trained internal auditors, and undertook several internal audits over the previous year to ensure compliance and continued improvement of the standard. The following audits were undertaken:

- Velindre University NHS Trust Headquarters
- Velindre Cancer Centre - Operational Services
- Velindre Cancer Centre - Estates
- Welsh Blood Service, Talbot Green
- Welsh Blood Service, Unit 4 Llanelli Gate
- Trust-wide Legal Register

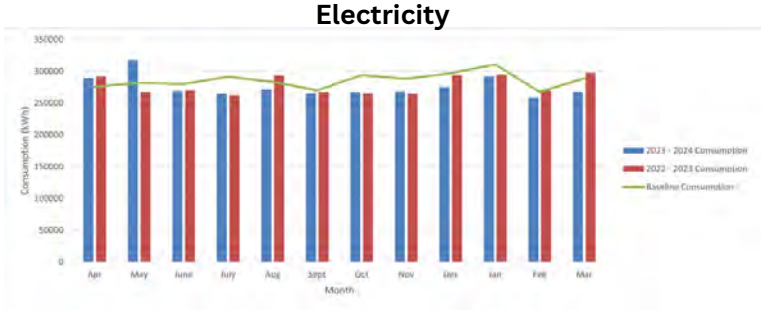
Energy Management

VUNHST (Velindre University NHS Trust) has a significant focus on energy management for 2023-24, driven by Welsh Government targets for decarbonisation and elevated utility costs. Effective energy management for VUNHST involves strategic planning, monitoring and optimisation of energy production and consumption to enhance efficiency, reduce costs and minimise environmental impact.

To further refine the strategic energy management plan for VUNHST, integrating the monitoring efforts of Team Sigma and the Estates department's regular Building Management Maintenance visits are essential. These initiatives will enhance the accuracy of utility billing and optimise building performance. Below outlines utility usage for Gas and Electricity by building.

Velindre Cancer Centre

Electricity

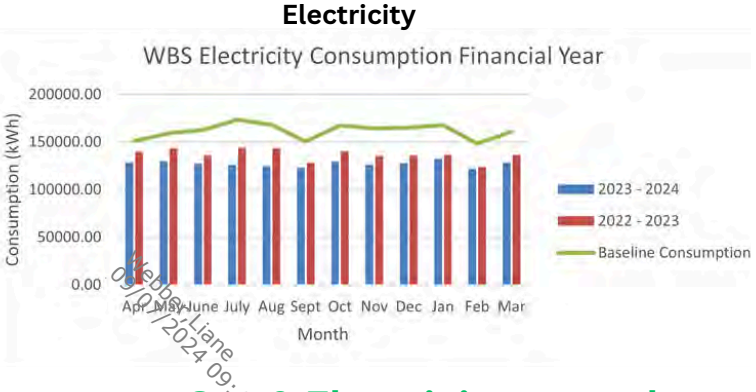


Gas

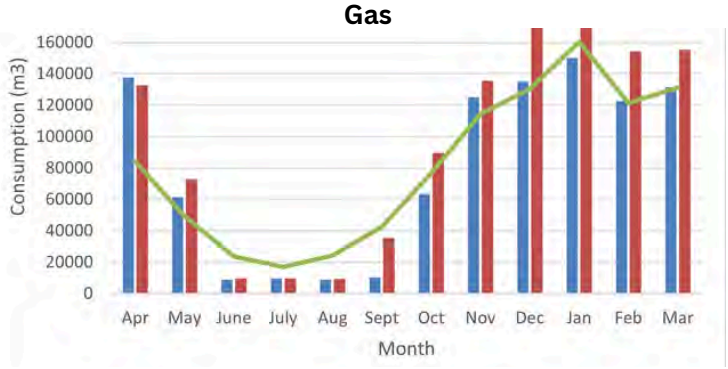
Gas & Electricity usage has reduced from the previous year

Welsh Blood Service All Buidings

Electricity



Gas



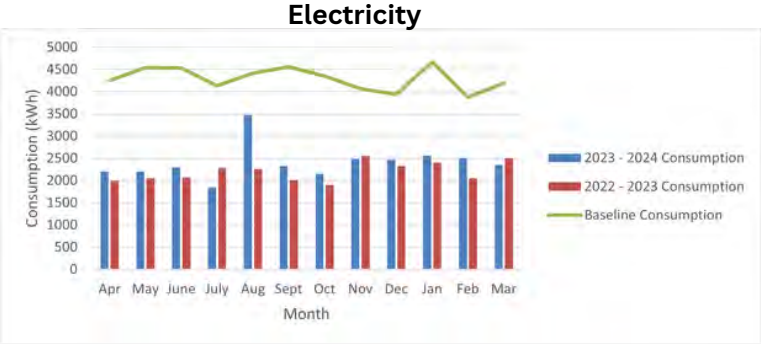
Gas & Electricity usage has reduced from the previous year

Energy Management

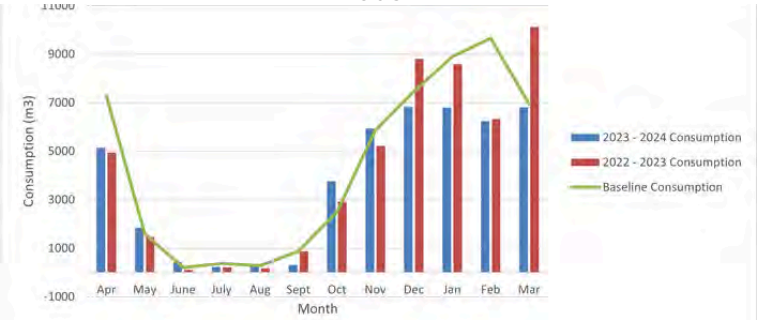
To improve monitoring and validation of consumption and billing from appointed energy companies, the Trust has recently appointed Team Sigma Energy to monitor the accuracy of billing.
Their role includes ensuring correct VAT and CCL charges have been applied to invoices and to ensuring consumption is verified - specifically for half hourly data processing.

