Public Quality, Safety & Performance Committee

Thu 12 September 2024, 10:00 - 13:00

Hybrid meeting

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

Agenda

1. PRESENTATIONS

1.1. Velindre Cancer Service - Patient Story

To be led by Rhian Hathaway, First Floor Ward Manager, Velindre Cancer Services

Not received

2. STANDARD BUSINESS

2.1. Apologies

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

2.2. In Attendance

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

2.3. Declarations of Interest

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

2.4. Minutes from the meetings of the Public Quality, Safety & Performance Committee held on 9th July 2024

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

2.4.0 Draft minutes - Public Quality Safety and Performance Committee 9th July 2024.pdf (9 pages)

2.5. Minutes from the meetings of the Public Quality, Safety & Performance Committee held on 11th July 2024

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

2.5.0 Draft minutes - Public Quality Safety and Performance Committee 11th July 2024.pdf (10 pages)

2.6. Review of Action Log

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

2.6.0 PUBLIC QSP Action Log July-September.pdf (6 pages)

2.7. Matters Arising

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

There are no matters arising

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2.7.1. SACT Gold Paper

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Chair

SACT Gold and Anne Carey, Interim Chief Operating Officer

- 2.7.1 SACT Gold Report.pdf (8 pages)

3. MAIN AGENDA

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

3.1. Workforce Supply & Shape and Associated Finance Risks

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

- Workforce
- Finance

- 3.1.0 Supply and Shape Paper QSP Sep 24.pdf (11 pages)

3.2. Anti-Racist Wales Action Plan

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

- 3.2.0 QSP Anti-racist Action Plan Update 12.09.24.pdf (7 pages)
- 3.2.0 Appendix 1 Anti-racist Action Plan Progress 12.9.24.pdf (7 pages)
- 3.2.0 Appendix 2 WRES report final 12.9.24.pdf (18 pages)

3.3. NHS Staff Survey 2023

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

- 3.3.0 QSP Staff Survey Results 12.09.24.pdf (11 pages)
- 3.3.0 QSP Staff Survey Results 12.9.24 Appendix 1.pdf (25 pages)
- 3.3.0 QSP Staff Survey Results 12.9.24 Appendix 2.pdf (2 pages)

3.4. Trust Values and Behaviour Framework

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

- 3.4.0 QSP Behaviour Framework 12.09.24.pdf (9 pages)
- 3.4.0 Appendix 1 Behavioural Framework April 2024 QSP 12.9.24.pdf (3 pages)

3.5. Compassionate Leadership Pledge 2024

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

- 3.5.0 QSP Compassionate Leadership Pledge 12.09.24.pdf (10 pages)

3.6. People and OD Policies and Processes

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

- 3.6.0 People and OD Polices and Processes Sep 24.pdf (7 pages)
- 3.6.0 1. Draft - People Development Policy.pdf (14 pages)
- 3.6.0 2. Draft - PADR Policy.pdf (12 pages)
- 3.6.0 3. Reviewed - Alcohol Drugs Substance Policy.pdf (23 pages)
- 3.6.0 4. Reviewed - Professional Registration Policy.pdf (10 pages)

3.7. Finance Report for the Period Ended 31st July 2024

To be led by Matthew Bunce, Executive Director of Finance

- 3.7.0 Month 4 Finance Report Cover Paper - QSP 12.09.2024 FINAL.pdf (11 pages)
- 3.7.0 Appendix 1 - M4 VELINDRE NHS TRUST FINANCIAL POSITION TO JULY 2024 - QSP 12.09.2024.pdf (28 pages)
- 3.7.0 Appendix 2 - TCS Programme Finance Paper (July 2024) - Main Report.pdf (15 pages)
- 3.7.0 Appendix 3 - Velindre 24-25 Month 4 MMR Commentary Final Signed.pdf (10 pages)
- 3.7.0 Appendix 4 - Velindre Core 2024-25 MMR - M2 - Table A Financial Plan & Movement against Plan.pdf (1 pages)

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3.8. 2024-2025 Quarter 1 Trust Quality & Safety Report

To be led by Tina Jenkins, Interim Deputy Director of Nursing, Quality & Patient Experience, Vivienne Cooper, Head of VCS Nursing and Peter Richardson, Deputy Director/Head of WBS Quality and Safety

- 3.8.0 Quality & Safety Q1 report to QSP.pdf (5 pages)

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

To be led by *Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital; Rachel Hennessy, Acting Director VCS; Alan Prosser, Director WBS; Sarah Morley, Executive Director Organisational Development & Workforce and Matthew Bunce, Executive Director of Finance*

- 3.9.0 QSP Cttee 12.09.24 JULY PMF Performance Report FINAL version 004.pdf (78 pages)

3.10. Trust Risk Register

To be led by Non Gwilym, Interim Director of Corporate Governance

- 3.10.0 QSP - Trust Risk Register v01.pdf (9 pages)
- 3.10.0 QSP APPENDIX 1 - TRUST RISK REGISTER v01.pdf (9 pages)

3.11. Trust Assurance Framework

To be led by Non Gwilym, Interim Director of Corporate Governance

- 3.11.0 QSP September TAF Cover Paper v01.pdf (8 pages)
- 3.11.0 V66 August TAF Dashboard EMB Shape - IMTP alignment_.pdf (29 pages)

3.12. Policy Compliance Update

To be led by Non Gwilym, Interim Director of Corporate Governance

- 3.12 Policy Compliance Report EMB SEP 2024 V1.pdf (30 pages)

BREAK - 10 minutes

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4. 2023-2024 ANNUAL REPORTS

4.1. FOR APPROVAL

4.1.1. Wellbeing of Future Generations Act (2015) Annual Report

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

- 4.1.1 QSP Cover Paper - v.04 (03.09.24).pdf (8 pages)
- 4.1.1 Appendix 1 - Questionnaire issued to staff, patients, donors and stakeholders.pdf (3 pages)
- 4.1.1 Appendix 2 - Trust Well-Being Objectives - Questionnaire Feedback Analysis.pdf (4 pages)
- 4.1.1 Appendix 3 - Current Trust Well-Being Objectives.pdf (1 pages)

4.1.2. Digital Services Annual Report

To be led by Carl Taylor, Chief Digital Officer

- 4.1.2 20240912 QSP Cover Paper - Digital Services Annual Report.pdf (6 pages)
- 4.1.2 20240912 QSP Appendix 1 Digital Services Annual Report.pdf (21 pages)

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4.2. ENDORSE FOR TRUST BOARD APPROVAL

4.2.1. Communications and Engagement Annual Report

To be led by Non Gwilym, Interim Director of Corporate Governance

- 4.2.1 QSP Communications and Engagement Annual Report Cover Paper.pdf (6 pages)

4.2.1 Comms and engagement annual report 2023-24 v4.pdf (24 pages)

4.2.2. Medical Devices Annual Report

To be led by Anne Carey, Interim Chief Operating Officer

Paper not received

4.3. FOR NOTING

4.3.1. Wales Infected Blood Support Scheme (WIBSS)

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

4.3.1 WIBBS cover paper.pdf (2 pages)
4.3.1 WIBSS Annual Report 2023-2024 Final 01.08.24.pdf (27 pages)

5. CONSENT ITEMS

5.1. FOR APPROVAL

5.1.1. Trust Policies for Approval

- IPC03 - Model Policy Aseptic Non-Touch Technique (ANTT)

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

- QS02 - Management of Safety Alerts and Important Notification Policy

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

- PP02 - Security Policy

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

5.1.1a QSP Policy paper September 2024 HHJ.pdf (60 pages)
5.1.1b QSP Safety Alerts Policy.pdf (12 pages)
5.1.1c Security policy cover paper 2024 June QSP.pdf (17 pages)
5.1.1c Appendix 1 Security policy EQIA.pdf (11 pages)

5.1.2. Committee Terms of Reference

To be led by Non Gwilym, Interim Director of Corporate Governance

5.1.2 QSPC ToR Review_August 2024 v1.pdf (7 pages)
5.1.2 Appendix 1 QSP TOR (current).pdf (12 pages)
5.1.2 Appendix 2 QSP TOR revision August 2024.pdf (12 pages)

5.2. CONSENT ITEMS FOR ENDORSEMENT

5.2.1. Annual and three-year Assurance Reports on Compliance with the Nurse Staffing Levels (Wales) Act 2016

To be led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science

5.2.1 QSP Annual nurse staffing assurance report_.pdf (19 pages)
5.2.1 appendix 2-3 Yearly Report 2021-2024-NSA EMB Aug24.pdf (7 pages)

5.2.2. Trust Policies for Endorsement

- WF01 Respect and Resolution Policy (All Wales)

  To be led by Amanda Jenkins, Head of Workforce

Paper not received

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5.3. CONSENT ITEMS FOR NOTING

5.3.1. Integrated Medium Term Plan (IMTP) Quarterly (Q1) Progress Report

To be led by Phil Hodson, Deputy Director of Planning & Performance

- 5.3.1 QSP Cttee 12.09.24 IMTP 2024.25 Quarter 1 Update version Master 009.pdf (89 pages)

5.3.2. Professional Nursing Forum Update

To be led by Annie Evans, Deputy Director of Nursing, Quality & Patient Experience

- 5.3.2 PNF Q1 Report to QSP.pdf (21 pages)

5.3.3. NHS – Regulation 28 Annual Report

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

- 5.3.3 NHS Wales-Regulation 28 Annual Report 2023-24 v3 (004).pdf (23 pages)

5.3.4. Workforce and Organisational Development Implementation Plans

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

- 5.3.4 WOD Implementation Plans Sep 2024.pdf (24 pages)

5.3.5. Value Based Healthcare Report

To be led by Matthew Bunce, Executive Director of Finance

- 5.3.5 QSP_VBH_Programme Update_August 2024 - QSP.pdf (10 pages)

5.3.6. Trust Estates Assurance Group Highlight Report

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

- 5.3.6 Trust Estates Assurance report QSP Aug 2024.pdf (25 pages)
- 5.3.6 Appendix 1 SOP CAFM System Draft.pdf (4 pages)

5.3.7. Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Reports 16th May 2024 and 20th June 2024

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

- 5.3.7 QSP Highlight Report Public 16.05.2024.pdf (3 pages)
- 5.3.7 QSP Highlight Report Public 20.06.2024_LF - SH.pdf (4 pages)

5.3.8. 15-Step Visits Update

To be led by Non Gwilym, Interim Director of Corporate Governance

- 5.3.8 15 Step Visit Schedule 2024-25 QSPC SEPT 2024.pdf (7 pages)

5.3.9. Llais Cymru Report

To be led by Amy English, Llais Cymru

- 5.3.9 Clinical Trials Report Final.pdf (16 pages)

6. INTEGRATED GOVERNANCE

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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. September 2024 Analysis of Triangulated Meeting Themes

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

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 14th November 2024 from 10:00-13:00.

10. CLOSE

The Quality, Safety & Performance Committee is asked to adopt the following resolution:

That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with Section 1(2) Public Bodies (Admission to Meetings) Act 1960 (c.67).

11. PRIVATE/PART B SESSION

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

- Sarcoma Update
- Private Transforming Cancer Services (TCS) Programme Scrutiny Sub Committee Highlight Report

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Chair's Brief

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: Tuesday 9th July 2024
Time: 14:00-16:00
Location: Hybrid meeting – Microsoft Teams/Velindre NHS Trust Headquarters
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Lindsay Foyster	Independent Member	LF
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Matthew Bunce	Executive Director of Finance	MB
Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Jacinta Abraham	Executive Medical Director	JA
Sarah Morley	Executive Director of Organisational Development & Workforce	SM
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
Annie Evans	Deputy Director Nursing	AE
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Sarah Richards	Head of Planning & Performance Services, WBS [on behalf of Alan Prosser]	SR
Carl Taylor	Chief Digital Officer	CT
Jonathan Fear	Interim Assistant Director of Estates, Environment & Capital Development	JF
Emma Rees	Deputy Head of Internal Audit, NWSSP	ER
Katrina Febry	Audit Wales	KF

APOLOGIES		
Carl James	Interim Chief Executive Officer	CJ
Alan Prosser	Director of Welsh Blood Service	AP
Emma Stephens	Head of Corporate Governance	ES
Helen Williams	Interim Regional Director, Llais Cymru	HW

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		ACTION
1.0.0	**PRESENTATIONS**	
1.1.0	**Staff Story - Welsh Blood Service** Led by Sarah Richards, Head of Planning and Performance Services SR gave a brief overview of the staff story video, shared with Committee members prior to the meeting, which showcased the service improvement journey at WBS from a staff perspective. The initiative has proved successful and has been met with enthusiasm and well embraced by staff. Over 370 improvements have already been made since the scheme was launched. More training and knowledge will be incorporated gradually, with a move towards launching full service improvement projects in the longer term. NW commended the level of pride demonstrated by WBS staff in relation to work they have undertaken and suggested that a similar approach be rolled out across VCS/Trust-wide.	
2.0.0	**STANDARD BUSINESS**	
2.1.0	**Apologies** Apologies were as noted above.	
2.2.0	**In Attendance** Attendees were as noted above.	
2.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair No declarations of interest were received.	
2.4.0	**Minutes from the meeting of the Public Quality, Safety & Performance Committee held on the 9th May 2024** Led by Vicky Morris, Quality, Safety & Performance Committee Chair The Committee **REVIEWED** and **APPROVED** the minutes from the 9th May 2024 Public Committee.	
2.5.0	**Review of Action Log** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science The action log was discussed and Committee members confirmed that they were assured that all actions identified as closed had been fully instigated and could therefore be closed. Items not yet due for completion were not discussed. The remaining action log was reviewed, and the following agreed:	

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	Action 7.3.0 [14.03.24] - Provide to the Committee forward programme for future 15-step visits - LF advised that the Corporate Governance team are currently working to produce a schedule of upcoming visits which will be brought to the September Committee. ***Action 3.7.0 [09.05.24] - Ascertain clinical audit requirement for Shared Services and advise the Committee accordingly*** - JA has met with Ruth Alcolado and Colin Powell and discussed the matter in respect of TrAMs. It was clear that the responsibility from a clinical audit perspective re TrAMs/medicines management would sit with health boards and Trusts, with the TrAMs function managed by MHRA inspections. **This action can therefore be closed.** SH queried the following closed action: ***4.1.0 [09.05.24] - Establish whether any additional costs (e.g. double-running) are covered by the overall risk and contingency funds*** - the update was noted, however SH raised concern regarding the requirement to ensure availability of funding should dual running costs occur. MB to investigate further and advise the Committee accordingly.	**LW** **MB**
2.6.0 **2.6.1**	**Matters Arising** **SACT Gold Paper** Led by Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Chair SACT Gold The Committee received the SACT Gold Paper which gave a positive overview of the position within SACT as of mid-June 2024 and detailed the actions and outcomes of the work being undertaken to address the SACT capacity issues. Ongoing and daily consultant-led prioritisation is in place for patients who are not able to be fitted in for treatment to ensure that any anticipated clinical urgency is addressed and a harm review process is in place for anyone who the clinical teams feel may be impacted by any delay. Where there is a delay beyond 21-days the majority of patients are now receiving their treatment within 28 days, as opposed to up to 60 days as experienced earlier this year. A robust pharmacy improvement plan has been agreed, overlaid by a booking and nursing plan. The Committee **NOTED** the report and the actions being taken to address the SACT capacity issues.	
2.6.2	**Change in Allocation of Noddfa Building Wellbeing Centre** Led by Rachel Hennessy, Interim Director, VCS	

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	RH gave a brief presentation with regards to the Noddfa Centre and its usage from a staff wellbeing perspective. A calendar of events and wellbeing activities are underway with further hosted activities planned. Key points going forward were noted as follows: • Flexible space will be used for workshops and pop-up events (protected for lunchtime) • Non-bookable, media-free space for relaxing, lunch, etc. with funding secured to purchase new furniture • Kitchen area • Therapies • The Pod quiet space for private calls, etc. • Covered and open outside space with seating • Digital training hub A formal launch of the new wellbeing space is anticipated for September 2024. DM was pleased to see progress but noted that the plans would provide only one non-bookable space and queried whether staff had been consulted with regards to the requirements of the facility. RH advised that an active working group comprising of staff representatives from across the division had been engaged and actively participated in terms of the look, function and furnishing of the space. The update was approved; however, it was agreed that this should be reviewed again in one year's time to ensure continued appropriate usage of the space, with future updates provided through the regular Workforce paper. It was noted that although the building was originally leased with COVID funding this is now covered by the division's core budget. The Committee **NOTED** the change in allocation of the Noddfa building and agreed to review again in one year, with relevant updates to be provided via the regular Workforce paper.	
3.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
3.1.0	**Staff Survey 2023-2024** Led by Sarah Morley, Executive Director of Organisational Development & Workforce SM gave a brief overview of the results of the staff survey conducted in autumn 2023. Although down slightly on the previous year a good response rate was received in comparison to NHS Wales overall and although some of the response categories are perhaps lower than they had been previously, the results show a positive picture when compared against the NHS Wales average.	

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	SM shared a slide re how feedback is being used at an organisational level. Divisional breakdowns received in May show that the two divisions are tracking at almost Trust averages, however the responses from Nursing were less positive and tracked at lower than Trust averages. The Committee will receive further analysis of the data in due course. HJ raised concern regarding the apparent increase in the number of staff members reporting personal experience of bullying or harassment in comparison to the data received from last year's survey. SM advised that this is being managed accordingly and hotspots are being monitored. The Committee **NOTED** the report.	
3.2.0	**Trust Risk Register** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital LF presented the Trust Risk Register, highlighting the changes since the last reporting cycle: • One risk of 15 relating to the financial risk in the leadup to financial close for the new Velindre Cancer Centre (nVCC) has now been closed through the Project Board review of all nVCC and mutual investment model risks. • Two new safety risks at 12 have been identified - one related to the storage of a nitrogen tank in WBS, the second related to safety for staff in terms of storage and cleaning space of the Therapies department. A detailed action plan in respect of both of these risks is in place. In respect of R3337 SACT risk, VM noted that the update almost mirrors the earlier narrative and so does not show progress as demonstrated in the SACT paper received earlier in this meeting. VM highlighted the need to ensure that updates are correctly entered in DATIX to ensure clear triangulation. SH queried R3350 re the ageing fleet of the Welsh Blood Service transport and queried whether there were any plans in place with regards to replacement of these vehicles. PR to discuss with WBS Operations team and report back to the Committee. The Committee: • **NOTED** the risks of 15 and above as well as risks in the safety domain with a risk level of 12 reported in the Trust Risk Register and highlighted in the paper. • **NOTED** the on-going developments of the Trust's risk framework.	**PR**
3.3.0	**Trust Assurance Framework** Led by Lauren Fear, Interim Executive Director of Strategic	

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	Transformation, Planning & Digital LF presented the Trust Assurance Framework. The Committee noted that Appendix 2 of this paper had not been included with the meeting papers but was circulated to Committee members by email during the meeting. Members were invited to submit any comments or questions following their review of this paper. VM highlighted that many parts of the narrative appear to remain unchanged from previous meetings and requested that the Executive Management Board monitors and challenges executive colleagues accordingly to ensure that updates have been provided. In respect of TAF05 CT advised that although an impact of 4 will remain given the supply chain cyber security risk, good progress is being made. The Committee **DISCUSSED** and **NOTED** the Trust Assurance Framework.	
3.4.0	**Finance Report for the period ended 31st May 2024 (M2)** Led by Matthew Bunce, Executive Director of Finance The Committee received the month 2 Financial Report which outlined the financial position and performance for the period to the end of May 2024. In addition, a brief verbal update was provided to the Committee to reflect the position as at the end of June. The Committee noted the year to date and forecast outturn position of Breakeven, the risks associated with the expected income to the Trust from Commissioners and the current position with Commissioners in terms of the contract rebase agreement. The Committee wished to extend their gratitude and congratulations to the teams for their efforts in resolving the significant financial challenges related to the Local Tariff Agreements (LTAs) and securing the best possible outcome for the Trust and NHS Wales. The efforts of the finance team, and the support from the former and interim CEO and their teams were specifically acknowledged for avoiding arbitration and managing to negotiate agreements that minimized financial risks for the Trust. The Committee **NOTED** the contents of the May 2024 financial report and in particular: • The year to date and forecast out turn position. • The risks associated with the income that the Trust is expected to receive from our Commissioners. • The current position with commissioners on the contract rebase agreement. • The latest position of the Trust savings schemes, and urgent action	

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	required from Divisional and Executive Directors to ensure that schemes RAG rated as amber or red have identified responsible officers tasked with confirming that action plans are in place to deliver the savings or proposals for alternative savings schemes.	
4.0.0	**2023-2024 ANNUAL REPORTS**	
4.1.0	**FOR APPROVAL**	
4.1.1	**Sustainability Annual Report (including decarbonisation)** Led by Jonathan Fear, Interim Assistant Director of Estates, Environment & Capital Development JF gave a brief overview of the Sustainability Annual Report. HJ queried whether it is possible to ascertain the financial impact in relation to the actions noted in report, i.e. reduction in single-use plastics, etc. JF advised that this information is available and can be added to future reports. The Committee **APPROVED** the Annual Report for translation and publication on the Trust's website.	
4.1.2	**Wellbeing of Future Generations Act (2015) Annual Report** The Wellbeing of Future Generations Act report was deferred to September due to the ongoing work with Audit Wales and a refresh of wellbeing objectives, which will feed into the report.	
4.1.3	**Digital Report** Led by Carl Taylor, Chief Digital Officer The Committee received a Digital quarterly report covering the period February to May and noted the highlighted key points. Clarity was sought with regards to the provision of an annual report and this will be reviewed outside of the meeting. The Committee **NOTED** the Digital Quarterly Report.	
4.1.4	**Freedom of Information Requests Annual Report** Led by Non Gwilym, Acting Director of Corporate Governance The Committee received the Freedom of Information Requests Annual Report. In terms of the source of requests, SH highlighted the three requests received from within the NHS and queried whether it was appropriate for these to be categorised as FOI requests, rather than inter-organisational requests? NG to look at this further.	**NG**

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	The applied level of assurance rating of 3 was discussed. However, due to the action plan in place and the improvements made following the appointment of the new FOI and Compliance Officer, the Committee agreed that a revised level of 4 should be applied. The Committee: • **REVIEWED** the level of compliance during the financial year 2023/24 and the improvement in compliance since the appointment of a new, permanent Freedom of Information Officer. • **NOTED** the level of assurance in relation to the Trust's compliance with the Freedom of Information Act and Environmental Information Regulations requests. • **APPROVED** the Freedom of Information Act / Environment Information Regulations Annual Report 2023/24 for translation and publication on the Trust's website and **AGREED** the revised level of assurance rating of **4**.	
4.2.0	**ENDORSE FOR TRUST BOARD APPROVAL**	
4.2.1	**Local Partnership Forum Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval.	
4.2.2	**Equality, Diversity & Inclusion Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the Equality, Diversity & Inclusion Annual Report. HJ noted the omission of comparison data to ensure no under-representation within workforce - SM noted the omission which had been included in the previous year's report. It was also noted that no level of assurance had been applied to this paper. These details are to be added to the paper prior to presentation to Trust Board. The Committee **ENDORSED** the Annual Report subject to the amendments discussed (above).	**SM**
4.2.3	**Gender Pay Gap Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received the Gender Pay Gap Annual Report. VM requested that details of which professional groups the pay gap most stark in be added to the report, along with the level of assurance rating which was omitted from this report.	

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	The Committee **ENDORSED** the Annual Report subject to the amendments discussed (above).	
4.2.4	**Welsh Language Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce The Committee received a comprehensive overview of the Welsh Language Annual Report. The omission of a level of assurance rating was noted and will be added prior to submission to Trust Board. The Committee **ENDORSED** the Annual Report subject to the amendments discussed (above).	
5.0.0	**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 full discussion is required).	
	There were no consent items for this meeting.	
6.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	There were no items identified for alert to Trust Board.	
7.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business.	
8.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will meet again on **Thursday 11th July 2024 at 10:00-13:00** to allow for the Committee to receive the remaining 2023-2024 Annual Reports.	
CLOSE		

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Velindre University NHS Trust

Minutes

Public Quality, Safety & Performance Committee

Velindre University NHS Trust

Date: Thursday 11th July 2024
Time: 10:00 – 13:00
Location: Hybrid meeting - Velindre NHS Trust Headquarters/Microsoft Teams
Chair: Mrs Vicky Morris, Independent Member

ATTENDANCE		
Professor Donna Mead OBE	Velindre University NHS Trust Chair	DM
Stephen Harries	Velindre University NHS Trust Vice Chair	SH
Hilary Jones	Independent Member	HJ
Lindsay Foyster	Independent Member	LF
Nicola Williams	Executive Director of Nursing, Allied Health Professionals & Health Science	NW
Matthew Bunce	Executive Director of Finance	MB
Lauren Fear	Director of Corporate Governance & Chief of Staff	LF
Sarah Morley	Executive Director of Organisational Development & Workforce	SfM
Annie Evans	Deputy Director Nursing	AE
Liane Webber	Business Support Officer (Secretariat)	LW

ADDITIONAL ATTENDEES		
Sarah Richards	Head of Planning & Performance Services, WBS [on behalf of Alan Prosser]	SR
Jonathan Fear	Interim Assistant Director of Estates, Environment & Capital Development	JF
Emma Rees	Deputy Head of Internal Audit, NWSSP	ER
Katrina Febry	Audit Wales	KF
Hayley Harrison Jeffreys	Head of Infection Prevention & Control *[item 3.1.1]*	HHJ
Fiona Davies	Head of Safeguarding *[item 3.1.2]*	FD
Anna Harries	Head of Nursing, Professional Standards & Digital *[item 3.1.4]*	AH
Steph Williams	Head of Health & Safety *[item 3.1.6]*	SW
Edwin Massey	Medical Director, WBS *[item 3.2.1]*	EM
Ruth Alcolado	Medical Director, NWSSP *[item 4.3]*	RA
Jonathan Fear	Interim Assistant Director of Estates, Capital and Environment *[item 5.1.2]*	JF

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APOLOGIES		
Carl James	Interim Chief Executive Officer	CJ
Rachel Hennessy	Interim Director of Velindre Cancer Service (VCS)	RH
Alan Prosser	Director of Welsh Blood Service	AP

Peter Richardson	Head of Quality Assurance and Regulatory Compliance, Welsh Blood Service	PR
Emma Stephens	Head of Corporate Governance	ES
Helen Williams	Interim Regional Director, Llais Cymru	HW

		ACTION
1.0.0	**STANDARD BUSINESS**	
1.1.0	**Apologies** Apologies were noted as above.	
1.2.0	**In Attendance** Additional attendees were noted as above.	
1.3.0	**Declarations of Interest** Led by Vicky Morris, Quality, Safety & Performance Committee Chair There were no declarations of interest.	
2.0.0	**MAIN AGENDA** (This section supports the discussion of items for review, scrutiny and assurance).	
	Nil items	
3.0.0	**2023-2024 ANNUAL REPORTS**	
3.1.0	**FOR APPROVAL**	
3.1.1	**Infection Prevention & Control Annual Report** Led by Hayley Harrison Jeffreys, Head of Infection Prevention & Control HHJ gave a succinct summary of the report, highlighting some of the many achievements through the year and aims for the year ahead. The applied level of assurance of 6 was discussed and, given the exemplary work undertaken across the year, this was widely supported by the Committee. Referencing Bare Below the Elbow, SH noted that in some cases, SMART watches are still being worn, and queried whether further actions are being taken to improve the messaging and compliance in this area. NW advised that the Infection Prevention & Control team are escalating each occurrence accordingly & communications reinforcing the standard have been drafted. All escalations reported to the Integrated Quality and Safety Group are to be brought through this Committee to ensure appropriate monitoring.	

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	The Committee **APPROVED** the Annual Report for translation and publication on the Trust's website and **AGREED** the level of assurance rating of **6**.	
3.1.2	**Safeguarding & Vulnerable Adults Management Group Annual Report** Led by Fiona Davies, Head of Safeguarding FD presented the report to the Committee and the key achievements were noted. The applied level of assurance rating of 6 was discussed and agreed by the Committee. The Committee **APPROVED** the Annual Report for translation and publication on the Trust's website and **AGREED** the level of assurance rating of **6**.	
3.1.3	**Patient & Donor Experience Annual Report** Led by Tina Jenkins, Head of Quality, Safety and Patient Experience TJ presented the report to the Committee and provided a brief summary. With reference to the "You Said, We Did" boards at VCS, SH highlighted that the updating of information on these boards appears to be a continuing issue. TJ/NW to follow up to ensure the Departmental Manager is clear on their duty of ensuring these boards are kept up-to-date. The applied level of assurance rating of 4 was discussed and was supported by the Committee. The Committee **ENDORSED** the Annual Report and **AGREED** the level of assurance rating of **4**.	**TJ**
3.1.4	**Nursing Strategy Annual Report** Led by Anna Harries, Head of Nursing, Professional Standards & Digital AH presented a positive report to the Committee and the good progress was noted. The applied level of assurance rating of 4 was discussed and was supported by the Committee. The Committee **APPROVED** the Annual Report and **AGREED** the level of assurance rating of **4**.	
3.1.5	**Information Governance Annual Report** Led by Matthew Bunce, Executive Director of Finance	

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	MB presented the report which offers assurance that the Trust is meeting its statutory and mandatory obligations in relation to information governance. The applied level of assurance rating of 3 was discussed. Although it was acknowledged that there is still some progress to be made, the Committee widely agreed that a level of 4 would be more appropriate, given the significant progress made in several areas. The Committee **APPROVED** the Annual Report and **AGREED** the level of assurance rating of **4**.	
3.1.6	**Health & Safety Annual Report** Led by Steph Williams, Head of Health & Safety SW presented the report to the Committee and the following points were raised: • With regards to the blood collection venues utilised but not owned by the Trust, SH sought assurance on the health and safety and fire safety assessments process in these locations. SW advised that although venue risk assessments are in place, this is an area which will be under further review over the coming year. • HW queried the Board reporting process in relation to improvement notices issued by the Health & Safety Executive (HSE) as this matter has not been previously raised at this Committee. Members noted that these notices were received prior to SW commencing the role of Health and Safety Manager and would be managed accordingly with the appointed personnel in each division. SW to review the reporting mechanism to ensure that any future improvement notices are brought through the Integrated Quality and Safety Group. The applied level of assurance rating of 2 was discussed and widely agreed by the Committee. The Committee **APPROVED** the Annual Report and **AGREED** the level **2** assurance rating.	**SW**
3.1.7	**Communications Annual Report** Led by Non Gwilym, Interim Director of Corporate Governance & Chief of Staff Receipt of the Communications Annual Report was deferred to September.	
3.2.0	**ENDORSE FOR TRUST BOARD APPROVAL**	
3.2.1	**Trust Clinical Audit Annual Report** Led by Jacinta Abraham, Executive Medical Director and Edwin Massey, Medical Director, WBS	

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	JA presented the report to the Committee. The applied level of assurance rating of 4 was discussed and supported by the Committee. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **4**.	
3.2.2	**Putting Things Right Annual Report** Led by Tina Jenkins, Head of Quality, Safety and Patient Experience TJ presented the report to the Committee. The applied level of assurance rating of 3 was discussed and supported by the Committee. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **3**.	
3.2.3	**Duty of Quality Annual Report** Led by Tina Jenkins, Head of Quality, Safety & Patient Experience TJ presented the Trust's first Duty of Quality Annual Report. SH acknowledged the contribution by Llais Cymru, for which the Committee extended their thanks. The applied level of assurance rating of 2 was discussed and subsequently agreed by the Committee. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **2**.	
3.2.4	**Performance Annual Report** Led by Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital LF gave a brief overview of the report. With regards to the forecast growth in demand for services, SH sought to receive assurance that the new Velindre Cancer Centre is design to be in a position to effectively manage this increased demand. LF advised that this detail can be added via cross-reference of the strategic case. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **4**.	

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3.2.5	**Quality, Safety and Performance Committee Annual Report** Led by Liane Webber, Business Support Officer The Committee received the Quality, Safety & Performance Committee Annual Report. HJ highlighted a possible error in respect of the percentage of meetings attended by Catherine O'Brien. LW to review and amend if necessary. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **4**.	**LW**
3.3.0	**MAIN AGENDA**	
	Nil items	
4.0.0	**NHS WALES SHARED SERVICE PARTNERSHIP**	
4.1.0	**Surgical Materials Testing Laboratory (SMTL) Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services, NWSSP The Committee received and **NOTED** the Annual Report.	
4.2.0	**Medical Examiner Service (MES) Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services, NWSSP RA presented the Medical Examiner Service (MES) Annual Report and the following query was raised: • LF sought clarity on the feedback mechanism in terms of the increase in the number of scrutinised deaths. RA advised that a feedback mechanism into Velindre, as with all other health boards and trusts, is in place to identify any concerns. TJ reported on the excellent work undertaken by the Quality and Safety team within the Cancer Service to ensure full compliance with the MES and all inpatient deaths are referred back to the MES. All learning derived from the MES is fed back through the Integrated Quality & Safety Group on a monthly basis and will be included in Quality reports from Quarter 1. RA highlighted the increase in regional working, and instances where deaths may occur within one health board, but have links to other health boards, and queried how this could be monitored. RA and TJ to discuss further. The Committee **NOTED** the Annual Report.	**RA/TJ**
4.3.0	**Duty of Quality Annual Report** Led by Ruth Alcolado, Medical Director, Corporate Services, NWSSP	

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	RA presented NWSSP's first Duty of Quality Annual Report. The Committee **NOTED** the Annual Report.	
5.0.0	**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).	
5.1.0	**FOR APPROVAL**	
5.1.1	**Medical Devices Annual Report** Led by Jacinta Abraham, Executive Medical Director The Medical Devices Annual Report was previously provided to the Committee via the Chief Operating Officer, the post of which is currently vacant. This report as therefore been deferred to September's Committee.	
5.1.2	**Estates Annual Report** Led by Jonathan Fear, Interim Assistant Director of Estates, Environment & Capital Development JF presented a detailed report to the Committee and key achievements were highlighted. In respect of the audits with limited assurance, HJ noted that although it is stated that actions plans are in place, the Committee would seek clear assurance that the urgent actions had been completed or were on course to be completed. With regards to the electrical low voltage audit recommendations, JF advised that the two outstanding actions are due to be addressed within the next few weeks. In relation to the fire recommendations, these recommendations are sitting within a priority improvement plan reporting into the Trust Health, Safety and Fire Management Board. JH also noted that the last audit in respect of fire was undertaken a number of years ago, and advised that NWSSP had been contacted in order to arrange another audit in this area, to ensure all actions are being completed. Referencing page 6 of the report SH highlighted the section outlining objectives to be achieved, particularly the bullet point "Opening the New Velindre Cancer Centre: Launching the new Velindre Cancer Centre by 2025" and requested that this be clarified in the report. JH advised that the wording would be changed to "Opening the new Velindre Cancer Centre by 2027". The Committee were advised that although a level of assurance had not been provided in the paper, a level of 4 was suggested. However following discussion, the Committee agreed to support an assurance level of 3.	

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	The Committee **APPROVED** the Annual Report and **AGREED** a revised level of assurance rating of **3**.	
5.2.0	**TO ENDORSE**	
	There were no items to endorse.	
5.3.0	**FOR NOTING** The Committee AGREED that there should be no Annual Reports for noting. This is to be reviewed.	
5.3.1	**Business Continuity & Emergency Planning Annual Report** Led by Sarah Richards, Head of Planning & Performance Services SR presented the report to the Committee. It was highlighted that a level of assurance had not been applied to this report. This will be fed back to the Committee following consultation with the authors of the report. The Committee noted the lack of clarity around the placement of some of the annual reports on the agenda. LF to look at this and provide further details of the rationale of actions by the Committee in respect of all Trust annual reports. The Committee **APPROVED** the Annual Report.	**SR** **LF**

5.3.2	**Professional Registration/Revalidation Report**
	Led by Anna Harries, Head of Nursing, Professional Standards & Digital, Nicola Williams, Executive Director of Nursing, Allied Health Professionals & Health Science and Dr Jacinta Abraham, Executive Medical Director
	
	AH presented the report to the Committee and the following queries were raised:
	
	• VM raised concern in terms of the policy which expired in October 2022 and sought assurance that this would be progressed in a timely manner. NW advised that the request for this had been submitted to the Workforce team and support offered accordingly.
	• SH queried the mechanism for ensuring locums and agency staff are compliant. JA highlighted the table within the report which demonstrates the number of locum and agency staff appraised. NW gave further assurance as follows:
	  o The Trust will endeavour to use on-contract agencies due to the assurance that the registration process is robust at a contractual level
	  o On occasions where use of off-contract agencies are needed it is the appointing manager's responsibility to ensure registration compliance as part of the onboarding process.
		AH/SM

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	The Committee revised the level of assurance rating of 3, the Committee was content to support this rating. The Committee **ENDORSED** the Annual Report for onward submission to the Trust Board for approval and **AGREED** the level of assurance rating of **3**.	
5.3.3	**People Strategy Annual Report** Led by Sarah Morley, Executive Director of Organisational Development & Workforce SM gave a brief overview of the report. An assurance level of 3 was proposed and agreed by the Committee. The Committee **APPROVED** the Annual Report and **AGREED** the proposed level of assurance rating of **3**.	
6.0.0	**INTEGRATED GOVERNANCE** (The integrated governance part of the agenda will capture and discuss the Trust's approach to mapping assurance against key strategic and operational risks).	
6.1.0	**July 2024 Analysis of triangulated meeting themes** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members The Committee discussed the triangulated meeting themes as follows: • NW noted overall levels of assurance averaging between 3 and 6 and the significant improvements made across the majority of areas considered. There appears to be recognition of areas that require further improvement and enhancement, but clear plans are in place to address these matters. VM - levels of assurance - important to mature this over the year	
6.2.0	**July 2024 Analysis of Quality, Safety & Performance Committee Effectiveness** Led by Vicky Morris, Quality, Safety & Performance Committee Chair supported by all Committee members • Due to the additional meeting held in this governance cycle, the Committee agreed that sufficient time had been allocated to enable focused discussion for the items of business received across the two meetings. • Open and productive debate was achieved within a supportive environment. • It was possible to identify cross-cutting themes to support effective triangulation.	