Trust HQ Nantgarw

Electricity



Gas



Gas & Electricity usage has reduced from the previous year

Professional Support

Talbot Green Infrastructure Project: Estates Management Team Leadership and Progress
Project Overview

The Talbot Green Infrastructure Project represents a significant initiative aimed at enhancing the facilities and operational capabilities within the Talbot Green area. This project, led by a team of professionals in collaboration with the WBS Senior Management Team (SMT), focuses on delivering a comprehensive Estates Annex to support the Outline Business Case (OBC) & Full Business Case (FBC) combined.

The project's progression through 2023/24 has set the stage for a streamlined and efficient construction phase, ensuring all necessary infrastructure and laboratory requirements are met.
Leadership and Collaboration

Satellite Radiotherapy Unit (SRU) at Nevill Hall

The Satellite Radiotherapy Unit (SRU) at Nevill Hall, set to open by Spring 2025, represents a significant advancement in cancer treatment for the residents of Gwent and those living in the northern and eastern catchment areas of Velindre Cancer Centre. This strategic investment aims to bring radiotherapy services closer to patients homes, providing numerous benefits in terms of accessibility, treatment quality and service efficiency.

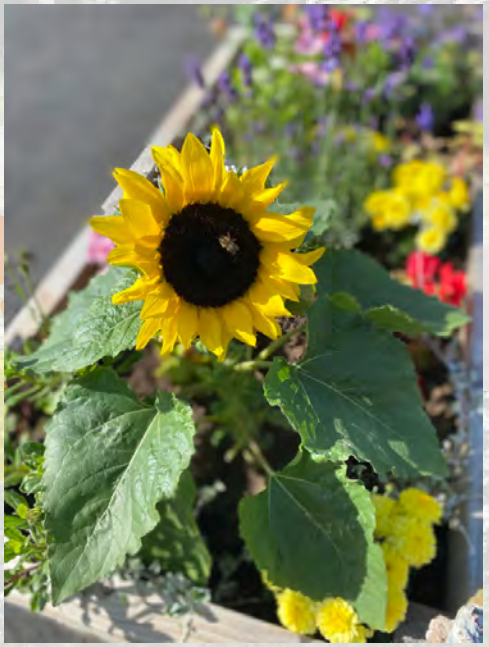
new Velindre Cancer Centre (nVCC)

The VUNHST Estates team has been pivotal in the development and design of the New Velindre Cancer Centre (nVCC) throughout the 2023-24 period. Their contributions have included facilitating safety group meetings, participating in design meetings and conducting drawing assessments to ensure the final design meets all necessary requirements. Additionally, they have identified unique maintenance needs across various mechanical and electrical disciplines.

Ray of Light Cancer Support

Ray of Light Cancer Support extends its heartfelt gratitude to Velindre University Trust Estates for their unwavering support and collaboration over the past 2023-24.

Support from Jonathan Fear: Jonathan Fear, interim Assistant Director Estates at Velindre, approached us with an offer to provide a hub complete with heating, lighting and shelter. This initiative enabled us to continue running our groups throughout the winter months, allowing our green social prescribing group to flourish. The hub has become a sanctuary for those affected by cancer, offering a place to take brief respite, engage in meaningful activities, and find solace in nature.



Green Social Prescribing Success:

Our green social prescribing scheme has gained recognition and earned a national award nomination under the Velindre University NHS Trust. This scheme encourages physical activity, relaxation, and mindfulness through nature-based activities, significantly impacting the well-being of our beneficiaries.

Reinforced Autoclaved Aerated Concrete (RAAC)

Background

Reinforced Autoclaved Aerated Concrete (RAAC) planks were widely used in the UK construction industry between the 1960s and 1980s. These materials served various structural purposes, including forming floor planks, roof planks, and wall panels. However, in May 2019, the Standing Committee on Structural Safety, an independent UK body, raised significant concerns about the structural safety of properties incorporating RAAC components. This alert underscored the potential risks associated with the aging and degradation of these materials over time.

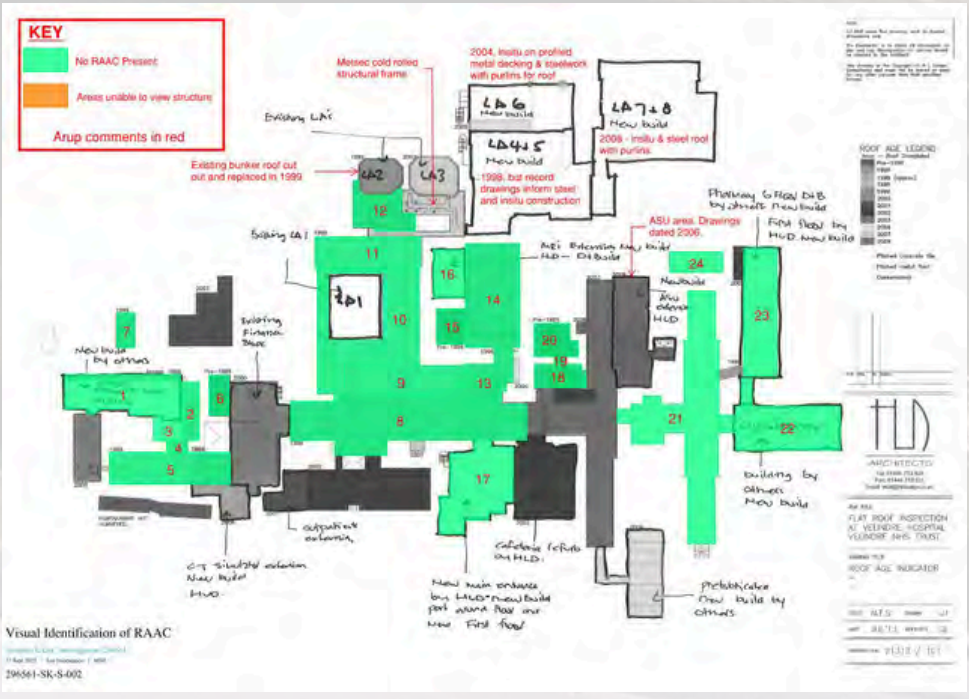
NHS Wales' Response

In response to the 2019 alert, NHS Wales Shared Services Partnership (NWSSP) has proactively engaged with NHS Wales to address the management and associated risks of RAAC in its buildings. NWSSP, which is responsible for maximising resources through the commissioning and procurement of work for the NHS on a once-for-Wales basis, has taken several critical steps to ensure the safety and integrity of NHS facilities.

From the visual inspections undertaken, it was reported that no RAAC (Reinforced Autoclaved Aerated Concrete) was present in any of the buildings inspected throughout VUNHST.

WBS is currently collaborating with property landlords to ensure that donor sites are not at risk due to the presence of Reinforced Autoclaved Aerated Concrete (RAAC) in the premises. This effort is being undertaken in conjunction with NHS Wales Shared Services Partnership (NWSSP).

Number	Name	Potential for RAAC identified in desk study	Arup Site Visit undertaken	Conclusion / Remarks	Remarks
1	WBS HQ Talbot Green	NO	YES	No RAAC	
2	WBS Wrexham, "Pembroke House"	NO	NO	No RAAC	Building construction 2008
3	WBS Bangor	NO	NO	No RAAC	Client photos and description confirm modern steel frame with lightweight metal deck roof.
4	WBS Dafen	NO	YES	No RAAC	Modern steel frame with lightweight metal deck roof.
5	Velindre NHS Trust, Nantgarw	NO	YES	No RAAC	Building construction 2001/2002. Timber trusses on steel beams.



Conclusion

Looking Ahead: Key Focus Areas for the Estates Department at VUNHST in 2024-25

After an exciting year within the Estates Department at Velindre University NHS Trust (VUNHST), it is now time to look ahead and focus on the key priorities for 2024-25. The upcoming year will centre around the implementation of strategic initiatives and the continuous development of infrastructure projects while maintaining a strong emphasis on sustainability, compliance and workforce development.

Key Focus Areas for 2024-25
Implementation of the Estates Strategy:

- Addressing Backlog Maintenance: A primary focus will be on addressing backlog maintenance to maintain Category B status. This will involve strategic capital investment throughout the financial year to ensure all facilities are up to standard and well-maintained.
- Capital Investment and Decarbonisation: Capital funding considerations will align with the Trust's decarbonisation and sustainability strategies, ensuring that all investments support sustainability goals and reduce the environmental impact of the Trust's operations.

Development of Major Infrastructure Projects:

- New Velindre Cancer Centre (nVCC): Continued development of the nVCC will be a key priority with ongoing engagement and structured conversations through the appropriate governance safety groups to ensure progress and safety.
- Talbot Green Infrastructure (TGI): Further development of the TGI project will be pursued, enhancing operational capabilities and infrastructure within the Talbot Green site.
- Satellite Radiotherapy Unit (SRU): The development of the SRU will be another focus, expanding access to critical radiotherapy services.

Recruitment, Retention, and Staff Development:

- Enhancing Workforce: The Trust will continue to focus on the recruitment and retention of staff, ensuring a robust and skilled workforce within the Estates Department.
- Training and Development: Further training and development initiatives will be implemented to enhance the skill sets of the estates team. This will ensure compliance in all engineering disciplines and help obtain higher assurance levels with NWSSP-SES.

Compliance and Assurance:

- Engineering Compliance: Ensuring compliance across all engineering disciplines will remain a priority, with a focus on obtaining further assurance levels through rigorous standards and maintaining above a bench mark of 95% compliance.
- Engagement with NWSSP-SES: Ongoing collaboration with the NHS Wales Shared Services Partnership - Specialist Estates Services (NWSSP-SES) will help maintain and improve compliance and assurance levels.

Stakeholder Engagement and Digital Strategies:

- Digital Strategies: Continued engagement with stakeholders leading digital strategies will be crucial. This includes integrating digital solutions to enhance operational efficiency and support the Trust's broader strategic goals.
- Divisional Drivers: Collaboration with other divisions within the Trust will ensure that the Estates Department's initiatives are aligned with organisational drivers and objectives, fostering a cohesive approach to healthcare service delivery.