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	• Sufficient assurance was provided to Committee members in relation to the Annual Reports and core essential business?	
7.0.0	**HIGHLIGHT REPORT TO TRUST BOARD**	
	There were no items identified to alert/escalate to Trust Board.	
8.0.0	**ANY OTHER BUSINESS**	
	There were no additional items of business brought for discussion.	
9.0.0	**DATE AND TIME OF THE NEXT MEETING**	
	The Quality, Safety & Performance Committee will next meet on Thursday 12th September 2024 from 10:00-13:00	
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		

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QUALITY, SAFETY & PERFORMANCE COMMITTEE - PART A

ACTION LOG

Minute ref	Action	Action Owner	Progress to Date	Target Date	Status (Open/Closed)
Actions agreed at the 13th July 2023 Committee					
9.1.0	Trust Annual Report template to be developed and Trust style determined to facilitate consistency for future annual reports	~~Emma Stephens (Head of Corporate Governance) / Lauren Fear (Director of Corporate Governance & Chief of Staff)~~ Non Gwilym (Interim Director of Corporate Governance)	**Update 09/09/24:** Template due for completion by end of September. Distribution and training to commence October.	~~31/03/24~~ ~~12/09/24~~ 14/11/24	OPEN
Actions agreed at the 14th March 202/4 Committee					
3.11.0	Provide the Committee with clear plan, with timescales for reviewing and providing for assurance all out-of-date policies	~~Lauren Fear (Director of Corporate Governance & Chief of Staff)~~ Non Gwilym (Interim Director of Corporate Governance)	On agenda for September Committee	~~09/05/24~~ ~~07/06/24~~ 12/09/24	CLOSED
7.3.0	Provide to the Committee forward programme for future 15-step visits	~~Lauren Fear (Director of Corporate Governance & Chief of Staff)~~ Non Gwilym (Interim Director of Corporate Governance)	On agenda for September Committee	~~09/05/24~~ ~~11/07/24~~ 12/09/24	CLOSED
Actions agreed at the 21st March Extraordinary Joint QSP/Audit Committee					

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2.1.0b	Trust Risk Register Executive Management Board, to look at how some of the risks could be combined and how the material total of the risk applies to the organisation and patients in terms of the root cause.	~~Lauren Fear (Director of Corporate Governance & Chief of Staff)~~ Non Gwilym (Interim Director of Corporate Governance)	**Update 09/09/24:** Update: WBS and VCS considering risk profile on monthly basis. EMB considering reportable risks via Trust Risk Register on monthly basis. EMB also considering impact of monthly risk position on strategic risks in TAF. All related improvements to be considered as part of phase two of the Governance, Assurance and Risk Programme. Phase two scope to be discussed by EMB on 30 September, considered by GAR group in October before endorsement by EMB on 29 October and Audit Committee in December 2024.	~~11/07/24~~ ~~12/09/24~~ 14/11/24	OPEN
Actions agreed at the 9th May 2024 Committee					
3.2.2a	Provide data in respect of patients who did not begin treatment within 21 days and urgent symptom control patients that were not seen within seven days.	Rachel Hennessy (Interim Director, VCS)	**03/09/24:** Breakdown of number of patients and length of treatment pathway included in PMF from June report period (July PMF)	11/07/24	CLOSED
3.2.2b	Trends around teams not currently reaching PADR compliance and high-level summary of management actions taken to be added to future PMF reports.	Sarah Morley (Executive Director of Organisational Development & Workforce)	Trends for performance has been added to narrative of the PMF for September QSP.	12/09/24	CLOSED
3.6.0	Update members by email re plan for management of Private Patient Service Improvement Group alerts.	Steve Ham (Chief Executive Officer)	**03/07/2024:** A regular highlight report goes from the Private patients improvement group, overseen by Exec Director Nursing to EMB NB: PP group is cancelled in September due to Chair and key members being on leave	11/07/24	CLOSED

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3.7.0	Ascertain clinical audit requirement for Shared Services and advise the Committee accordingly.	Jacinta Abraham (Executive Medical Director)	**Update 01/07/24:** This action will be addressed with Ruth Alcolado and Colin Powell, NWSSP Director for Pharmacy Services at a meeting arranged on 04/07/24.	11/07/24	CLOSED
4.1.0	Establish whether any additional costs (e.g. double running) are covered by the overall risk and contingency funds.	Gareth Tyrrell (Accountable Pharmacist)	**Update 04/09/24:** Detailed transition plans not yet reviewed as at this stage the BJC is focussed on securing the capital funding for the programme. The initial discussions suggest this has been considered, however there is not anticipated to be additional cost to "double running" as Velindre would only be responsible for revenue expenditure that remains at Velindre if there is a staggered approach to the transition **Additional update 11/09/24:** Radiopharmacy BJC has been written and approved by Partnership committee and is with the minister for sign off. The Hub OBC covering SACT/CIVAS is currently being written and one of the appendices to that document will include the detailed transition plans.	11/07/24	OPEN
Actions agreed at the 9th July 2024 Committee					
3.2.0	Discuss replacement of vehicle fleet with WBS Operations team and report back to the Committee.	Peter Richardson (Head of Quality, Safety & Regulatory Compliance, Deputy Director of WBS)	BJC for the fleet replacement has been endorsed by WBS SLT on 12th August, due to be presented to EMB Shape for endorsement on 9th September prior to submission to Strategic Development Committee for approval	12/09/24	CLOSED

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4.1.4	Review whether requests received from within the NHS are to be categorised as FOI requests, rather than inter-organisational requests.	Non Gwilym (Interim Director of Corporate Governance)	Head of Information Governance has confirmed that future requests for information from any NHS organisation should be considered as BAU rather than an FOI request.	12/09/24	CLOSED
4.2.2	Comparison data and level of assurance to be added to the Equality, Diversity and Inclusion Annual Report.	Sarah Morley (Executive Director of Organisational Development & Workforce)	The report was amended as requested for submission to Trust Board.	12/09/24	CLOSED
Actions agreed at the 11th July 2024 Committee					
3.1.3	Ensure VCS Departmental Manager is clear on their duty of ensuring "You Said, We Did" boards are kept up to date.	Tina Jenkins (Head of Quality, Safety & Patient Experience)	Departments have been reminded of the importance of updating and dating the boards. The Q&S team are setting up a monthly meeting with representation from all depts to strengthen the governance and assurance around patient feedback. This will include - • Ensuring the feedback is being shared with all staff in the department • That the "you said we did" boards are being updated monthly (with both positive and not so positive feedback) • That any areas for improvement identified by patients are actioned or escalated up as needed • That any themes or trends in the feedback are being noted and captured • That the monthly CIVICA feedback is discussed in team and directorate meetings	12/09/24	CLOSED

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3.1.6	Review reporting mechanism to ensure that any future improvement notices are brought through the Integrated Quality and Safety Group.	Steph Williams (Head of Health & Safety)	**Update 02/09/24:** Currently this action is still open. Plans to update the PMF with accurate and relevant information continues and is being developed to include improvement and enforcement notices	~~12/09/24~~ 14/11/24	OPEN
3.2.5	LW to review accuracy of percentage figures for QSP attendance by Board members.	Liane Webber (Business Support Officer)	**Update 11/07/24:** Figures checked, one minor amendment made.	12/09/24	CLOSED
4.2.0	Discuss monitoring of instances where deaths occur within one health board or trust, whilst having links to other health boards and trusts.	Ruth Alcolado (Medical Director, Corporate Services, NWSSP) and Tina Jenkins (Head of Quality, Safety & Patient Experience)	The Medical Examiner Service, as part of their scrutiny of all deaths within Wales, will contact known consultants in the following circumstances *When there are any queries as to whether current or recent treatment may have been a contributory factor to the cause of death e.g. chemotherapy/immunotherapy/radiotherapy* This is normally done via email, and updates may be dependent on the email being answered. However, the hospital/health care setting/team caring for the individual should update the patient record system and any deaths should be flagged there. It would also be expected that where joint care is taking place, the consultants should communicate any deaths.	12/09/24	CLOSED
5.3.1	Establish Level of Assurance rating for Business Continuity & Emergency Planning Annual Report	Sarah Richards (Head of Planning & Performance Services)	Assurance rating of 3 applied. Revised paper submitted to Committee secretariat.	12/09/24	CLOSED

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5.3.1	Provide details of the rationale of actions by the Committee in respect of all Trust annual reports.	Non Gwilym (Interim Director of Corporate Governance)	Standard Operating Procedure to support future Annual Report process to be developed by January 2025.	~~12/09/24~~ 16/01/25	OPEN
5.3.2	Establish timeline for update of Professional Registration /Revalidation Policy	Anna Harries (Head of Nursing, Professional Standards & Digital and Sarah Morley, Executive Director of Organisational Development & Workforce	The Professional Registration Policy is on the Agenda for endorsement on 12th September.	12/09/24	CLOSED

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

Quality, Safety and Performance Committee

SACT GOLD REPORT

DATE OF MEETING	12th September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	ASSURANCE
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science, Tersa Humphreys, SACT Transformation Lead & Anne Carey, Interim Chief Operating Officer
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science & Anne Carey, Interim Chief Operating Officer
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHP & Health Science & Anne Carey, Interim Chief Operating Officer

EXECUTIVE SUMMARY	Business Continuity arrangements were commenced in relation to SACT delivery in February 2024. There is a SACT Transformation lead in post who is supporting enhanced monitoring and capacity and demand modelling as well as delivering the required delivery improvements and efficiencies. There is currently a pharmacy capacity gap of 70 regimes a week. Performance against the 21-day non-emergency SACT target since January 2024 has been between 64% and 91%. Although the validated position for June 2024 was 88% the length of time that some patients are waiting for SACT is 35 days. The validation of July's position is being completed. The position is anticipated to be around 88%.

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	Bi-weekly SACT Gold meetings have continued, and the following actions have taken place since the last report (June 2024): • No harm has been reported as a result of SACT treatment delays. • A total additional capacity of 34 regimens per week has been introduced between April 2024 and the end of August 2024.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to ***NOTE*** the current position and ongoing recovery work.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
SACT Gold Command	July-August 2024
Executive Management Board	29th August 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Matters discussed, oversight provided, and decisions made on matters escalated.	
7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 2 - Symptomatic issues being addressed

1. BACKGROUND

In January 2024 the Velindre Cancer Services' ability to provide non-urgent SACT (Systemic Anti-Cancer Treatment) within the required 21 days significantly reduced due to increased demand for treatments. As a result, Business Continuity arrangements were instigated and SACT Gold Command established on 2 February 2024. Regular Gold Command meetings have been held (mainly weekly).

Gold Command is chaired by the Executive Director of Nursing, AHP & Health Science with the Executive Medical Director and Vice Chair. At this time the main capacity / demand gap was identified as being the provision of the required treatments (pharmaceuticals).

A significant increase in demand is reported across other cancer services within the UK.

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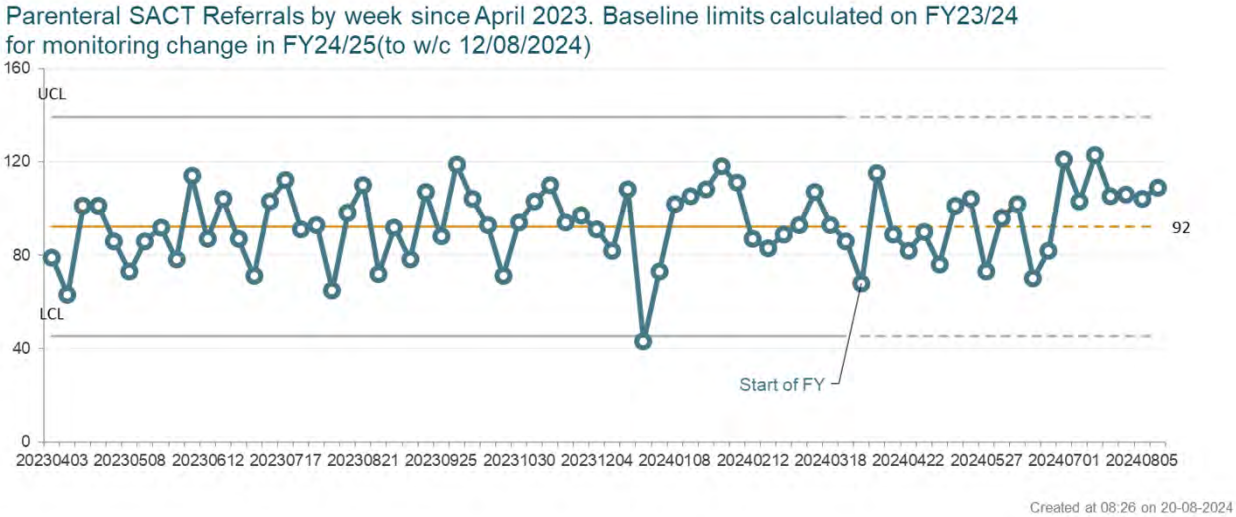
2. SACT PERFORMANCE

2.1 Emergency Performance

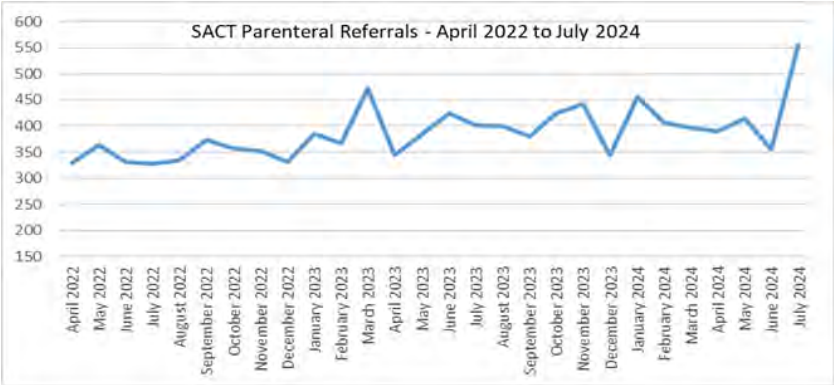
Emergency patients have all been prioritised and treated within the target of 5 days maintaining 100% performance over the last 12 months. This is not anticipated to change as will be prioritised.

2.2 Non-Emergency Performance

Demand on the service has continued to grow with 4% more referrals between April and July 2024 compared to 2023/2024.



The monthly variation in demand for SACT cycle 1 treatments has been significant in the last two months going from -12% in June 2024 to +28% in July 2024.



The table below provides an overview of the validated breach position in respect of non-emergency SACT. The compliance target is 98%:

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	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
Non-Emergency referrals	394	413	358	434	386	280	443	457	356	361	445	341
Non-Emergency Compliance	94%	92%	90%	98%	85%	90%	64%	79%	91%	75%	76%	88%
Total number of non-emergency referrals treated within 21 days	370	380	323	424	329	251	283	362	323	271	338	300
Total Number of breaches	**25**	**32**	**35**	**10**	**57**	**29**	**160**	**95**	**33**	**90**	**107**	**41**

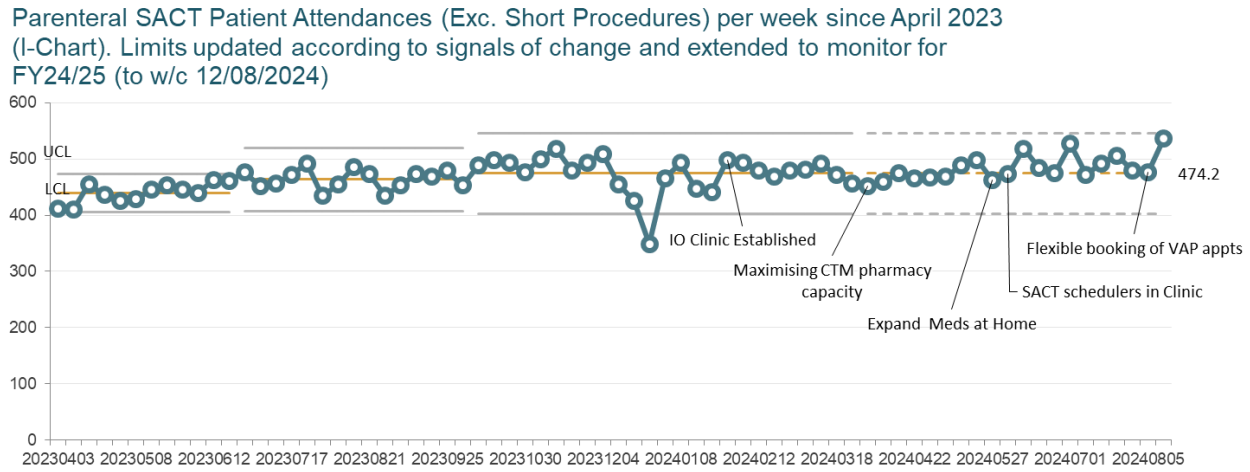
The July forecasted position is expected to increase further.

Although performance appears to have slightly improved the length of time some patients are waiting for non- emergency SACT is up to 35 days.

Longest Waits Non-Emergency

Wait time	referrals	percentage
0-7 days	132	39.8%
8-14 days	44	13.3%
15-21 days	133	23.1%
22 - 28 days	32	10.7%
29 - 35 days	9	5.1%
36 – 42 days	0	0%
43 – 49 days	0	0%
50 – 52 days	0	0%
Total	**341**	

The current plan is anticipated to demonstrate further improved performance in July (above the June 2024 performance) with measures in place to support delivery further from September. The next phase initiatives are planned to further stabilise and improve performance through 2024/2025 and into 2025/2026.



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2.3 Pre-SACT Assessment

It has been recognised that in addition to increasing the capacity to provide SACT treatment, SACT Pre-assessment (the start of the pathway) processes and pathways also requires urgent change.

A dedicated SACT Pre-assessment session was held between VCS Senior Leadership Team and the Executive Team on 19th August 2024 where the current pressures in Pre-SACT Assessment were quantified and a number of actions agreed to transform the SACT Pre-assessment process. This work will significantly increase the provision of Nurse / Pharmacy led clinics and virtual assessment clinics, releasing medical time, reducing pressures on well overbooked clinics and creating greater flexibility in being able to spread treatments across five days a week as currently the way the clinics are configured places disproportionate demand for treatments to be delivered Wednesday to Friday with unused capacity earlier in the week. Whilst it is recognised that this will take time to fully enact, a plan to move some clinics in the short term to spread SACT delivery demand are being enacted.

3. ENSURING PATIENT SAFETY

Consultant Led Clinical Prioritisation continues and to date no harm to any patients have been identified.

4. SACT DELIVERY IMPROVEMENTS

4.1 Overarching Improvement Plan

The SACT improvement plan which covers the following areas is being progressed (whole plan shared with previous report):

- a full review of capacity and demand modelling and forecasting has been undertaken for SACT Delivery
- increased availability of pharmaceuticals and SACT treatment in line with predicted 2-year re-modelled growth.
- the introduction of nurse led Immunotherapy Clinics
- expansion of our Medicine at Home provision between April and September 2024 equating to an increase of 40 patient treatments per week.
- increasing outsourced pharmaceutical product capacity.
- piloting pathway improvements, including decoupling of bloods from clinics to improve booking flexibility, to ensure we maximise the utilisation of all our available capacity,
- a senior SACT Improvement Lead to support rapid SACT improvement delivery and a comprehensive improvement plan is in place.
- additional capacity across key ‘bottlenecks’ in the pathway
- ‘a single source of truth’ at patient level feeding into a patient tracking list and a daily sitrep.

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The plans to increase the Nurse and Pharmacy provision (expansion plans) are underway with posts being actively recruited into.

4.2 Capacity Increases made to Date

Since April 2024 the total number of regimens per week has increased by 34:

- Mobile Unit – capacity increased from 24 in April 2024 to 48 by the end of August 2024.
- VCC Pharmacy Capacity plan to increase from 515in April 2024 to 525 by 1st August 2024.

The plan for September 2024 will see SACT treatment capacity increase by a further 21 regimens per week, which will equate to a total increase of 55 regimens per week since April 2024.

5. FUTURE FORECASTING

The plan in place will see performance improve further in July but is anticipated to reduce in August and September prior to stabilisation and improvement through the remainder of 2024/2025 and into 2025/2026. This level of performance is based upon the forecast demand which represents a risk given the current volatility.

A number of other initiatives are in place to increase Pharmacy capacity to support SACT delivery from early September, aiming to achieve an additional 21 regimens per week.

A Patient Tracking List is in development with Digital Insight team to develop a real time 'single source of truth' for each patient pathway as well as understanding the demand for individual components of the service including oral and parental SACT, pharmacy, nursing and booking and to allow a higher degree of visibility on the number of patients waiting more than 21 days for treatment to be able to refine the improvement trajectory.

6. 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	☐

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• 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 provision of timely cancer treatment will impact on all aspects of Quality & Safety and the Trusts requirements to meet the Duty of Quality.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	Provision of timely cancer treatment directly impacts on Trust's Healthier Wales responsibilities.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There is a cost implication as additional front-line capacity is required to deliver the required increase in SACT provision over and above IMTP provision. This is within: pharmacy, nursing, Virtual Assessment Service (VAP). This is currently being quantified.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required for this type of report
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	There is the potential for litigation as a result of harm that may occur if patients' SACT Treatment is delayed beyond clinical optimal timescales.

7. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*There is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm*
WHAT IS THE CURRENT RISK SCORE	20
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	It is anticipated that the SACT Improvement Plan & Pharmacy Plan will reduce the risk significantly
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Sustained improvement and risk reduction should commence in September 2024. Initial target risk score is 12.
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Finance, availability of the required trained personnel, leading time for staff from novice to competent practitioner.
WHAT IS THE RISK?	*There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment*
All risks must be evidenced and consistent with those recorded in Datix.	

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE SUPPLY AND SHAPE & ASSOCIATED FINANCE RISKS

DATE OF MEETING	12th September 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	Amanda Jenkins, Head of Workforce Steven Coliandris, Head of Financial Planning & Reporting
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce Matthew Bunce, Executive Director of Finance
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The workforce issues in delivering the correct Supply and Shape of the Workforce is the ability to (1) recruit and retain the workforce (2) ensure a work environment that supports staff's wellbeing (3) develop effective service and workforce plans. The emerging risk is the availability of staff to deliver services due to vacancy gaps in specialist hotspot areas and staff absence due to sickness. The paper key priorities, noting the action taken, those delivered and issues and risk mitigation in

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	the action plan. In summarising each priority, the current level of assurance is provided with an overall assurance level provided

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the workforce supply and shape updates and associated financial impacts as outlined within the contents of the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date n/a**
Executive Management Board	29/08/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted	

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

APPENDICES	
	No Appendices

1. SITUATION/BACKGROUND

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The People Strategy articulates the key priorities and focus for its delivery:

- Attraction and Retention
- Wellbeing and Equalities
- Education and Learning

- Workforce Supply and Shape
- Leadership and Succession

This report concentrates on delivery against those key priorities, noting the action taken, those delivered and issues and risk mitigation in the action plan. In summarising each priority, the current level of assurance is provided. The paper also references the financial implications of the workforce risk.

2. ASSESSMENT/ SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Attraction and Retention

Attraction and Retention
Actions Delivered Qtr. 1 24/25
• Onboarding and integration programme for international nurse recruits (13 WTE at Velindre Cancer Services) • Trust engagements with the NWSSP recruitment modernisation programme board improving time to hire, from vacancy creation to start date of candidate (reduced from 85.2 days in July 2022 to 45.1 days in July 2024) • Application to be a disability confidence employer level 3 (currently level 2) • Nurse Retention Plan • Exit interview dashboard • Fully implemented the Trust Recruitment Policy with focus on workforce planning and establishment control • Streamlined scrutiny process with POD and Finance approvals being made in Trac to reduce administrative burden on service leads.
Actions Qt 2 24/25
• CEO and other key senior roles to be reviewed in line with workforce planning principles and resources to ensure the leadership within the Trust is maintained • Attraction campaign and promotional materials for Cancer Service being developed • Become accredited as a disability confident employer level 3 • Develop a local framework for managing industrial action utilising learning from recent action • Implementation of a policy review group to ensure all POD policies are aligned to our new values and support staff appropriately • Engagement with the All Wales Bank incentive programme board to improve AFC terms of engagement

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Issues/Mitigation
• Agency spend review ongoing – *more detail in section 3 – associated finance costs* • Labour market challenges – ongoing Trust activities to grow and develop our own workforce. *Development of the POD Activity and Project Plan to clearly identify a delivery programme with agreement from the services*
Levels of assurance
4 – Increased extent of impact from actions

2.2 Wellbeing and Equalities

Wellbeing and Equalities
Actions delivered Q1 2024-25
• Wellbeing Project Coordinator appointed • Vivup (EAP) launch and engagement sessions with staff • NHS Staff Survey results received and reported to EMB. • Strategic Equality Plan 2024-28 developed and approved. • First iteration of WRES data reported and report received • Data reporting around work related stress has begun with a reviewed and improved stress risk assessment process
Actions Q2 2024-25
• Noddfa to be furnished (funded by NHS Charities Together). • Annual action plan to implement the Strategic Equality Plan developed. • Launch NHS Wales Health and Wellbeing Framework. • Engagement with HEIW on launching Staff Survey 2024-25
Issues/Mitigation
• Stress is biggest reason for sickness absence – data being collected on the different types of stress experienced. • Collaboration and engagement with service and workforce is key in addressing issues - *Development of the POD Activity and Project Plan to clearly identify a delivery programme with agreement from the services*
Levels of assurance
4 – Increased extent of impact from actions

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2.3 Education and Learning

Education and Learning
Actions delivered Q1 2024-25

• People Development Policy completed and in the Trust's governance process for approval • Health Care Support Worker group established and key roles appointed • Review of PADR process under way though a Trust wide task and finish group. • Final programme of Fundamental of Management Training programme agreed. • Ongoing implementation of Education Strategy audit recommendations
Actions Q2 2024-25
• Launch Fundamental of Management Training • Approve new PADR policy and process • Ongoing development of Trust Training plan with service leads • Ongoing implementation of Education Strategy audit recommendations
Issues/Mitigation
• The Education Strategy Audit has provided valuable feedback and has allowed the Trust to tighten its approach to planning and reviewing training and development. • Engagement and collaboration with workforce is key to ensure actions are proactively taken forward – *Development of the POD Activity and Project Plan to clearly identify a delivery programme with agreement from the services*
Levels of assurance
4 – Increased extent of impact from actions

2.4 Leadership and Succession

Leadership and Succession
Actions delivered Q1 2023-24
• Trust Values approved. • 7th Cohort on Inspire. • Approval of Fundamentals of Management Training • Learn at work week
Actions Q2 2024-25
• Approve Behaviour Framework and embed into People Processes. • New Values and Behaviour Framework launched in July 2024.
Issues/Mitigation
• The Values and Behaviour Framework represent aspects of the culture of the trust and it will take time for people to understand where they can develop their styles at work to better encapsulate Caring, respectful and Accountable. • Key requirement for this to be led by Executive management Board

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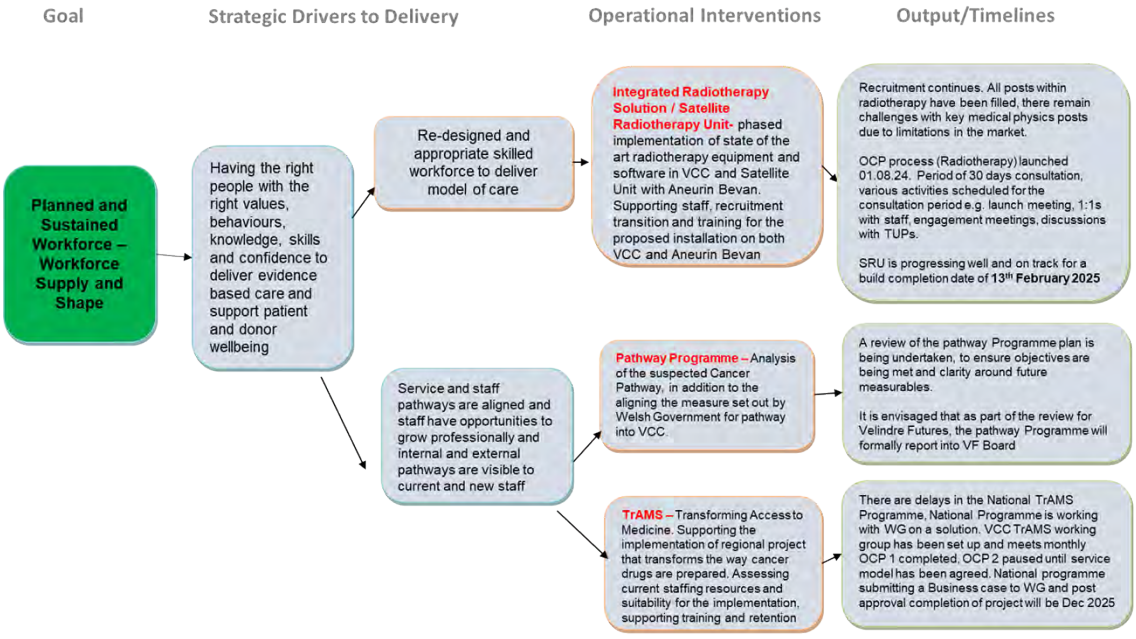
Levels of assurance
4 Increased extent of impact from actions

2.5 Supply and Shape

Supply and Shape
Actions Delivered Qtr. 4 23/24
• Implementation plan for the People Strategy - *Development of the POD Activity and Project Plan to clearly identify a delivery programme with agreement from the services* • Regular reporting and monitoring of work plans by Senior Leadership Teams, Executive Management Board and the Quality Safety and Performance Committee via monthly workforce dashboards and this paper quarterly respectively • Ongoing infrastructure of workforce planning training embedded via the Trust management and leadership Inspire Programme • Workforce planning and establishment control built into the Recruitment planning process through the new recruitment Policy.
• Divisional Updates
VCC



WBS

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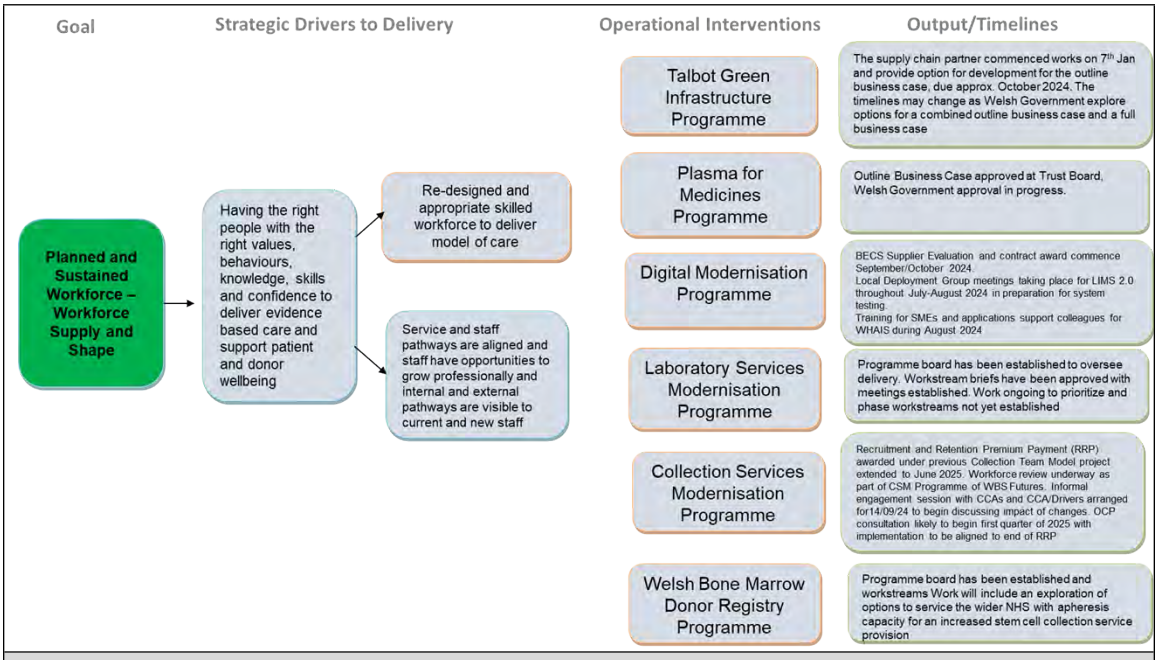

Issues/Mitigation
• Workforce plan across the Trust. Work underway to take this forward in Q2-Q4 • Engagement and collation with the service is key – *Development of the POD Activity and Project Plan to clearly identify a delivery programme with agreement from the services* • Dependency on national initiatives impacting on deliverables
Levels of assurance
3 Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

3. The associated financial risk to Workforce Supply and Shape

The financial risk associated with workforce supply and shape will be monitored and managed through the pay budget monitoring process. This includes staff who were permanently recruited in response to Covid where guaranteed funding from Welsh Government is no longer available. Funding is now linked to activity delivered compared to 2019-20 levels as part of the Long-Term Agreements with Commissioners.

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Pay Budget 2024/25

The full year pay budget as at end of July 2024 is £85.612m based on 1,675 WTE. The Trust has reported cumulative year to date spend on pay of £29.445m against a budget

of £29.231m resulting in current overspend of £(0.214)m. The pay costs include the costs of agency staff, on-call and overtime.

Pay Award

The Trust has now received confirmation from WG via the pay matrix that the full 2023-24 consolidated pay award will be funded.

The Trust has not yet received any formal notification from WG in relation to the 2024-25 pay award.

Agency

The spend on agency for July'24 was £0.063m (June £0.062m) with a current forecast outturn spend of circa £0.322m (£0.775m 2023/24).

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance & Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

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Where possible the Trust will aim to utilise bank staff to reduce reliance on agency and the premium costs associated.

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	Covid staff costs that may not be fully covered by WG or Commissioner income Ongoing premium cost of agency
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	Individual elements of work described in this paper may be subject to EQIA.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*This is reflected in the Trust Assurance Framework Risk 03*
WHAT IS THE CURRENT RISK SCORE	12
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*This paper provides an overview of work being undertaken to impact the Supply and Shape of the workforce.*

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BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Currently being reviewed
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	External factors impacting on recruitment
All risks must be evidenced and consistent with those recorded in Datix	

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Anti-racist Wales Action Plan – Six-monthly Update

DATE OF MEETING	12th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	In line with Welsh Government policy, the Trust agreed an Anti-racist Action Plan in December 2022. The Trust has made progress with putting strong foundations in place and is now looking to develop further. Some areas of action are dependent on national resources which are still under development.

RECOMMENDATION / ACTIONS	To NOTE the update for onward submission to the Trust Board.

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GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB	29/08/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Noted by EMB	

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	
1	Anti-racist Action Plan Progress - August 2024.
2	VUNHST Workforce Race Equality Standard (WRES) report

1. SITUATION

1.1 In July 2022 Welsh Government published the Anti-racist Wales Action Plan. This plan is shaped by three factors:

- It is built on the desire to strive for a nation in which there is zero tolerance of racism in all its guises
- It has been developed through co-creation with stakeholders from the breadth of racial and ethnic groups in Wales

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- It is designed as a stepping stone between the legal requirements under the Equality Act 2010 and the practical implementation of racial equality in day-to-day life

To this end, all public sector organisations in Wales have concurrently created plans to make Wales an anti-racist country by 2030. Progress with the Trust's plan is set out at Appendix 1, with a description provided below.

2. BACKGROUND

2.1 Subsequent to the agreement of the Anti-racist action plan, the Trust refreshed its Strategic Equality Plan (SEP) for the period 2024 to 2028. The four objectives within the SEP all touch on Anti-racism and the actions have been coordinated and are monitored in the same forum, the Healthy and Engaged Steering Group.

2.2 A major plank of the Anti-racist plans nationally has been the development and implementation of the Workforce Race Equality Standard (WRES) across NHS Wales. VUNHST has supported this coming into being by providing data and feedback to the central team. This has led to the successful publication of WRES reports across Wales, both for the Trust and all other health organisations. The first annual report, received in June 2024, is attached at Appendix 2.

3. ASSESSMENT

3.1 Appendix 1 captures the progress made across the breadth of the Anti-racist Wales plan.

3.2 The actions in the plan will also encompasses the recommendations that came with the WRES report in June 2024. There were four issues highlighted by WRES for attention within the recommendations:

1. Likelihood of ethnic minority staff being appointed after shortlisting (especially medical and non-clinical appointments)

   Recommended actions:
   - structured interviews, independently scored
   - use of positive action when needed
   - including at least minimum number of minoritised individuals at interview
   - supporting staff who fail an interview with reapplication

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2. Progression of ethnic minority staff to middle and senior grades (especially Black staff)

   Recommended actions:
   - board members to have specific measurable inclusion objectives to which they will be individually and collectively accountable
   - talent pipeline management
   - embed fair and inclusive recruitment processes
   - implement appropriate induction and onboarding processes for internationally recruited staff

3. Poor levels of declaration of ethnicity, especially given that staff reporting worst experiences were those who did not declare ethnicity

   Recommended actions:
   - set targets for declaration for all staff, including specifically senior members of staff
   - programmes to drive increased self-declaration via payslip, outreach, etc

4. Dissatisfaction from some White staff about equality of career opportunity

   Recommended actions:
   - Needs internal engagement of colleagues to better understand the concerns and identify the barriers to equality of opportunity

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 There are a number of actions still to be completed under the themes of:

- Staff Race Forum and staff stories
- Patient Engagement and Donor Engagement strategies.
- Programmes for Board development, staff training and coaching
- Objectives for all staff
- Executive Equality Ambassador and Cultural Ambassador roles
- Talent pipeline
- Equalities analysis of access to development, employment and experience of bullying and discrimination
- Recruitment process and People Policies review
- ESR data collection

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- Embedding Speaking Up Safely and providing effective channels for reporting

4.2 Progress with these actions is dependent on collaboration between a wide range of people across the organisation, with specific responsibilities with the Board, with the People and OD team and with Welsh Government, who are providing learning materials. Key activities are to conclude the roll out of the Anti-racist plan are:

- Staff Race Forum meeting during August 2024 which will open up dialogue of the experience of working in VUNHST for people with minority ethnic background
- People and OD team session is booked for the 3 October 2024 to address issues raised in the WRES and the Policies Review
- Implementing the Board development and staff training packages once they have been received
- Review and extension of Speaking Up Safely arrangements from September 2024.

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	☒

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RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
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
	Click or tap here to enter text. **Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	None

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EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

3. RISKS

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

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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust

Anti-Racist Action Plan 2022-25

Aim

This plan aims to create an organisational culture in which all members of staff are able to enjoy working free from discrimination and where ethnic background is a source of strength, not a barrier. The plan aims to ensure that anyone who interacts with our blood or cancer services can be confident that they will be treated without any form of discrimination related to their race or ethnic background. It also aims to reduce differential outcomes for patients relating to their ethnic group and to ensure a wide cross-section of ethnic groups are actively engaged in being blood and bone marrow donors.

Ref	National Actions	Date	Trust Actions	Progress 6.8.24
1	Trust Chair's objective to be set in support of this anti-racism work, to be discussed by relevant stakeholder groups and agreed by Ministers or Welsh Government Senior officials.	September 2023	• Share the Chair's objectives with all Board members to highlight Anti-racism commitments	Completed. Specific objective regarding Anti-racism contained within Chair's and Independent Member for ED&I's Objectives.
2	Trust to develop anti-racism action plans; for both employment and service delivery as a specific part of their wider approach to equality, inclusion and diversity.	December 2022 December 2022	• Map Anti-racist goals against the goals of the Strategic Equality Plan and set out how the two work together • Include Anti-racism within the IMTP process using the Equality Impact Assessment.	Completed. Strategic Equality Plan 2024-28 embeds Anti-racism as a key outcome. Progress with both monitored through H&E Steering Group Completed. EQIA was embedded into the development of the IMTP for 2024-25 – 2026-27.

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		March 2023	• Consult with staff, patients and donors to test what their experience is and what needs to change	Staff Race Forum recruited to throughout 2024. First meeting to take place in August 2024. Patient Engagement and Donor Engagement leads are agreeing stakeholder engagement strategies.
		March 2023	• Establish a current baseline set of data relating to staff, patients and donors in respect of race. Compare this data with local demographic data relating to racial diversity.	Completed. Baseline set of data in place for staff and this is compared with 2021 Census data for Wales. For patients and donors, the EQIA methodology was used in the IMTP to help 'baseline' where we are as a Trust in supporting our patients, donors and staff who may have a range of challenges as defined by the 'nine protected characteristics', and to identify any potential improvements that can be added to the Vulnerable Persons Work Plan Research was undertaken into the demographics of our patient (S.E. Wales) and donor (All Wales) populations, using ONS Census and other sources, to further enhance our appreciation of the proportion of people with protected characteristics plus tapping into some CIVICA data on cancer referrals.

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		December 2022 and ongoing	• Develop, implement and monitor the plan through the Healthy and Engaged Steering Group.	Completed. Quarterly reports come through the Healthy and Engaged Steering Group.
3	All NHS Board members will begin anti-racist development in 2022 and undertake an anti-racist education programme	Summer 2023 December 2023	• Deliver Board Development awareness session on importance of cultural competence • Deliver Board development programme during 2023 commissioned by Public Bodies Unit, WG	Completed. Introductory presentation from Diverse Cymru presentation 27.10.22. Awaiting on materials from Welsh Government
4	All NHS Board members will have and report progress against personal objectives to meet vision of an anti-racist Wales.	December 2022 December 2022 and ongoing December 2023	• Establish personal objective in support of Anti-racist Wales for each Board member. • Board members will role model anti-racist practices by challenging discrimination, listening to lived experiences and considering racial perspectives when making decisions. • Anti-racist objectives to be cascaded through every level of the organisation and made relevant to each job role.	Completed. Ongoing. A specific development programme for Board Members is to be developed by 31st October 2024 in conjunction with the IM for ED&I. Not completed.

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5	Staff, volunteers and students to complete redesigned anti-racist education programmes to bring enhanced awareness of race, racism, micro behaviours, microagressions at all levels of the organisation.	December 2023 June 2023 June 2023 June 2023	• Implement programme when available • Embed anti-racism into management and leadership development activities • Offer coaching to support leaders implement and enhance practice in supporting their Black, Asian and racially minoritised colleagues • Embed anti-racism into staff induction by developing a welcome programme of activities for staff joining the organisation via international recruitment activities. This may involve establishing a buddying / support network for staff and drawing on experience of other Health organisations who have established such an approach.	Not yet available Completed. Anti-racism is covered in Inspire and Fundamentals of Management. To be developed Completed. A wide programme of welcome and induction activities was put in place for the cohort of Nurses recruited from India in 2024. This will become standard practice for subsequent cohorts.
6	Appointing 'Executive Equality Champions' and 'Cultural Ambassadors	September 2023 September 2023	• Build on existing role of Executive Equality Ambassador • Develop Cultural Ambassador role once role profile is available	To be actioned Not yet available

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7	Implementing a leadership and progression pipeline plan for Black, Asian and Minority Ethnic staff	September 2023 September 2023	• Establish a pipeline for Black, Asian and Minority Ethnic staff as part of Trust talent management approach • Review promotion and development process to ensure there is no bias or bias is mitigated	To be actioned The WRES 2024 report reflects opinions about access to development in line with ethnic origin. Fuller analysis to take place at year end 2024-25.
8	Review People policies to ensure they fully support all employees	December 2023 December 2023 December 2023	• Support All Wales programme of review of national policies • Review Trust level policies through active use of an Equality Impact Assessment for each policy • Examine all Trust recruitment processes through an anti-racist lens	Completed – VUNHST HQ hosted an engagement event Completed. All new and revised policies are now accompanied by an EQIA WRES data will be reviewed by the People and OD team on 3.10.24 to determine any changes to processes required. The recommendations of the All Wales Audit of Workforce Policies through an anti-racist lens will also support this work. These are being embedded in actions plans from September 2024.
9	Implement an anti-racist communication plan and create forums for Black, Asian and Minority Ethnic	September 2023	• Re-Establish Black and Ethnic Minority staff group. Terms of Reference to set out how they have access to the Board and that they are	Advertising and recruitment undertaken. First meeting due August 2024.