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Business Continuity & Emergency Preparedness Annual Report

DATE OF MEETING	09/07/2024
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	Andrew Mapstone, Business Continuity Lead
PRESENTED BY	Alan Prosser, Director of Welsh Blood Service
APPROVED BY	Steve Ham, Chief Executive
EXECUTIVE SUMMARY	This report intends to provide updates on the key activities during 2023 to 2024 and the ongoing work leading into 2025 in the Business Continuity & Emergency Preparedness remit. In summary; • The Business Continuity Lead and Head of Operations continue to work closely to progress the VUNHST BC & EP work programme and share good practice

	• The divisions are sharing learning from 2023 HSE inspection at WBS to progress work within the Velindre Cancer Centre • The VUNHST, primarily Velindre Cancer Centre planned for and responded to the various industrial action periods effectively • The Welsh Blood Services Major Incident response to the Treforest explosion and fire. • The exercise, test and training activities completed and those prioritised for the remainder of the year. • The ongoing collaboration with partners to proactively exercise business continuity and emergency plans

RECOMMENDATION / ACTIONS	None – report is for information.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
VUNHST Business Continuity & Emergency Preparedness Group	21/06/2024
Executive Management Board	25/06/2024
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS **The VUNHST BC & EP group received the paper and approved its content to be submitted to QSP.**	

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**

	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	Business Continuity & Emergency Preparedness Report

1. SITUATION

The VUNHST Business Continuity & Emergency Preparedness group continues to meet every two months to coordinate and seek assurance on progress of the VUNHST BC & EP programme.

The Trust now receives an annual report into Executive Management Board and Quality Safety and Performance group to provide updates on key activities with the business continuity and emergency preparedness remit.

2. BACKGROUND

The Velindre UNHS Trust has duties under the civil contingencies act to engage and implement effective business continuity and emergency preparedness arrangements. The Velindre UNHS Trust has a documented programme, approved by the Executive Management Board identifying various activities for completion with the business continuity and emergency preparedness remit. Following approval of this programme, a requirement to provide annual reports into Executive Management Board and Quality Safety & Performance group was agreed.

3. ASSESSMENT

There are no proposed actions within this report, this report is an annual report for information only, providing a summary of key activities completed and ongoing within the business continuity & emergency preparedness remit.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Executive Management Board are to acknowledge the annual report to be received at Quality Safety & Performance group.

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*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
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.aspx*	Not required - please outline why this is not required
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Click or tap here to enter text
	Legal duties under the Civil Contingencies Act 2004.

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
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?	No
	[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	

Business Continuity & Emergency Preparedness

Annual Report for 2024

Gwasanaeth Gwaed Cymru
Welsh Blood Service

GIG Cymru NHS Wales
Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Canolfan Ganser Felindre
Velindre Cancer Centre

The Velindre UNHS Trust continues to make progress by;

- completing activities identified on the Trust BC & EP Programme to further enhance the Trusts preparedness, resilience and response
- achieving a reasonable assurance rating from the Business Continuity Audit conducted by NWSSP Audit Assurance Services
- planning for, and responding effectively to disruptive incidents
- identifying learning from incidents, exercises and inspections and sharing good practice across the operational divisions (Welsh Blood Service and Velindre Cancer Centre).

Sharing learning and improving across the Trust

The Welsh Blood Service established a task and finish group which included various remits across the Trust to progress findings relating to emergency procedures from a Health & Safety Executive (HSE) inspection. The group received compliments from the HSE inspector following prompt completion of identified actions.

A working group has been established within the Velindre Cancer Centre (VCC), which includes a WBS rep and other relevant remits to share the learning from this inspection, identify any gaps and enhance the emergency procedures within the Velindre Cancer Centre.

The Trust responds to real incidents

Industrial Action
The Velindre Cancer Centre (VCC) activated planning and response teams to effectively plan for and respond to various periods of BMA industrial action. These teams assessed the impact on services, identified alternative working arrangements and shared information to staff and patients throughout each period of BMA industrial action to ensure services to patients continued.

Major Incident Response
On the 13th December 2023, at approximately 19:30 the Welsh Blood Service (WBS) responded to a declared Major Incident due to an explosion and large fire. The WBS Major Incident declarations are tested frequently to prepare for real incidents and within less than 30 minutes a trained 24/7 on call responder was at WBS site, communicating with potential receiving hospitals and readily available to provide urgent blood to any affected patients.

Business Continuity & Emergency Preparedness

Annual Report for 2024

Gwasanaeth Gwaed Cymru
Welsh Blood Service

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Canolfan Ganser Felindre
Velindre Cancer Centre

Improvements identified from other incidents;

- Enhance security arrangements by updating site security plans to current guidance
- Improve staff awareness of security arrangements during incidents
- Include security incidents and procedures into Exercise, Test and Training Programme including lockdown
- Review and test alternative communication methods for contingency phones to increase resilience

Improving the Trust's preparedness, resilience and response through proactive exercise, test and training

The operational divisions (Welsh Blood Service and Velindre Cancer Centre) continue to participate in scenario-based exercises, and test and train to their business continuity and emergency plans.

What has been done?

- Various senior leads and identified deputies have completed Tactical Emergency Management training, responding to various scenario-based incidents
- A live emergency blood exercise has been run with our Emergency Medical Retrieval Transfer Service (EMRTS) / Welsh Air Ambulance (WAA) partners
- The Trust participated in a national Mass Casualty Exercise involving all of NHS Wales
- The Business Continuity Leads across UK Blood Services have held a workshop to develop a national exercise to run later this year involving all UK Blood Services

Next steps?

The Trust by its operational divisions (Welsh Blood Service and Velindre Cancer Centre) continues to;

- identify priority risks and threats by reviewing national risk registers and horizon scanning to form the Trusts exercise, test and training programme
- engage with partners including the NHS Wales transfusion colleagues to collaborate on developing a future Major Incident exercise
- increase its cyber resilience with aims to run various cyber exercise and tests later this year
- Test and exercise site lockdown

QUALITY, SAFETY & PERFORMANCE COMMITTEE

2023/24 PROFESSIONAL REGULATION / REVALIDATION ANNUAL REPORT

DATE OF MEETING	11th July 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	N/A
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Anna Harries, Head of Nursing Professional Standards and Digital, Bethan Tranter, Chief Pharmacist and Elizabeth Eddie, Executive Medical Business Manager
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Science and Dr Jacinta Abraham, Executive Medical Director
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs & Health Sciences and Dr Jacinta Abraham, Executive Medical Director

EXECUTIVE SUMMARY	This Professional Registration/Revalidation Report covers the period 1st April 2023-31st March 2024 and is to provide assurance in relation to professional regulation governance. During this period: • There were no Health Care Professionals Council, General Pharmaceutical Council or General Pharmaceutical Council registration lapses. • There was one Nursing & Midwifery Council Registration lapse of one day, the staff member was not on duty during this period and did not work whilst not registered. • 81 medical appraisals were undertaken, 19 recommendations to revalidate and 2 recommendations to defer.

	• The Trust Revalidation and Registration Policy expired October 2022, and requires updating. This was identified as an action within the 2022/23 annual report.

RECOMMENDATION / ACTIONS	To **ENDORSE** the 2023/24 position in respect of professional registration/revalidation compliance across all professional groups within Velindre University NHS Trust prior to onward Trust Board approval.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum	28/04/2024
Executive Management Board	25/06/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSION Report Noted.	

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

1. BACKGROUND

All healthcare professionals are required to re-register, and some revalidate. There is variation across the professional groups that is detailed below:

1.1 Nursing & Midwifery Council (NMC)

Every qualified nurse on the NMC Professional register is required to complete a process of re-registering yearly and revalidation three yearly. If a registrant does not re-register or revalidate when due their registration will lapse. If registration lapses a registrant cannot practice and they will need to apply to the NMC to be re-registered – this can take up to 6 weeks.

There is a legal requirement for any individual using the protected title of registered nurse or registered midwife in the UK to revalidate every three years. Nurses must evidence that they have met the following requirements in order to revalidate:

- 450 practice hours

- 35 hours of continuing professional development (20 of which must be participatory)
- Five pieces of practice-related feedback
- Five written reflective accounts detailing learning, resultant changes or improvements to practice, and relevance to the Code
- A reflective discussion with another NMC-registered nurse
- Declarations of health and character
- Evidence of appropriate indemnity arrangements.
- Confirmation of adherence with the revalidation process, usually by the employer.

1.2 Health & Care Professions Council (HCPC)

The HCPC regulate 15 professions. These professions have designated titles that are protected by law and professionals must be registered with the HCPC to use them. These are:

- Arts Therapists
- Biomedical Scientists
- Chiropodists / Podiatrists
- Clinical Scientists
- Dieticians
- Hearing Aid Dispensers
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Paramedics
- Physiotherapists
- Practitioner Psychologists
- Prosthetists / Orthotists
- Radiographers
- Speech and Language Therapists

HCPC Registrants need to re-register every two years. Each profession has a set month during the two-yearly cycle when registration is required to be completed by. Registrants will receive notification of renewal deadlines and needs to complete a professional declaration and pay a renewal fee no later than the deadline to avoid being removed from the register. If removed, they cannot practice. A random sample of 2.5 percent of the profession will be selected to submit a continuing professional development (CPD) profile for the renewal period.

There are no revalidation requirements.

1.3 General Medical Council (GMC)

Every doctor on the General Medical Council (GMC) register is required to revalidate, normally every five years. To maintain a license to practice a doctor must demonstrate that they work in line with the principles set out within the GMC's Good Medical Practice Guidance. Medical revalidation, through statutory duties will provide assurance that doctors in the UK are fit to practice.

A Responsible Officer or suitable person is required to make a recommendation to the GMC about whether a doctor connected to them should be revalidated. Following this, the GMC decides whether a doctor can be revalidated based on the recommendation and any other information that they hold. There are three types of revalidation recommendations that can be made:

- Recommendation to revalidate
- Recommendation to defer
- Recommendation of non-engagement

In order to make a recommendation which is consistent, fair and reliable the Responsible Officer requires evidence that a doctor is regularly appraised on their whole practice, ensuring the completeness and quality of supporting information and their reflections on it. Any areas for development in a doctor's practice should be identified and addressed in a targeted way, and concerns about a doctor's fitness to practice referred to the GMC where appropriate.