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	staff to communicate their experiences and ideas. Providing Ethnic Minority Networks appropriate levels of resource and access to the Board.	September 2023	a resource for consultation and communication. • Standardise the consideration of staff, patient and donor stories setting out the lived experience of people from different racial backgrounds.	To be developed by staff forums
10	Improve workforce data quality and introduce a Workforce Race Equality Standard (WRES)	September 2023 September 2023 September 2023 September 2023	• Request all staff to update their demographic information on ESR • Work with NHS colleagues in adopting the WRES, ensuring ESR is able to produce the reports • Use WRES to understand the experience of ethnic minority staff in relation to pay and treatment • Ensure monitoring is in place and includes Leavers, Promotions, Training Opportunities, Grievances,	Regular requests come through ESR. Our WRES report for 2024 highlighted we need to increase completeness of demographic information for more senior roles to provide better insight into differential experiences of ethnic groups; targeted communications will be issued to improve this before the next report. Completed. Fully supported the initiation of the WRES reports and provided all data in time. WRES 2024 now received and being applied to our actions under the Strategic Equality Plan. To be reported for year end 2024-25.

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			Complaints, recruitment applications v shortlisted v successful and staff engagement surveys	
11	Implement systemic monitoring of concerns of workforce discrimination and bullying raised by staff through the Joint Executive Team process. Review and scrutinise reporting processes for reporting racism, discrimination, inappropriate behaviours.	December 2023 December 2023 December 2022 and ongoing December 2023	• Capture and include discrimination and bullying data within Workforce Reports. • Develop clear robust processes and provide sufficient channels for staff to record and report racial discrimination and for the Trust to take action • Issue regular communications regarding zero tolerance of inappropriate behaviour • Work with Trades Unions to find ways for lower paid workers from ethnic minorities to raise concerns such as Speak Up initiatives, surveys and networks. Monitor uptake and remove barriers to access.	The systems for Speaking Up Safely have been established with links available and information on the intranet providing clear processes for recording and reporting discrimination. The NHS Staff Survey data and the WRES indicators on Bullying and Harassment will be examined during Q3 2024-25 to lead recommendations of how to bring this to life for all staff by removing barriers to access.
12	Ensure our COVID-19 recovery plans are fully inclusive and targeted to address known health inequalities in access to care and service provision.	September 2023	• Apply Equality Impact Assessment to COVID 19 recovery plans and link to known health inequalities.	Completed.

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GIG CYMRU NHS WALES

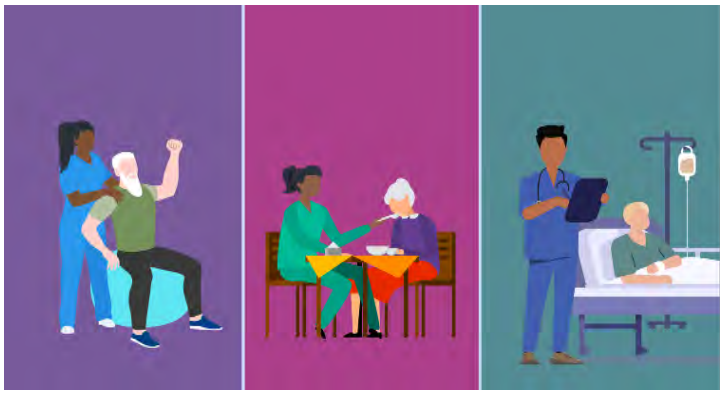
Gofal Cymdeithasol Cymru
Social Care Wales

Llywodraeth Cymru
Welsh Government

Safon Cydraddoldeb Hil y Gweithlu (SCHG)
Gweithlu cynhwysol sy'n darparu'r gofal gorau

Workforce Race Equality Standard (WRES)
An inclusive workforce provides the best care

The Workforce Race Equality Standard for Wales



WORKFORCE RACE EQUALITY STANDARD ORGANISATIONAL REPORT

VELINDRE NHS TRUST

2024

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WORKFORCE RACE EQUALITY STANDARD ORGANISATIONAL REPORT 2024

VELINDRE NHS TRUST

Foreword

When the NHS was created in 1948, launched by Tredegar-born Health Secretary, Aneurin Bevan, it was based on three core values: that the services were for everyone, that healthcare was free at the point of delivery and that care would be provided based on need rather than ability to pay. All of these are predicated on principles of fairness and equity and apply to patients and staff equally. Sadly, in the 76 years of the NHS, those ideals have not always been lived up to, not least with regard to race. The COVID pandemic brought to the forefront what had been clear to many minoritised people for a long time. The publication of the Anti-racist Wales Action Plan (ArWAP) by Welsh Government in 2022 was a recognition that to halt this damaging inequity, we needed to actively identify and eradicate the structures and processes that result in worse outcomes for individuals from an ethnic minority.

A key component of the ArWAP was a wide consultation, and it became clear that NHS staff felt that to advance race equality in the service, it was important to have a robust dataset to allow a detailed understanding of the problem, as well as a means of monitoring it. This was the basis of the Workforce Race Equality Standard, and the inaugural data is published in this report. To have achieved this within two years of the launch of the ArWAP is a signal of the commitment of the Welsh government and NHS Wales organisations to this important task, and it is the intention that this data is but the first step in undertaking the transformation of our systems and processes that perpetuate injustice.

This report shows the detail of the workforce in Velindre NHS Trust. It is structured around the themes of representation, development, disciplinary equality, and institutional culture. It is the ambition that this allows identification of the areas of greatest deficit, and hence a call to action to develop a local strategy to tackle that. This report is not shared with other NHS organisations, but will complement a published national WRES report displaying the state of these themes across the whole of Wales.

These reports should give pause for brief reflection by national and local leadership, and then a commitment to action to improve both equality for our Black, Asian and minority ethnic staff and the experience of patients.

Anton Emmanuel, Lead for the WRES NHS Wales and Social Care

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KEY FINDINGS WRES 2024

VELINDRE NHS TRUST

	VUNHST	NHS Wales
Undeclared ethnicity rate overall (%)	5.7%	10.8%
Undeclared ethnicity rate Band 8 + (number)	4	290
Staff survey completion rate	33.9%	20.7%
Workforce reflective of population	partly	yes
Full appointment data (Ind 5)	yes	incomplete
Ind 1: Board representation	4.8%	5.9%
Ind 2: ESP representation	3.2%	6.4%
Ind 2: Disparity ratio lower to middle	1.09	1.51
Ind 2: Disparity ratio middle to upper	2.6	1.81
Ind 2: Disparity ratio upper to senior	0.16	0.72
Ind 3: Equitable perception of progression opportunity (% difference)	-22.9%	18.8%
Ind 5: Equitable likelihood ratio of appointment Overall	0.4	0.57
Ind 5: Equitable likelihood ratio of appointment Non-clinical	0.32	0.47
Ind 5: Equitable likelihood ratio of appointment Clinical	0.35	0.58
Ind 5: Equitable likelihood ratio of appointment Medical	0.95	0.57
Ind 6: Equitable likelihood ratio of accessing non-mandatory training	1	0.98
Ind 8: Equitable likelihood of entering formal disciplinary process	0	1.07
Ind 9: Equitable likelihood of entering local capability process	0*	3.46
Ind 10: Equitable % experiencing harassment from patients/public (% difference)	-32.50%	8.54%
Ind 11: Equitable % experiencing harassment from colleagues (% difference)	0.0%	13.2%
Ind 12: Equitable % experiencing discrimination from managers (% difference)	-13.3%	10.3%

Colour rating explanation:
Green = within zone of parity of four-fifths rule
Amber = within 2 standard deviations of the mean
Red = outside 2 standard deviations of the range

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Introduction

The NHS is the largest employer in Wales with some 111,000 employees. This first WRES data report requires the organisations employing these staff to report against eleven of twelve indicators of race equality. The data is presented in a nuanced fashion with stratification and disaggregation by gender to enable leaders to identify how the intersection of discriminations affects individuals, and where energy should be best directed to reverse inequity. These indicators (detailed in Appendix A) cover the four core domains which experience and the literature show are responsible for differential attainment:

- Representation and leadership (5 indicators)
- Professional development and training (2 indicators, one is not reported in 2024)
- Disciplinary and capability (2 indicators)
- Discrimination, bullying and harassment (3 indicators).

In Velindre NHS Trust (VNHT), this report identifies some uncertainty around the accuracy of recording disciplinary and capability proceedings. Additionally, the key headline areas of inequality relate to:

1. **likelihood of ethnic minority staff being appointed after shortlisting (especially non-clinical appointments)**
2. **progression of ethnic minority staff to senior grades**
3. **poor levels of declaration of ethnicity, especially by staff experiencing bullying and harassment**

This data reflects the systematised and complex picture that applies to racial discrimination. It provides both a tool for improvement, and a stimulus to transformational action. Translating data into delivering enduring change is a challenge that must be met by all organisations locally, as well as at a national level.

The data insights must be read and used by HR Directors, Clinical Leaders and Boards to develop evidence-based policy interventions. A foundational principle of change theory is to identify the data that is most unequal and focus actions on improving that – too often we see ineffective action targeted at either trying to make perfect what is already 'good', or worse, a continuation of actions unsupported by any data.

The indicators are displayed for your organisation, and shown in comparison to the national picture – this is to help focus intention to those areas of greatest need within the organisation, while comparing it to an all-Wales picture.

The WRES Team is keen to work with VNHT to draw on the knowledge of what works, based on the literature and on learning from other organisations in Wales. In producing this report, the intention is to support organisations to focus on the approach they will adopt to end the cycle of inequality that harms staff and patients.

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Methodology

Data collection

NHS Wales delivers services through 7 local health boards and 3 NHS trusts (Velindre University NHS Trust, Welsh Ambulance Services Trust, Public Health Wales); additionally there are three specialised healthcare services (Health Education and Improvement Wales, Digital Health and Care Wales and NHS Wales Shared Services Partnership).

The WRES mandates all organisations to self-assess against twelve indicators of workforce experience. Six are based on data derived from the NHS electronic staff record and electronic recruitment systems, five on data from the national NHS staff survey questions, and one considers Black, Asian and minority ethnic representation on boards. The detailed definition for each indicator can be found in the WRES Technical Guidance.

Data collection was as of October 2023 for the staff survey derived indicators and April 2024 for the other indicators.

Data analyses

We have analysed the data for all 13 organisations against each indicator. The presentation in this report shows VNHT data, compared with the aggregated national picture.

We have presented the data in a granular way as a method of optimising understanding of what the indicators reveal. This disaggregation is by gender (men and women) and by ethnicity (broken into sub-categories of Black, Asian and Mixed/Other). Further disaggregation by specific ethnicity was not possible due to the risk of displaying small numbers. Where there is an issue with small numbers even with the current categories, it has been shown as “less than 10, <10”.

Data caveats

Five of the WRES indicators (3, 4, 10, 11, 12) are drawn from questions in the national NHS staff survey. The reliability of the data drawn from those indicators is dependent upon the overall size of samples surveyed, the response rates to the survey questions, and whether the numbers of BME staff are large enough to not undermine confidence in the data.

We didn’t adjust the national score based on the number of staff employed by each organisation. Instead, we considered the results in relation to the number of survey respondents, accounting for disaggregated comparisons by ethnicity and gender.

The data for indicator 5 is from the Trac, the recruitment admin system, and only includes AfC recruitment processed by NWSSP Recruitment. Specifically it does not include medical appointments and any processed by the organisations themselves. This will however be sought for future data collections.

There is no data available for indicator 7, since the anti-racist training programme was not available at the time of data collection. This will however be available for all future data collections.

For indicators 8 and 9, the calculation uses a review of the period April 2023 to April 2024.

The results in this report are as at 31st March 2024, and revised after the clarification period as at 31 May 2024.

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Terminology

Throughout this report, we use the term 'Black, Asian and minority ethnic'. For the purpose of brevity and visualisation, this is abbreviated to 'BME' in figures and tables, but written in long-form in the text. Where possible we have followed guidance to disaggregate into more specific categories, but avoid the information governance risks associated with small numbers we have kept to categorisations of 'Black', 'Asian', and 'Mixed/Other' to refer to those members of the NHS workforce who are not White. This is largely driven by the data collection process. As set out in the WRES technical guidance, the definitions of ethnicity used in the WRES have followed the national reporting requirements of ethnic category in the NHS data model and dictionary.

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INDICATOR 1: Percentage difference by ethnicity between the organisations' Board executive and non-executive membership and its overall workforce

VNHT

Ethnicity	Workforce Overall	Executive Membership	Non-Executive Membership	Overall Board Membership
Asian	3.10%	7.69%	0.00%	5.56%
Black	1.19%	0.00%	0.00%	0.00%
Mixed & Other	2.03%	7.69%	0.00%	5.56%
White	87.98%	84.62%	80.00%	83.33%
Unknown	5.70%	0.00%	20.00%	5.56%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**

NHS Wales

Ethnicity	Workforce Overall	Executive Membership	Non-Executive Membership	Overall Board Membership
Asian	5.35%	2.22%	2.41%	2.29%
Black	1.56%	0.74%	1.20%	0.92%
Mixed & Other	2.64%	0.74%	0.00%	0.46%
White	79.67%	77.78%	60.24%	71.10%
Unknown	10.78%	18.52%	36.14%	25.23%
Total	**100.00%**	**100.00%**	**100.00%**	**100.00%**

Table 1: Board make up of VNHT compared with NHS Wales, disaggregated by ethnicity

Summary: There is good ethnic minority makeup of the Board in VNHT

Nationally there is a 5.9% deficit between composition of the Black, Asian and minority ethnic workforce and the make up of leadership nationally, but this is not seen in VNHT (Figure 1).

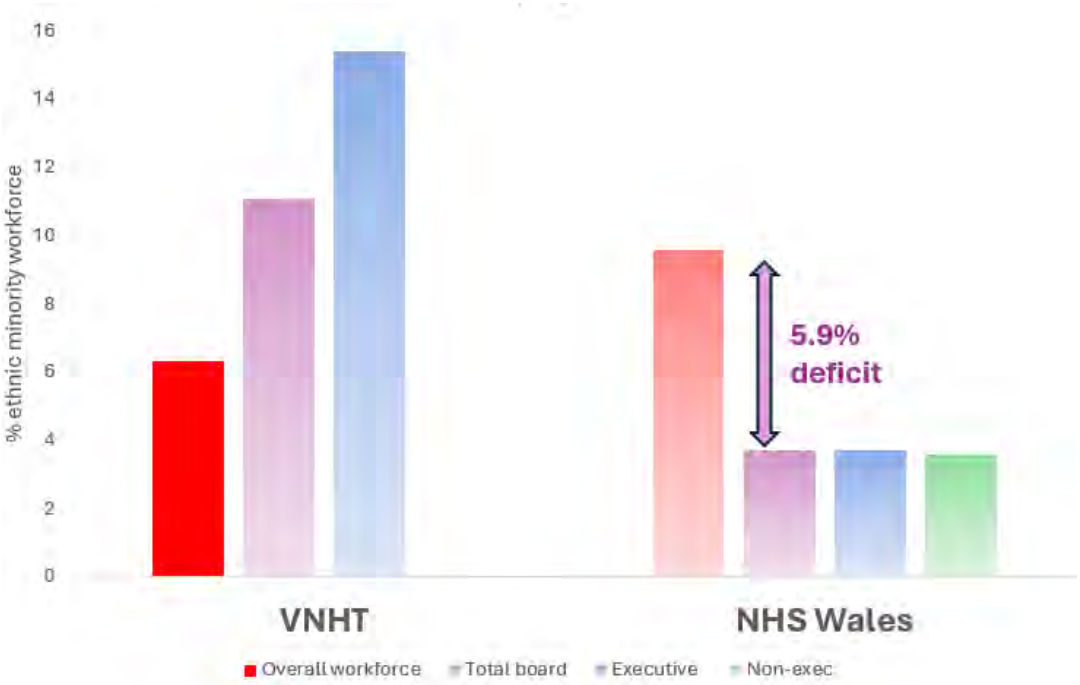

Figure 1: Composition of representation of ethnic minority workforce with board membership in VNHT and NHS Wales

Summary: There is ethnic minority executive (but not non-exec) Board representation in VNHT.

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INDICATOR 2: Percentage of staff by ethnicity in each of the AfC Bands 1-9 and ESP compared with the percentage of staff in the overall workforce

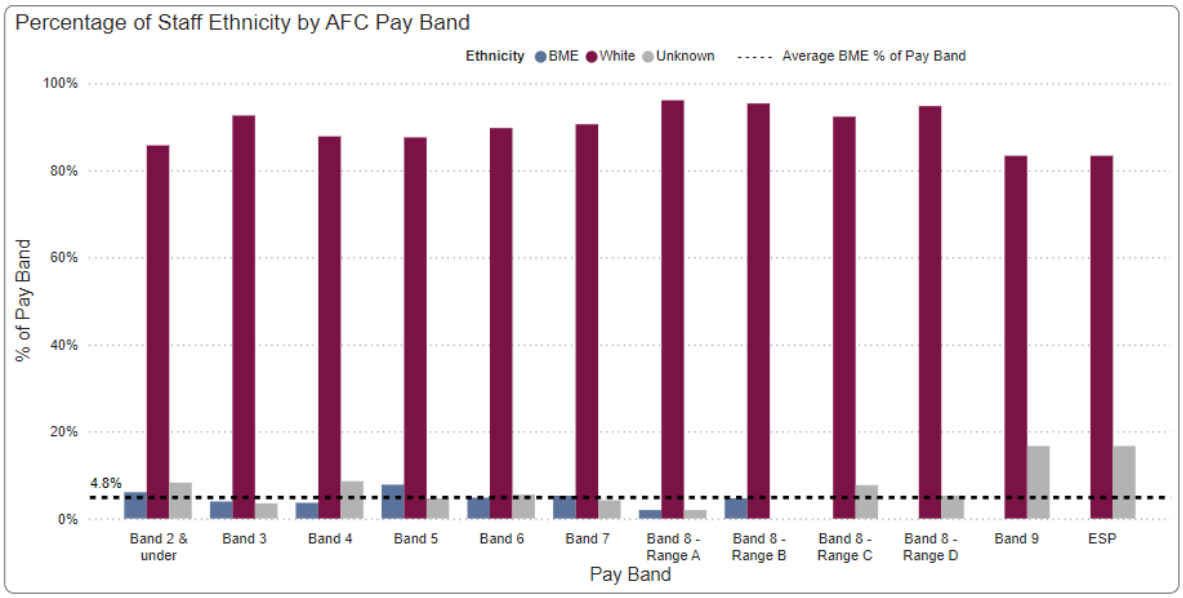

Figure 2: Percentage of staff by AfC pay band and ethnicity for VNHT

Summary: 1. Ethnic minority staff under-represented above Band 8b
2. Overall, the undeclared ethnicity rate in VNHT is 5.7%, but is especially high for higher Banded individuals.

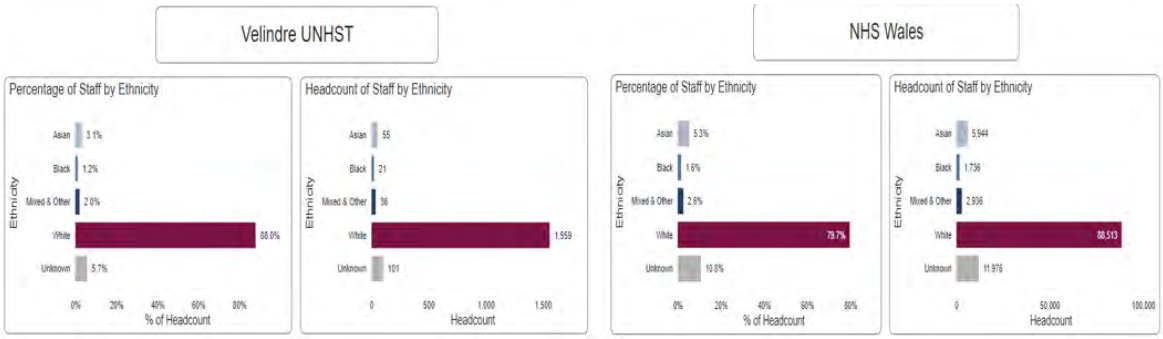

Figure 3: Comparison of ethnicity make up of VNHT compared to NHS Wales

Summary: Minority ethnic make up of VNHT similar to the national NHS Wales picture, but slightly lower.

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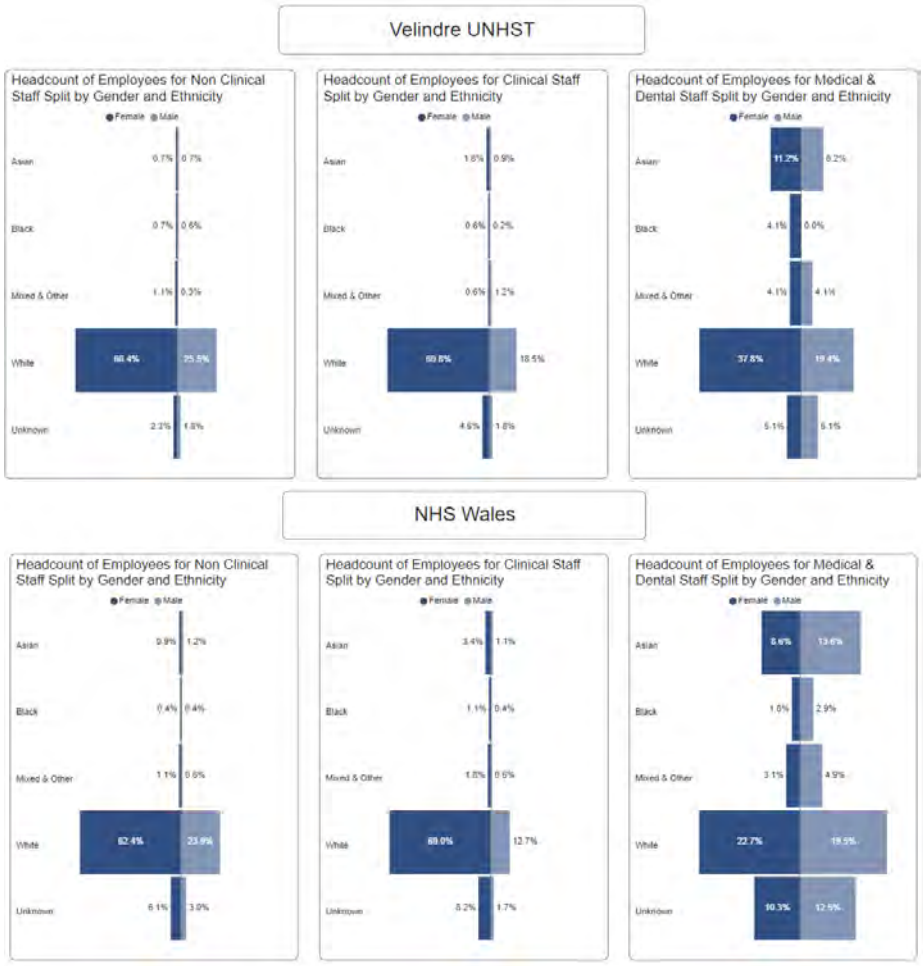

Figure 4: Comparison of ethnicity make up of VNHT compared to NHS Wales disaggregated by gender for non-clinical, clinical and medical/dental professions

Summary: Minority ethnic make up of VNHT overall similar to national picture but higher representation of Black, Asian and minority ethnic Medical staff.

There are two ethnic minority ESPs in VNHT, **compatible with the composition of the whole workforce**, compared to a national figure of 6.3% deficit.

	Lower – Middle	Middle – Upper	Upper – Senior
VNHT	1.09	2.60	0.16
NHS Wales	1.51	1.81	0.72

Table 2: Comparing disparity ratio for VNHT with NHS Wales: the disparity ratio is a reflection of staff representation across pay bands, comparing Black and ethnic minority with White staff. (Lower bands refer to band 5 and below, middle bands 6 and 7, upper bands 8a to 9, and senior relates to ESPs. A ratio of 1 reflects parity of progression, and values higher than '1' reflect inequality, with a disadvantage for BME staff.)

Summary: The disparity ratio identifies that the inequality in VNHT relates to progression of staff from middle to upper grades (above band 8a).

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INDICATOR 3: Percentage of staff by ethnicity believing their organisation provides equal opportunities for career progression or promotion

Based on staff survey: response rate 33.9%

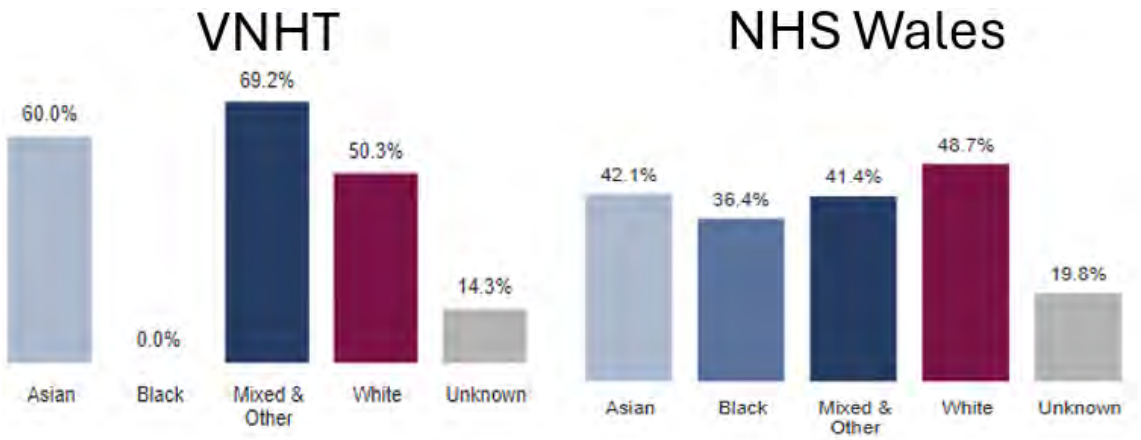

Figure 5: Comparing percentage of staff (in VNHT versus NHS Wales) believing that they have equal opportunities for career progression or promotion, disaggregated by ethnicity

Summary: Minoritised staff in VNHT are likely to feel they have equal opportunities in terms of career progression, but a zero response noted for Black staff

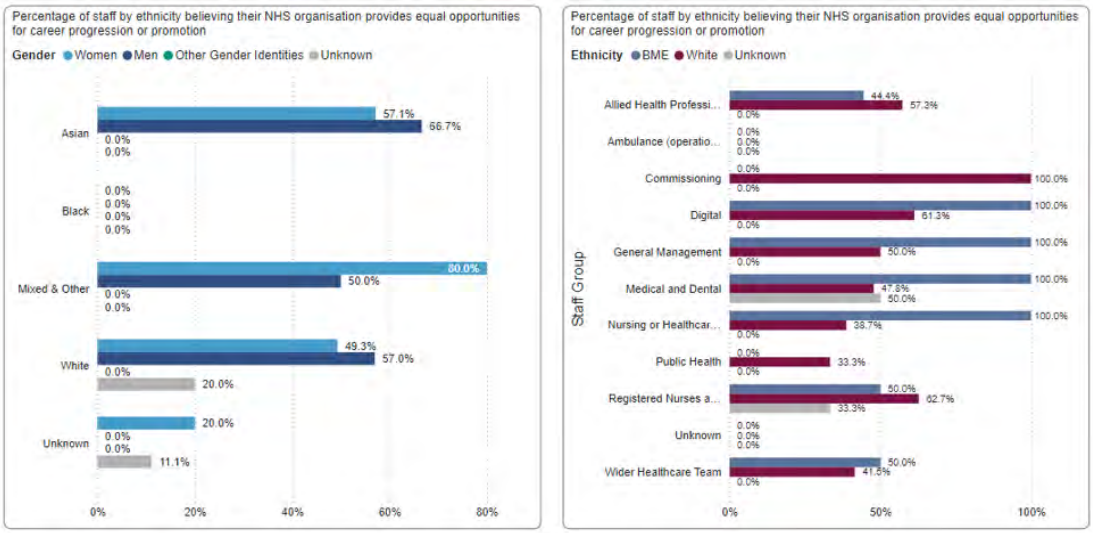

Figure 6: Comparison of gender, ethnicity and profession for staff believing that VNHT provides equal opportunities for career progression or promotion

Summary: White staff reported higher levels of dissatisfaction about career opportunities

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INDICATOR 4: Percentage of staff (a) who have sought a progression opportunity in the last 12 months and (b) who would consider seeking a progression opportunity, comparing Black and ethnic minority staff compared to White colleagues

Based on staff survey: response rate 33.9%

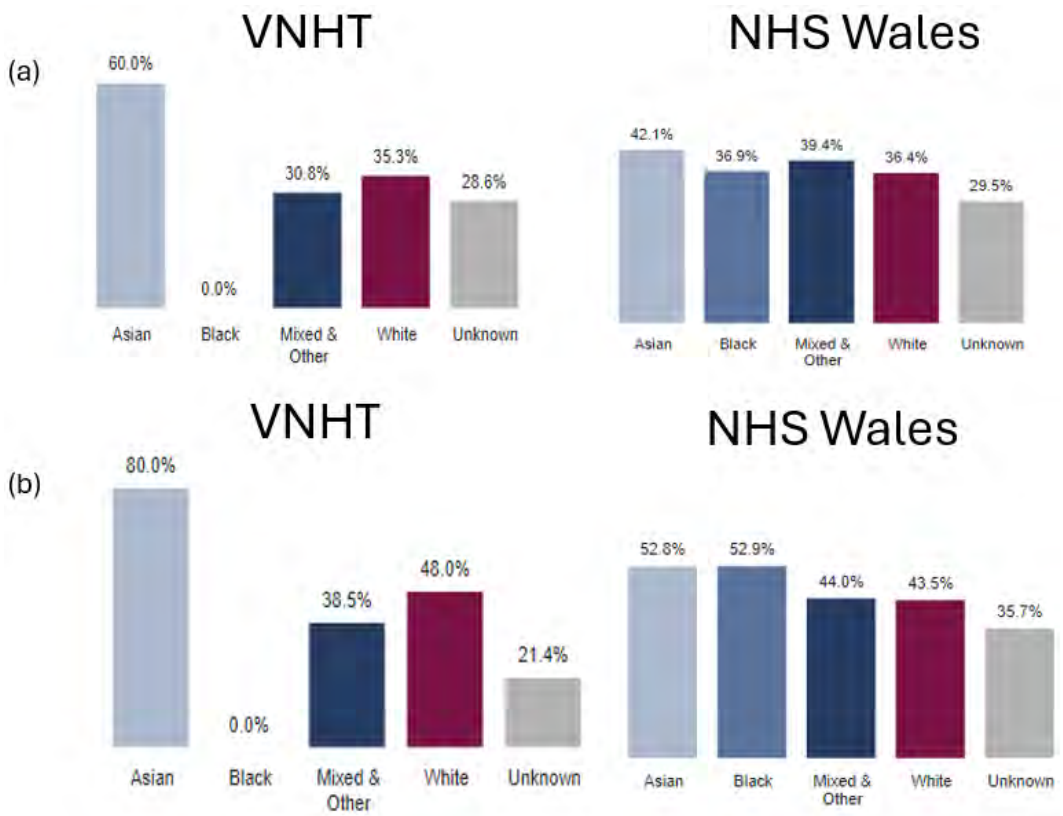

Figure 7: Comparing percentage of staff (in VNHT versus NHS Wales) who have (a) sought progression and (b) would consider seeking a progression, disaggregated by ethnicity

Summary: 1. There was a marked discrepancy between Asian, Mixed/Other ethnicity and Black respondents to the survey (zero response noted for the latter) in terms of having sought, or intending to seek, progression.

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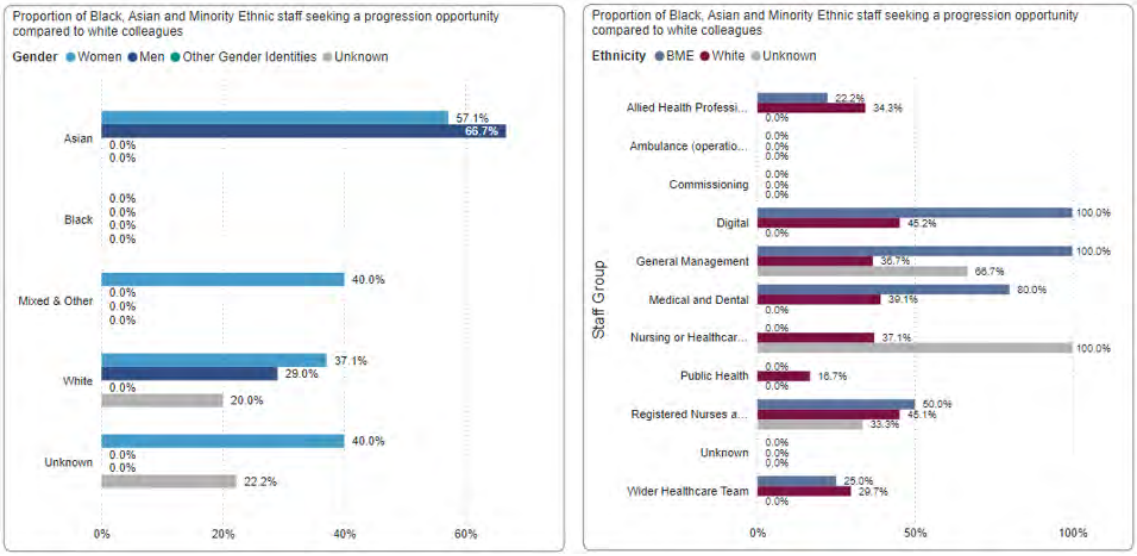
(a)



(b)

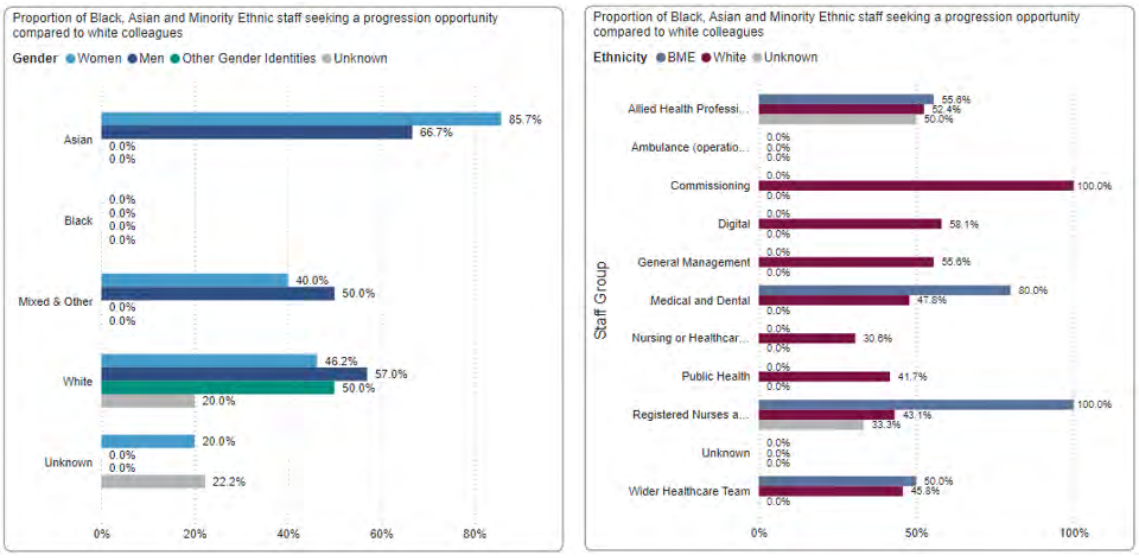


Figure 8: Comparison of gender, ethnicity and profession for staff in VNHT who have (a) sought progression and (b) would consider seeking a progression, disaggregated by ethnicity

Summary: There was a marked discrepancy between Asian, Mixed/Other ethnicity and Black respondents to the survey (zero response noted for the latter) in terms of having sought, or intending to seek, progression.
This warrants more detailed exploration, alongside the survey finding of White staff not feeling they have equal career opportunities.

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INDICATOR 5: Relative likelihood of staff being appointed from shortlisting across all posts

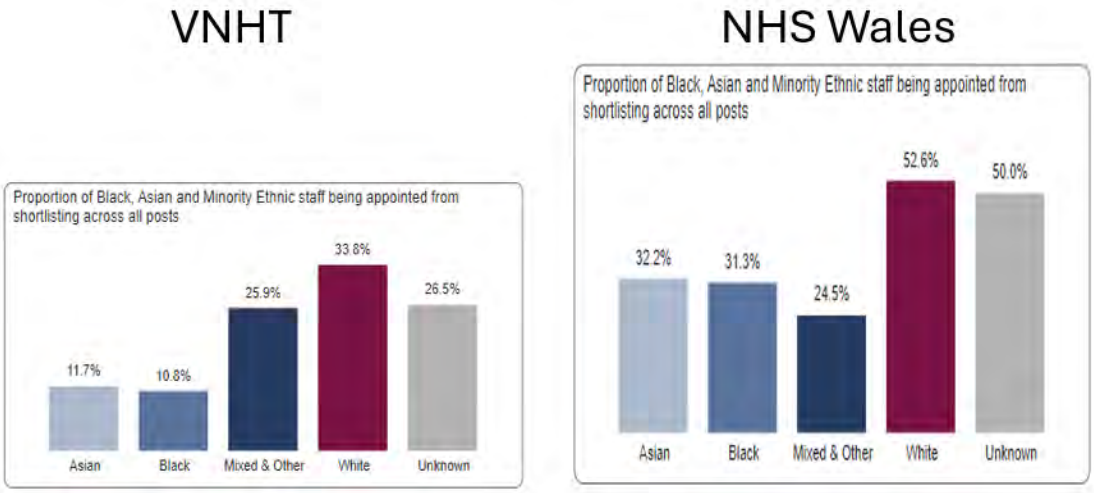

Figure 9: Comparison of ethnicity make up of VNHT compared to NHS Wales for likelihood of appointment from shortlist

Summary:

1. Rates of recruitment from interview are lower in VNHT than the national picture: this may reflect numbers of candidates being interviewed.
2. Black and Asian applicants are less likely to be appointed than White ones.

Overall in VNHT, once shortlisted, Black and ethnic minority applicants were only 40% as likely to be appointed as their White peers. This was most marked among non-Medical Clinical roles (where it fell to 35%) and to non-Clinical roles where it is 32%.

INDICATOR 6: Relative likelihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues

	Likelihood ratio overall
VNHT (%minoritised : %White)	**1.0** (100% : 99.6%)
NHS Wales (%minoritised : %White)	**0.98** (93.8% : 96.2%)

Table 3: Likelihood ratio of staff accessing non-mandatory training, by ethnicity

Summary: There is no racial inequality in access to training in VNHT or NHS Wales

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INDICATOR 8: Relative likelihood of Black, Asian, or Minority Ethnic staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to White colleagues

	Likelihood ratio overall
VNHT (%minoritised : %White)	**0** (0.00% : 0.64%)
NHS Wales (%minoritised : %White)	**1.07** (0.66% : 0.62%)

Table 4: Likelihood ratio of staff entering formal disciplinary process, by ethnicity

Summary: In an organisation of a little over 1600 staff, these data are not surprising but worth corroborating with staff networks and regulators.

INDICATOR 9: Relative likelihood of Black Asian or minority ethnic staff entering capability processes compared to white colleagues

	Likelihood ratio overall
VNHT (%minoritised : %White)	**0** (0.00% : 0.00%)
NHS Wales (%minoritised : %White)	**3.46** (0.21% : 0.06%)

Table 5: Likelihood ratio of staff entering formal disciplinary process, by ethnicity

Summary: In an organisation of a little over 1600 staff, these data are not surprising but worth corroborating with staff networks.