Connected doctors are required to have annual appraisals where there is evidence of:

- Scope of work
- Review of PDP
- CPD
- Review of complaints and compliments
- Review of Significant events
- Probity and Health declarations
- In every revalidation cycle the doctor additionally is required to provide evidence of Formal patient and colleague feedback.
- Information supporting a quality improvement.

1.4 General Pharmaceutical Council (GPhC)

To practise in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and have satisfied the council that they meet its requirements.

Pharmacist and pharmacy technician are protected titles and therefore there is a legal requirement that only registered and re-validated individual can use these titles.

Pharmacies must also be registered with the GPhC (or be a pharmacy department based in a hospital or health centre) to operate in Great Britain and to use the title 'pharmacy'.
Pharmacists, pharmacy technicians and registered pharmacies must renew their registration annually, which involves completing a declaration stating that they meet all professional, fitness to practise and ethical standards.

Annual re-validation for pharmacists and pharmacy technicians includes submission of:

- 4 x CPD records,
- a peer review discussion to ensure engagement with others on the individual's learning and practice and

- a reflective account to encourage consideration of how the individual meets professional pharmacy standards.

2. ASSESSMENT

2.1 Trust Registration / Revalidation Policy

The policy expired in October 2022. The need to update this was identified in the 2022/23 annual report and this remains outstanding.

2.2 Registration Assurance

There were no HCPC, GPhC, or GMC registration lapses or revalidation issues.

2.3 Registration Lapses

During the year 1st April 2023 – 31st March 2024 there was only one registration / revalidation breach. This was an NMC breach, an experienced SACT nurse who registration lapsed by one-day. The nurse promptly informed their manager while off duty and re-registered immediately. The standard operating procedure, the lapse was escalated to the Director of Nursing.

An initial assessment was conducted, during this process, it was discovered that although the nurse believed they had made payment following revalidation, they had not. The assessment also explored the possibility of the individual transitioning from a one-off payment to direct debit payments.

Registration process will be added to the monthly assurance audits for each area from June 2024.

2.4 GMC Appraisals

There are 93 prescribed connections for VUNSHT and 81 completed appraisals (87%). 12 doctors (13%) were exempt from appraisal due to having less that one year's service or extenuating circumstances. 19 Revalidation recommendations were due in the period 1 Apr 23 – 31 Mar 24. 17 positive recommendations were made and 2 deferral recommendations were made due to reasonable extenuating circumstances.

Welsh Revalidation and Appraisal Group reporting as at the 31.03.2023			
IMPORTANT: ONLY DOCTORS WITH WHOM THE DESIGNATED BODY HAS A PRESCRIBED CONNECTION SHOULD BE INCLUDED IN THIS SECTION. EACH DOCTOR SHOULD BE INCLUDED IN ONLY ONE CATEGORY	Number of prescribed connections	No of doctors exempt from appraisal	No of completed appraisals (summary agreed)
Consultants (including honorary contract holders)	68	2 (long-term leave)	66

Staff grade, associate specialist, specialty doctor (including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere)	9	3 (2 with less than one year in post, therefore appraisal not due, 1 extenuating circumstances)	6
Doctors with practising privileges (for independent healthcare providers only); all doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)	0	-	-
Temporary or short-term contract holders (including trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts)	15	7 (less than one year in post, therefore appraisal not due)	8
Other (Including some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc.)	1	0	1
Overall	**93**	**12** (12%)	**81** (87%)

The Responsible Officer is supported by the revalidation team which comprises of the Deputy Responsible Officer, the Executive Medical Business Manager, the Consultant Clinical Appraisal Lead, and the Revalidation and Appraisal Manager. Regular compliance meetings are held where forthcoming recommendations are discussed to allow sufficient time to make a recommendation ahead of revalidation dates.

In response to the recommendations made in the HEIW external quality assurance review visit, the Trust has adopted the All- Wales recommendation of a 0.5 session remuneration per 10 appraisals. An additional two appraisers have been trained, and the need for further recruitment remains under review. This will ensure the appraiser pool remains sustainable moving forward and the distribution of appraisals among the appraiser pool remains fair and equitable.

A benchmarking exercise across Wales Health Boards is planned for Summer 2024 to look at duties, job descriptions/person-specs, and recruitment and remuneration of lay representatives. Proposals for lay representative involvement in the revalidation process will then be submitted to the Medical Workforce Group and Executive Management Board for consideration.

The full Revalidation Progress Report is available from the Executive Medical Director if required.

3. SUMMARY OF MATTERS FOR CONSIDERATION

The Executive Management Board is asked to **NOTE** 2023/24 position in respect of Professional Registration / Revalidation compliance across all professional groups and the action that has been taken forward in respect of the lapse that had occurred.