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INDICATOR 10: Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months compared to white colleagues

INDICATOR 11: Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from staff in last 12 months compared to white colleagues

INDICATOR 12: Percentage of Black, Asian or Minority Ethnic staff compared to white colleagues, experiencing personally experiencing discrimination at work from either manager/team leader or other colleagues

Based on staff survey: response rate 33.9%

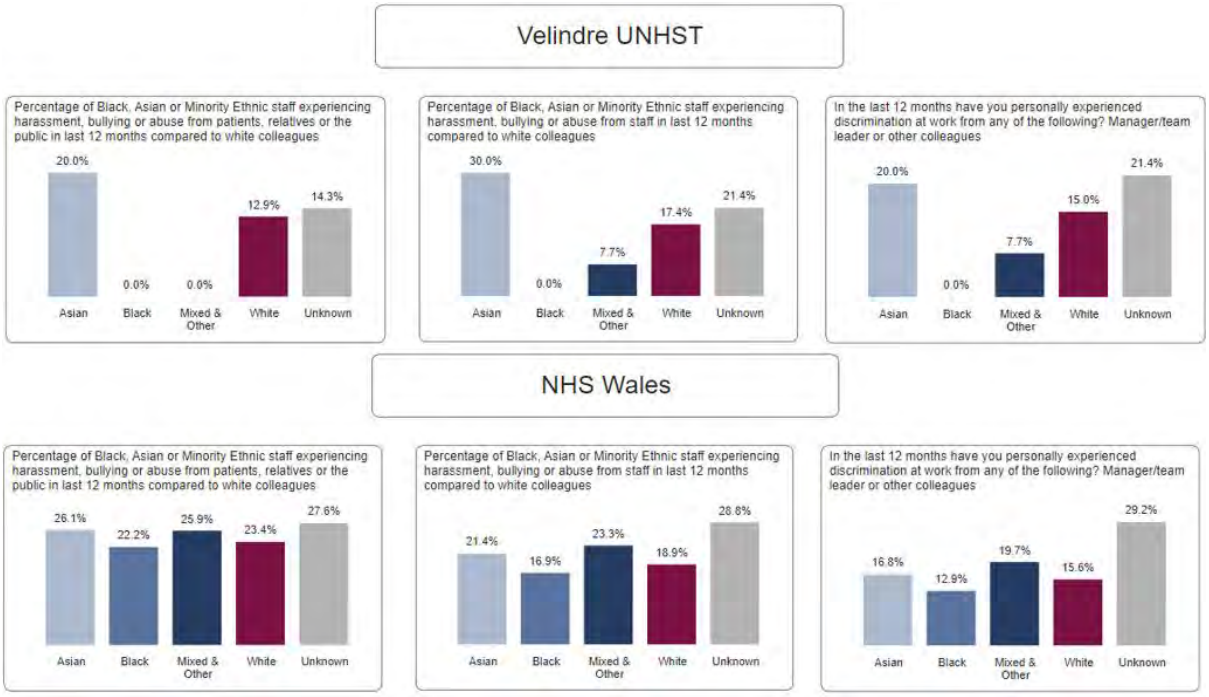

Figure 10: Comparison of experiences of bullying, harassment and discrimination, disaggregated by ethnicity

Summary:

1. At VNHT Asian staff were the most likely to report experiencing harassment or abuse from both patients and carers as well as colleagues or discrimination from managers. Note zero response from Black staff.
2. At VNHT staff with high rates of experiencing harassment and discrimination from colleagues and managers were the least likely to declare ethnicity.

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Conclusions and Next Steps

If the NHS is to become a model employer the establishment of an equitable and just workplace culture should become a key metric by which leadership is judged. The data shared in this report reflects the current state and complexity of race inequality in VNHT and the NHS in Wales.

If this WRES is to achieve its intended goal in VNHT, it must speak to the community it affects. It must recognise the context and the need for action to reverse uncomfortable facts presented by the data. The only way to tackle this effectively is for the organisational leadership to prioritise race and gender equality. At a time of low staff morale, and with the knowledge that inclusion benefits all staff, not just the minoritised, it is an ambition that workforce equality should become an indicator of how the system values its workforce.

The detailed demographic analysis of your organisation, juxtaposed with the national data, allows for a focus to be taken on the necessary targets to address. To advance race equality in VNHT will take a clear and continuous targeting of a small number of key indicators in this first stage. Focussing specifically on the data in VNHT the following is a list of metrics with the areas of greatest race inequality, and associated possible areas for action to tackle them:

1. likelihood of ethnic minority staff being appointed after shortlisting (especially medical and non-clinical appointments)
    - structured interviews, independently scored
    - use of positive action when needed
    - including at least minimum number of minoritised individuals at interview
    - supporting staff who fail an interview with reapplication
2. progression of ethnic minority staff to middle and senior grades (especially Black staff)
    - board members to have specific measurable inclusion objectives to which they will be individually and collectively accountable
    - talent pipeline management
    - embed fair and inclusive recruitment processes
    - implement appropriate induction and onboarding processes for internationally-recruited staff
3. poor levels of declaration of ethnicity, especially given that staff reporting worst experiences were those who did not declare ethnicity
    - set targets for declaration for all staff, including specifically senior members
    - programmes to drive increased self-declaration via payslip, outreach, etc
4. Dissatisfaction from some White staff about equality of career opportunity
    - Needs internal audit of colleagues to better understand the concerns and identify the barriers to equality of opportunity

Having read this report, the ambition is that it will trigger a deep consideration of how effective – or not – current plans are likely to be in actually disrupting the data. This requires an understanding of the dataset presented and resourcing a small number of actions. Trying to address too broad a range of actions is not an effective way of delivering meaningful and sustained change.

Webber, Jayne
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Additionally, the Health Board will want to understand its own data to see whether the above metrics have arisen from a single site where focussed action is needed. This sort of curiosity

about staff experience is also crucial in delivering effective improvement. Such local intelligence is critical to embedding processes which have buy-in from the relevant teams.

Developing an inclusive workforce which has a sense of belonging requires local action; the function of national structures being to align that with wider regulatory ambitions and to share examples of best practice from other healthcare organisations, and indeed other sectors.

Local implementation will be allied to identifying key measures of success which need to be monitored in a range of ways, including the subsequent annual WRES data collection. The WRES thus represents a recurring and future-focussed catalyst for action, helping organisations improve race and gender equality and fulfil their requirements to both the Equality Act 2010 and the Antiracist Wales Action Plan, challenging us to be better for our workforce and our patients.

A workshop took place at the beginning of June 2024 where examples of data sets within this report were shared with NHS Wales Equality Leads Network, in order to help them to interpret your organisations data and understand the opportunities to respond. Your Equality Leads have a pivotal role with regard to both local action and liaison within the network of their peers in other organisations. Their understanding of the needs of local staff networks and how the data relates to the lived experience of the workforce is vital in terms of defining effective actions. The leadership of the organisation equally have a critical role in setting the tone and in embedding these actions in the fibre of the organisation: translating ideas into actions is what effective leadership teams do, and the data in this report compels a systematic approach to be developed to tackle the systemic nature of inequality and discrimination in our NHS. It is in our individual and joint gift to meet this challenge, and it is in our patients' and national interests for us to do so.

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APPENDIX A: The Workforce Race Equality Standards indicators

Domain		Indicator
Leadership and Representation	1	Percentage difference by ethnicity between the organisations' Board executive and non-executive membership and its overall workforce
	2	Percentage of staff by ethnicity in each of the AfC Bands 1-9 and ESP compared with the percentage of staff in the overall workforce
	3	Percentage of staff by ethnicity believing their organisation provides equal opportunities for career progression or promotion
	4	Percentage of staff (a) who have sought a progression opportunity in the last 12 months and (b) who would consider seeking a progression opportunity, comparing Black and ethnic minority staff compared to White colleagues
	5	Relative likelihood of staff being appointed from shortlisting across all posts
Professional development and training	6	Relative likelihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues
	7	Percentage of staff by ethnicity (a) completing anti-racist training and (b) having inclusion objectives set during appraisal
Disciplinary and capability	8	Relative likelihood of Black, Asian, or Minority Ethnic staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation compared to White colleagues
	9	Relative likelihood of Black Asian or minority ethnic staff entering capability processes compared to white colleagues
Discrimination, bullying and harassment	10	Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months compared to white colleagues
	11	Percentage of Black, Asian or Minority Ethnic staff experiencing harassment, bullying or abuse from staff in last 12 months compared to white colleagues
	12	Percentage of Black, Asian or Minority Ethnic staff compared to white colleagues, experiencing personally experiencing discrimination at work from either manager/team leader or other colleagues

Webber,Liane
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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

NHS Staff Survey 2023

DATE OF MEETING	12th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	CLAIRE BUDGEN, HEAD OF ORGANISATIONAL DEVELOPMENT
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	The NHS Staff Survey 2023 reflects the views of staff in VUNHST and NHS Wales. The Trust had a higher response rate than the last survey in 2020 and showed a higher level of staff engagement than the NHS Wales average. However, there was a decline in experience between 2023 and 2020 on the majority of questions where comparison was possible. This data has been triangulated with other forms of staff feedback and now informs a range of development programmes for improving organisational culture and experience for staff.

Webber,Liane
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RECOMMENDATION / ACTIONS	Quality, Safety and Performance Committee is asked to NOTE the report for onward submission to Trust Board.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Proposed - Executive Management Board	29.8.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS NOTED	

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	
1	VUNHST Staff Survey Results 2023
2	Table of Actions and Quarter 1 Progress

1. SITUATION

Webber, Diane
11/09/2024 10:57:

1.1 NHS Wales conducted a national staff survey in October 2023, the first since 2020. The Trust level results were received on 23 February 2024 followed by Divisional and demographic results in May 2024. The key findings at Trust level were shared with EMB on 18 March 2024. The themes were considered in light

of a range of other staff feedback and considered at a Board Development Session on 23 July 2024. This paper summarises key findings, agreed actions and progress to date with those actions.

2. BACKGROUND

2.1 There has been an increased interest in measuring and understanding staff experience across NHS organisations in Wales over the past three years. This led to the previous NHS Staff Survey being expanded to encompass 10 themes, broadly in line with the staff survey used by NHS England since 2003.

2.2 Health Education and Improvement Wales (HEIW) coordinated the development and delivery of the survey on behalf of health organisations. There is a commitment to run this annually in future to allow the aggregation of results in the Trust and nationally over time. This will offer a rich source of information about the experience of staff as a basis for making improvements.

2.3 The NHS Staff Survey has been positioned in Velindre University NHS Trust as a positive tool for engaging with staff and building dialogue, leading to trust and stronger working relationships. It is seen as part of the work on developing a positive organisational culture in support of delivering Destination 2033.

3. ASSESSMENT

3.1 Appendix 1 presents the Trust level results. Key points that arise from the results are set out below.

- The Trust had a response rate of 34% compared with the NHS Wales response rate of 21%. This was also higher than the Trust response rate of 25% in 2020.

- The Trust Engagement Score of 76% was higher than the NHS Wales score of 73%. However, both these scores had decreased since 2020, when the Trust scored 78% and NHS Wales 75%.

- Compassionate culture was rated highly by staff, reflecting views about how we respond to patients, service users and colleagues in distress. However, the scores for compassionate leadership, how my line manager listens to my problems and helps me overcome them, were lower.

Webber,Liane
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- Burnout is hidden in the figures yet Burnout and Health and Safety Climate are the joint worst scoring sub-themes overall.

- Morale, which is the lowest scored theme, is a product of all the experiences at work and possibly outside of work. It measures work pressure and those thinking of leaving the organisation. Responses in this category will only improve through taking action across the other themes so that pressure is lower and staying with the Trust is a more appealing prospect.

- Responses to 'having time to reflect and learn' has been a positive change for the Trust.

- There is a generally worse experience being reported compared with the 2020 survey.

- A Trust-wide focus on staff retention is essential to help build a stable and motivated workforce, offering professional and career development where possible.

- There is a degree of unplanned work in the organisation which is being picked up in a variety of ways. Moreover, it is virtually as common as not to stay on at work even with no pay; this risks burnout and poor morale.

4. SUMMARY OF MATTERS FOR CONSIDERATION - TAKING THIS FORWARD

4.1 These results have been triangulated with a number of other forms of staff feedback:

Board interviews on values and culture 2022
CQC review of NHSBT report
Working Together Listening Exercise Feedback
Exit interviews themes
Health Inspectorate Wales Inspection Report, First Floor Ward, VCC July 2022
Values Survey
Analysis of sickness and leavers statistics
Retention Project engagement and feedback
Speaking up Safely Task and Finish group

Webber,Liane
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The feedback can be summarised through three priorities within the People Strategy: Leadership, Healthy Workforce and Engaged Workforce.

Leadership

- Face to face contact is lost.
- No connection on Vision across the 3 Divisions.
- Working relationships strained at senior levels.
- Variability in strength of connection between senior leaders and staff in all roles at all levels.
- Values need to be seen in action.

Quotes from staff

The survey is difficult to complete - my immediate line manager is extremely supportive and respectful of me as a person and my professional abilities. However, senior managers with whom I interact frequently do not respect me, my department or my profession.

There is a disjoint between senior management and operational work. Most people on the shop floor don't know what the function of the senior management is, who they are, what they look like.

Management don't seem to care about our personal health and wellbeing at all.

Healthy Workforce

- Staff are tired or burnt out.
- Pace of change difficult – having to change whilst delivering higher volumes of work.

Quotes from staff

Demands on teams can sometimes be unrealistic and then over longer times turns into burnout.

I never get home on time! And as long as my work is done the organisation do not care what time you leave.

Webber,Liane
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I feel like on the whole this department is a good place to work. However, short staffing levels and increased number of patients is making the workload unbearable and morale is low because people don't feel particularly valued in their role.

Team members are struggling like never before. Dedication is high, colleagues are 'on the edge' - doing more and more but are struggling. I really worry about what the future holds.

Engaged Workforce

- Face to face contact is lost.
- We need an organised and structured programme of engagement, which is visible and owned by staff.
- We need structured, regular evaluation of staff feedback, shared with staff with clear management response.
- Staff feedback shows that staff do not always feel that leadership is present.

Quotes from staff

People do not engage and provide feedback to the junior staff that need it to progress work. There is no team feeling, no care amongst colleagues, the fun of work and looking forward to going in has declined.

It is felt that staff are not valued trusted or listened to, there is never feedback or explanation, the atmosphere destroys morale and drive it just breaks people.

This used to be an amazing place to work where I felt truly appreciated and people cared about each other and we all worked well as a team. Sadly, I have not felt that in the last few years and in the last 12 months I feel it has got worse.

If our voices were being heard and we had the resources to put into our team, then we wouldn't be losing very experienced staff.

Webber,Liane
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4.2 An integrated programme of work has been agreed at the Healthy and Engaged Steering Group as one that will support improvement of staff experience and therefore contributing towards improved Staff Survey scores in 2024.

Theme	**Action 2024 - 25**
Morale	Develop Retention Plan for all staff groups
Patient Safety	Build a data set measuring psychological safety and run Pulse Surveys Approve Incident Management Framework and Learning Framework
Staff Engagement	Develop a staff engagement framework
Compassionate and inclusive	Adopt Values and Behaviour Framework. Leaders to be visible and accessible. Training for staff to support the roll out of the values
Recognising contributing	Run the Employee Excellence Awards 2024
Able to Speak Up	Test and develop methods and feelings around Speaking Up
Stronger Together	Review resources for team development
Healthy Working Environment	Identify examples of long hours culture
Champion Flexible Working	Develop managers' understanding of flexible working and hybrid working
Continuously learning and improving	Review People Development Policy and PADR Policy.

The complete plan including progress in Quarter 1 2024-25 is included as Appendix 2.

4.3 The staff survey results are assisting in the implementation of Our Vision for Equality, in the Strategic Equality Plan 2024 to 28. The full statement is replicated below to set the context of work around Staff Survey results and the final sentence is highlighted in bold for emphasis. It is in relation to this point that a Deep Dive analysis is taking place on the Bullying and Harassment data and comments from the 2023 survey in September to October 2024. This will lead into actions targeted at reducing the incidence of bullying and mitigating its impact.

Webber,Liane
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Our vision for equality is that our values of Caring, Respectful and Accountable are evident in everything we do, thereby improving the lives of all our stakeholders, irrespective of their background. We will use this Strategic Equality Plan to put patients, donors and staff at the heart of everything we do. The lens of equality will allow us to challenge the status quo and ask questions so that we can design our organisation and systems around people, taking heed of individuals' views, requirements and aspirations. Our overarching ambition is to ensure that there is enhanced collaboration between the members of the Leadership and management teams and the people we employ. There will be an improved relationship between staff and patients and we will strive to eliminate barriers to care. Teams throughout Velindre Cancer Service, the Welsh Blood Service and Trustwide Services will reduce working in silos and will have an improved knowledge of other departments' working strategies and aims. There will be increased engagement throughout the Trust which will in turn develop relationships and knowledge sharing. Patients and Donors will be invited to networks to listen to their feedback which will then improve services delivered in Cancer and Blood services and we will develop strategies to reduce barriers to care and service delivery. ***A positive working environment will be fostered with clear channels of staff feedback, tackling each equality issue raised.***

4.4 It is noted that undertaking the survey has been hard work, for colleagues across Wales, VUNHST managers and everyone who participated and submitted their views. It is important that this initial investment of effort is not squandered and that we follow through with continued efforts for the 2024 survey and annual surveys thereafter.

4.5 There is a particular need to gain feedback from any groups in the workforce who may experience disadvantage so that actions can be targeted to create an inclusive workplace. For example, progress with our Anti Racist Action Plan, as measured through the Workforce Race Equality Standard, is dependent on hearing from Black, Asian and minoritised ethnic staff.

4.6 Alongside the annual NHS Staff Survey, there is a commitment to running pulse surveys to measure aspects of working life, including perceptions of psychological safety. This is being developed through the work of the Corporate Quality Hub where expertise from all corporate functions is coming together with a focus on improving quality.

Webber,Liane
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5. IMPACT ASSESSMENT

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

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*	04 - Organisational Culture
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 This report sets out feedback from staff together with an outline plan of action. There is no difference in relation to Socio Economic status.
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

Webber, Liane
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	A More Equal Wales – a society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This report sets out feedback from staff together with an outline plan of action. There is no difference in relation to protected characteristics.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item

Webber, Jayne
11/09/2025 10:57:44

All risks must be evidenced and consistent with those recorded in Datix	

Webber,Liane
11/09/2024 10:57:44

Microsoft | Power BI

Staff Survey Dashboard - Velindre University NHS Trust

View in Power BI

Webber,Liane
11/09/2024 09:07:44

Last data refresh:
22/02/2024 16:32:48 UTC

Downloaded at:
23/02/2024 14:59:28 UTC

Dear Colleagues,

Thank you to everyone who participated in this year's NHS Wales Staff Survey. We heard from a total of 22,535 colleagues and we are working in the background to undertake thematic analysis of your feedback. The Staff Survey offers a snapshot in time of how people experience their working lives, gathered at the same time each year. Its strength is in capturing a national picture alongside local detail, enabling NHS Wales to explore staff experience across different parts of the NHS and work to bring about the necessary improvements.

This dashboard has been created to share NHS Wales wide survey results. In April, your NHS organisation will be granted access to run more detailed directorate level reports (with no identifier information) for your organisation, please bear with us. If you have any questions, you can email the NHS Wales Staff Survey team at nhswalesstaffsurvey@wales.nhs.uk.

Reporting Design

The survey results have been grouped under the following headings for ease. The Staff Engagement score is located at the end.

1. Morale
2. Patient Safety
3. Staff Engagement
4. We are compassionate and inclusive.
5. We recognise everyone's contribution.
6. We are all able to speak up.
7. We are stronger together.
8. We nurture healthy working environments.
9. We champion flexible working.
10. We are continuously learning and improving.

Please note: A question may appear more than once, if the question relates to more than one category.

Webber, Liane
13/09/2024 10:57:42

Response Rates

For response rate information, click the information icon at the top right.

NHS Wales Staff Survey Response Rates

GIG Cymru Arolwg Staff Mae eich llais yn bwysig | NHS Wales Staff Survey Your voice matters

The staff survey was launched on 16th October 2023 and closed after a period of 6 weeks, on 27th November 2023. The overall response rate was 20.7% with the following breakdown across NHS Wales:

Organisation	Sample Size	Paper	Online	Smartphone	Total Response	Response Rate
Aneurin Bevan UHB	15,108	43	2,299	396	2,738	18.1%
Betsi Cadwaladr UHB	19,891	257	3,267	497	4,021	20.2%
Cardiff and Vale UHB	17,096	101	2,938	623	3,662	21.4%
Cwm Taf Morgannwg UHB	12,685	113	1,116	1,071	2,300	18.1%
Digital and Health Care Wales	1,191	0	653	68	721	60.5%
Health Education and Improvement Wales	467	0	326	25	351	75.2%
Hywel Dda UHB	11,659	27	1,125	250	1,402	12.0%
NHS Wales Shared Services Partnership	5,823	24	992	172	1,188	20.4%
Powys Teaching HB	2,405	26	547	100	673	28.0%
Public Health Wales	2,351	16	1,119	143	1,278	54.4%
Swansea Bay UHB	13,932	156	2,083	386	2,625	18.8%
Velindre University NHS Trust	1,679	22	508	40	570	33.9%
Welsh Ambulances Services NHS Trust	4,344	22	785	199	1,006	23.2%
All Wales Total	**108,631**	**807**	**17,758**	**3,970**	**22,535**	**20.7%**

Webber, Yvonne
11/09/2024 10:57:44

Select Theme

Stressors | Thinking about leaving | Work pressure

Morale

Stressors

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I always know what my work responsibilities are.	2%	6%	8%	55%	29%
I am involved in deciding on changes introduced that affect my work area/team/department.	7%	14%	19%	41%	20%
I have a choice in deciding how to do my work.	4%	10%	21%	43%	22%
My immediate manager (line manger) encourages me at work.	5%	7%	17%	40%	31%
Relationships at work are strained.	11%	38%	26%	19%	6%

Question	Always	Often	Sometimes	Rarely	Never
I have unrealistic time pressures.	9%	19%	40%	26%	6%

Webber, Liane
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Select Theme

Stressors | **Thinking about leaving** | Work pressure

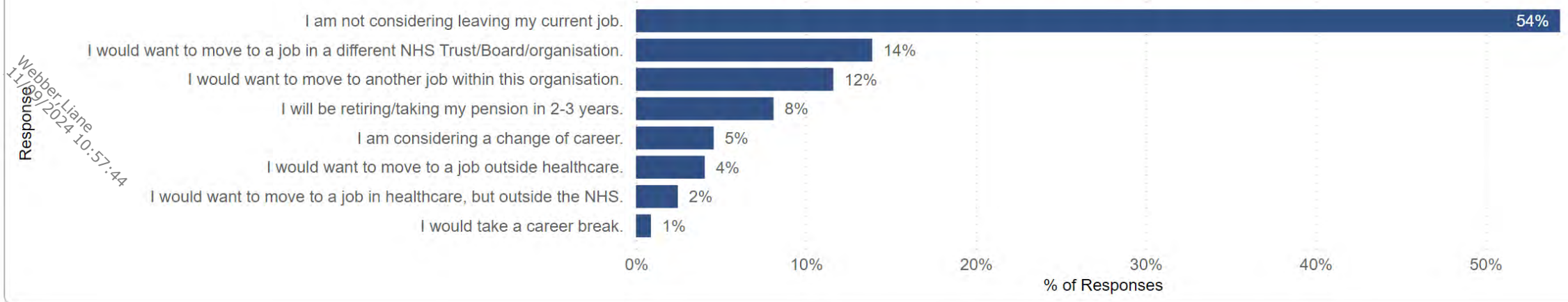
Morale

Thinking about leaving

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am satisfied in my current role and intend to remain in it for the foreseeable future.	6%	13%	24%	38%	20%

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
As soon as I can find another job, I will leave this organisation.	32%	32%	23%	7%	5%
I often think about leaving this organisation.	19%	34%	21%	20%	7%
I will probably look for a job at a new organisation in the next 12 months.	25%	33%	22%	14%	7%

If you are considering leaving your current job, what would be your most likely destination?



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Select Theme

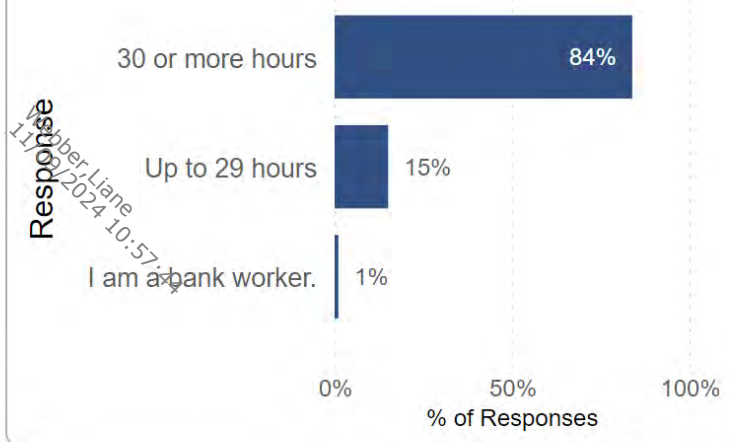
Stressors | Thinking about leaving | **Work pressure**

Morale

Work pressure

Question	Never	Rarely	Sometimes	Often	Always
I am able to meet all the conflicting demands on my time at work.	2%	13%	31%	44%	11%
I have adequate supplies, materials and equipment to do my work.	1%	6%	15%	41%	37%
There are enough staff at this organisation for me to do my job properly.	9%	15%	34%	32%	9%

How many hours a week are you contracted to work?



Webber, Liane
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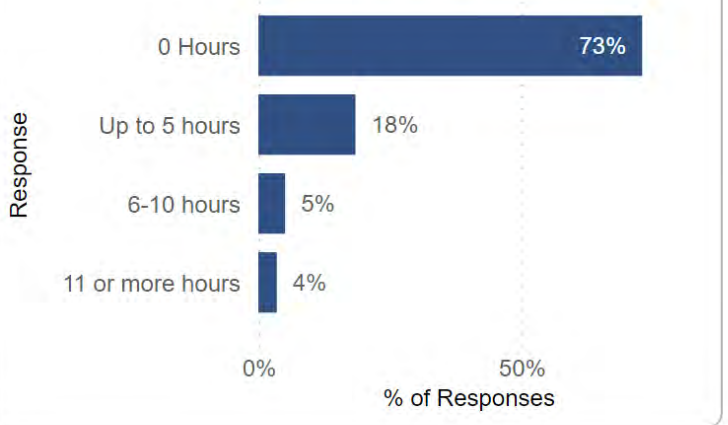
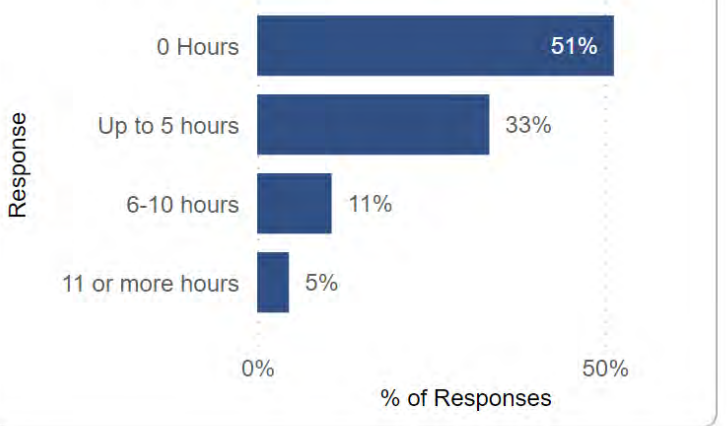
On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?



On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?



Patient Safety

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My organisation encourages us to report errors, near misses or incidents.	2%	2%	12%	53%	31%
My organisation treats staff who are involved in an error, near miss or incident, fairly.	2%	6%	37%	41%	14%
We are given feedback about changes made in response to reported errors, near misses and incidents.	4%	10%	32%	42%	12%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	2%	5%	25%	51%	18%

Question	Yes	Prefer not to say	No
In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or patients/service users?	26%	2%	72%

Webber,Liane
11/09/2024 10:57:44

Staff Engagement

Ability to contribute towards improvement at work

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am able to make improvements in my area of work	3%	10%	22%	48%	16%
I am involved in deciding on changes introduced that affect my work area/team/department.	7%	14%	19%	41%	20%

Intrinsic psychological engagement (Motivation)

Question	Never	Rarely	Sometimes	Often	Always
I am enthusiastic about my job.	1%	5%	25%	44%	26%
I am happy to go the extra mile at work when required.	1%	1%	15%	38%	44%
I look forward to going to work.	3%	9%	35%	42%	11%

Webber, Liane
11/09/2024 10:57:44

Staff advocacy and recommendation (Advocacy)

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am proud to tell people I work for my organisation.	2%	1%	14%	47%	36%
I would recommend my organisation as a place to work.	5%	8%	21%	44%	21%

Select Theme

Compassionate culture | Compassionate leadership | Diversity and equality | Inclusion

We are compassionate and inclusive

Compassionate culture

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Care of patients/service users is my organisation's top priority.	1%	2%	14%	43%	39%
I feel safe to speak up about anything that concerns me in this organisation.	4%	11%	21%	46%	18%
I'd feel able to speak up in my team if I noticed poor or incorrect practice.	4%	7%	14%	50%	25%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	1%	3%	13%	46%	36%
My organisation acts on concerns raised by patients/service users.	1%	3%	19%	48%	30%
People here are compassionate in the way they behave towards patients/service users.	0%	1%	12%	49%	37%
People here are compassionate towards colleagues when they face problems.	1%	4%	16%	61%	19%
People here give good support to colleagues who are distressed.	1%	5%	14%	58%	22%
People here take effective action to help patients/service users in distress.	0%	1%	13%	48%	38%

Wednesday 11/09/2024 10:11:44

Select Theme

Compassionate culture | **Compassionate leadership** | Diversity and equality | Inclusion

We are compassionate and inclusive

Compassionate leadership

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My immediate manager (line manger) is interested in listening to me when I describe challenges I face.	6%	8%	16%	41%	29%
My immediate manager (line manger) takes effective action to help me with any problems I face.	6%	8%	18%	38%	29%
My immediate manager (line manger) works together with me to come to an understanding of problems.	6%	8%	17%	41%	28%

Webber,Liane
11/09/2024 10:57:44

Select Theme

Compassionate culture | Compassionate leadership | **Diversity and equality** | Inclusion

We are compassionate and inclusive

Diversity and equality

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas)	2%	6%	24%	49%	19%

Question	No	Don't know	Prefer not to say	Yes
Does your organisation act fairly with regard to career progression/promotion, regardless of age, disability, ethnic background, gender, gender identity, religion or sexual orientation?	17%	29%	4%	50%
In the coming 12 months would you consider applying for a progression opportunity in your workplace?	31%	18%	4%	48%
In the last 12 months have you sought a progression opportunity in your workplace?	58%	2%	4%	35%

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11/09/2024 10:37:44

Question	Yes	Prefer not to say	No
In the last 12 months have you personally experienced discrimination at work from a manager/team leader?	5%	4%	91%
In the last 12 months have you personally experienced discrimination at work from other colleagues?	6%	4%	90%
In the last 12 months have you personally experienced discrimination at work from patients/service users, their relatives, or other members of the public?	3%	2%	95%

Select Theme

Compassionate culture | Compassionate leadership | Diversity and equality | **Inclusion**

We are compassionate and inclusive

Inclusion

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I feel valued by my team.	5%	8%	18%	43%	27%
The people I work with are polite and treat each other with respect.	2%	6%	14%	53%	25%
The people I work with are understanding and kind to one another.	2%	7%	15%	51%	25%

Webber,Liane
11/09/2024 10:57:44

We recognise everyone's contribution

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I get recognition for good work.	5%	11%	25%	42%	16%
My immediate manager (line manger) values my work.	5%	6%	16%	41%	31%
The organisation values my work.	6%	12%	29%	39%	14%
The people I work with show appreciation to one another.	2%	7%	17%	52%	22%

Webber,Liane
11/09/2024 10:57:44

Select Theme

Autonomy and control | Raising concerns

We are all able to speak up

Autonomy and control

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I always know what my work responsibilities are.	2%	6%	8%	55%	29%
I am involved in deciding on changes introduced that affect my work area/team/department.	7%	14%	19%	41%	20%
I am trusted to do my job.	2%	4%	8%	48%	38%
I have a choice in deciding how to do my work.	4%	10%	21%	43%	22%
There are frequent opportunities for me to show initiative in my role.	2%	8%	14%	48%	28%

Webber,Liane
11/09/2024 10:57:44

Select Theme

Autonomy and control | **Raising concerns**

We are all able to speak up

Raising concerns

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am confident my organisation would address my concern.	4%	12%	25%	44%	15%
I feel safe to speak up about anything that concerns me in this organisation.	4%	11%	21%	46%	18%
I would feel secure raising concerns about unethical behaviour.	3%	7%	12%	52%	27%
I would feel secure raising concerns about unsafe clinical practice.	2%	4%	17%	48%	28%
If I spoke up about something that concerned me, I am confident my organisation would address my concern.	6%	11%	30%	39%	13%

Webber,Liane
11/09/2024 10:57:44

Select Theme

Line management | Team working

We are stronger together

Line management

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My immediate manager (line manger) asks for my opinion before making decisions that affect my work.	10%	11%	19%	37%	22%
My immediate manager (line manger) encourages me at work.	5%	7%	17%	40%	31%
My immediate manager (line manger) gives me clear feedback on my work.	6%	10%	19%	41%	24%
My immediate manager (line manger) is interested in listening to me when I describe challenges I face.	6%	8%	16%	41%	29%
My immediate manager (line manger) recognises the importance of staff emotional wellbeing.	8%	6%	17%	36%	33%
My immediate manager (line manger) takes a positive interest in my health and well-being.	7%	6%	16%	39%	32%
My immediate manager (line manger) takes effective action to help me with any problems I face.	6%	8%	18%	38%	29%
My immediate manager (line manger) values my work.	5%	6%	16%	41%	31%
My immediate manager (line manger) works together with me to come to an understanding of problems.	6%	8%	17%	41%	28%

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Select Theme

Line management | **Team working**

We are stronger together

Team working

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I enjoy working with the colleagues in my team.	2%	3%	11%	46%	38%
I feel able to ask other members of this team for help when I need it.	2%	3%	7%	49%	38%
I feel valued by my team.	5%	8%	18%	43%	27%
I'd feel able to speak up in my team if I noticed poor or incorrect practice.	4%	7%	14%	50%	25%
Team members are able to communicate closely with each other to achieve the team's objectives.	2%	8%	15%	55%	20%
Team members take time out to reflect and learn.	5%	20%	24%	41%	11%
Team members trust each other.	4%	9%	15%	48%	24%
Team members understand each other's roles.	2%	11%	10%	55%	21%
Team members work well with other teams.	3%	6%	16%	55%	20%
The team I work in has a set of shared objectives.	2%	6%	11%	58%	22%
The team I work in often meets to discuss the team's effectiveness.	6%	12%	13%	47%	22%

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11/07/2024 10:57:44

We champion flexible working

Support for work-life balance

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I achieve a good balance between my work life and my home life.	8%	16%	18%	40%	18%
I am satisfied with the opportunity for flexible working patterns.	11%	9%	14%	39%	27%
I can approach my immediate manager (line manager) to talk openly about flexible working.	8%	7%	14%	39%	31%
My organisation is committed to helping me balance my work and home life.	11%	11%	18%	39%	19%

Webber,Liane
11/09/2024 10:57:44

Select Theme

Burnout | Health and safety climate | Negative experiences

We nurture healthy working environments

Burnout

Question	Always	Often	Sometimes	Rarely	Never
How often, if at all, are you exhausted at the thought of another day/shift at work?	7%	22%	34%	26%	11%
How often, if at all, do you feel burnt out because of your work?	7%	26%	35%	24%	8%
How often, if at all, do you feel that every working hour is tiring for you?	5%	13%	31%	34%	17%
How often, if at all, do you feel worn out at the end of your working day/shift?	10%	33%	36%	17%	4%
How often, if at all, do you find your work emotionally exhausting?	7%	27%	38%	21%	7%
How often, if at all, do you not have enough energy for family and friends during leisure time?	6%	20%	37%	25%	11%
How often, if at all, does your work frustrate you?	7%	32%	42%	15%	4%

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Select Theme

Burnout | **Health and safety climate** | Negative experiences

We nurture healthy working environments

Health and safety climate

Question	Never	Rarely	Sometimes	Often	Always
I am able to meet all the conflicting demands on my time at work.	2%	13%	31%	44%	11%
I have adequate supplies, materials and equipment to do my work.	1%	6%	15%	41%	37%
There are enough staff at this organisation for me to do my job properly.	9%	15%	34%	32%	9%

Question	Never	Rarely	Sometimes	Often	Always
I have unrealistic time pressures.	6%	26%	40%	19%	9%

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My organisation takes positive action on health and wellbeing.	5%	11%	32%	41%	10%

Question	No	Don't know	Not applicable	Yes, a colleague reported it	Yes, I reported it
The last time you experienced harassment or bullying at work, did you or a colleague report it?	20%	1%	58%	3%	17%
The last time you experienced physical violence at work, did you or a colleague report it?	3%	0%	86%		11%

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Select Theme

Burnout | Health and safety climate | **Negative experiences (Part 1)** | Negative experiences (Part 2)

We nurture healthy working environments

Negative experiences (Part 1)

Question	No	Don't know	Not applicable	Yes, a colleague reported it	Yes, I reported it
The last time you experienced abuse at work (work from patients/service users, their relatives, or other members of the public) did you or a colleague report it?	10%	1%	73%	1%	15%

Question	Yes	No
During the last 12 months have you felt unwell as a result of work-related stress?	31%	69%
In the last 12 months, have you experienced musculoskeletal problems (MSK) as a result of work activities?	20%	80%
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	50%	50%

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Question	Yes	No	Not applicable
Have you felt pressure from your manager to come to work?	11%	40%	48%

We nurture healthy working environments

Negative experiences (Part 2)

Question	Never	1-2	3-5	6-10	More than 10	Prefer not to say
In the last 12 months how many times have you personally experienced abuse at work from patients/service users, their relatives, or other members of the public?	92.98%	4.91%	0.88%	0.53%	0.35%	0.35%
In the last 12 months how many times have you personally experienced harassment or bullying at work from managers/team leaders?	81.72%	8.44%	3.87%	0.88%	1.93%	3.16%
In the last 12 months how many times have you personally experienced harassment or bullying at work from other colleagues?	79.26%	10.37%	4.22%	1.05%	1.93%	3.16%
In the last 12 months how many times have you personally experienced harassment or bullying at work from patients/service users, their relatives, or other members of the public?	85.96%	8.25%	1.93%	1.40%	1.23%	1.23%
In the last 12 months how many times have you personally experienced physical violence at work from managers/team leaders?	99.12%	0.53%				0.35%
In the last 12 months how many times have you personally experienced physical violence at work from other colleagues?	99.47%		0.18%			0.35%
In the last 12 months how many times have you personally experienced physical violence at work from patients/service users, their relatives, or other members of the public?	98.60%	0.88%	0.18%			0.35%
In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault from patients/service user	94.39%	3.68%	0.88%	0.18%	0.53%	0.35%
In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? This may include offensive or inappropriate sexualised conversation (including jokes), touching or assault from	92.79%	4.22%	1.41%	0.53%	0.53%	0.53%

*their relatives or other members of the public.

Wednesday 1/5/1 11:08:03

Select Theme

Development | PDR/Appraisal

We are continuously learning and improving

Development

Question	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I am able to access the right learning and development opportunities when I need to.	4%	12%	22%	46%	16%
I feel supported to develop my potential.	5%	15%	21%	42%	17%
I have opportunities to improve my knowledge and skills.	4%	10%	15%	51%	20%
There are opportunities for me to develop my career in this organisation.	7%	16%	24%	39%	14%
This organisation offers me challenging work.	2%	6%	20%	52%	20%

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11/09/2024 10:57:44

Select Theme

Development | **PDR/Appraisal**

We are continuously learning and improving

PDR/Appraisal

Question	No	Can't remember	Yes
In the last 12 months, have you had an appraisal, PADR, annual review or development review?	16%	2%	82%

Question	No	Not applicable	Yes, to some extent	Yes, definitely
It helped me agree clear objectives for my work.	15%	18%	43%	24%
It helped me to improve how I do my job.	28%	18%	42%	13%
It left me feeling that my work is valued by my organisation.	21%	18%	35%	26%

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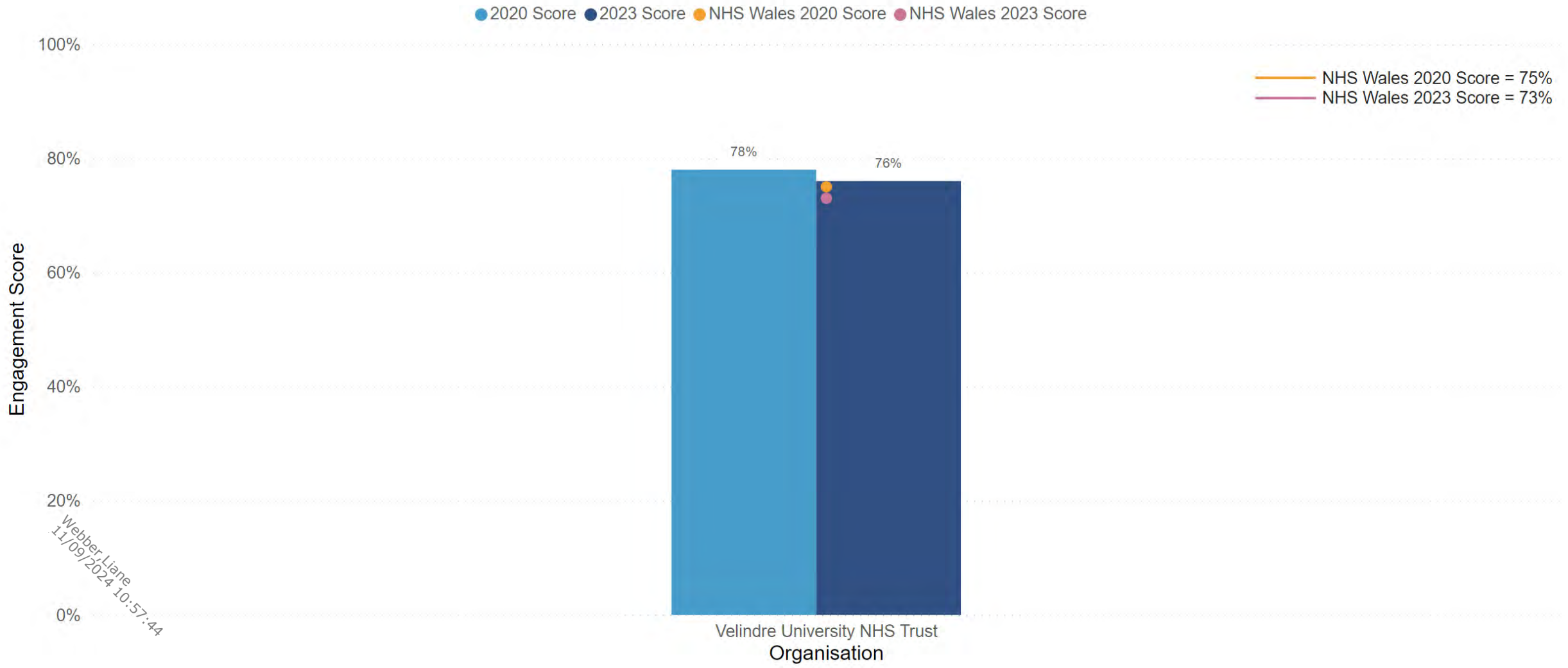
11/09/2024 10:57:44

NHS Wales and Organisation Engagement Score



Note: Digital and Health Care Wales 2020 score is the score for NHS Wales Informatics Services.

Theme	Action 2024-25	Measure	Cross reference	Q1 Progress
Morale	Develop Retention Plan for all staff groups	An agreed retention plan in place.	Retention Action Plan	Draft Nurse Retention Action Plan accepted by EMB (25 June 2024) as 1st phase in Trustwide Staff Retention Plan
Patient Safety	Build a dataset based on NHS Staff Survey report showing psychological safety and run Pulse Surveys	Results are extracted, Pulse Surveys in place, results fed back to staff regularly	SCC Leadership Project	Initial discussion with Digital Lead has taken place. Next steps - plan sampling methodology, identify questions for pulse surveys and implement.
Patient Safety	Approve Incident Management Framework and Learning Framework	Frameworks approved and in place	Integrated Quality and Safety workplan	Frameworks have been approved and are in place
Staff Engagement	Develop a staff engagement framework informed by the Staff Survey results and Working Together output	Staff Engagement framework approved and in place	OD Programme	First draft available by end of July 2024. Staff consultation until end of September 2024. Launch Framework mid-October 2024.
Compassionate and Inclusive	Adopt Values and Behaviour Framework	Values and Behaviour Framework approved and in place	OD Programme	Values approved. Working Together staff briefing took place 22 July 2024. All policies on course to be updated by September 2024.
Compassionate and Inclusive	Leaders are visible and accessible in all work areas - from Executive level down to Team Leader	Staff feedback show people feel that leadership is present.	OD Programme	Launch Framework mid-October 2024.
Compassionate and Inclusive	Briefings and training for all staff to support the roll out of Values, to include communication skills and speaking up when values are being broken	Sessions are held through a range of mediums and times.	OD Programme	Approximately 150 staff atttended the All Staff Briefing on 22 July 2024. The slides and recording of this session will be used in the Autumn for a programme of training overseen by the Executive Director of OD and Workforce.
Compassionate and Inclusive	Implement Anti Racist Action plan	Anti-racist action plan is monitored and implemented.	Strategic Equality Plan action plan	In process of setting up Task and Finish Group. Awaiting WRES report to determine next steps.
Recognising Contribution	Run the Employee Excellence Awards 2024	Event takes place, increased nominations from 2023	Wellbeing Action Plan	Taks and Finish Group in place. Nomination form and comms written - ready to launch for nominations from 1 July to 31 August 2024.
Able to Speak Up	Test and develop methods and feelings around Speaking Up	Improvement in Staff Survey ratings for Speaking Up	Healthy and Engaged Work Plan	Communication programme pushing our messages on the imprtance of speaking up safely, updated Intranet page to explain the process to speaking up safely, IM Champion appointed, improved reporting on cases.

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Stronger Together	Review resources for team development	Group established and meeting monthly	SCC Leadership Project	Support for OD Commissioning Space confirmed at Education Steering Group on 25 June 2024. Next steps - set up and run as 6 month pilot.
Healthy Working Environment	Identify examples of long hours culture	Case studies avaiable for EMB discussion.	Retention Action Plan	Draft paper written detailing the key themes identified through staff stories and exit discussions for further refinement and discussion before submitting widely
Champion Flexible Working	Develop managers' understanding of flexible working and hybrid working	Improvement in Staff Survey ratings for Flexible Working	POD Workplan	Policy implemented. Eduction via Inspire Programme
Continuously Learning and Improving	Approve People Development Policy and implement processes	6 month progress report after approval of Policy.	Education Strategy Audit	Policy drafted. Processes in design with Digital. EMB discussion on 8.7.24. Aim for Trust Board 26.9.24.
Continuously Learning and Improving	Review and approve PADR policy and processes	6 month progress report after approval of Policy.	Education Strategy Audit	Staff consultation started on 20.6.24. EMB discussion on 8.7.24. Aim for Trust Board 26.9.24

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Trust Values and Behaviour Framework

DATE OF MEETING	12th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	YES

PREPARED BY	CLAIRE BUDGEN, HEAD OF ORGANISATIONAL DEVELOPMENT
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development and Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	A behaviour framework has been developed to help people apply the Trust values. The framework will be designed into People Policies and into our Communications and Engagement campaigns. The role of leadership is critical in role modelling the values and behaviours and setting an open culture with regard to giving and receiving feedback. This is essential in developing psychological safety.

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RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to NOTE the report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Proposed - Executive Management Board	29.8.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS NOTED	

7 LEVELS OF ASSURANCE	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 5 - Majority of actions implemented; outcomes not realised as intended

APPENDICES	
1	Trust Values and Behaviour Framework

1. SITUATION

1.1 The Trust Board approved a new set of organisation values in January 2024. These are Caring, Respectful and Accountable. The next phase of work was to develop a Behaviour Framework to bring the values to life. This paper sets out the Behaviour Framework and sets out the remaining action plan leading to full dissemination of the values.

2. BACKGROUND

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2.1 Since the approval of the values, a programme of work has been undertaken to develop a Behaviour Framework to support the values. A draft framework was developed from comments received during the consultation on the values. This was shared for further feedback on the intranet and with key Trust groups, specifically the Executive Team, the Local Partnership Forum and the WBS and

VCS Senior Leadership Teams. Further feedback has been gathered via an on-line survey and through discussions with staff.

2.3 The resulting Trust Values and Behaviour Framework is attached at Appendix 1.

3. ASSESSMENT

3.1 The feedback from all sources was consistent. The use of feedback gained during the consultation on the values showed that the behaviour statements rang true for staff and were well received. However, there were four themes which came through very strongly from all groups. These have been reflected in the attached Trust Values and Behaviour Framework and a summary is included below.

Theme	Feedback
Format	Make it snappy and simple to read. Summarise, remove duplication, use an overarching 'We always…'. Make sure it speaks to everyone – avoid jargon and management terminology. Don't limit the actions to just one value. Make sure patients and donors are visible in the statements.
Implementation	Put it into processes including PADR, recruitment advertising, interview questions and the Employee Excellence Awards. Provide branded materials including email signatures and Teams backdrops. Hold discussions at Team Meetings on how the values are being applied at work. Engage managers and Trade Union representatives. Publicise positive examples using pictures and stories. Introduce hard copy materials such as posters and displays to supplement digital communications. Provide staff briefings and training to explain the values, behaviours and consider how to implement in practice including how to react if values are being broken. Update Inspire to reflect new values and behaviours in relation to compassionate leadership and equalities training. Develop messaging for patients and donors explaining the benefits and impact of the framework.

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Leadership	Senior Leaders are critical to the success of the values and Implementation framework. Leaders to visibly role model the values and behaviours. Create mechanisms that show how senior managers listen to those who challenge poor behaviour or raise concerns. Leaders must be consistent in dealing with issues. Leaders must lead by example and develop a culture where challenge is accepted and it is possible to raise issues with someone more senior. Demonstrate the feedback loop – that action is taken when someone raises a concern. Develop a culture of active listening and learning. Clarify the relationship between the Trust Vision and the WBS Vision.
Inclusion	Some behaviours related to being flexible might be difficult for some people with neuro diversity. Deaf Awareness training is one example of how to build a more respectful organisation. Make it applicable to all job roles, including Medical. Go out and about to discuss it with staff, especially groups who do not use computers routinely at work.

3.2 A programme of communications to inform and educate staff about the new values will be completed by September 2024.

3.3 A programme of updating the People policies and processes with the new values will be completed by the end of September 2024.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 The importance of a Behaviour Framework to bring the values to life was fully acknowledged by Trust leaders during the development of the values in 2022-23, so this paper does not raise a new priority, instead it provides some detail on how to take things forward.

Webber,Liane 11/09/2024 10:57:44

4.2 The additional feedback captured at 3.1 must be noted and reflected in our next steps. Feedback to staff that this is happening must be provided to close the

feedback loop.

4.3 Matters relating to Format and Implementation have been coordinated through Corporate Departments in the Trust through a communications campaign, policy reviews and training and briefing.

4.4 Matters relating to Leadership have to be enacted by all in leadership roles with a particular focus on Directors, the Executive Team and the Board as a whole. There needs to be visible commitment to the values and the behaviours backed up with a clear invitation to speak to a leader regarding the values and how the leader's behaviour is being perceived. Only by bridging these potentially awkward conversations will trust and confidence grow, essential for deeper engagement and psychological safety.

5. Progress to date

5.1 Official branding has been developed with an external provider so that the look and feel of the values complements Destination 2033 and clearly connects our Purpose, Vision and Values. This includes logos for use in documents, email signatures, an MS Teams background and a PowerPoint template. This branding is now in use and will be key in future communications.

5.2 The Values and Behaviours are included in Croeso and Inspire to ensure key cultural messages are shared with staff. This fits well with the focus on Compassionate Leadership that is designed into our internal programmes as our values of Caring Respectful and Accountable sit well with the Compassionate Leadership elements of Attending, Supporting, Empathising and Helping.

5.3 The Employee Excellence Awards 2024 asks for feedback on how the nominee has applied the Values of Caring, Respectful and Accountable within the example submitted for consideration.

5.4 Executive Directors hosted a Working Together All Staff Briefing on the Values and Behaviours on 22 July 2024. Over 150 staff joined the call to hear from Directors about the Values and their personal perspectives on why they are important. The recording of the presentation will be used in future briefings or training sessions about the Values.

6. Next Steps

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6.1 Develop a Working Together session utilising the material from 22 July 2024 to take around the Trust, in person and on-line, between September and December

2024.

6.2 Confirm all workforce policies and processes no longer refer to the previous Values. Similarly, confirm that all internal training programmes are updated.

6.3 Continue the positive messaging through corporate communications about the Values including using case studies to highlight Values being applied in work. Provide banners to all sites as visual representation of the Values.

6.4 The next NHS Staff Survey will be launched in October 2024. This will be an opportunity to also raise the question of how well people have transitioned to using the new Values and how they have helped create a positive culture. Results from this smaller questionnaire can be gathered and analysed by December 2024, in advance of the NHS Staff Survey results in March 2025.

7. 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*	04 - Organisational Culture
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Select all relevant domains below
	Safe ☐

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	Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
	This framework gives clarity to staff, patients and donors about what we can all expect from others.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes

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TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The EQIA of the Trust Values from December 2023 was updated to reflect the feedback gathered during the development of the Behavioural Framework. The resulting actions are captured in the Theme of Inclusion at paragraph 3.1 above.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

8. 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?	

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BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

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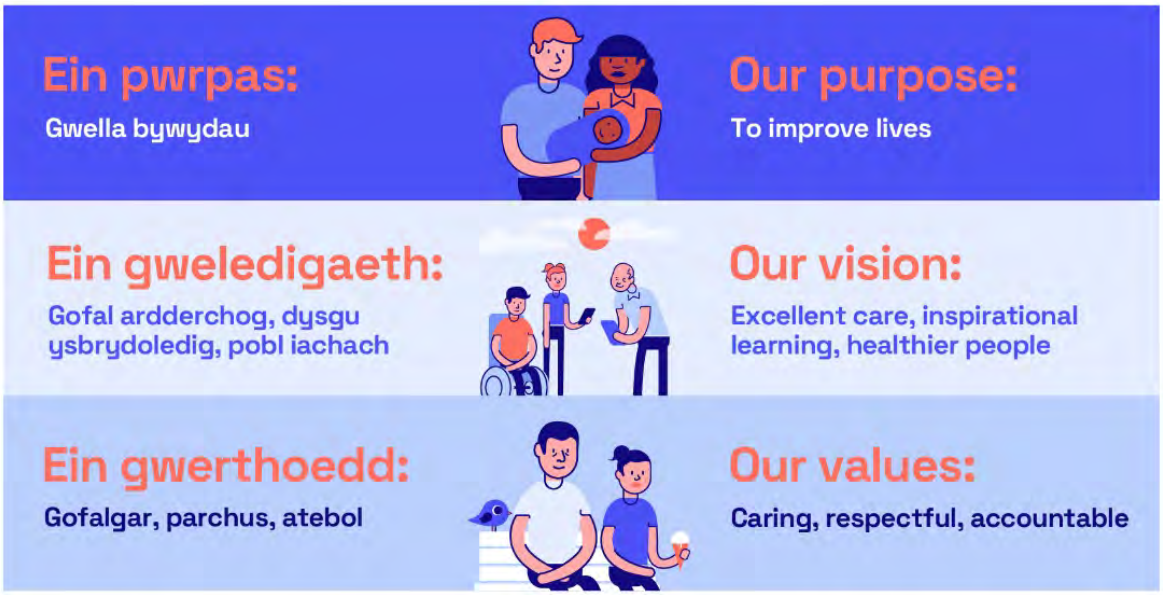
Velindre University NHS Trust
Values and Behaviour Framework
April 2024

Our values describe how we will work to achieve Our purpose, to improve lives, and towards Our vision, excellent care, inspiration learning, healthier people.



Caring
We are always kind, supportive, approachable and show compassion to all.

Respectful
We seek to understand other people's perspectives. We are always open and transparent.

Accountable
We always take personal responsibility for what we do and how we do it.

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We bring the values to life in every aspect of work through our actions. Some examples of helpful actions are highlighted in our Behaviour Framework. There will be lots of other examples of positive actions that we take and these may vary from role to role. The list below covers things which are likely to be relevant to everyone. The ticks give a suggestion about which values the action reflects however feel free to see them from another point of view.

We always…	Suggested Values		
	Caring	Respectful	Accountable
Care for all: patients, donors and colleagues	✓	✓	✓
Collaborate with others to achieve positive outcomes		✓	✓
Communicate with people simply and respectfully		✓	
Consider the impact of how we speak to people	✓	✓	
Deliver on our commitments to each other	✓	✓	✓
Give and receive feedback in order to improve	✓	✓	✓
Help people when they are new and welcome their experiences and contribution	✓	✓	✓
Include everyone in discussions about things that affect them	✓	✓	✓
Listen when people speak up about things which concern them	✓	✓	✓
Listen to learn and improve	✓	✓	✓
Nurture our team and help it grow and develop	✓	✓	✓
Put patients and donors at the heart of what we do	✓	✓	✓
Respond in a timely manner		✓	✓
Role model the values	✓	✓	✓
Share information openly and transparently	✓	✓	✓
Show appreciation to others as a matter of course	✓	✓	
Strive to improve services for patients and donors	✓	✓	✓
Support each other	✓	✓	

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Take responsibility for our actions		☒	☒
Talk about barriers or problems in order to resolve them	☒	☒	☒
Tell people when they are doing a good job	☒	☒	
Treat people equally and fairly	☒	☒	☒
Trust each other to do a good job		☒	☒

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Compassionate Leadership Pledge 2024

DATE OF MEETING	12th September 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	Oghogho Oyan, Workforce Development Manager and Claire Budgen, Head of Organisational Development
PRESENTED BY	Sarah Morley, Executive Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	Health Education and Improvement Wales launched the Compassionate Leadership Pledge in June 2024. The objective is to engrain compassionate leadership in our behaviours. It focuses on relationships through careful listening to, understanding, empathising with and

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	supporting other people, enabling those we lead to feel valued, respected and cared for, so they can reach their potential and do their best work.

RECOMMENDATION / ACTIONS	QSP are asked to **ENDORSE for APPROVAL** ahead of forward 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 - Run	29/08/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB stated that the way in which we use the pledge is crucial. The behaviour indicators were seen as the possible starting point for a Board Development Programme and also should be reflected in the Executive Team objectives. EMB also emphasised the need for the Board to put the compassionate leadership principles and trust values at the heart of its agenda with a re-balancing of board time spent on all elements of its remit.	

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

APPENDICES	
None	

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1. SITUATION

1.1 The NHS was created in 1948 to be compassionate and inclusive. Having a compassionate leadership translates to compassionate cultures, which in turn translates to highly motivated teams that provide compassionate health care to people of Wales. NHS Wales has followed Compassionate Leadership principles for several years and that thinking has underpinned our current leadership and management development programmes and the NHS Staff Survey. Health Education and Improvement Wales have now built on this philosophy by launching a Compassionate Leadership Pledge for organisations, teams/departments and individuals to tangibly demonstrate their understanding of and commitment to leading others with compassion.

1.2 More recently, the NHS Wales Chief Executive has written to all organisations to encourage senior leaders to use the Nurturing Kindness and Inclusion behavioural indicators from the NHS Wales Success Profile for current and aspiring CEOs (see below) as a tool for self-reflection and identifying areas of development.

	Nurturing kindness and inclusion - this is about taking personal responsibility for embedding an inclusive and compassionate culture where staff, partners and citizens are valued for their uniqueness and the differences between individuals are celebrated.
16.	Genuine, able to connect with people at a personal level, and interested in the lives and aspirations that extend beyond their day-to-day work.
17.	Brave and uncompromising in tackling discrimination, bullying or prejudice, whether within their own Health Board, local system or at a national level.
18.	Champions and models the benefits of inclusion and diversity for all aspects of team, organisational and system effectiveness.
19.	Builds trust and creates psychological safety through expressing personal vulnerability, sharing their shortcomings, and demonstrating forgiveness.
20.	Works proactively with their Chair and Board members to shape a culture that values empathy and support as much as candor and a willingness to challenge.

2. BACKGROUND

2.1 The report proposes that the Trust formally signs the Compassionate Leadership Pledge in order to foster a culture of compassion throughout the workforce by implementing the compassionate leadership principles. This approach aims to dismantle barriers that impede compassionate behaviours towards oneself and colleagues. Research evidence shows the importance of this initiative, demonstrating that exclusion has detrimental effects on individuals' health and well-being. Moreover, a lack of compassion correlates with diminished performance, highlighting the integral role of compassion in both personal welfare and organisational effectiveness.

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3. SUMMARY OF CONSIDERATIONS

3.1 Compassionate Leadership Pledge

There are seven key elements of the compassionate leadership pledge:

- Developing supportive and effective team working
- Creating environments where collective leadership thrives
- Improving equality, inclusion and diversity
- Establishing the conditions for continuous improvement and innovation
- Agreeing on direction and ensuring alignment and commitment
- Enabling safe, trusting and engaging systems and cultures
- Managing difficulties and challenges positively, openly, courageously and ethically.

3.2 Actions to achieve sign-off of the Compassionate Leadership Pledge

Organisational culture starts at the top therefore the Trust Board has a particular role in supporting and enacting the Compassionate Leadership Pledge. At the same time, every staff member is considered a leader and all staff should sign the Compassionate Leadership Pledge. To facilitate this signing, the following actions will be taken.

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3.2.1 Organisational Level - Sign-off by the Trust Board

All Board members will formally sign a paper copy of the pledge which will be displayed in Trust Headquarters. A formal statement of endorsement will be recorded in the minutes of the Trust Board meeting of 26 September 2024 demonstrating the organisational-level signing of the pledge.

3.2.2 Team/Departmental Level - Compassionate Leadership team discussions

Teams will be asked to discuss the Pledge as part of their regular pattern of meetings. This will provide an opportunity to reinforce the principles of empathy, support and inclusivity, ensuring that compassionate leadership remains a living, breathing part of our organisational culture. By regularly revisiting these values, we empower our staff to lead with compassion in every interaction, fostering a more understanding and collaborative work environment. This continuous commitment to compassionate leadership will not only enhance team dynamics but also positively impact our service to the community.

3.2.3 Individual Level - Sign off at Croeso Induction Programme

Croeso Induction will now incorporate the Compassionate Leadership principles, ensuring that every newly recruited staff member is introduced to the pledge from the outset. By signing the pledge during their induction, new employees will recognise these values early in their employment, making compassionate leadership an integral part of their professional roles and daily interactions. This commitment will foster a culture of empathy, understanding and support, enriching both the workplace and the broader community we serve.

3.2.4 Individual Level - Sign off at Inspire Leadership Programme

During the Inspire training session on Leadership, attendees will sign the pledge, giving upcoming managers the opportunity to commit to compassionate leadership. This step ensures that they not only understand but also embody the principles of empathy, support, and inclusivity as they grow into their managerial roles. By doing so, we cultivate a leadership culture grounded in compassion, which will positively influence their teams and the overall organisation.

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3.3 Actions that embed the Compassionate Leadership Pledge

Our existing leadership development and equality programmes are rooted in compassionate principles and are therefore a vehicle for us to demonstrate the pledge in action.

Principle	Benefits to the Trust	Actions
Improve equality, inclusion and diversity, consciously removing barriers and boundaries	Enhanced employee morale and retention. Broader range of perspectives and ideas.	Demonstrate that diversity and inclusion is a compulsory module within Inspire and an essential component of the Croeso programme (30.9.24). Update the generic template for People Policies Equality Impact Assessments to ensure Compassionate Leadership is reflected as an enabler of inclusion (30.9.24)
Strengthen respect, voice, influence, and choice	Increased employee engagement. Improved decision-making processes	Strengthen the network of Diversity Forums to create open forums for feedback and discussion. Circulate Newsletter for Diversity Forums to demonstrate activity (31.12.24). Ensure Compassionate Leadership is reflected in the emerging staff engagement framework which is based on the Working Together programme of meetings and

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Principle	Benefits to the Trust	Actions
		two-way communication. Promote a culture of caring, respect and accountability (31.3.25).
Develop supportive and effective team and inter-team working	Higher productivity and efficiency. Better problem-solving and innovation	Issue guidance to teams for holding Compassionate Leadership discussions (31.10.24). Facilitate team-building activities and celebrate milestones and encourage cross-departmental projects and collaborations (31.3.25)
Enable safe, trusting and engaging systems and cultures	Reduced workplace conflicts and stress. Higher levels of trust and collaboration	Ensure Compassionate Leadership is reflected in the emerging staff engagement framework which is based on the Working Together programme of meetings and two-way communication. Promote a culture of caring, respect and accountability (31.3.25). Senior leaders to use the Nurturing Kindness and Inclusion behaviour indicators for reflection and identifying areas for development (31.10.24).
Manage behaviour positively, openly,	Enhanced organisational reputation.	Embed Trust Values and Behaviours in everything we say and do. Roll out training

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Principle	Benefits to the Trust	Actions
courageously, and ethically	Increased trust and respect among employees.	and briefings to support this (30.9.24).
Establish the conditions for our workforce to reflect, learn, continually improve and innovate	Continuous improvement and innovation. Better adaptability to change.	Implement the Trust Quality Priorities 2024-25, including implementing the Incident Management Framework and the Learning Framework (31.3.25).
Create environments where collective leadership thrives	More resilient and adaptable teams. Distributed decision-making leading to faster responses	Update leadership development activities to reflect shared decision making and responsibility. Introduce Fundamentals of Management and Gwella resources as wrap-around to the Inspire taught programme (31.3.25).

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 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	☒

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RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	04 - Organisational Culture
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
	Click or tap here to enter text.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A More Equal Wales – a society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Signing the Compassionate Leadership pledge confirms commitment to an existing model of leadership rather than proposing a change.

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

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

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

People and OD Policies and Processes

DATE OF MEETING	12th September 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	JUDY STAFFORD, PEOPLE AND RELATIONSHIP TEAM MANAGER
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce

EXECUTIVE SUMMARY	This paper provides an overview of updates made to Workforce and OD Policies, bringing them up to date with current employment legislation and best practice.

RECOMMENDATION / ACTIONS	QSP is asked to endorse these amendments / new polices for approval.

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GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

Professional Nurse Forum	03/10/2023
Executive Management Board	29/08/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Professional Nurse Forum have commented specifically on the Professional Registration Policy suggesting minor amendments to wording following an incident investigation. Executive Management Board endorsed all the policies for approval	

APPENDICES	
1	Draft – People Development Policy
2	Draft – PADR Policy
3	Reviewed – Alcohol and Substance Misuse Policy
4	Reviewed – Professional Registration Policy

1. SITUATION

This paper provides an overview of updates made to People and OD Policies, bringing them up to date with current employment legislation and best practice.

2. BACKGROUND

Pending the introduction of a more systematic and sustained way to review People and OD policies that will take place from September 2024 onwards, the following polices have been developed or reviewed for legislative and best practice compliance.

3. ASSESSMENT

The following are the changes or additions to current policies to bring them up to date with current legislation and best practice that EMB are asked to endorse:

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3.1 <u>People Development Policy</u>

- Task and Finish Group in place since January 2024 and helped create new policy and archive the current Study Leave Policy.

- Document simplified
- Clear categorisation of approval levels
- Flexibility to delegate to Training Panel if budget holders decides
- Inclusion of Standing Financial Instructions requirement that decisions over £2,000 will be referred to Executive Director of OD and Workforce.
- Questions for the Study Leave application form are included at Appendix 1. They will be put into an MS Forms digital application process.
- Copied the wording about the repayment of fees from the previous policy under the section on learning contract and included a proforma learning contract
- Copied the wording about travel time from the previous policy

3.2 PADR Policy

- Task and Finish Group established July 2024
- Toolkit to be designed and developed with digital support
- Policy document simplified
- PADR form covers core sections with optional extras in a PADR Toolkit, e.g. guidance notes on preparing for PADR, reflection, 360 feedback, talent mapping.
- Values question simplified to included new values and behaviour framework
- Prompt for revalidation reminder to cover all professions
- Prompt for review of Job Description every three years
- Clarification of interplay with Pay Progression Policy and process

3.3 Alcohol Drugs and Substance Misuse

- Minor amendments to structure and language
- Amendment to level of management who can refer to professional body. Decreased level from Executive Director to appropriate Senior Manager and Divisional Director
- TU requested amendment to section 10.1 regarding if a member of staff is asked to attend work in emergency on-call situation and not as part of rota, should they not be able to attend that there would be no detriment to them
- All support organisations checked and updated

3.4 Professional Registration Policy

- Minor amendment made by Professional Nurse forum which states: ‘escalate situations of concern with registration to Head of department and if required to relevant executive lead’.

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4. SUMMARY OF MATTERS FOR CONSIDERATION

QSP is asked to accept these changes and endorse the polices for Board approval.

5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: 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*	04 - Organisational Culture
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 ☒

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	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of both employer and employee. Having well-articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Yes
	NA – assessments completed on each policy

TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	A Wales of Vibrant Culture and Thriving Welsh Language -Promoting and protecting culture, heritage and the Welsh language, encouraging people to participate in the arts, and sports and recreation
	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	Yes - please outline what, if any, actions were taken as a result

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For more information: *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Each policy has undergone an EQIA in line with the statutory requirements of assessing policy impact on Protected Characteristics. None of the polices outlined in this paper required further action.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Not having well designed people polices could result in further challenge through employment tribunals.

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	TAF 01 - There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources. TAF 03 - There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives. TAF 04 - There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes. TAF 06 - There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
WHAT IS THE CURRENT RISK SCORE	Various as outlined on the Trust Assurance Framework
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Having well designed and values driven People Policies will support the Trust to ensure fairness and inclusion by outlining the responsibilities of

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	both employer and employee. Having well articulated and clear directions for staff will can impact motivation, organisation reputation and the ability to attract and retain talent, creating mutual benefits for employees and organisations as well as providing statutory protections where these are essential for the Trust.
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	NA – Specific risks aligned to the strategic Trust risks and reviews as part of the Trust Assurance Framework
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Yes - please detail below
	Ensuing the right people are able to review and comment on the policy development. This will hopefully be mitigated by a new systematic review process that will commence in September 2024.
All risks must be evidenced and consistent with those recorded in Datix	

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REF: ()

PEOPLE DEVELOPMENT POLICY

Executive Sponsor & Function	Executive Director of OD and Workforce
Document Author:	Claire Budgen, Head of Organisational Development
Approved by:	Sarah Morley, Executive Director of Workforce and OD
Approval Date:	26 September 2024
Date of Equality Impact Assessment:	4.April 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	
Version:	

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1. INTRODUCTION/AIM

Velindre University NHS Trust is committed to ensuring that staff have access to appropriate education, learning, development and training.

This applies across all job roles. It covers essential training that supports safe delivery of services within the immediate job role. It also includes professional development that allows people to grow into new areas and build new opportunities.

2. OBJECTIVES

This policy ensures:

- All employees are encouraged to develop and learn through the course of their work
- Decisions regarding development are made on clear criteria
- Resources for education and development are allocated in line with organisational priorities.

3. SCOPE OF POLICY

This Policy applies to all employees.

Equality of access to development opportunities should apply regardless of age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex/gender or sexual orientation.

4. ROLES AND RESPONSIBILITIES

4.1 Executive Management Team

- Set out organisational priorities within the IMTP.
- Allocate financial resources at organisational level to support learning and development relating to known demands.

4.2 Budget Holders

- Plan training resources to meet current and future service requirements
- Consider applications in line with agreed decision-making criteria.
- Approve/reject applications with clear rationale.
- Apply conditions relating to the training, including any time away from work or the requirement to complete a Learning Contract.
- Monitor expenditure.
- May choose for efficiency and effectiveness to delegate Study Leave decisions to a local Training Panel.

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- In line with Standing Financial Instructions, refer applications for more than set limit (£2,000 as at July 2024) to the Executive Director of OD and Workforce.
- Utilise the on-line study leave application to consider requests and record decisions.

4.3 Line Managers

- Discuss development opportunities with every employee as part of the Performance Appraisal and Development Review Process.
- Develop a supportive environment for learning and development in the team and helping reduce any barriers to learning or access to development.
- Approve/reject applications within their remit, following the requirements of the legal Right to Request Training (see Section 10).
- Confirm with the employee any conditions relating to the training, including any time away from work or the requirement to complete a Learning Contract.
- Support applications which require funding by referring them on to the relevant budget holder for decision.

4.4 Employees

- Maintain compliance with their statutory and mandatory training as listed in ESR.
- Actively engage in the Performance Appraisal and Development Review process by reflecting on their own learning and future plans.
- Cooperate with manager in ensuring the impact of absence in kept to a minimum.
- Participate in any learning activities to the best of their abilities.
- Fulfil agreed commitments including agreements regarding time away from the workplace or undertaking a Learning Contract.
- Provide feedback on their learning.
- Contribute to a supportive environment for learning within their workplace.
- Apply for study leave using the VUNHST electronic form (questions included for reference at Appendix 1).

4.5 Trust Trainers and Educators

- Deliver training in line with their professional remit to agreed organisational outcomes.
- Maintaining professional registration or certification as required.
- Comply with quality assurance requirements, including providing written records of course materials, recording attendance and gathering evaluation data.
- Contribute to organisational learning by sharing their learning and experience with other trainers.

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4.6 People Development and Education Team

- Ensure statutory and mandatory training is available in line with job requirements.

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- Ensure statutory and mandatory training is accessible in line with individual requirements and reasonable adjustments.
- Provide recording and reporting system through ESR.
- Produce annual training plan outlining core training requirements and provision.
- Provide learning resources and advice to staff and line managers.
- Support quality assurance of training through developing effective approaches to training design, delivery and evaluation.
- Advise budget holders when considering part-funding courses or qualifications to build consistency in decision making.
- Annually review equity of access to training resources.

5. DECISION MAKING

5.1 All personal professional development requests must be referenced in the Performance Appraisal and Development Review. This may happen during the annual review or be added at a later date.

Decisions will be made in line with this table. Training requests for over £2,000 will be referred to the Executive Director of Workforce and OD for decision.

Time is allocated where the training falls within working time. Training hours outside of normal working hours will not normally be reimbursed.

Category of Training	**Allocation**
Statutory and Mandatory Training	100% time. No funding required. No Study Leave form required. Always approved.
Essential Training for current role	100% time. 100% funding. Study Leave form required. Always approved.
Non-accredited courses - Non-essential training for current role Training and development for future NHS role (non-accredited)	Time and funding negotiable, depending on attendance time required, cost to the Trust and benefit to the service. Study Leave form required. Applications can be deferred to next year. Reasons for rejection need to demonstrate adherence to the Right to Request Training criteria as set out in Section 10.

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	Part-funding decisions need to be discussed with the People Development and Education Team to promote consistency in decision-making across the Trust.
Accredited courses including professional qualifications, Post Graduate Certificates and Diplomas, Masters qualifications.	Time and funding negotiable, depending on attendance time required, cost to the Trust and benefit to the service. Study Leave form required. Employees will be required to repay a proportion of the course fees if they leave within 2 years of the end of the course. Applications can be deferred to next year. Reasons for rejection need to demonstrate adherence to the Right to Request Training criteria as set out tin Section 10. Part-funding decisions need to be discussed with the People Development and Education Team to promote consistency in decision-making across the Trust. Spaces on centrally-funded accredited programmes (such as Advanced Practice) will be allocated by the relevant professional lead.
Conferences and training days	100% time. 100% funding where application approved. Study Leave from required. Approved subject to business need and availability of funds.

5.2 Travelling Time

It is recognised that attendance at some courses necessitates significant travelling time or overnight stay before, during or after the event. Neither the Working Time Regulations 1998 or relevant Department of Trade and Industry guidance provide a definitive resolution to the issue of whether time spent travelling before or after a study leave event is classed as ‘working time’. As such the following is provided as internal Trust guidance for local implementation within division/department as necessary:

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- Where the course of study is agreed as being Essential or Desirable by the manager and member of staff (but not mandatory or statutory), it should be noted that time spent on the course, or travel time to it, outside of normal working hours will not be considered as working time.
- No payment, or time in lieu, will be granted in relation to time spent travelling time to or from, or overnight stay before, during or after a study leave event.
- Wherever possible travel to and from a study leave event should be undertaken within the 'normal' working hours for the member of staff attending. Staff who normally work part time hours may request an alteration to their 'normal' working hours for the purposes of travelling time. Managers are required to give all such requests due consideration and grant at their discretion and only if service demands.

5.3 Record Keeping

All professional development will be discussed during Performance Appraisal and Development Reviews and documented in the Personal Development Plan. This can be updated at any point in the year, should training and development needs arise.

All requests above statutory and mandatory levels will be entered into the on-line Study Leave application form which will provide a comprehensive record of development requests and decisions held by the People and OD department. This includes courses where no funding is required. This will be reviewed annually to examine equity of access to learning and development.

6 LEARNING CONTRACT

6.1 Managers must ensure as far as is possible, that any employee of the Trust who wishes to undertake training either involving regular release over one academic year or more and/or is applying for study leave where there is significant financial outlay, is intending to remain in the Trust for at least two years after the training/course is completed. Any employee who is thinking of undertaking such training and who may be entitled to financial assistance from the Trust must be made aware of the commitments they have to both completing the course and to the Trust itself. Serious consideration should be given to the possibility of reclaiming the financial assistance given if an employee fails to complete the course or leaves the Trust within two years of finishing it, without good reason. A pro=forma for a Learning Contract is provided at Appendix 2.

6.2 Reclamation rates are based on the following:

The period of time elapsed between final date of course attendance, assignment submission or examination attendance (whichever falls on the most recent date and /or	Percentage of the course cost, met by Velindre NHS Trust, for the total, or final year (in cases of Further or Higher education courses where attendance extends beyond a single

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would be consider the 'end' of the course) and employee leaving Velindre University NHS Trust employment falls within the period:	academic year), fees to be repaid by the employee:
12 months	50%
18 months	25%
24 months	10%
NB: The pursuit of financial reclamation will be at Divisional Director's discretion.	

6.3 It is the authorising manager's responsibility to explain the conditions for granting leave and financial support with regard to continued employment in the Trust. It is recommended that the Authorising Manager obtain a signed agreement from the applicant confirming their intention of remaining in the Trust for two years and an understanding that the financial assistance or a proportion thereof may be reclaimed. Further advice and an appropriate agreement is available from the People and OD department. It is also a condition of financial support that members of staff who have been offered/have received financial assistance to attend training/education may have support withdrawn/be required to reimburse the Trust in certain other circumstances. In the case of monies being reclaimed, an appropriate sum may be deducted from the member of staff's salary. It is not possible to be totally prescriptive about this, since the circumstances of each individual case will vary. Before a decision is made the matter will be discussed with the individual, his/her manager, and where relevant the training/education provider and/or budget holder. During such discussion, the employee may be accompanied by a trade union representative, or a work colleague. Where monies are to be withheld/reclaimed, the Payroll Department must be notified as soon as possible by the employee's manager. However, no monies will be reclaimed whilst discussions are still in progress. The Trust reserves the right to withhold support/ask for reimbursement in the following circumstances, although the individual circumstances of each case will be assessed on its merits: Failure to Complete/Withdrawal From a Course Where a member of staff fails to complete a course, or withdraws from a course following commencement, the member of staff may be asked to make a repayment of the financial assistance provided by the Trust, unless there are exceptional circumstances, or a medical certificate is provided in the case of sickness. N.B.:

- Failure to sit exams or assignments after the normal period of instruction will count as failure to complete a course.
- Unsatisfactory Progress: where a member of staff is unsuccessful in examinations or assignments at the second attempt, the Trust will not provide any further assistance or time off.
- Unsatisfactory Level of Attendance : where attendance on a course falls below the minimum acceptable to the training/education provider/awarding body, taking into account illness, annual leave, and/or other extenuating circumstances, the employee may be asked to make a repayment of the financial assistance provided by the Trust

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7. RESOURCES

Time, money and learning materials will be made available in line with the Education Strategy. These resources will be determined and funded through the use of the Trust Training Plan and other strategic workforce plans.

8. TRAINING

No specific training is required to support this policy. The process will be reflected in training for using the Performance Appraisal and Development Review.

9. IMPLEMENTATION AND COMPLIANCE

This policy will be implemented alongside the Performance Appraisal and Development Review process.

The central database of Study Leave requests may be measured periodically against the Training budget codes to identify whether training requests are being processed through the on-line system.

Equity of access to learning opportunities will be assessed annually.

10. REFERENCES

Right to Request Training

https://www.gov.uk/training-study-work-your-rights gives guidance on the legal right to request training. Key points are highlighted below but staff and managers should consult the website to view full details.

Employees should follow their organisation's rules to ask for time off. If there aren't any they can write to their employer saying it's a request 'under Section 63D of the Employment Rights Act 1996' with the following details:

- *the date*
- *the subject matter of the study or training*
- *where and when it would take place*
- *who'll be providing the training*
- *the name of the qualification they could get - if any*
- *why they think this study or training will help them do their job better and help their employer's business*
- *if they've made a request before and when*

An employer does not have to consider the request if all this information is not included.

Employees can only make 1 request a year.

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The employer has 28 days to:

- *accept the request*
- *hold a meeting with the employee to discuss it*

This might be longer if the person who deals with these requests is off when the request is sent in.

The employee can take a trade union representative or colleague to the meeting. They can ask for the meeting to be postponed if this person can't make it.

If the employer decides to hold a meeting about it they must make a decision within 14 days of it, unless the employee agrees in writing to extend this time.