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
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
	Professional registration is a legal requirement. Having appropriately registered clinical staff is critical for clinical safety.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	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	Yes - please Include further detail below, including funding stream
	Financial impact if staff unable to practice due to failure of this process and potential legal action. No direct financial implication from this paper

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
	All Registered staff to be considered in this process, including those on long term leave. The Trust policy would have included this Equality Impact Assessment.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	It is a legal requirement for registrants to have a live registration when practicing.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Staff must be registered to practice by legislation*
WHAT IS THE CURRENT RISK SCORE	8
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*One risk remains as the policy update is still awaited from last year's recommendation*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	24th August 2024
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

QUALITY & SAFETY COMMITTEE

People Strategy Annual Report

DATE OF MEETING	11th July 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Susan Thomas, Deputy Director of OD and Workforce
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
EXECUTIVE SPONSOR APPROVED	Sarah Morley, Executive Organisational Development & Workforce

REPORT PURPOSE	FOR NOTING

COMMITTEE/GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING		
COMMITTEE OR GROUP	**DATE**	**OUTCOME**
Executive Management Board	25th June	NOTED

ACRONYMS	

SITUATION/BACKGROUND

Our People Strategy describes how we will create the workforce we need to deliver our vision 'Healthy People, Great Care, Inspirational Learning'.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys. The strategy is grounded in our Values: Caring, Respectful and Accountable, which were agreed in 2024

The report attached provides the Executive Management Board with an update on the development in 22/23 of the Trust's People Strategy.

ASSESMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The report highlights the key workforce issues in delivering the People Strategy describing the risk in the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness. This has been compounded this year due to strike action and the need to deliver an infrastructure to support Industrial Action and wellbeing offer for staff during strikes.

However, over 23/24 a great deal of work has been ongoing to deliver a People Strategy Implementation plan that focuses on specific actions to improve our attraction and retention rates, focus on our staff's health and wellbeing and to plan for our future. In year due to the action we have taken (noted in the report in detail) we have reduced the sickness absence rate, reduced vacancy gaps and improved our turnover rates.

The report provides an update on the People Strategy key priorities including:

- Attraction and Retention
- Wellbeing
- Education and Learning
- Leadership and Succession
- Workforce Supply and Shape

Key outputs in these areas alongside work undertaken within the Welsh Language and Equality agenda are noted in the report. The report concludes with a summary of the governance and performance measures that are utilised to monitor outcomes.

IMPACT ASSESSMENT

QUALITY AND SAFETY IMPLICATIONS/IMPACT	Yes (Please see detail below)
	Impact on service delivery due to staff availability is noted in the TAF 03 and 04 risks with action plan in place to address the risk
RELATED HEALTHCARE STANDARD	Staff and Resources
EQUALITY IMPACT ASSESSMENT COMPLETED	Yes
	EQIA being undertaken in line with other enabling strategies
LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Finance implications in relation to workforce noted in separate performance reports

RECOMMENDATION

QSP is asked to NOTE the People Strategy Annual.

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

People Strategy

Being an Employer of Choice

Annual Report 2023/24

Our People Strategy: The Vision

Our People Strategy describes how we will create the workforce we need to deliver our vision ‘Healthy People, Great Care, Inspirational Learning’.

It sets out our strategic priorities and the approach we will take to deliver them. The strategy builds on our successes and is supported by feedback from staff surveys. The strategy is grounded in our Values: Caring, Respectful and Accountable, which were agreed in 2024.

Our Vision is to have a Skilled and Developed, Planned and Sustained and Healthy and Engaged People. The key priorities for this we have been working on are:

Workforce Priorities – Where are we now?

The workforce issues in delivering the People Strategy 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. This has been compounded this year due to strike action and the need to deliver an infrastructure to support Industrial Action and wellbeing offer for staff during strikes.

However, over 23/24 a great deal of work has been ongoing to deliver a People Strategy Implementation plan that focuses on specific actions to improve our attraction and retention rates, focus on our staff's health and wellbeing and to plan for our future. In year due to the action we have taken (noted below in more detail) we have reduced the sickness absence rate, reduced vacancy gaps and improved our turnover rates.

Focus on Priorities – Actions completed

More detail on the progress achieved in 23/24 is detailed below under our workforce priorities

Attraction and Retention

To recruit the right people in the right place at the right time with the right skills we have progressed focused activities on our recruitment plans to reduce our vacancies. Specific actions taken include:

- 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
    - Working with national colleagues streamlined our recruitment processes to improve time to hire rates

- Implemented our ‘pre-exit’ interview process to improve our retention rates and implemented Retention toolkit to understand our staff’s issues
- 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

Health and Wellbeing of our Staff

The Trust Health and Wellbeing Plan 22/23 has been delivered to support staff wellbeing and engagement whilst at work, successful actions taken include:

- The NHS Staff Survey ran in Wales in October 2023, the first time since 2020. This survey was more ambitious in its scope than previous surveys and covered more questions than ever before. There is a commitment for this to run annually so that we can establish a dataset showing movement in staff perceptions of the quality of life at work. We had a higher response rate than in 2020, rising from 25% to 34%, compared with a national response rate of 21%. The Trust also showed higher engagement with an Engagement Score of 76% compared with the NHS Wales score of 73%. However, both these scores had decreased since 2020, when the Trust scored 78% and NHS Wales 75%. The data from the survey is being used as a core reference point for all initiatives relating to staff wellbeing and engagement. It will also provide feedback to be used by Divisions and Departments in improving conditions at work.
- Our Employee Assistance Programme has been retendered and taken on by Vivup. This provides staff with wellbeing and counselling support 24/7
- Listening to our staff is key and the Trust have undertaken a range of engagement and listening exercises with staff. The Staff Survey results have been received and outputs and themes considered to ensure action plans are taken forward. We have appointed new Wellbeing Project Coordinator to support a focus on staff wellbeing actions. Working in partnership with our Trade Unions on this agenda is also key. We are in the process of appointing a Social Partnership Lead role to ensure management and TU decisions making is aligned.