The employer can only turn down a request if:

- *the training would not benefit their business*
- *they would run up extra costs for the business*
- *they would not be able to meet customer demands*
- *they cannot re-organise the work among other members of staff*
- *they cannot recruit extra staff*
- *it would damage quality and business performance*
- *there would not be enough work for the employee to do at the times they intend to work*
- *it conflicts with planned structural changes*

The employer doesn't have to pay for the training or study. They can choose to pay all or part of the fees if they think it will benefit the business.

11. DUTY OF QUALITY

This policy supports the Workforce enabler within the Duty of Quality, specifically 'Our workforce planning focuses on investing in our people and nurturing, growing and transforming our workforce to create a sustainable workforce for the future'.

12. EQUALITY STATEMENT

The Trust is committed to ensuring that the way it provides services to the public and the way it treats its employees reflects their individual requirements and does not discriminate against individuals or groups.

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An Equality Impact Assessment was completed which highlighted that the policy has to be communicated in a clear way and be easily available to all staff. Equally, it must be available in Welsh.

13. ENVIRONMENTAL IMPACT

Employees, Line Managers and Budget Holders are encouraged to make training decisions which minimise impact on the environment by considering local or virtual learning opportunities.

14. AUDIT

The People Development and Education Team will audit Study Leave applications annual to measure equity of access against protected characteristics.

15. REVIEW

The People and OD department will review the operation of the policy and make updates when required.

16. GETTING HELP

Help, advice and guidance is available from the People and OD department.

17. RELATED POLICIES AND PROCUDRES

- Performance Appraisal and Development Review
- All Wales Study Leave Policy for Doctors and Dentists in Training
- Section 63D of the Employment Rights Act (1996),

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APPENDIX 1

Application for Study Leave (this form will be digitised and include routing of decision making)

Employee Section
Name
E-mail
Employee Number
Job Title
Department
Division – drop down box
Pay Band – drop down box
Part time/Full time
Title of Course/Conference
Training / Education Provider
Start Date
End Date
Time away from the workplace
Benefits of attending – organisational and personal
How workload will be managed during training?
Contained in PADR Yes/No
Submit to Line Manager
Line Manager Section
Approved in full Yes/No
If not approved, give reason for non-approval.
Approved in part - specify what has been approved.
Does it require a Learning Contract? Yes/No
Provide specific dates and course fees subject to the Learning Contract.
Further approval required Yes/No – if yes, submit to Budget Holder/Training Panel
Budget Holder/Training Panel Section
Approved in full Yes/No If not approved, give reason for non-approval.
Approved in part – specify what has been approved
Notify Line Manager where a Learning Contract needs to be signed
Approval by Executive Director of OD and Workforce for fees over £2,000
Approved – Yes/No

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Appendix 2

Learning Contract

Course details	
Employee Name	
E-mail	
Employee Number	
Job Title	
Department	
Division	
Line Manager	
Title of Course/Conference	
Training / Education Provider	
Start Date	
End Date	
Course Fee Granted by VUNHST	

The period of time elapsed between final date of course attendance, assignment submission or examination attendance (whichever falls on the most recent date and /or would be consider the 'end' of the course) and employee leaving Velindre University NHS Trust employment falls within the period:	Percentage of the course cost, met by Velindre NHS Trust, for the total, or final year (in cases of Further or Higher education courses where attendance extends beyond a single academic year), fees to be repaid by the employee:
12 months	50%
18 months	25%
24 months	10%

Declaration by employee

I confirm I intend to remain in the Trust for two years after the end of my course and I understand that the financial assistance or a proportion thereof may be reclaimed if I leave before the two years has elpased.

It is also a condition of financial support that members of staff who have been offered/have received financial assistance to attend training/education may have support withdrawn/be required to reimburse the Trust in certain other circumstances including:

- Failure to sit exams or assignments after the normal period of instruction will count as failure to complete a course.
- Unsatisfactory Progress: where a member of staff is unsuccessful in examinations or assignments at the second attempt, the Trust will not provide any further assistance or time off.
- Unsatisfactory Level of Attendance: where attendance on a course falls below the minimum acceptable to the training/education provider/awarding body,

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taking into account illness, annual leave, and/or other extenuating circumstances, the employee may be asked to make a repayment of the financial assistance provided by the Trust

I confirm that in the case of monies being reclaimed, an appropriate sum may be deducted from my salary.

SIGNED:

Employee: …….. Date: ……..

Line Manager: …… Date: …….

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REF: ()

PERFORMANCE APPRAISAL AND DEVELOPMENT REVIEW POLICY

Executive Sponsor & Function	Executive Director of OD and Workforce
Document Author:	Head of Organisational Development
Approved by:	Executive Director of OD and Workforce
Approval Date:	26 September 2024
Date of Equality Impact Assessment:	5 August 2024
Equality Impact Assessment Outcome:	No adverse impact on any protected characteristics
Review Date:	
Version:	

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1. Policy Statement

1.1 Velindre NHS Trust is committed to the performance management and continuous development of its employees in order to meet service needs and organisational ambitions. The process of Performance Appraisal and Development Review (PADR) is fundamental to achieving this aim.

2. Purpose

2.1 To provide a framework for meaningful work-based conversations between employees and their line managers. This includes setting out work objectives, enabling achievement of those goals and reviewing professional development, both within the immediate demands of the role and looking further ahead.

2.2 Appraisal of performance and reviewing development needs are fundamental to the delivery of healthcare services. It occurs informally throughout the year and is formalised annually in a PADR.

2.3 The policy aims to increase effectiveness and satisfaction at work by giving employees influence over what they do and how they do it and by regularly reviewing progress and resolving barriers.

3. Scope

3.1 This Policy will apply to all employees of the Velindre University NHS Trust who are subject to Agenda for Change terms and conditions of service.

3.2 For employees new to the Trust, the first formal PADR will take place after Induction activities are completed and no longer than 6 months after coming into post. For employees who transfer to new roles within the Trust, the PADR should be revised at the earliest opportunity to reflect objectives and development needs relevant to their new role.

3.3 From time to time, employees will be eligible for a pay step within their pay band under Agenda for Change pay arrangements. There are five standards in the Pay Progression Policy which must be met in order to progress through the pay gateway:

i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards
ii. There is no formal capability process in place
iii. There is no formal disciplinary sanction live on the employee's record.
iv. Statutory and mandatory training has been completed
v. For line managers only – appraisals have been completed for all staff.

The PADR is used as an opportunity to hold this Pay Progression review.

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3.4 Where a capability issue has been identified it will be managed under the Capability Policy.

4. Aims and Objectives

4.1 To improve quality and effectiveness of work by:

- Clarifying expectations of what needs to be done and how it should be done
- Providing a forum for giving and receiving constructive and timely feedback
- Allowing space to review and improve services

4.2 To improve skills, knowledge and capabilities in all areas of the Trust through discussing and agreeing personal and professional development in line with the needs of the job, individual aspirations and in light of available resources.

5. Roles and Responsibilities

5.1 Executive Directors

- Monitor PADR activity and ensure it is being implemented in all areas of the Trust
- Nurture an organisational culture supportive of PADR
- Provide direction for workplace objectives through corporate plans and strategies, as relevant.

5.2 Line Managers

- Maintain regular dialogue with employees about work objectives, challenges and development opportunities
- Undertake PADR with each employee annually
- Undertake the Pay Progression confirmation section of the PADR process 12 weeks prior to the employee's pay step, when notified by ESR (this may be in addition to a previously timetabled PADR)
- Hold an open conversation on the challenges and opportunities that the individual experiences in their job role following Compassionate Leadership principles
- Review individual performance over the past 12 months incorporating review of any existing objectives
- Establish performance objectives for the next 12 months
- Agree a Personal Development Plan for the next 12 months
- Where applicable, confirm whether a member of staff has achieved their pay step in accordance with the All Wales Pay Progression policy
- Inform the Payroll Department using the Pay Progression Deferral Form (Appendix 2) if they are deferring an employee from receiving their increment in accordance with the Pay Progression Policy
- Seek to meet any specific needs to ensure that the process is fair for any member of staff with a disability or other specific need.
- Ensure that the member of staff understands the implications of the Trust Strategy and Integrated Medium Term Plan (IMTP) as relevant to their department, team and own role.
- Refresh the job descriptions with the member of staff every three years.

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- Review the member of staff's training records to identify if mandatory and statutory training needs have been met.
- Confirm any professional body revalidation or quality processes are being undertaken in order to maintain registration
- Work jointly with the individual to identify challenging, yet achievable objectives for the coming 12 months, which align with IMTP and Trust Strategy.
- Identify examples of when the Trust values and behaviours have been demonstrated and consider how they will inform future objectives
- Work jointly with the individual to identify their learning and development needs.
- Record the date of the PADR on ESR.
- Record the date of a Pay Progression review on ESR.

5.3 **Employees**

- Play an active role in the discussion at PADR
- Help develop relevant objectives
- Commit to learning and development, including maintaining any statutory or mandatory learning
- Ensure that they have completed the mandatory and statutory training needs as required by their role
- Have an appropriate awareness of the Trust values and behaviours and their department's IMTP
- Reflect on their work performance and progress with objectives and be ready to discuss their views with their line manager
- Consider challenges and barriers which need to be addressed
- Consider examples of when they have used the Trust values in the course of their work and where there have been challenges in the workplace linked to the Trust values
- Consider what objectives they would like to work towards over the coming 12 months.
- Identify what learning and development will be of help over the next 12 months.

5.4 **PADR and the Welsh Language - Information for staff and Line Managers**

All staff have the right to access bilingual information, paperwork, and processes relevant to their yearly appraisal. The Welsh Language Standards support the bilingual rights of Welsh speaking members of staff. Staff have a legal right to use the Welsh Language in all aspects of their daily lives.

If the staff wishes to follow the PADR process through the medium of Welsh, then they should please consider appropriate discussions with their line manager at the earliest convenience. The staff should contact their line manager as soon as possible to discuss their requirements.

If the line manager cannot provide a bilingual discussion, then the Trust can support the needs via simultaneous translation. Line Managers who require further information or the process for booking translation, should please contact the Welsh Language Manager - Jo.williams5@wales.nhs.uk.

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Further information on the Welsh Language Standards can be found on the Trust intranet pages.

6. Monitoring and Delegation

6.1 The People and OD team produce PADR reports monthly to allow managers to monitor compliance.

6.2 Where organisational structures or absence makes it difficult to organise PADRs for everyone in a team, the role can be delegated to someone else within their management structure as long as they are competent to act in that role and have sufficient authority to be able to arrange learning and development opportunities.

7. Equality

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

7.2 The Equality Impact Assessment found that there was no detrimental impact to the equality groups mentioned and this policy will have a positive impact on all of the protected characteristic groups. The assessment highlighted that employees have the right have their PADR through the medium of Welsh. Managers will be able to seek advice from the Welsh Language Manager when this occurs. It was also highlighted that staff with some forms of disability may be disadvantaged if the policy is not communicated effectively.

8. Training

8.1 Line Managers and anyone with delegated responsibility are required to complete the Trust's PADR training module.

8.2 A Toolkit of resources will support this policy including guides on how to enter Appraisal dates and Pay Progression dates into ESR.

8.3 All employees are encouraged to complete the ESR PADR module.

9. Implementation

9.1 PADR is an ongoing cycle of review, planning, development and evaluation which links individual and organisational development needs. Whilst the objectives fall in with the annual business planning cycle of April to March each year, in reality work-based objectives may arise and be completed at any point in the year. Managers and staff are encouraged to meet regularly to update progress, add or change objectives and review learning events and the Personal Development Plan.

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9.2 The process is an ideal time to explore how people are getting on at work and if their wellbeing is being promoted. Managers may need to pick up other conversations following on matters raised during the PADR to attend to wellbeing or stress at work.

9.3 Paperwork and Record Keeping

- The PADR form must be completed at least annually and copies retained by employee and line manager. It must include as a minimum a review of progress, objectives for the next period and a Personal Development Plan.
- A PADR Toolkit includes other resources which are optional and may be used in line with individual needs including forms for Reflection, Preparation, Talent Mapping, or 360 feedback.

10. Audit and Monitoring

10.1 It is the responsibility of the manager to record the date that the PADR is undertaken on ESR to allow for analysis and reporting.

10.2 The quality of PADR will be monitored by the People and OD team through sampling of documentation throughout the year.

11. Review

11.1 The Performance Appraisal and Development Review Policy will be reviewed three years, after approval.

12. Associated Policies

- Pay Progression Policy
- People Development Policy
- Wellbeing Guidelines (formerly Employee Mental Health and Wellbeing and Stress Management Policy)

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Appendix 1

Performance Appraisal and Development Review

This form will be digitised

Section 1 - Introduction
Employee
Job Title
Department
Is Pay Step due within the next 12 weeks?
Line Manager
PADR meeting date
Appraisal Review Period (covering the last year)

Section 2 - Review of the last 12 months
Recognition of good work
How have things gone, what highlights and out, what were the challenges?
Progress with previous objectives, including discussion of reasons for things not going as planned
Discussion of constructive feedback regarding employee
Feedback from employee to line manager

Section 3 – Context
Review of Trust Values and Behaviours identifying examples of Caring, Respectful and Accountable behaviour
Discussion of Trust strategies and IMTP, as relevant to the role

Section 4 – Planning for next 12 months
Objectives need to be carried forward from last year and new objectives – SMART

Section 5 – Personal Development Plan
Recognition of achievement
Progress with pervious PDP
Career conversation – steady in current role or looking to move
New items for next PDP
Link to Study Leave application.

Section 6 – Reminders
Has the job description been updated in the last 3 years?
All registered professionals – are revalidation and registration processes in hand (this is the registrant's responsibility)

Section 7 – Pay Progression
If a pay step is due within the next 3 months, please confirm yes or no to these clauses:

i. The appraisal process has been completed within the last 12 months and outcomes are in line with the organisation's standards
ii. There is no formal capability process in place
iii. There is no formal disciplinary sanction live on the employee's record
iv. Statutory and mandatory training has been completed
v. For line managers only – appraisals have been completed for all staff.

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Section 8 – Sign off
Employee name and date Line manager name and date

Appendix 2

Pay Progression Deferral Form

This form will be digitised

Department Section
Cost centre
Directorate
Department

Employee Section
Title
First name
Surname

Post Details
Job title
Pay band
Pay ste date

Pay step review outcome
I confirm that the outcome at the pay step was Unsatisfactory – has not met all the core organisation objectives and /or has not demonstrated the right behaviours and ways of working and/or has not shown how they have developed or imporvied their area of work. Therfore, no increment/pay step will be awarded.

Line Manager
Name
Job title
Email address
Date

Please email to Payroll and the Velindre Workforce and OD mailbox

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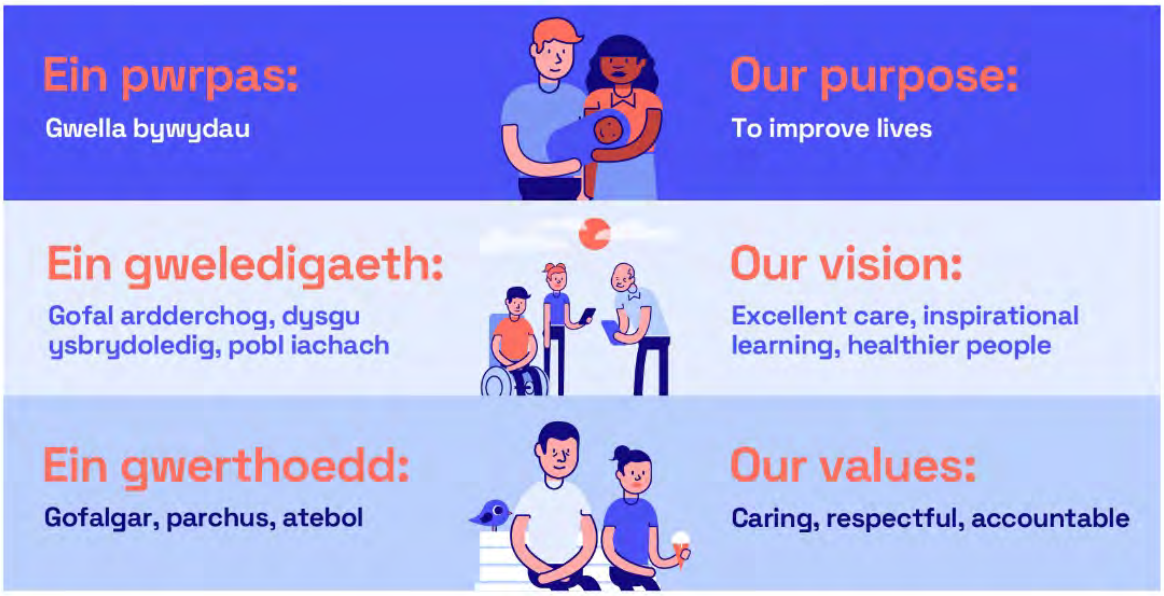
Appendix 3

Velindre University NHS Trust
Values and Behaviour Framework
April 2024

Our values describe how we will work to achieve Our purpose, to improve lives, and towards Our vision, excellent care, inspiration learning, healthier people.



Caring — We are always kind, supportive, approachable and show compassion to all.

Respectful — We seek to understand other people's perspectives. We are always open and transparent.

Accountable — We always take personal responsibility for what we do and how we do it.

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We bring the values to life in every aspect of work through our actions. Some examples of helpful actions are highlighted in our Behaviour Framework. There will be lots of other examples of positive actions that we take and these may vary from role to role. The list below covers things which are likely to be relevant to everyone. The ticks give a suggestion about which values the action reflects however feel free to see them from another point of view.

We always…	Suggested Values		
	Caring	Respectful	Accountable
Care for all: patients, donors and colleagues	✓	✓	✓
Collaborate with others to achieve positive outcomes		✓	✓
Communicate with people simply and respectfully		✓	
Consider the impact of how we speak to people	✓	✓	
Deliver on our commitments to each other	✓	✓	✓
Give and receive feedback in order to improve	✓	✓	✓
Help people when they are new and welcome their experiences and contribution	✓	✓	✓
Include everyone in discussions about things that affect them	✓	✓	✓
Listen when people speak up about things which concern them	✓	✓	✓
Listen to learn and improve	✓	✓	✓
Nurture our team and help it grow and develop	✓	✓	✓
Put patients and donors at the heart of what we do	✓	✓	✓
Respond in a timely manner		✓	✓
Role model the values	✓	✓	✓
Share information openly and transparently	✓	✓	✓
Show appreciation to others as a matter of course	✓	✓	
Strive to improve services for patients and donors	✓	✓	✓
Support each other	✓	✓	

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Take responsibility for our actions		✓	✓
Talk about barriers or problems in order to resolve them	✓	✓	✓
Tell people when they are doing a good job	✓	✓	
Treat people equally and fairly	✓	✓	✓
Trust each other to do a good job		✓	✓

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GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Felindre Velindre NHS Trust

Ref: WF18

ALCOHOL, DRUGS AND SUBSTANCE MISUSE POLICY

Executive Sponsor & Function	People and OD
Document Author:	People and Relationships Manager
Approved by:	
Approval Date:	
Date of Equality Impact Assessment:	
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1. INTRODUCTION

Velindre University NHS Trust is a provider of healthcare and associated services and promotes the highest standards of awareness, health and safety in the workplace. The Trust recognises the importance of the welfare of its staff in all matters and issues relating to substance misuse, in or out of work. The Trust treats alcohol and substance misuse and issues related to this condition as a health and wellbeing matter that requires advice, support and treatment.

For the purpose of this policy, “substances” are defined as alcohol, illegal or prescribed drugs and substances. Refer to Section 6 of the policy for the definitions.

1.1 The Trust expect all members of staff to adopt the highest standards of performance and conduct. Alcohol, drugs and substance misuse can adversely affect an individual’s skill and judgement, which may detrimentally affect their performance and the standard of service delivery to patients, donors, service users and colleagues, potentially causing unacceptable levels of risk and harm;

1.2 The Trust has an obligation as a provider of health care and related services to minimise risks, dangers and complaints concerning the standards of health and wellbeing, conduct and capability of its workforce, in the context of alcohol, drugs and substance misuse.

2. POLICY STATEMENT

The purpose of the policy is to help protect our staff and others that use our services, by raising awareness of the consequences of substance misuse and to encourage those with a problem to seek help and support.

2.1 The Trust will offer support, guidance and access to services, to promote an honest, positive and caring approach to all staff regarding potential and actual problems of alcohol, drugs and substance misuse within and outside of the workplace;

2.2 Throughout the Policy, misuse refers to the use of psychoactive substances, including illegal drugs, alcohol, prescribed medicines and substances and there misuse, regardless of whether the use is deliberate or unintentional;

2.3 The term misuse refers to inappropriate use, habitual misuse and/or excessive use of alcohol, drugs including prescribed medicines and substances;

2.4 The Trust has a duty to ensure that a staff member’s use of alcohol and substances outside of the workplace does not impair the safe and efficient delivery of our services, or results in risks to their health and safety and that of others, to comply with the health and safety legislation.

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3. SCOPE OF POLICY

3.1 This policy applies to all Velindre University NHS Trust employees and workers (including hosted organisations) and anyone working on Velindre University NHS Trust premises. This list includes:

- Bank and Agency Workers;
- Contractors;
- Honorary Contract Holders;
- Secondees;
- Students;
- Volunteers;

NB. This list is not exhaustive

3.2 This policy covers misuse of psychoactive substances, including illegal drugs, alcohol, prescribed medicines, solvents and substances.

3.3 Staff issues concerning alcohol, drugs or substance misuse will be managed in accordance with this policy and in the strictest of confidence.

3.4 It is recognised that for some staff alcohol, drug or substance misuse is a medical condition.

3.5 Staff must not drink alcohol or use drugs or substances, other than prescribed medication, while on duty or on Trust premises. Should a member of staff be required to take prescribed medication and believe that is has the potential to or is affecting their performance or ability to carry out their role safely, they should bring the matter to the attention of their manager.

3.6 Staff must not be under the influence of alcohol, drugs or substances at the commencement of their working day or when they are required to work on call or be on standby. Staff are not permitted to drink alcohol, use drugs (other than prescribed medication, where appropriate and safe to do so) or substances when in work, including during a paid or unpaid break following which they are required to return to work. All staff should be aware of the time required for the body to recuperate from the effects of alcohol, drugs and substances.

3.7 Alcohol must not be consumed on Trust premises at any time.

3.8 Should a member of staff attend for work under the influence of alcohol, drugs, or substances, the Trust will make the necessary arrangements to ensure they get home safely.

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3.9 All staff should be aware of the potential impact on patients etc. should they be able to smell alcohol on their breath. This can relate to concerns over their actual or

potential ability to perform effectively and safely in their role, their professional image and reputation and that of the Trust. This is an important consideration, as a large proportion of our staff have face to face contact with colleagues, patients, donors, carers, relatives, visitors and the public and they are required to exercise their professional skills and judgement to ensure the provision of safe and effective services.

3.10 A staff member who is required to discuss allegations of alcohol, drug or substance misuse in the workplace with their manager, an investigating officer, etc. will be entitled to be accompanied by their trade union representative or a workplace colleague, not acting in a legal capacity.

4. AIMS AND OBJECTIVES

The overall aim of the policy is to ensure that the Trust provides support and assistance to staff with alcohol, drugs, substance misuse related problems. The objectives include:

4.1 To minimise and ultimately eliminate risks and complaints concerning the standards of conduct, performance and capability of our staff;

4.2 To protect and maintain the health, safety and wellbeing of our staff, patients, donors, service users, visitors and the general public;

4.3 To promote the health and wellbeing of staff;

4.4 To ensure that the principles of equity and consistency are applied when dealing with staff who may have alcohol, drugs and substance misuse related problems;

4.5 To ensure that alcohol, drugs and substance misuse issues are addressed and treated as a health related issue.

4.6 To ensure that staff are treated sympathetically and offered appropriate support and assistance, to address their health related issue;

4.7 To balance the requirement of dealing with alcohol, drugs and substance misuse issue as a health related issue against the requirement to invoke the disciplinary policy, in instances of misconduct. Where the disciplinary policy is invoked, the disciplining officer will consider the mitigation and that the staff member may require a more understanding approach, due to their dependency.

5. ROLES AND RESPONSIBILITIES

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5.1 The Manager

- To be aware of how to identify and deal with staff presenting for work showing signs of alcohol, drugs or substance misuse, as they have a duty of care for

their staff, patients, donors and service users etc. Managers should make themselves familiar with the Manager's Guide to Dealing with Alcohol and Drugs in Work;

- To ensure that all staff are aware of and adhere to this policy, and understand its implications;
- To manage staff with an alcohol, drug or substance misuse health issue in accordance with the provisions set out in this policy;
- To ensure that they treat all alcohol, drug or substance misuse related cases confidentially, with sensitivity and a compassionate approach;
- To provide support and assistance to staff in the workplace and encourage them to seek help voluntarily, in the first instance;
- To refer staff to external advice, support and / or counselling organisations, where appropriate;
- To ensure they know their staff and are aware of their health, safety and welfare needs.

5.2 The Employee

- To behave responsibly and to remember they must comply with their professional codes of practice, at all times;
- To be aware of their responsibilities under health and safety legislation, public interest disclosure and clinical governance in respect of the implications of being under the influence of alcohol, drugs or substances in the workplace.
- To report any concerns and seek advice from their manager or the People and OD Department immediately should they have concerns that a colleague may have a substance misuse health related issue. Under no circumstances should they try to “cover up” for a colleague in the workplace as this could endanger the health and safety of colleagues and service users;
- To be aware of their personal responsibility to report where the health and safety of staff or service users etc. may be at risk, where alcohol, drugs or substance misuse may be affecting a colleague’s performance, conduct etc.;
- To seek appropriate support and advice from their manager, Occupational Health Department, Employee Assistance Programme, the People and OD Team or their GP, as appropriate should they believe they have a substance misuse health related issue;
- To cooperate with the support and assistance offered by the Trust and / or support organisations working with them, to address their substance misuse issue;
- To take proactive steps to seek and obtain help and support for themselves should they believe that they have an alcohol, drugs or substance misuse related problem;
- To be aware of the potential implications of substance misuse in respect of other relevant Trust policies e.g. Capability Policy, Disciplinary Policy, Dignity at Work, Violence, Domestic Abuse and Sexual Abuse Workplace Policy,

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5.3 The Occupational Health Department

- Provide an impartial and confidential service to staff;
- To provide general advice and support to managers and staff on substance misuse issues, as appropriate;
- To provide medical advice and support to staff with a performance, capability or conduct issue that may be related to substance misuse;
- To assess staff who self refer or are referred by their manager for substance misuse advice and support. This may include a medical assessment and / or a referral to an external advice, support or counselling substance misuse organisation;
- To provide timely, effective and appropriate communication in the form of medical reports, between staff and individual who are involved in the management of the case. This includes the line manager, Workforce Department, GP and any therapeutic organisation;
- To keep appropriate records;
- To advise the manager should a staff member not attend a planned appointment;
- To make staff aware of the policy and actively promote health promotion initiatives and awareness in relation to alcohol, drugs and substance misuse.

5.4 The People and OD Department

- To provide advice, guidance and support to managers and staff as and when required, in respect of the application of this policy and other relevant Trust policies e.g. Disciplinary Policy, Capability Policy etc.;
- To ensure that all staff with a substance misuse issue are treated fairly, consistently and with compassion.

5.5 Recognised Trade Union Representatives

- To ensure that their members are aware of the Policy and understand the implications of not adhering to it;
- To Inform their members of their rights and responsibilities under the policy;
- To offer and provide support and accompany their members to meetings conducted under the policy;
- To encourage and support their members to seek help for an alcohol, drug or substance misuse issue, where appropriate;
- To provide information of external organisations that can provide advice, support and counselling, to assist them with their misuse issue.

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6. DEFINITIONS

6.1 Psychoactive Substances

The Psychoactive Substances Act 2016 captures all psychoactive substances that are not classified as illegal drugs. For the purpose of this policy, psychoactive substances are those ‘capable of producing a psychoactive effect in a person who consumes it’. Psychoactive substances include those, which are often misleadingly referred to as ‘legal highs.’ These substances are designed and produced to mimic the effects of drugs such as cocaine, cannabis and ecstasy but have been created so that their chemical structure is different enough to avoid being controlled under current drug laws. This includes inhalation of substances that can affect an individual’s coherence, health and wellbeing e.g. solvents.

6.2 Illegal Drugs

The Misuse of Drugs Act 1971, states that controlled drugs are those that are ‘dangerous or otherwise harmful’, primarily under a 3-tier system of classification, Classes A, B and C. The classification provides a framework within which criminal penalties are set with reference to the harm a drug has, or is capable of having, when misused and the type of illegal activity undertaken in regard to that drug.

6.3 Alcohol

Alcohol is a drug which when used in excess affects concentration, coordination and work performance. The misuse of alcohol interferes with an individual’s health and wellbeing and it may cause harm to colleagues, service users etc., as well as affecting the quality of the service as a whole. Drinking even small amounts of alcohol before carrying out work that is 'safety critical' will increase the risk of an accident. Alcohol can also affect those driving to work after a night of heavy drinking, as the staff member may have blood alcohol levels in excess of the legal limit and may therefore be unfit to drive and to work.

Staff are not permitted to consume alcoholic drinks, take illegal drugs or substances at any time during their working day. This includes all breaks during the working day whether paid or unpaid. It also applies to offsite retirement / leaving functions, which may take place during the working day.

6.4 Prescribed Medicines

This applies to the misuse and dependence on prescribed or over the counter medication. If a staff member believes that their prescribed or over the counter medicine has the potential to or has an adverse effect on their ability to perform their duties, they should stop working and report this matter to their manager immediately.

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7. POLICY COMPLIANCE

7.1 In the context of work, not only does use of alcohol, drugs and substances damage the staff member's health and wellbeing, it can also affect their future employment as a result of:

- Safety concerns raised by colleagues, patients, donors, service users etc.;
- Loss of productivity and poor performance;
- Conduct issues;
- Lateness and absenteeism.
- The effect on team morale and staff relations;
- General concerns and negative publicity, which can result in reputational damage.

7.2 No member of staff should report to work either under the influence of or smelling of alcohol. Depending on the circumstances, which should be investigated, this may constitute a disciplinary offence under the Trust's Disciplinary Policy (see 11 below). All staff members are also expected to pay due consideration to their professional and personal accountability in this regard.

7.3 Where it is identified that a member of staff is in possession of using or suppling illegal drugs or psychoactive substances in the workplace, this will be investigated under the All Wales Disciplinary Policy. The matter will also be reported to the police.

7.4 If a manager suspects a member of staff may have an alcohol, drug or substance misuse issue they should firstly undertake a private and confidential meeting with them, to discuss their suspicions. The manager is required to ensure that they make and retain a written record of the meeting.

7.5 Should a member of staff be observed in work, in what their manager or colleagues considers to be an unfit / unsafe state, due to alcohol, drug or substance misuse, their manager will consider the situation, seeking advice from the People and OD Department. This situation may result in the member of staff being dealt with in accordance with the Disciplinary Policy, following an initial assessment of the case. The member of staff will be required to attend a meeting with their manager and a People and Relationships Advisor upon their return to work.

7.6 Where necessary, the member of staff will be taken home immediately. The manager will be responsible for ensuring that they are taken home safely. The manager will also ensure that the staff member has access to immediate support via the Employee Assistance Programme and / or Occupational Health, by providing them with their contact details.

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7.7 Where a bank, agency or contractor worker is observed in work in what a member of staff or manager considers an unfit / unsafe state due to alcohol, drug or substance misuse, the matter must be reported to the responsible manager. The responsible manager will arrange to ensure that the worker is taken home safely, using a safe method of transport. The responsible manager will also be required to report the incident to the Bank Office, agency or contractor.

7.8 As soon as it becomes apparent that a member of staff has alcohol, drugs or substance misuse issue, the manager should immediately seek advice from the People and OD Department. Full consideration will be given to any information provided and suggestions put forward by the member of staff, as well as any actions that need to be taken immediately, to ensure the safety of colleagues, patients, donors, service users etc. The manager may consider the appropriateness of suspending the staff member from work, depending on the circumstances. The manager is required to write to the member of staff following the meeting to outline the issues discussed and the advice and support offered e.g. provided with a copy of the policy and advised of the potential implications, an Occupational Health referral, signposting to the Employee Assistance Programme and other external advice, support and counselling organisations.

7.9 The staff member must be referred to the Occupational Health Department as soon as possible to obtain advice on the extent of the alcohol, drugs or substance misuse related issue and to determine the potential and real effects on their ability to fulfil their duties and responsibilities of their role.

7.10 A member of staff who has identified or been identified as having an alcohol, drugs or substance misuse issue will be required to cooperate fully with any referral or treatment recommended by the Occupational Health Department.

7.11 The manager will consider the Occupational Health advice and will decide whether the member of staff should remain in work, taking into consideration the risks involved and the extent of the alcohol, drugs or substance misuse related issue.

8. IDENTIFYING AN ISSUE

8.1 Research suggests that the workplace is an appropriate place to create an environment in which individuals who misuse alcohol, drugs or other substances can be encouraged to make decisions, to change their behaviour. The potential of job loss and future career prospects can often be a prime motivating factor.

8.2 Alcohol, drugs and substance misuse concerns may come to the attention of a manager in a variety of ways. Managers must therefore be alert to the issue of substance misuse within their team and the wider organisation. Please refer to the Manager's Guide to Alcohol and Drugs in the Workplace;

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8.3 Education and support in recognising signs of alcohol, drugs and substance misuse will be made available for managers.

8.4 All staff should be aware that they do not need to wait to be approached by their manager or a colleague before seeking help with a substance misuse issues. Staff may recognise themselves that they have a substance misuse issue before it comes to the attention of their manager. In this situation, staff are actively encouraged to seek help from the Occupational Health Department or the Employee Assistance Programme, voluntarily.

Issue Identified through General Observations

8.5 Where a manager reasonably suspects a member of staff has a potential alcohol, drugs or substance misuse issue through general observation they are obliged to explore the matter further with them.

8.6 The manager should discuss their concerns with the staff member in private. They should approach the matter in an honest, non-judgemental and empathetic manner, while understanding that these symptoms may have some other origin e.g. side effects from prescription drugs. During these discussions, the manager should always offer help and support, with reference to this policy and agree a written support plan. At the same time, the manager should remind the member of staff of their personal and professional responsibilities when reporting for work. The right to be accompanied by a trade union representative or a workplace colleague, to a meeting of this nature, would not ordinarily be refused.

8.7 All staff members are actively encouraged to voluntarily seek advice and support under this policy, should they believe that they have a potential alcohol, drugs or substance misuse problem, before it becomes an issue in the workplace.

8.8 Staff members who voluntarily seek help or are managed under this policy will normally be guaranteed confidentiality. However the Trust may have a duty to inform the appropriate authorities if there is evidence that suggests that the staff member's substance misuse issue has resulted in them breaking the law at work e.g. in roles which involve driving. It should also be noted that colleagues etc. who are aware that a staff member has a substance misuse issue that has the potential to or is having an impact on them undertaking their duties and responsibilities, must report the matter to the manager. This will ensure that appropriate action is taken to protect the health, safety and wellbeing of other colleagues, patient, donors and service users etc.

Issues of a Disciplinary Nature

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8.9 Staff may be identified as having an issue with alcohol, drugs or substance misuse because of an incident or allegations of a disciplinary nature. Staff with an alcohol,

drugs or substance misuse issue cannot be excused from complying with the accepted standards of conduct, health and safety etc.

8.10 It is acknowledged some religions believe in the use of some drugs, as elements of their faith. While this is recognised, drugs such as marijuana (except for prescribed cannabinoids) are illegal and therefore staff under the influence of, or found to be using such drugs in the workplace will be managed under the Disciplinary Policy.

8.11 The policy has been developed to help identify early problems of alcohol, drugs or substance misuse and provides appropriate advice and support to staff to avoid their issue leading to a breach of the disciplinary rules. Staff must be aware that where a serious offence is committed, they will be subject to the All Wales Disciplinary Policy. This does not prevent a member of staff providing evidence of a substance misuse issue in their mitigation during a disciplinary investigation and hearing.

8.12 Staff who have an alcohol, drugs or substance misuse issue being managed under the All Wales Disciplinary Policy will continue to be offered advice and support in accordance with the provisions contained in this policy.

Issues with Registration with a Professional Body

8.13 Where a member of staff is registered with a professional body and it is identified and confirmed that they have an alcohol, drugs or substance misuse issue, the appropriate senior Manager/Director will decide whether they should be reported to them. Where it is deemed appropriate to report a member of staff, the Manager/Director will follow the relevant professional body's mechanism for notification of such circumstances.

8.14 In circumstances where a member of staff's substance misuse leads to the loss of their professional registration, which is an essential requirement for them to practice and work in their role, their employment with the Trust may be terminated. In such circumstances, redeployment may be sought as an alternative to termination of employment, in the first instance. If the Trust is unable to redeploy the member of staff to another role, the Trust will have no alternative other than to follow a fair dismissal procedure.

8.15 In circumstances where a member of staff's substance misuse leads to the loss of a licence e.g. driving licence or the loss of an essential requirement contained in the job description and person specification, which is necessary for them to work in their role, their employment with the Trust may be terminated. In such circumstances, redeployment may be sought, as an alternative to termination of employment, in the first instance. If the Trust is unable to redeploy the member of staff to another role, the Trust will have no alternative than to follow a fair dismissal procedure.

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Issues for Staff Who Perform Driving Duties

8.16 All staff have a responsibility to ensure they are able to perform their duties in compliance with the law (***see Appendix 3***).

8.17 Staff must consider how the effects of alcohol, drugs or substance misuse may inhibit their ability to drive as part of their duties.

8.18 Where applicable staff should always plan if they are going to be drinking alcohol on the night etc. before attending for work, to ensure that they are fit to drive the following day and are not in breach of the drink and drive alcohol limits. This should also be considered by staff who drive, to and from work for business purposes. In such circumstance, they should consider using public transport, not attending work etc. to protect their health and safety and that of others.

8.19 Staff are required to consult with their GP etc. if they feel their ability to drive may be impaired by prescribed medication. Where a staff member's ability to drive is deemed to be impaired by a health professional, they have a duty to report the matter to their manager. They may also have a duty to inform the DVLA, upon the advice of their GP etc.

8.20 Staff have a duty to report to their manager if they feel their ability to drive is affected by alcohol, drugs or substances.

9. THE OFFER OF HELP

9.1 The offer of help will normally commence with referral to the Occupational Health Department. The Occupational Health Department will offer advice and support to the member of staff and they may suggest a referral to another external organisation. There is also the option of the staff member contracting the Employee Assistance Programme to obtain substance and alcohol misuse support and counselling EAP Contact Information.

9.2 In some circumstances it may be more appropriate or more acceptable for the staff member to contact the external organisation directly for advice and support. In these circumstances, it is appropriate for the manager to request that the chosen organisation provides written confirmation that the member of staff has accepted and will attend for treatment.

9.3 Staff who wish to voluntarily seek help for a substance misuse issue are encouraged to contact the Occupational Health Department directly Occupational Health Contact Information or the Employee Assistance Programme EAP Contact Information. The Occupational Health and Employee Assistance Programme Contact information is also available via the Trust's People and OD Intranet site. Staff and managers

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should refer to ***Appendix 1*** of the policy for details of external organisations that offer advice on alcohol and substance misuse and counselling services.

9.4 Staff are also encouraged to seek advice and support from their General Practitioner.

9.5 Where a manager makes a referral to the Occupational Health Department, they will be provided with a written assessment of the staff member's fitness for work. Where treatment has been recommended, the Occupational Health Department will provide confirmation to the manager of the staff member's acceptance and continued attendance for treatment. Details regarding the treatment record of the staff member will remain strictly confidential.

9.6 Where a member of staff makes a self-referral to the Occupational Health Department the manager will not normally be provided with a medical report outlining their assessment or advice provided etc., unless they have been given express permission by the member of staff. Any disclosure will be made in accordance with the guidance on confidentiality, issued by the General Medical Council or Nursing & Midwifery Council or other relevant professional regulatory bodies.

9.7 The offer of support and help will be made with the understanding that if necessary, the staff member will be granted paid time off work to undergo face to face counselling or treatment, should it fall within their contractual hours. If the staff member is unfit to attend work during a period of ongoing treatment, the absence will be treated as absence in accordance with the All Wales Managing Attendance at Work Policy.

9.8 Where a member of staff has taken a period of sick leave following identification of an alcohol, drugs or substances misuse issue they will be able to return to the same post, unless this would be inconsistent with the long-term resolution of the employee's problem or they have had their professional registration, driving licence etc. suspended / removed. Where a return to the same post is not advisable, or possible, consideration will be given to redeployment, if appropriate.

10. EMERGENCY ATTENDENCE AT WORK

10.1 It is recognised that staff may unexpectedly be called into work to cover staff shortages or to comply with an unplanned emergency on-call situation. In such circumstances, staff are expected to behave responsibly. If a staff member is under the influence of alcohol, drugs or substances, as defined in this policy, they must not report for duty and must inform their line manager that they are unable to fulfil such duties without any detriment.

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11. DISCIPLINARY ACTION

11.1 Consumption of alcohol or any other substances as outlined in Section 6 of this policy or presenting for work under the influence of these substances will be managed in accordance with the All Wales Disciplinary Policy, as appropriate.

11.2 Staff who may misuse alcohol or any of the other substances referred to in this policy cannot be excused from complying with the accepted standards of conduct, health and safety etc. at work. Any staff member who behaves contrary to the Trust's standards will be subject to the Disciplinary Policy.

11.3 In all cases where the Disciplinary Policy is used in connection with alcohol or substance misuse, the staff member concerned will also be offered advice and support with their issue, at each stage of the procedure.

12. PROMOTION AND AWARENESS

12.1 The philosophy of this policy is that education on alcohol and other substances should be part of a wider ongoing programme of health promotion and health and wellbeing at work, for the whole workforce. It is not only aimed at those who are identified as having issues with alcohol, drugs or substance misuse, but to raise staff awareness and interest in their health and wellbeing, to the extent that alcohol, drug and substance misuse issues may be prevented from occurring or may be prevented from developing into a worse dependence issue. Messages about healthy lifestyles and the benefits will be continually provided by the Trust for the benefit of all staff.

12.2 In practical terms this means having appropriate measures in place to regularly promote healthy living messages about reducing alcohol consumption etc. by means of campaigns, events, displays, leaflets, posters, newsletters and e-mails, which include factual information regarding the effects misuse of alcohol, drugs and substances can have on staff and families.

12.3 Managers have a responsibility to know their staff, as such they too have a responsibility to ensure that in addition to general health and wellbeing information, appropriate messages regarding alcohol, drugs and substances are targeted at their staff.

13. EQUALITY

The Trust recognises and values the diversity of our workforce. The Trust aims to provide a healthy and safe environment for our staff, where they are all treated fairly, consistently and with dignity and respect. The Trust recognises that the promotion of equality and human rights is central to its work both as a provider of healthcare and related services and as an employer.

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13.1 Equality Impact Assessment Statement

This policy has been screened for relevance to equality. No potential negative policy impact has been identified during the assessment process.

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APPENDIX 1

EXTERNAL ORGANISATIONS OFFERING DRUGS AND ALCOHOL ADVICE AND COUNSELLING

Please click on the links to access services

City & County of Cardiff Community Alcohol and Drug Team
CAVAMH
Vale of Glamorgan
Newlands
26 Newland Street
Barry
CF62 8EA
Tel 01446 700943

Inroads - Cardiff Street Drugs Project
2-10 Holton road
Barry
CF63 4HD
01446 506079

96-98 Neville Street
Cardiff
CF11 6LS
029 2040 7407

Pen-yr Enfys Council on Alcohol Fitzhamon Centre
53b Fitzhamon Embankment
Riverside
Cardiff
CF11 6AN
Tel: 029 20 388003
Fax: 029 20 226660

Cardiff Alcohol and Drugs Team (CADT)
CADT
02920 788300

Betsi Cadwallader UHB Substance Misuse Service (SMS)
Link below
SMS
Wrexham
03000 859 444
Flintshire
03000 849 900
Denbighshire
03000 856 828
Conwy
01492 523 828
Gwynedd
03000 853 333
Anglesey
03000 853 355

Merthyr Home Detox
Merthyr Drugaid Needle Exchange
1st and 2nd floor, Oldway House
Merthyr Tydfil
CF47 8UX
Tel: 01685 721991

DASPA – Drug & Alcohol single point of access – 0300 333 0000

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MIDAS Drugaid Merthyr
Midas House
2nd Floor, Oldway House
Castle Street,
Merthyr Tydfi;
CF47 8UX

Kaleidoscope Powys
(Substance Misuse Integrated Team)
01686 207111
Welshpool 2 Severn Street SY21 7AB 01938 555922

Newtown Severn House, Severn Square SY16 2AG 01686 610 422

Llandrindod Grosvenor Rd LD1 5NA 01597 825 102

Brecon 9 Castle St LD3 9DD 01874 622 33

Drugaid
16 Clive Street
Senghenydd
Caerphilly
CF83 1GE
Tel: 023 2086 8675

BCUHB substance Misuse Service
Gwynedd Substance Misuse Service

North West Wales NHS Trust Drug Service

Gwynedd Community Alcohol Service
Cyngor Alcohol Information Services (CAIS)

Cyswllt Ceredigion Contact
49 North Parade
Aberystwyth
Ceredigion
SY23 2JN
Tel: 01970 626470

PRISM Mid and West Wales Alcohol and Drug Advisory Service
Forestry House
Brewery Road
Carmarthen
SA31 1TF
Tel: 01267 231634

Gwent drug and Alcohol Service
Resolven House
St Mellons Business Park
Fortran Road
St Mellons
CF3 0EY
Tel: 01633 811950

West Glamorgan Council on Alcohol and Drug Abuse
Celtic Court
Tremains rd
Bridgend
CF13 1TZ
Tel: 01656 650999

Drugaid
59 Commercial Street
Abertillery
NP13 1DQ
Tel: 01495 211999

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APPENDIX 2

NATIONAL SOURCES OF HELP AND ADVICE

Adfam National
The largest non-statutory organisation that works with and on behalf of families affected by drug and alcohol problems. This organisation is helpful for the family of an alcohol or drug user.
Helpline: 020 7553 7640

Alcoholics Anonymous
It is the largest self-help group for people who acknowledge they cannot handle alcohol and want a new way of life without it. Access to their services are free.
Helpline: 0845 769 7555
The comprehensive website explains the philosophy of AA, what to expect and details of local groups.

Cocaine Anonymous
A national self-help group specifically for cocaine users.
Helpline: 0800 612 0225, open 10:00am to 10:00pm

DAN 24/7
Free Bilingual Drug and Alcohol Helpline for Wales.
Telephone: 0808 808 2234

Drinkaware
Drinkaware is an independent charity working to reduce alcohol misuse and harm in the UK. They work to help people make better choices about drinking.
Telephone: 020 7766 9900
If you're unable to find the answer to your query on the website, then please email on contact@drinkaware.co.uk

Narcotics Anonymous
The largest self-help group for people who want to stop using drugs. Access to their services are free.
Helpline: 0845 373 3366
The website includes details of local groups.

Talk to FRANK
A Government funded free service, previously named the National Drugs Helpline. It provides advice to the drug user or anybody concerned about a drug user. It has a database of local support and treatment services that can help drug users. The focus of the helpline is for young people and concerned parents, but it will also assist adult drug users.
Helpline: 0800 77 66 00
The website provides detailed information on drugs that the non-specialist can understand.

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APPENDIX 3

THE LEGAL POSITION

1. Velindre University NHS Trust has a duty under the **Health and Safety at Work etc. Act 1974** (HSW Act) to ensure, as far as is reasonably practicable, the health, safety and welfare at work of all staff and persons who use our services or enter our premises.

2. There is also a duty under the **Management of Health and Safety at Work Regulations 1999**, to assess the risks to the health and safety of our staff. The Trust is concerned for the good health and wellbeing of all staff to enable them to work safely and effectively, to ensure that the Trust's reputation is not damaged by incidents related to alcohol or substance misuse.

3. The **Road Traffic Act 1988** states that any person who, when driving or attempting to drive a motor vehicle on a road or other public place, is unfit to drive through drink or drugs shall be guilty of an offence. An offence is also committed if a person unfit through drink or drugs is in charge of a motor vehicle, in the same circumstances.

4. It is an offence under the **Misuse of Drugs Act 1971** for any person knowingly to permit the production, supply or use of controlled substances on their premises except in specified circumstances e.g. when they have been prescribed by a doctor or registered healthcare professional.

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APPENDIX 4

ISSUES AT WORK CAUSED BY ALCOHOL, DRUGS AND SUBSTANCE MISUSE

Given the wide variety of roles within the Trust, some of the following issues may be relatively more important and significant than others, dependent on the responsibilities and duties undertaken by the member of staff. It is recognised that alcohol, drugs and substance misuse can cause severe issues, not only for the staff member and their family, but also for colleagues, patients, donors, service users etc. These issues can occur not just in the obvious area of health and safety, but also in unsatisfactory work performance, sickness absence, conduct and poor relationships at work.

It is important to recognise that issues can be caused by misusing alcohol, drugs and substances occasionally, in excess and because of chronic use and dependency.

Alcohol, drugs and substance misuse issues can manifest in some or all of the following ways, but it is important to be aware that the following issues can also be caused by other factors such as stress, mental health problems, physical illness or the use of prescribed medication.

1. Work Performance

- Poor decision-making.
- Absences from work i.e. more than normally expected.
- Overlong breaks.
- Decrease in concentration - jobs take longer, require greater effort.
- Difficulty in recalling instructions and details.
- Decline in quality and quantity of work and effort cannot be sustained.
- Increase in errors of judgement.
- Increased fatigue.
- Loss of interest in work.
- General unreliability and unpredictability.
- Improbable excuses for poor performance, lateness and absences.

2. Accidents

All staff have responsibilities and duties under the Health and Safety at Work Act to take reasonable care for their own and others' safety. Evidence suggests that alcohol, drugs and substance misusers can be between 3 to 4 times more likely to have or cause an accident at work, than someone without a problem of this nature. It should be noted that even "sensible limits" of alcohol could have significant effects on judgement and application of "motor" skills.

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Problems can manifest themselves via:

- High accident rates in work.
- Accidents off the job, i.e. at home or travelling to and from work.

3. Poor Relationships with Colleagues

- Over reaction to real or imagined criticism.
- Unreasonable resentment.
- Irritability or aggression.
- Complaints from colleagues.
- Borrowing money from colleagues.
- Avoidance of manager and/or colleagues.

All of these can subsequently lead to poor performance, grievances and dignity at work complaints in the workplace.

4. Individual Behaviour

- Reporting to work smelling of alcohol.
- Increasingly unkempt appearance.
- Decline in personal hygiene.
- Sudden mood changes.
- Depression.
- Acts of aggression.

5. Non Attendance

This is perhaps the most obvious area, which causes difficulties for colleagues and ultimately patients, donors, service users etc. The cost to industry and business throughout the UK of alcohol abuse has been estimated by Public Health Wales to be approximately £7 billion for the NHS and estimated £21 billion because of sickness absence, unemployment, early retirement and premature death PHW Healthy working Wales

Non-attendance at work can manifests itself in a number of ways, for example:

- Unusually high levels of short-term and long-term sickness related absences, often accompanied by imprecise reasons on return to work self certificates, e.g. flu-like symptoms, colds, gastric problems, fatigue, nervous debility.
- Multiple instances of unauthorised days off work.
- Late applications for half or one day's annual leave.
- Excessive lateness at start of work or and after lunch breaks.
- Leaving early.
- Unauthorised breaks.

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

PROFESSIONAL REGISTRATION AND REVALIDATION POLICY

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1. Policy Statement

Velindre University NHS Trust recognises that professional registration and revalidation is intended to protect the public, ensuring that those who practice as a health professional are doing so safely. The purpose of this policy is to ensure that the Trust is fully able to exercise its duty to protect the public, patients and service users through the employment of registered staff.

It is a requirement that individuals who work within certain professional groups and who are employed and/or undertake work on behalf of Velindre University NHS Trust, are registered with their respective professional regulatory body. Some professional bodies also require their registrants to apply for revalidation as part of the registration process.

If a member of staff's professional registration lapses they will not, contractually and in many cases legally, be able to continue to carry out the duties of their post, if their post requires them to be registered.

In view of the professional and legal obligations, this policy sets out the Trust's requirements for all professionally registered staff to maintain their professional registration, and comply with revalidation requirements. In addition, this policy describes the process to be followed for checking employees' professional registration status of health practitioners employed or engaged by the Trust.

2. Scope of Policy

This policy applies to all staff within Velindre University NHS Trust, including hosted organisations whose employment requires them to be registered, and in some cases revalidate, with a respective professional regulatory organisation. The policy also applies to all staff engaged as a Bank Worker, Honorary Contract holders, Locum/Agency staff and contractors.

This policy also applies to individuals attending Trust premises as a trainee or on Work Placements.

3. Aims and Objectives

The aims of this policy is to provide guidance to;

- Staff on their contractual requirements to maintain their professional registration, if this is a requirement of the role they are employed in
- Managers on the processes for checking and recording professional registration during the recruitment of staff and ensuring that all staff employed or engaged with the Trust (whether on a substantive, temporary, fixed term contract, a bank worker or engaged on an honorary appointment etc.), maintains their registration during their employment or engagement with Velindre University NHS Trust.
- All staff on the actions which may be taken if it is discovered that a health professional's registration has lapsed.

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4. Responsibilities

4.1 Employees/Bank Worker/Honorary Contract Holder/Contractor

The Trust regards it as the responsibility of the individual to register with their regulatory body and to ensure that they maintain such registration as is necessary to enable them to practise their profession.

As such, it is the responsibility of the individual to:

- provide evidence of statutory registration and qualifications, prior to commencing their employment/engagement with the Trust;
- renew their registration in a timely manner in accordance with the relevant professional bodies procedures ;
- ensure that they maintain their registration throughout their employment or engagement with the Trust, including;
- when on maternity, adoption, shared parental or paternity leave;
- long term absence from work due to sickness ;
- on secondment;
- on an employment break;
- any other period away from the workplace;
- take the responsibility of informing their line manager / Trust contact of any issues relating to their registration or re-registration and/or fitness to practice, such as being arrested or receiving a Police caution;
- ensure that their Manager/Trust contact is provided with sufficient evidence of their registration and the expiry date on renewal of their registration;
- inform the relevant statutory regulatory body and the Trust via Electronic Staff Survey (ESR) Self Service where possible, of any change in personal circumstances e.g. change of address, name, status etc.

4.2 Managers

Managers are responsible for checking and recording (on ESR/Personnel File) the professional registration of their staff who are required to register with a regulatory body.

Managers are also responsible for taking responsibility for ensuring that the follow-up process for checking statutory registration is undertaken and that registration numbers and renewal date records are maintained appropriately in ESR. This responsibility may be designated within their Department to an appropriate managerial level.

Responsible Managers must ensure that;

- they are familiar with the requirements of relevant legislation governing the employment of registered professional staff;
- they (or their nominee) verify the relevant qualifications and professional registration(s) of all employees, who require professional registration to undertake their duties, during the recruitment process following appointment;
- they have suitable arrangements in place for a systematic review and check of their registered professional staff's registration, in accordance with their relevant regulatory bodies' renewal schedule (also see section 5.3);
- checks are made on the professional registration of those staff returning from maternity, adoption, shared parental, paternity leave, employment break, long term

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sickness absence, secondment or any other extended period away from the workplace to confirm no changes have occurred (also see section 5.3);

- they establish procedures within their department(s) to ensure that the registration of honorary contract holders, agency, locum, bank workers etc. are checked and verified, and appropriate records are maintained;
- they ensure that immediate action is taken to protect the interests of the public, patients and service users when a member of staff is found not to be appropriately registered (see section 5.6 below);
- managers should inform employees of the impact that any delay in registration will have in relation to salary banding (refer to section 5).
- escalate situations of concern with registration to Head of department and if required to relevant executive lead.

4.3 Workforce and Organisational Development (OD) Department

The Workforce Information Team will;

- monitor the ongoing registration, via the ESR, for professional bodies e.g. the General Medical Council (GMC), Health and Care Professions Council (HCPC) and Nursing & Midwifery Council (NMC);
- provide timely and accurate alert reports from ESR and notify Managers when their staff members' registration is due for renewal, reminding them of the need to instigate their local checking procedures;
- ensure that any lapses of registration flagged up on the ESR system are immediately reported to Workforce and the relevant line manager.

The Workforce and OD Department will;

- provide guidance and advice to Managers and staff should a member of staff's registration lapse, ensuring that swift action is taken to protect the interests of the public, patients and service users.

5. Implementation and Policy Compliance

5.1 Procedure for Validation of Statutory Registration

All existing and prospective employees of Velindre University NHS Trust are required to submit details of their professional qualifications and professional registration(s) (as appropriate), as part of the recruitment process. This also applies to Bank Workers.

Validation of professional qualifications and registration(s) will be undertaken by the Appointing Manager, or their nominee, during the interview and recruitment process ensuring that:

- The employee is registered with their appropriate regulatory body;
- The employee's registration covers the role being recruited to; and
- The employee's registration is not subject to any current restrictions or subject to any fitness to practice investigation(s).

This documentation will also be verified by the NHS Wales Shared Services Partnership (NWSSP) Recruitment Team, as part of the mandatory pre-employment check process. The NWSSP Recruitment Team will provide the Appointing Manager with a copy of all the pre-employment check documentation. The Appointing Manager should ensure a copy of this is retained on the individual's personal file.

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Upon commencement of employment with Velindre University NHS Trust, the new employee will be required to provide their professional registration details. This information will be recorded in the ESR system and used to monitor the individual employees' registration compliance with their regulatory body.

Where an individual has been appointed to a post which requires them to be registered with a regulatory body and their registration cannot be verified, they will not be permitted to commence employment in that role with the Trust and the offer of employment may be withdrawn.

5.2 New Entrants to the Register

There may be occasions when newly qualified professional staff commence their employment within Velindre University NHS Trust prior to receipt of their registration.

In such circumstances, the individual will initially be employed and may work, under supervision, at the pay band for the relevant level for a Health Care Support Worker employed within the specific area, until the individual's registration is confirmed. Once registration has been confirmed, the employee's position and contract will be amended to reflect a registered post status. Pay will not be retrospectively adjusted, as the member of staff will not have worked to the job description of the registered post during this period.

In these instances advice should be sought from the Workforce Team before this position is agreed with an individual.

5.3 Existing employees

Each departmental manager must have an active follow-up process, which ensures that regular checks of its employee's statutory registration(s) are made. Managers should utilise ESR to support this process.

An expiry notification will be sent to the employee via ESR Employee Self Service four months and one month prior to the expiry of their professional registration informing them that they need to renew.

In addition, line managers will also receive a summary listing, showing all their staff with professional registrations due to expire in four months and one month before the expiry date

The appropriate Manager, or their appointed nominee, will confirm the current registration status, including the relevant part of the register where appropriate, using the correct registration confirmation service, either on-line, by telephone or in writing (Please see Appendix A).

5.4 Agency / Locum Workers / Contractors / Honorary Contract Holders

The relevant agency of locum provider, contractor or substantive employer must be asked to provide the Trust, via the relevant manager or Medical Staffing Department, with the appropriate registration details (registration number, renewal date and date of birth) of the individuals booked to fill any regulated healthcare professional vacancy. This must be verified before the individual is engaged with the Trust. The individual may also be required to present evidence of their registration when they commence their engagement with the Trust.

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5.5 Trainees and Work Placements

All registered individuals attending the Trust to participate in specific work placements, or participate in training, will be required to be registered with the appropriate professional body.

The substantive employer of the individual will be required to verify the statutory registration and provide the Trust with the registration details (registration number, renewal date and date of birth), prior to the commencement of their work placement or training. The individual may also be required to present evidence of their registration when they commence their engagement with the Trust.

5.6 Dealing with instances of lapsed Professional Registration

Clear and robust audit mechanisms will ensure that there is adherence to registration and re-registration procedures, as outlined above.

From time to time, situations arise whereby registered professional staff allow their registration with the appropriate statutory professional body to lapse. Failure to have, or to renew, registration will result in the member of staff being managed and supported as follows;

5.6.1 Substantive employees

The employee will be advised that until they have been restored to the appropriate register, they cannot continue to undertake their professional duties as required in a registered role;

The employee will not be able to work in their registered capacity until their re-registration has been confirmed. To facilitate this, they may take annual leave that has been accrued and not taken up to the date of the lapse of registration, paid at the band/salary at which it was accrued;

Should the employee not have enough accrued annual leave, they will be required to take unpaid leave;

Any lapse of professional registration will be considered in accordance with the Trust's Disciplinary Policy, and may lead to disciplinary action including dismissal;

In circumstances where lapsed registration has occurred due to the failure of the statutory regulatory body, the appropriate Manager will clarify the position with the professional body concerned;

The subsequent return to work of the individual concerned and/or resumption of pay at their band/scale will be subject to the availability of confirmation of re-registration;

The individual's line manager, or their nominee, will be required to confirm re-registration, via the appropriate registration service, either on-line, via telephone or in writing.

5.6.2 Bank Workers/Honorary Contract Holders/Contractors/Trainee and Work Placements

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In these instances the individual will be advised that until they have been restored to the appropriate register, they cannot continue with their engagement with the Trust.

Bank Workers will be provided with the opportunity to take any annual leave that has been accrued and not taken up to the date of the lapse of registration, paid at the band/salary at which it was accrued.

6 Removal from the register

If an employee is removed from the register by their own professional body, they will no longer be able to be legally employed by the Trust, in a professionally registered capacity. This will be managed in accordance with the Trust's Disciplinary Policy.

7 Reporting

In all cases of lapsed registration, an initial assessment will be undertaken in accordance with the Trust's Disciplinary Policy. The department manager will ensure that the lapse is reported to Workforce and OD, Divisional Director and the appropriate professional lead for the Velindre University NHS Trust e.g., Executive Medical Director or Executive Director of Nursing Allied Health Professions and Health Sciences.

8 Notification to Registered Bodies of breaches of Professional Codes of Conduct

In circumstances where a registered professional member of staff is proven to have breached their relevant Professional Code of Conduct, Velindre University NHST Trust will follow the relevant professional, regulatory bodies' notification mechanism.

8.1 Fitness to Practice

Registered professional staff have a responsibility to report to their Manager any matters that may arise, which may call into question their continued fitness to practice. The need for the staff member to be reported to the appropriate regulatory body will vary, dependent on the circumstances and the regulatory bodies agreed Code of Conduct/Standards. If a staff member is unsure whether they should report a matter to their Manager, they can discuss the matter with the appropriate regulatory body in the first instance.

Where a Manager judges that a registered professional staff member's fitness to practice has been called into question, they must discuss the matter with the relevant Trust Professional Lead, the Head of the Department and Workforce.

Where appropriate, a fitness to practice issue may be investigated, in accordance with the Velindre University NHS Trust's Disciplinary Policy, (where the matter is related to professional misconduct and calls into question the staff member's 'fitness to practice') or the Trust's Capability Policy, if this is found to be the case.

Where it is found, on the basis of probability or available evidence, that it is appropriate to call into question a member of staff's fitness to practice, the Trust Professional Lead or Head of Department should inform the appropriate Regulatory Body.

Prior to the Trust Professional Lead/Head of the Department informing the appropriate Regulatory Body of their concerns, he/she will write to the staff member concerned, advising them that their fitness to practice has been called into question, the reason(s) for this decision and informing them that the appropriate Regulatory Body will be informed of the breach.

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9. Equality Impact Assessment Statement

The Velindre University NHS Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees, reflects their individual needs and does not discriminate against individuals or groups.

The Velindre University NHS Trust has undertaken an Equality Impact Assessment (EQIA) and received feedback on this Policy and the way it operates. The Trust wanted to know of any possible or actual impact that this Procedure may have on any groups in respect of gender (including maternity and pregnancy, as well as marriage or civil partnership issues), race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

The EQIA Assessment found that there was no impact to the equality groups aforementioned.

10. References

- Disciplinary Policy - Disciplinary Policy WF 02
- Employment Break Policy - Employment Break Scheme
- Maternity, Adoption, Paternity and Parental Leave Policy - Maternity, Paternity, Adoption and Parental Leave Policy WF 29
- Shared Parental Leave Guidance - LINK
- Capability Policy - Capability Policy WF 09
- Equalities and Human Rights Act Legislation - Equalities and Human Rights Act

11. Getting Help

The Professional Registration Policy will be available via Velindre University NHS Trust intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a copy of this Policy

Further information and support is available from the Workforce Department.

The relevant Professional body will be able to provide advice and support to staff. A list of the contact details is available in Appendix A of this Policy.

12. Information, Instruction and Training

Whilst there are no formal training programmes in place to ensure implementation of this Policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Head of Nursing, Divisional Nurse, Departmental Manager and Head of Department(s) must ensure that Managers and all registered professional staff are made aware of the Policy provisions and that they are adhered to at all times.

13. Policy Review

This policy will be revised and updated to reflect any amendments to the staff groups who are required to register with a regulatory body to practice within their profession.

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Appendix A

REGISTRATION BODIES

General Medical Council (GMC)

By law, Doctors need to be registered and hold a licence to practise medicine in the UK. Doctors renew their registration annually.

In addition, licensed doctors must be revalidated by the GMC every five years. This means that doctors will be asked to evidence that they have been practising medicine in line with the principles set out in the guidance booklet "Good Medical practice Full Registration", which permits doctors to engage in any form of professional employment within the United Kingdom.

Provisional Registration – is held by newly qualified doctors for one year, to enable them to complete their Foundation Programme Year 1 posts, within a hospital setting.

Contact Details	Website Address	Online Register
https://www.gmc-uk.org/contact-us	www.gmc-uk.org	www.gmc-uk.org/doctors/medical_register.asp

General Pharmaceutical Council (GPhC)

Pharmacist and Pharmacy Technicians Registration is renewable with the GPhC on an annual basis.

Contact Details	Website Address	Online Register
https://www.pharmacyregulation.org/contact-us	www.pharmacyregulation.org	www.pharmacyregulation.org/registers

Health and Care Professions Council (HCPC)

HCPC Practitioners Registration – Each profession covered by the HCPC renews at a set time. These times are the same every two years and are staggered throughout the year. The practitioner groups covered (as relevant to Velindre University NHS Trust) are;

- Biomedical Scientists
- Clinical Scientists
- Dietitians
- Operating department practitioners
- Occupational Therapists
- Practitioner psychologists

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- Physiotherapists
- Practitioner Psychologists
- Radiographers
- Speech and Language Therapists

For the full list of practitioner groups registered with the HCPC and up to date information on the renewal deadlines for each profession, please visit the HCPC website; https://www.hcpc-uk.org/registration/registration-renewals/when-to-renew/

Contact Details	Website Address	Online Register
https://www.hcpc-uk.org/contact-us/	www.hcpc-uk.org	https://www.hcpc-uk.org/check-the-register/

- **Nursing and Midwifery Council (NMC)**

Nurse and Midwifery Registration – is renewable with the NMC on an annual basis.

All nurses, midwives and health visitors must be registered with the NMC. The register is split into three parts, 1) Nursing, 2) Midwifery, and 3) Specialist Community Public Health Nursing.

In addition, registered nurses must be revalidated by the NMC every three years. Revalidation provides assurances that that Nurses practice safely and effectively, encourage Nurses to reflect on the role of the Code in their practice and demonstrate that they are 'living' the standards set out within it

The revalidation requirements can be accessed via the NMC website; http://revalidation.nmc.org.uk/welcome-to-revalidation.1.html

Contact Details	Website Address	Online Register
https://www.nmc.org.uk/contact-us/	www.nmc-uk.org	https://www.nmc.org.uk/registration/search-the-register/

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Velindre University NHS Trust

QUALITY, SAFETY AND PEFORMANCE COMMITTEE

FINANCE REPORT FOR THE PERIOD ENDED 31ST JULY (M4)

DATE OF MEETING	12/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Choose an item

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Steve Coliandris – Head of Financial Planning & Reporting / Chris Moreton Deputy Director of Finance
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance

EXECUTIVE SUMMARY	The attached report outlines the financial position and performance for the period to the end of July 2024. The three main issues are highlighted below: **1. LTA's & Contract Rebase** • The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 Health Boards (HBs) which

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	outlined their disagreement with the rebasing proposal. The other 4 HBs and Joint Commissioning Committee (JCC) were in agreement to proceed but subject to all HBs agreement to the contract rebase. • As commissioners were not able to reach a consensus on the rebasing before the 30th June deadline to agree LTAs the Trust had to revert back and prepare LTAs on the historic baseline. • To avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement. The financial impact to the Trust for 2024/25 is: £318k reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan. £483k reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP. **2. IMTP – Financial Plan / Forecast** • The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024. • Following agreement on the LTA the Trust financial plan was revised and the shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures thus ensuring that the Trust continues to have a balanced financial plan.

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	3. Key Financial targets / KPIs • The Trust is currently reporting a small underspend on revenue and is forecasting to achieve an outturn position of Breakeven. • The Trust is currently overachieving and expected at this stage to meet the Public Sector Payment Performance (PSPP) target of paying 95% of non-NHS invoices within 30 days for 2024-25. • The Trust is expecting to achieve the Capital Expenditure Limit (CEL), however a risk remains as funding has not yet been secured from WG for several schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters.

RECOMMENDATION / ACTIONS	**QSP** is asked **NOTE** the contents of the July 2024 financial report and in particular: • The year to date and forecast revenue out turn position and PSPP performance. • The agreed position on LTA income for 2024-25 from our Commissioners. • The position with commissioners on the contract rebase agreement. • That the Trust is still waiting to secure Capital funding from WG in relation to the nVCC, Enabling Works and Whitchurch Hospital and land matters for 2024-25.

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GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**

Executive Management Board	29.08.2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The paper was received and noted at EMB on the 29TH August 2024.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed. N/A	
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"*** N/A

APPENDICES	
Appendix 1	Trust Finance Report – July 2024
Appendix 2	TCS Finance Report – July 2024
Appendix 3	Velindre Core WG MMR Commentary
Appendix 4	Velindre Core WG MMR Table A – Financial Plan and Movement against Plan.

1. SITUATION/ BACKGROUND

1.1 The attached report outlines the financial position and performance for the period to the end of July 2024.

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1.2 The financial information included within this report relates to the Core Trust (Including HTW). The financial position reported does not include NWSSP as it is directly accountable to WG for its financial performance. The balance sheet (SoFP) and cash flow

provide the full Trust position as this is reported in line with the WG Monthly Monitoring Returns (MMR).

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

2.1 Performance against Key Financial Targets:

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.000	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.397	6.322	31.521
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.4%	96.9%	95.0%

2.2 Revenue Budget

At this stage of the financial year the overall revenue budget remains broadly in line with expectations as planned within the IMTP, with a projected forecast outturn position of breakeven however there are risks associated in achieving this.

The overall position against the profiled revenue budget to the end of July 24 is an underspend of **£0.008m.**

It is expected that cost pressures will be managed by budget holders in line with the Trust's budgetary control procedures to ensure the delegated expenditure control limits are not exceeded.

LTA Contract Position

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The Trust obtained agreement from all HBs to proceed with the contract rebasing from 2024-25 at the collective commissioner's group meetings in January and February which

was reflected in the LTAs issued by the Trust in March. However in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4 HBs and JCC were in agreement to proceed but subject to all HBs agreement to the contract rebase.

As commissioners were not able to reach a consensus on the contract rebasing before the 30th June deadline to agree LTAs the Trust had to revert back and prepare LTAs on the historic basis.

Following discussions between Chief Executives, and to avoid arbitration, a compromise position was agreed on the LTA financial values which has led to a financial impact to the Trust for 2024-25 as follows:

£318k Reduction in recurrent discretionary income compared to plan.
£483k Reduction in non-recurrent income compared to plan.
The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of increased savings target, pausing previously agreed investment decisions and mitigating cost pressures.

The Trust is reporting a year end forecast revenue breakeven position, however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

2.3 Savings

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875m was required to help compensate for the loss of income from the LTA agreements.

One Scheme within VCS remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

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2.4 PSPP Performance

During July'24 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

2.5 Covid Expenditure

The Trust is currently not expected to draw down any covid funding support during 2024-25.

2.6 Reserves

The financial strategy for 2024-25 has enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation and delivery programmes. These reserves were accommodated on the assumption that all expected income is received, planned savings schemes are delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

2.7 Financial Risks

At the beginning of the year there were several financial risks that could have impacted on the successful delivery of a balanced position for 2024-25. As of the end of June some risks have either been mitigated such as, turning the Red RAG rated savings schemes Green, removing the risk of the 2023-24 pay award and the costs associated with the Whitchurch site following confirmation of funding from WG, or the risk has crystallised such as the 3.67% baseline LTA uplift.

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The reaming material risks which have been flagged to WG and considered to be either high or medium risk include Non Delivery of Savings (Amber schemes £0.150m), and the risk associated with the increased energy cost where current forecast exceeds budget.

There are several opportunities highlighted in the finance report including utilisation of the uncommitted investment reserves and the emergency reserve which would be used to support these risks should they crystallise. However, currently the non-recurrent reserve and emergency reserve are being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs.

2.8 Capital

All Wales Programme

Capital funding has not yet been allocated to several capital schemes including the nVCC, Enabling Works and Whitchurch Hospital and land matters requirement for 2024-25. WG are fully aware of the requirement with an expectation that a request will go imminently to the Minister to secure funding.

All other schemes without agreed funding are under discussion with WG colleagues with confidence at this stage that Capital funding will be provided to support the schemes.

Other Major Schemes in development that are detailed in the finance report will be considered during 2024-25 or beyond in conjunction with WG.

Discretionary Programme

The discretionary programme was fully allocated from previous prioritisation decisions other than a £0.100m contingency, which following confirmation of WG funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against other prioritised schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

3. IMPACT ASSESSMENT

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TRUST STRATEGIC GOAL(S)

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

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

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For more information: *https://www.gov.wales/socio-economic-duty-overview*	N/A. **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:
	N/A
	If more than one wellbeing goal applies please list below: **Click or tap here to enter text**
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Trust reported a revenue financial position of **£0.008m** underspend to July'24, whilst currently in line with the IMTP plan there are risks associated as outlined in the paper.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no requirement for this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	N/A

4. RISKS

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.

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ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A

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?	Choose an item
	N/A
All risks must be evidenced and consistent with those recorded in Datix	

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Canolfan Ganser Felindre
Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

FINANCIAL PERFORMANCE REPORT

FOR THE PERIOD ENDED JULY 2024/25

QUALITY, SAFETY & PERFORMANCE COMMITTEE 12/09/2024

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1. Introduction

The purpose of this report is to outline the financial position and performance for the year to date, performance against financial savings targets, highlights the financial risks, and forecast for the financial year, outlining the actions required to deliver the IMTP Financial Plan for 2024-25

2. Background / Context

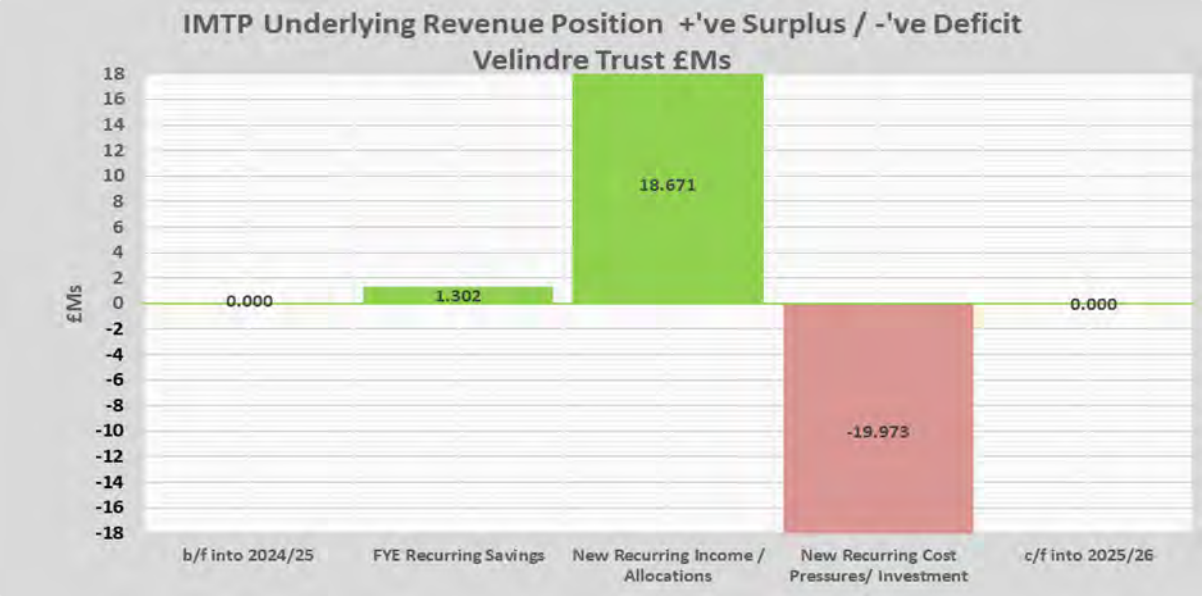
The draft Trust IMTP Financial Plan for the period 2024-2027 was set within the following context.

- The Trust submitted a balanced three year IMTP, covering the period 2024-25 to 2026-27 to Welsh Government on the 30 March 2024.

- For 2024-25 the Plan included;
  - A balanced position brought forward from 2023-24,
  - FYE **of new cost pressures / Investment** of **-£19.973m,**
  - offset by **new recurring Income** of **£18.671m,**
  - and Recurring FYE **savings schemes** of **£1.302m,**
  - Allowing **a balanced position** to be carried into 2025-26.

- **A significant risk is currently associated with the income that the Trust is expected to receive from its commissioners in relation to the 3.67% discretionary uplift, which could impact on the plan and the ability to achieve a balanced financial position.**

- **In order to achieve a balanced financial position the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or manged through the Trust reserves.**



Underlying Position +Deficit/(-Surplus) £Ms	b/f into 2024/25	Recurring Savings	New Recurring Income / Allocations	FYE New Cost Pressures/ Investment	c/f into 2024/25
Velindre NHS Trust	0.000	1.302	18.671	-19.973	0

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3. Executive Summary

Summary of Performance against Key Financial Targets (Excluding Hosted Organisations)

(Figures in parenthesis signify an adverse variance against plan)

Table 1 - Key Targets

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Revenue	Variance	0.000	0.008	0.000
Capital (To ensure that costs do not exceed the Capital Expenditure limit)	Actual Spend	1.397	6.322	31.521
Public Sector Payment Performance (Administrative Target – To pay 95% of non NHS invoices within 30 days measured against number of invoices paid).	%	98.4%	96.9%	95.0%

Performance against Planned Savings Target

	Unit	Current Month £m	Year to date £m	Year End Forecast £m
Efficiency / Savings	Variance	0.000	0.000	0.000

Revenue

The core Trust has reported a nil in-month position for July'24, which give a cumulative year to date position of **£0.008m** underspent and an outturn forecast of **Breakeven.**

Following discussions between Chief Executives, and in order to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan. The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will need to be considered part of the financial plan included with the IMTP.

The shortfall in LTA income has been recovered through a combination of an increased savings target, pausing previously agreed investment decisions, and mitigating cost pressures.

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Capital

The approved Capital Expenditure Limit (CEL) as of July 2024 is **£19.250m**. This represents all Wales Capital funding of **£17.339m**, and Discretionary funding of **£1.911m.** The Trust reported Capital spend to July'24 of £6.322m and is forecasting to remain within the CEL of £19.250m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.

The Trust's current CEL is broken down as follows:

	£m
Discretionary Capital	**1.911**
All Wales Capital:	
IRS	5.164
IRS RSC	11.265
Digital RISP	0.160
BECS	750
Total All Wales Capital	**17.339**
Total CEL	**19.250**

PSPP

During July'24 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

Efficiency / Savings

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.875 was required to help compensate for the loss of income from the LTA agreements.

One Scheme remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

Revenue Position

Cumulative				Forecast		
£0.008m Underspent				Breakeven		
Type	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)	Full Year Budget (£m)	Full Year Forecast (£m)	Forecast Variance (£m)
Income	(70.216)	(70.698)	0.482	(214.898)	(214.898)	0.000
Pay	29.231	29.445	(0.214)	85.612	85.612	0.000
Non Pay	40.985	41.244	(0.259)	129.285	129.285	0.000
Total	**0.000**	**(0.008)**	**0.008**	**0.000**	**0.000**	**0.000**

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The overall position against the profiled revenue budget to the end of July 2024 is an underspend of **£0.008m** and is currently expecting to achieve an outturn forecast of **Breakeven.**

The Trust is reporting a year end forecast revenue breakeven position, however this assumes that all planned additional income is received, the revised planned savings targets are achieved, and that all current and potential future financial risks are mitigated during 2024-25.

4.1 Revenue Position Highlights / Key Issues

Underlying Position

As per the IMTP Financial Plan the Trust brought a balanced position into 2024-25 and is expected to maintain this position over the course of the 3-year planning period.

In order to retain a balanced position, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge over the course of the period.

Income

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

WBS overachievement on Plasma sales had been significantly impacted by supplier payment issues which has been referred to CCI debt management. However, Since the referral the Trust has negotiated a re-payment plan with the supplier Randox and the first instalment was received at the beginning of August.

VCS Long Term Agreement (LTA) Contract Performance

The Trust has undertaken discussions with LHB Commissioners in accordance with a number of important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

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Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. In order to manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

In order to avoid arbitration, discussions between Chief Executives led to a compromise on the LTA financial settlement. The financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan.
- £483k Reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed but not expected to be material. The £483k will become recurrent in 2025/26 with a further reduction of c£360k which will need to be considered as part of the financial plan included within the IMTP.