- Our values have been reviewed and updated with a supporting behaviour framework currently in development. This was a thorough engagement exercise with input from staff, patients and donors throughout 2022 and 2023. The code of values that has been adopted as a result of this dialogue is that 'We are always Caring, Respectful and Accountable'. Listening to others during the development of the values ensured that we have a set of values that resonate with people whilst equipping us with the values base that will support the Trust in achieving its objectives.
- Being able to Speak Up Safely is key for a healthy and engaged workforce. A Task and Finish Group was convened to promote the importance of Speaking up Safety. A communications programme has been launched to inform staff of the process to speak up. An Independent Member has been appointed as a Champion to speaking up safely and regular board reports on issues within the Trust is reported via Committee structures.

Supply and Shape of our Workforce – Planning for the Future

To ensure we are delivering services for today and looking to our future workforce we have the following infrastructure within the Trust

- Implementation plan for the People Strategy 23/24 delivered with a 24/25 plan agreed
- 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
- 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

Skilled and Developed Workforce - Education and Training

The Education and Training Steering Group oversees the implementation of the Trust Education Strategy and Training plan. This year the following has been progressed:

- Encouraged widening access routes:
    - 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
- Staff awards ceremony in September 2023 to recognise staff achievement
- Education Strategy Audit undertaken and report received.
- Health Care Support Worker group established.

Skilled and Developed Workforce - Leadership and Succession

The Trust's Inspire Leadership and Management programme continues to go from strength to strength. *The Inspire Leadership Programme is an internal development programme for first line managers with a bespoke 'Just in time, just for you' offer for further development.* The Programme is in its 7th cohort and provides a educational baseline to develop management and leadership competences in the Trust based on our values.

Welsh Culture Plan

- The Cultural plan has been updated and runs alongside the ethos of the Welsh Government framework ‘More than Just Words…’ prioritising the need to communicate using any level of skill available. We have delivered on our training priority and ran two ‘raising confidence’ courses this year. We will review our training for staff in 2024/25 and continue to work in partnership with the Welsh Government funded organisation, Work Welsh to identify future training needs.
- Divisional Welsh Language groups continue to support the Trust proactively. This year Welsh Blood have continued to work on the promotion of the Active Offer and we have worked closely with them to ensure front line staff have received up to date training and awareness around this issue. Our focus at Velindre Cancer Centre has been in support of the bilingual telephony and communication needs of our patients and we will continue to prioritise this aspect in the coming year.
- Additional resources have been identified to achieve a high level of service in 2024 and into 2025. We have increased our funding for translation and our team continues to go from strength the strength. Our Service level agreement with NWSSP also improves and a shared memory software approach once again streamlines our services. We will continue to work proactively on translation to ensure our patients, donors and staff receive the best bilingual service we can provide.
- Recruitment continues to be a focus for us and now with all Job Descriptions and job adverts being translated. We have also developed a language assessment tool for new posts, encouraging an open dialogue around the skills needed for a role but also recognising the level needed to support the team and ultimately the patient or donor. This will be reviewed in 2024/5.
- We have and continue to work on our input into the Equality Impact assessment process. This again will be monitored for compliance requirements in this year and we will work closely with the Equality team to ensure an understanding of Welsh Language needs and perspective are given to this important process.

Embedding Equality

- The Trust has approved an Anti-racism Action Plan which will shape training, engagement and policies in relation to race over the next few years
- We have commissioned Diverse Cymru to deliver Cultural Competency training. This will shortly be rolled out to members of staff.
- The Gender Pay Gap and Annual Equality Reports have been produced annually.
- Diversity forums are continuing to be established for groups of staff. A British Sing Language (BSL) Forum has been developed on a national basis and involves members of NHS staff from Wales.
- Executive Equality Champions are in place.
- The EQIA toolkit is continuing to be reflected upon and reviewed. Bitesize training is being delivered to members of staff regarding this subject.
- We are a member of the Disability Confident Employer scheme – Disability Confidence Leadership is being researched and initial work has been conducted in order to implement this.
- BSL week - Deaf professionals and interpreters were invited to give an insight into navigating the workplace and striving for better accessibility standards and practice for Deaf individuals and BSL users.
- The Strategic Equality Plan has been finalised for the next four years.

Governance and Measurement

In relation to our governance arrangements, the Healthy and Engaged Steering Group and the Education and Training Steering group oversee the operational work plan for the People Strategy. This group include multi-disciplinary membership from all areas of the Trust including our union colleagues. The groups meet quarterly to agree and oversee the implementation of the Health and Wellbeing plan, Education, and Training plan for the Trust. A highlight report form the group is presented to EMB following the meetings.

The key performance indicators for workforce, reported to Executive Management Board are:

People Wellbeing and Engagement

- Qualitative reports on exit interviews, pulse surveys and staff survey results
- Monthly % sickness absence

Skilled and Developed People

- Monthly % Personal Development Reviews completed
- Monthly % Statutory and Mandatory training completed

Employer of Choice – Attraction and Retention

- % Turnover rate
- Vacancy rates
- Agency spend

Our Future People – Workforce 2024 and Beyond

With the continued focus on implementation of the above priorities within the agreed Workforce Framework, the Trust can enable the transition of its people across all its key deliverable areas to create a Health and Engaged, Skilled and Developed and a Planned and Sustained Workforce. A key area of alignment in 23/24 will be with the digital strategy to ensure progress in delivering a digital ready workforce.