The contract model rebase is still required to align with the new contracting model so that allocations from WG to LHBs are aligned with spend on Velindre's services on local population basis. Discussions with Commissioners will continue in 2024-25 to resolve the matter.

Pay Highlights / Key Issues

The Trust has now received confirmation from WG via the pay matrix that the full 2023-24 consolidated pay award will be funded.

The Trust is yet to receive formal confirmation from WG on the pay award for 2024-25, however at this stage we would assume that it would be fully funded, albeit with some risk until confirmed.

A number of posts in VCS and WBS were recruited at risk to create additional capacity required to respond to the Covid activity backlog and service developments without certainty around LTA income pending activity undertaken or FBC funding approval by WG and Commissioners. Work will continue during 2024-25 to update the likely cancer activity demand forecasts and associated income to help mitigate the financial risk exposure.

On top of the savings plans VCS (£0.450m), WBS (£0.450m) and Corporate (£0.150m) hold a recurrent vacancy factor target, which will need to be achieved in order to balance the financial plan for 2024-25.

Non Pay Key Issues

Per the allocation letter the Trust has received £0.563m of recurrent funding from WG to support the increase in energy prices during 2024-25. The latest forecast schedule from NWSSP suggests that the full year energy costs will be c£1.745m, this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provided by WG) which is held by the Trust.

Each Division holds both a general reserve to meet unforeseen costs and a savings target / Cost Improvement Plan (CIP). The Trust revised savings target for each division has been updated as VCS £0.939m, WBS £0.569m (previously £0.650), RD&I £0.230m and Corporate £1.138m (previously £0.787m) for 2024-25.

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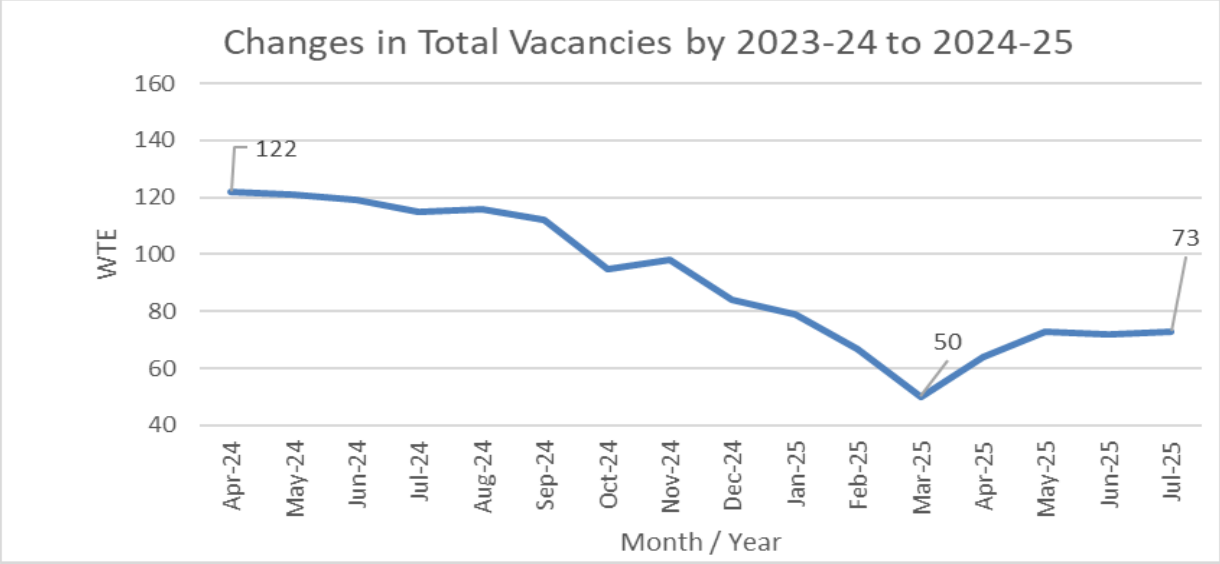
The Trust reserves and previously agreed unallocated investment funding is held in month 12 and will be released into the position to match spend as it occurs throughout the year.

4.2 Pay Spend Trends (Run Rate)

As of July 2024, the current staff in post is 1,602 WTE (June 1,588). The number of vacancies is 73 WTE, which represents a vacancy rate of 4.4% (4.3% June) against the budget of 1,660 WTE. The vacancy gap is largely being met by the use of agency staff or overtime and is also supporting each of the division's vacancy factor savings target.

The level vacancies fell over the course of 2023-24 across several services areas, in particular due to the recruitment of 17wte Nurses via the international recruitment scheme, which is demonstrated in the chart below and the historic trend line. As of July 24 vacancies have risen slighlty which is largely due to vacancies materialising from approved projects.



The total Trust vacancies as of July 2024 is 72wte (June 72wte), VCS (42wte), WBS (5wte), Corporate (9wte), R&D (14wte), TCS (1wte) and HTW (1wte).

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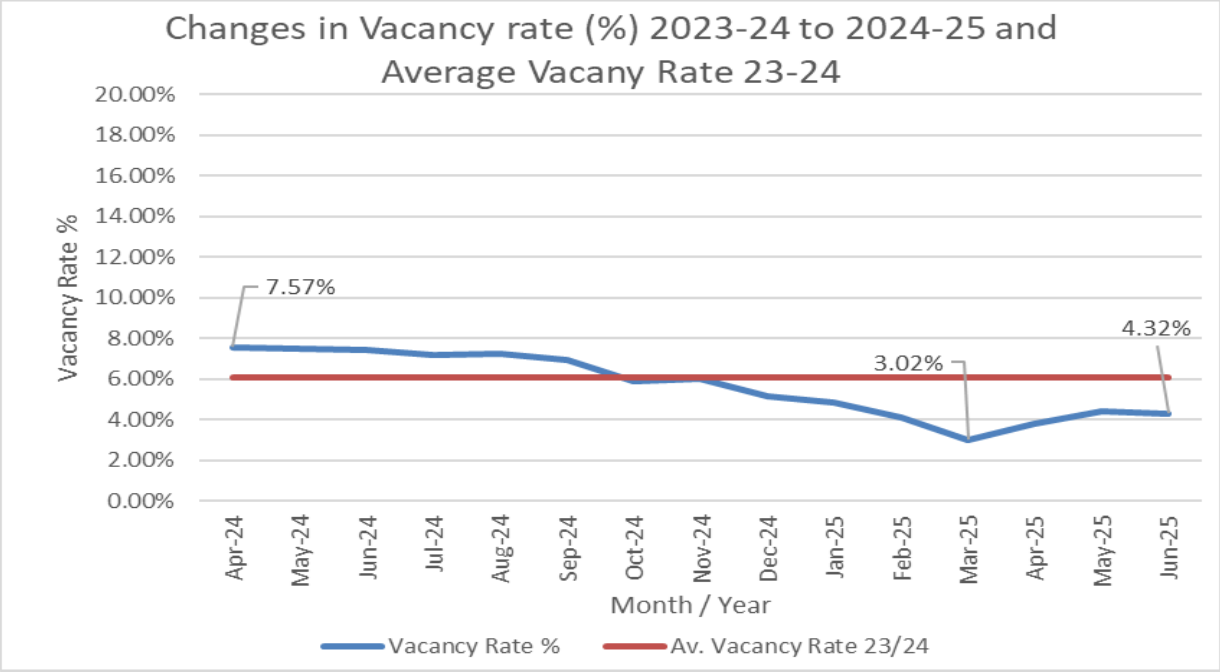

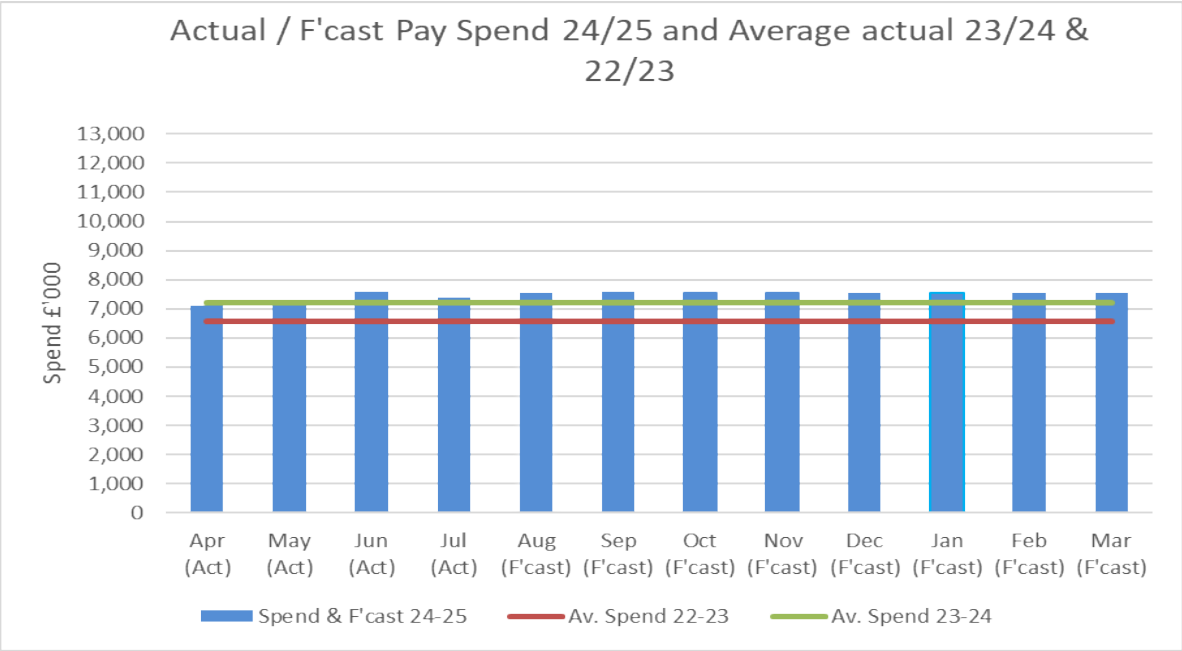

The pay award for 2024-25 is yet to be agreed so these costs are not yet reflected in the pay spend.

The spend on agency for July'24 was **£0.063m** (June £0.062m) which gives a cumulative year to date position of **£0.222m** and a current forecast outturn spend of circa **£0.322m** (£0.775m 2023/24).

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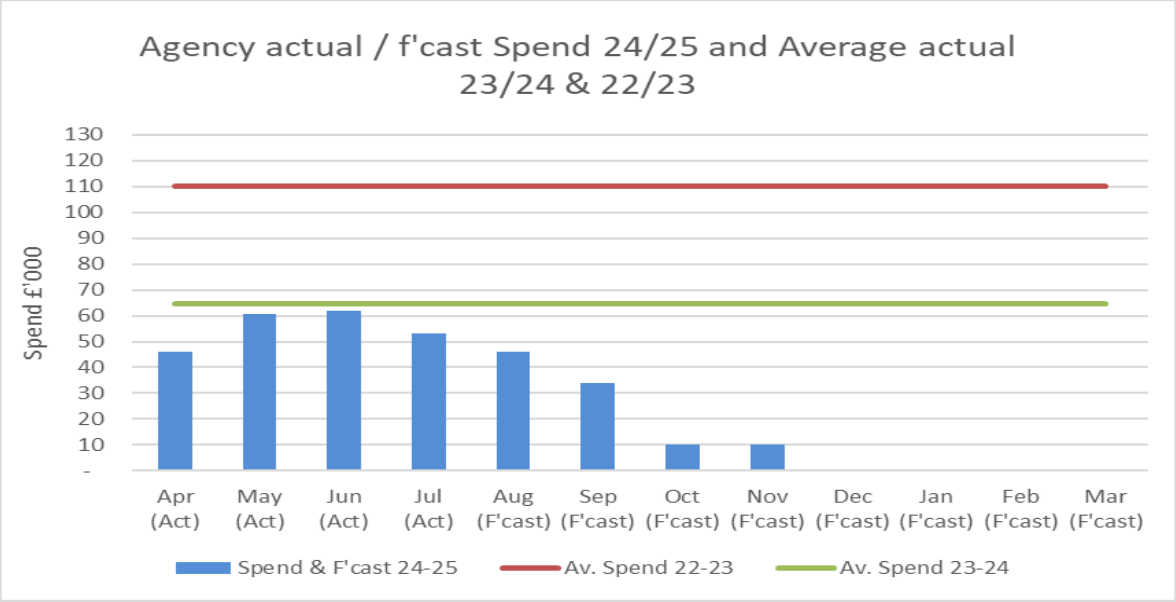

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

4.3 Non Pay

Average non-pay spend for 2023/24 was £9.9m per month which is a £1.4m increase from the previous whole year average. Largest movement was in drug spend which has increased by £10m in total or £0.9m average per month when compared with the previous year's spend for the same period. Other notable increases year on year include WBS Wholesaling £3.3m or £0.3m average per month and depreciation charges of £1.2m or £0.100m per month.

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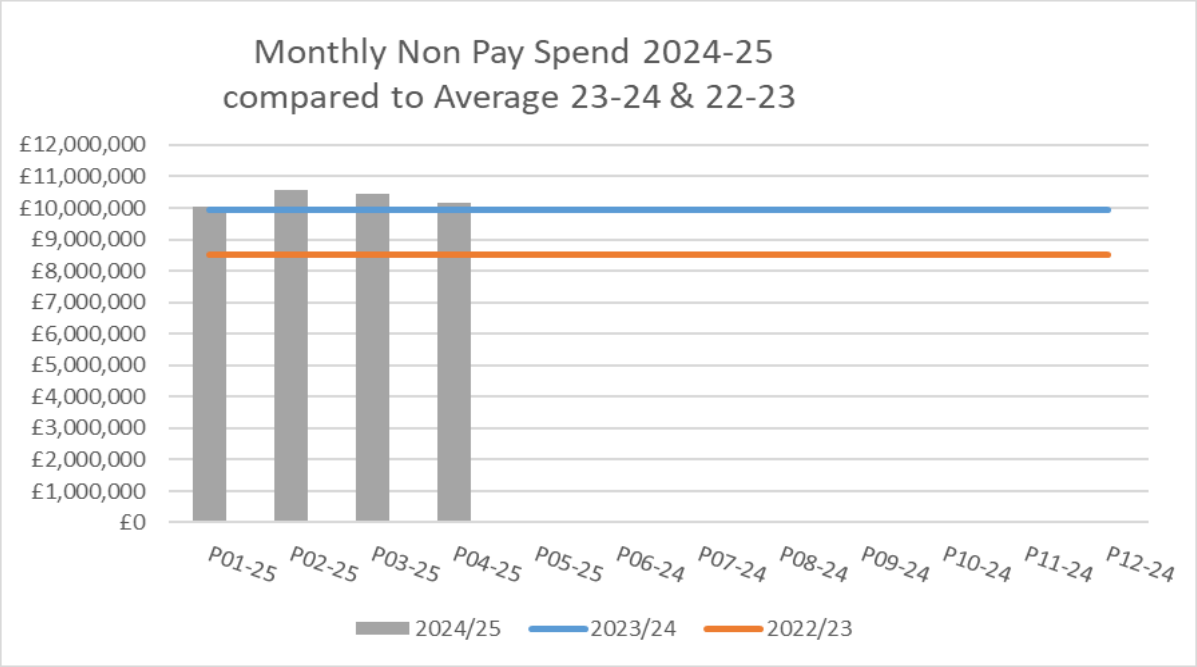
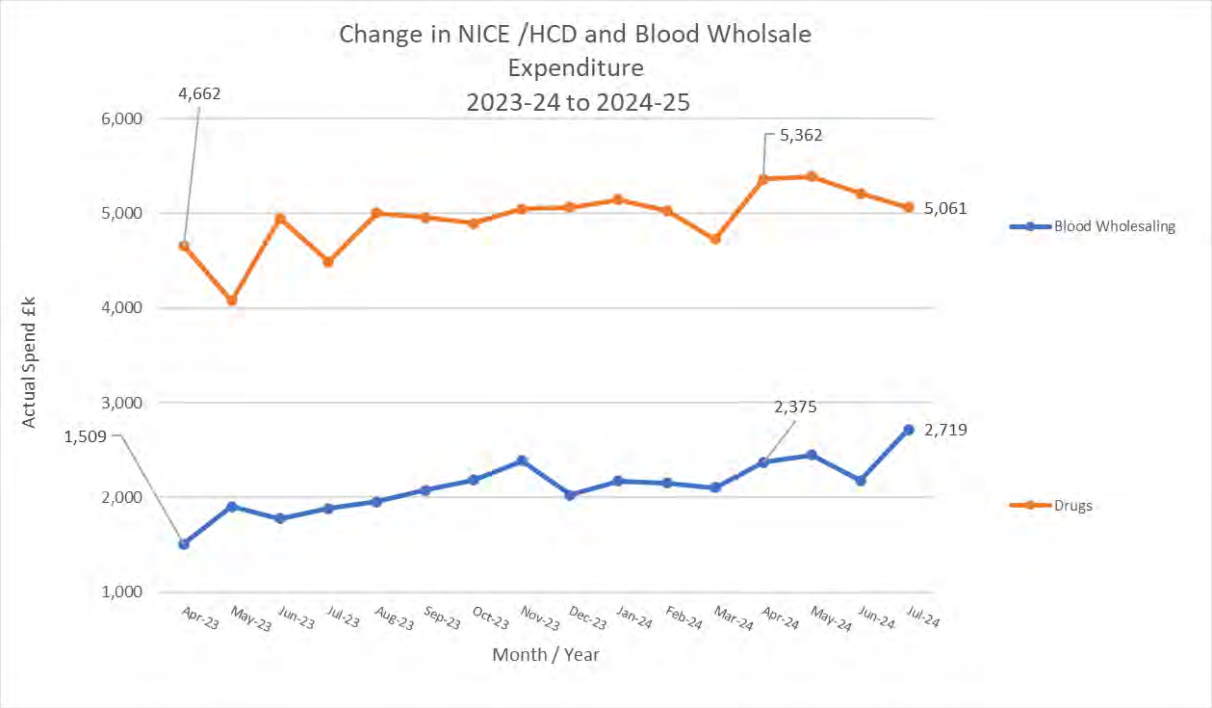
Non-Pay average so far for 2024/25 is currently £10.3m which is currently £0.4m higher than the average for last year. NICE and HCD drugs costs (£0.2m), and blood wholesale costs (£0.6m) have seen the largest average increase when compared to last year's average for the same period.



The graphs provided below show the change in non-pay spend split by expenditure category over the period from April 2023 to July 2024.



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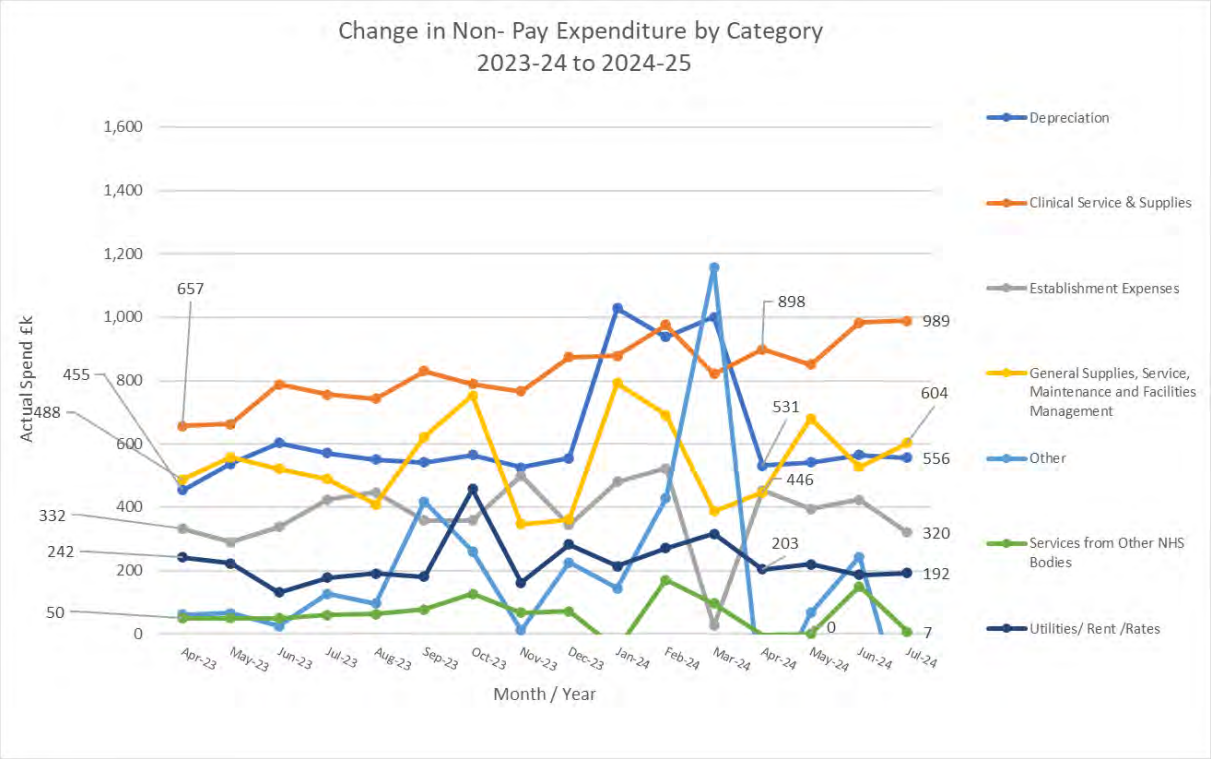

Establishment Expenses includes expenditure such as travel, lease cars, education, printing, postage, stationary, mobile phone charges, and other miscellaneous expenditure.

*Other spend in period M12 23-24 includes a provision for legal fees which has been partly released in 24-25.

*The graph excludes one off spends which incurred in period M12 23-24 such as the £7.35m AZ income received and transferred as expenditure to the Charity, along with the pass back contribution to WG which supported the overall NHS position.

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

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Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

4.4 Covid-19

The Trust is currently not expected to draw down any covid funding support during 2024-25. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

4. Savings

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed to be implemented or had not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, the majority of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2024-25.

The private patients scheme remains in amber as the Trust is assessing the external expert private patient management support it requires to facilitate delivery of the scheme, however we expect that once the external support contract is signed the income generation will be realised turning the scheme green. If not, a replacement savings scheme will be found, or the Trust can utilise one of the opportunities such as the emergency reserve mitigating any risk.

It is extremely important that divisions continually review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the Savings target is met for 2024-25.

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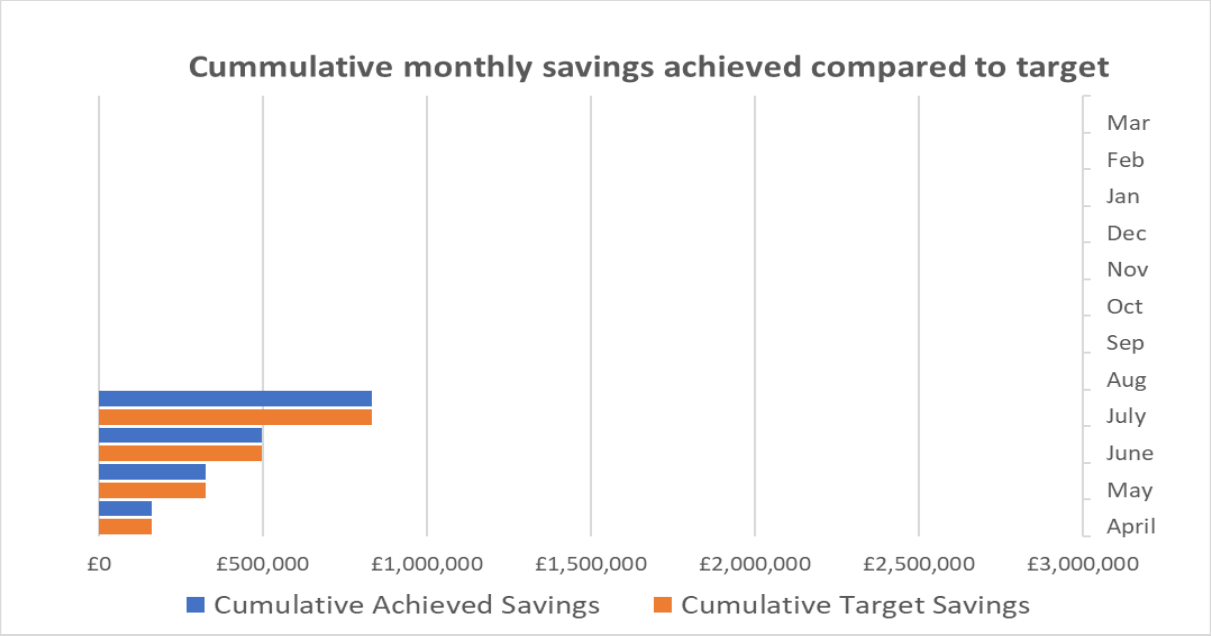

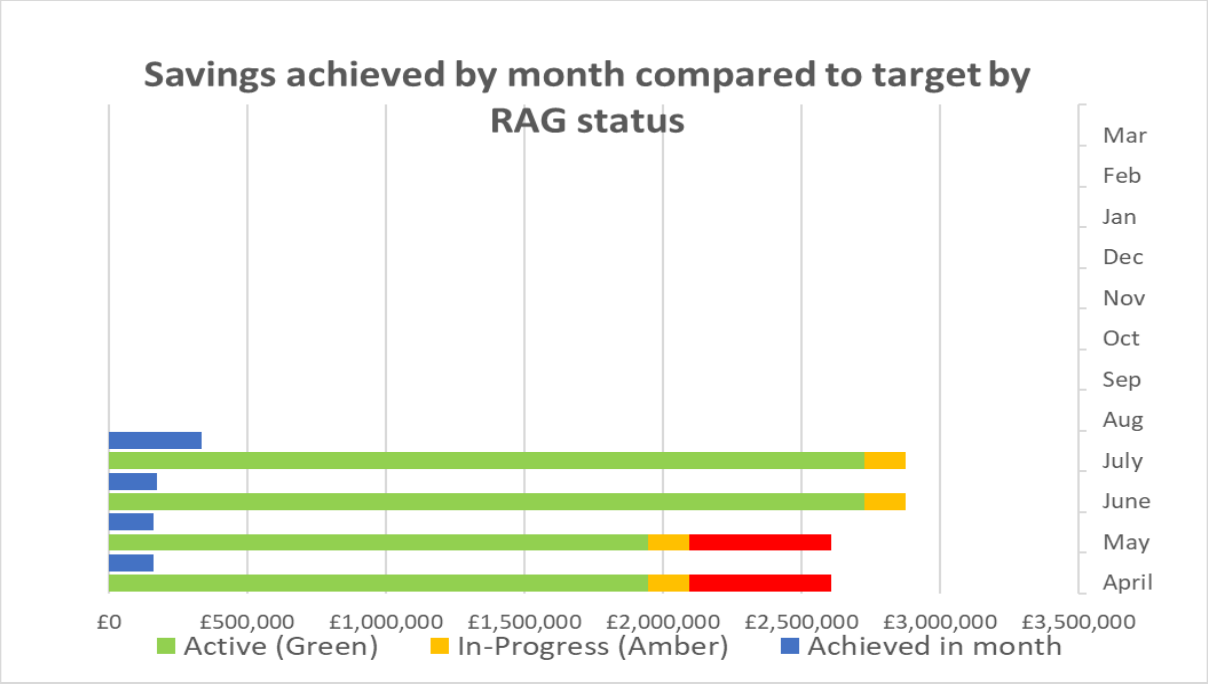

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ORIGINAL PLAN	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
VCS TOTAL SAVINGS	**939**	**199**	**199**	**0**	**939**	**0**
			100%		**100%**	
WBS TOTAL SAVINGS	**569**	**223**	**223**	**0**	**569**	**0**
			100%		**100%**	
CORPORATE TOTAL SAVINGS	**1,137**	**332**	**332**	**0**	**1,137**	**0**
			100%		**100%**	
RD&I TOTAL SAVINGS	230	**77**	**77**	**0**	**230**	**0**
					100%	
TRUST TOTAL SAVINGS	**2,875**	**831**	**831**	**0**	**2,875**	**0**
			100%		**100%**	

Scheme Type	Division	Recrrent / Non-Recurrent	RAG Rating	TOTAL £000	Planned YTD £000	Actual YTD £000	Variance YTD £000	F'cast Full Year £000	F'cast Variance Full Year £000
Savings Schemes									
Radiation Services - Agency Reduction	VCS	NR	Green	50	17	17	0	50	0
Establishment Control	VCS	R & N/R	Green	234	75	75	0	234	0
Service Workforce Redesign	VCS	R & N/R	Red						
Procurement - Supply Chain	VCS	R	Green	50	6	6	0	50	0
Establishment Control	WBS	R	Green	54	42	42	0	54	0
Stock Control - Scan for Safety Enabled	WBS	NR	Green	150	50	50	0	150	0
WBS Demand Planning	WBS	R	Red						
WBS Demand Planning	WBS	NR	Green	75	20	20	0	75	0
WBS Productivity Efficiencies	WBS	NR	Red						
Procurement - Supply Chain	WBS	R	Green	50	6	6	0	50	0
Service Workforce Redesign	WBS	R	Red						
Departmental CIP	Corporate	R	Green	50	17	17	0	50	0
Establishment Control	Corporate	R & N/R	Green	75	25	25	0	75	0
R&D Establishment Control	RD&I	R & N/R	Green	80	27	27	0	80	0
New / Replacement Schemes					0		0	0	0
Productivity Efficiencies	VCS	R & NR	Green	35	4	4	0	35	0
SACT Provision	VCS	R	Green	150	30	30	0	150	0
Creditor Review	WBS	NR	Green	100	100	100	0	100	0
Budget Efficiences	WBS	NR	Green	40	4	4	0	40	0
Total Saving Schemes				**1,193**	422	422	0	1,193	0
Income Generation									
Private Patients - Recovery of Debt	VCS	NR	Green	150	50	50	0	150	0
Private Patients - Contract Renewal	VCS	R	Amber	150	0	0	0	150	0
Productivity Efficiencies	VCS	R	Red						
Sales of Plasma	WBS	R	Green	100	1	1	0	100	0
WBS Productivity Efficiencies	WBS	R	Red						
Bank Interest	Corporate	R & N/R	Green	662	221	221	0	662	0
R&D Commercial Income	RD&I	R	Green	150	50	50	0	150	0
New / Replacement Schemes					0		0	0	0
Private Patients	VCS	NR	Green	70	8	8	0	70	0
Maximising Income	VCS	R	Green	50	10	10	0	50	0
Bank Interest	Corporate	R	Green	350	70	70	0	350	0
Total Income Generation				**1,682**	409	409	0	1,682	0
TRUST TOTAL SAVINGS				**2,875**	**831**	**831**	**0**	**2,875**	**0**
						100%		**100%**	

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5. Reserves

The financial strategy for 2024-25 enabled the establishment of a recurrent and non-recurrent reserve to support the Trust investment, transformation, and delivery programmes. These reserves were accommodated on the assumption that all expected income was received, planned savings schemes were delivered and new emerging cost pressures managed. In addition, the Trust holds an emergency reserve of £0.500m.

The use of investment reserves has been on hold while the Trust reached an agreement with our commissioners around the 3.67% baseline LTA uplift. However, following a review of the overall Trust financial position undertaken in June £0.808m of funding was made available to support investment decisions / choices which were agreed at EMB on the 25th June 2024.

The non-recurrent reserve and emergency reserve are currently being used to cover the financial risk in relation to n VCC implementation staff & advisor costs and EW advisor costs.

6. End of Year Forecast / Risk & Opportunity Assessment

The Trust is currently reporting a year end breakeven position against its revenue budget, however several financial risks that could impact on the successful delivery of a balanced position for 2024-25, although the majority have now either been reduced in risk or mitigated completely. The remaining key financial risks & opportunities which have been highlighted to Welsh Government are provided below.

Risks

LTA – *(£0m to £0.100m) Likelihood – Low (Risk reduced following LTA agreements and some crystallisation of income loss)*

The Trust has undertaken discussions with LHB Commissioners in accordance with a number of important principles: -

- national guidance from WG regarding the principle of pass through (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

The key differences in LHB Commissioner positions relate to the pass through of the Recurrent Discretionary uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

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Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for LHB Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. In order to manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

In order to avoid arbitration, discussions between Chief Executives led to a compromise LTA Financial settlement The financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent discretionary income (£145k ABUHB, £115k CTMUHB & £58k reverting to old baseline) compared to plan
- £483k Reduction in non-recurrent income compared to plan with The £483k reduction in income will become recurrent in 2025/26 together with a further recurrent reduction of c£360k which will be considered within the IMTP as part of the financial plan.

The contract model rebase is still required to align with the new contracting model so that allocations from WG to LHBs are aligned with spend on Velindre's services on local population basis. Discussions with Commissioners will continue in 2024-25 to resolve the matter.

Non-Delivery of Savings – (*£0.150m) Likelihood - Medium*

The Trust has identified a revised savings target of £2.875m to be achieved during 2024-25. The savings target was originally set to ensure that the Trust had the ability to mitigate against the significant cost pressures with the service, and then increased in order to help support the loss of income from the LTA agreements.

One Scheme remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

Whitchurch Hospital Site Transfer – Financial Consequences – (Low)

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the cost implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer is imminent and is expected to take place in the next couple of months once we finalise the detail. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the disposal or development of the residual Whitchurch estate. It is expected that the Trust will need to incur future capital cost to make good and dispose of the site.

The annual costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT). The Trust doesn't have a formal funding letter yet, however the Deputy Chief Executive NHS Wales confirmed in a letter to VUNHST CEO and Cardiff and Vale LHB CEO on 26 March 2024 that the Health Strategy Board is aware of the on-going revenue costs that are linked to the site which will initially be covered by the Welsh Government but will be offset against any future disposal receipts for the site. The proposed funding model for this arrangement will need to be agreed between WG and VUNHST as the Trust will require revenue funding to cover the annual costs, whereas the proposed funding source is a future capital receipt on disposal. At the Trust WG CRM in May 2024, WG's Deputy Director for NHS Capital, Estates and Facilities confirmed the Trust should invoice the Capital Finance team for the revenue costs incurred so therefore the risk has been reduced to low.

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The site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) and the make safe cost for the Whitchurch Hospital is estimated at between £1.65m - £2.73m (Exc VAT) subject to negotiations with WG and Cardiff Council. These costs require agreed capital funding as part of the All Wales Capital Funding Programme.

Rise in Energy Prices above forecast MTP plans - *(£0.142m) Likelihood – High*

Latest forecast schedule from NWSSP suggests that the Trust energy costs for 2024-25 will be c£1.745m this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provide by WG) which is held by the Trust.

Management of Operational Cost Pressures - *(£0.500m) Likelihood - Low*

There are several cost pressures that are already within the service which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that these current pressures may be beyond divisional control which is being recognised within the table.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

Opportunities

Vacancy Turnover – (Low)

Further vacancy turnover savings above the vacancy factor held in divisions.

Emergency Reserve – (Medium)

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2024-25 then like in 2023-24 the Trust may be in a position later in the year to release this funding on a non-recurrent basis.

Reduction in Energy Prices – (Low)

At this stage the funding received to support the increase in energy prices is expected to be required by the Trust, however whilst unlikely given the latest forecast position from NWSSP if costs were to reduce then an opportunity may crystalise.

Savings Opportunities Pipeline

The Trust has identified some initial opportunities that could be explored but these require further development but are highlighted below:

Pre-Operative Anaemia Pathway Project (Health Board savings)

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Value Based Healthcare project led by WBS where all patients undergoing elective major surgery in Wales will be screened pre-operatively and offered treatment with intravenous Iron as required

prior to surgery. Savings to be established and delivered via Health Boards and represents WBS / VUNHST contribution to system wide financial performance.

Medicine Unit Supply

Identify opportunities to increase use of NWSSP Medicines unit to identify further potential cost savings for high cost drugs. Note that any cost savings are passed through to LHB Commissioners

Workforce Re-design

Review of workforce models and pathways to identify opportunities to deliver services more efficiently in addition to the schemes outlined in the savings tracker.

Procurement

Procurement working with divisions on a regular basis to review non pay spend and ensure delivery of savings target and identify other cost improvement opportunities above the savings target.

7. CAPITAL EXPENDITURE

Administrative Target

- *To ensure that net Capital expenditure does not exceed the Capital Expenditure Limit (CEL) approved by the Welsh Government.*
- *To ensure the Trust does not exceed its External Financing Limit*

	Approved CEL 2024/25 £m	YTD Spend £m	Budget Remaining @ M4 £m	F'cast Spend 2024/25 £m	Year End Variance 2024/25 £m
All Wales Capital Programme					
IRS - Integrated Radiotherapy Solution	5.164	2.042	3.122	5.164	0.000
IRS RSC - Radiotherapy Satellite Centre	11.265	0.854	10.411	11.265	0.000
nVCC Enabling Costs	0.000	2.289	(2.289)	3.368	(3.368)
nVCC Project Fees	0.000	0.719	(0.719)	3.622	(3.622)
nVCC Whitchurch Hospital Site	0.000	0.003	(0.003)	3.636	(3.636)
nVCC Governance Review	0.000	0.140	(0.140)	0.140	(0.140)
nVCC Governance Review Implementation (PW	0.000	0.000	0.000	0.350	(0.350)
WBS TGI	0.000	0.000	0.000	0.363	(0.363)
Digital - WHAIS	0.000	0.000	0.000	0.442	(0.442)
Digital - RISP	0.160	0.000	0.000	0.160	0.000
BECS	0.750	0.000	0.000	0.750	0.000
WBS Electrical Resilience - Backlog Maintenanc	0.000	0.000	0.000	0.350	0.000
WBS Liquid Nitrogen	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	17.339	6.047	10.382	29.610	(11.921)
Discretionary Capital	1.911	0.275	1.636	1.911	0.000
	19.250	6.322	12.018	31.521	(11.921)

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The approved 2024-25 Capital Expenditure Limit (CEL) as of July 2024 was £19.250m. This includes All Wales Capital funding of £17.339m, and discretionary funding of £1.911m.

A total of £11.116m is now forecast to be required to support the nVCC enabling, project, Governance review costs and to make good the Whitchurch Site during 2024-25. WG are aware of the total requirement and are looking to put a request to the Minister imminently.

Discussions are ongoing with WG colleagues around securing the funding requirement in relation to WHAIS and the costs associated with the WBS TGI OBC, with WG having supported these projects up to this date.

In addition, the Trust has been awarded funding from WG towards the WBS electrical resilience, however the Trust received confirmation during July that the WBS Liquid nitrogen scheme which was initially supported was not approved by the Minister. The Trust will now be looking to secure funding either from year end capital spend should it become available, or the scheme will be included within next year's IMTP plans with a view to secure funding before the contract ends.

The finance team are in conversation with WG colleagues to ensure that the funding for all of the above Capital Schemes form part of the CEL for 2024-25.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24.

The discretionary programme was fully allocated from previous prioritisation decisions other than a £0.100m contingency, which following confirmation of WG funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against other prioritised schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

A review of the recent conditions survey of the VCC site is currently underway and will require funding support from the discretionary programme. This is currently estimated to be c£0.160m.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

Performance to date

The actual expenditure to July 2024 on the All-Wales Capital Programme schemes was £6.047m, this is broken down between spend on the nVCC schemes of £3.151m, the IRS £2.289m, and RSC £0.854m.

The current spend on the Discretionary Capital programme as of July 2024-25 is £0.275m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position subject to the Trust securing funds for the nVCC and other projects on WG radar.

Major Schemes in Development

The Trust has also been in discussions with WG over other projects which it is seeking to secure funding from the All-Wales Capital programme.

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The Trust has a process through which to prioritise competing capital cases, both in terms of submissions to WG for All Wales funding and the allocation of Trust discretionary Programme funding.

The capital investment required over the period of the IMTP are schemes that have or will be submitted to Welsh Government as cases for consideration against the All-Wales Capital Fund.

The latest position of schemes that was included in the IMTP for 2024-25 is provided in the table below:

All Wales Approved and Unapproved Capital Schemes	2024-25 £m	2025-26 £m	2026-27 £m	2027/28 £m	Further Years £m	Total All Wales Schemes £m
All Wales Approved Schemes						
TCS nVCC enabling works		1.547				1.547
Integrated Radiotherapy Solution (IRS)	5.164	2.040	15.800	0.839		23.843
Radiotherapy Satellite Unit	11.265					11.265
Total Approved Capital Schemes	**16.429**	**3.587**	**15.800**	**0.839**	**0.000**	**36.655**
All Wales Unapproved Schemes						
TCS nVCC	15.791	11.000	36.962	1.741		65.494
TCS nVCC Enabling works	2.900		0.600			3.500
Digital - IT Infrastructure	1.086	0.688	0.680	0.400		2.854
WHAIS	0.494	0.092				0.586
WBS Electrical Resilience	0.320					0.320
Liquid Nitrogen Vessel	0.500					0.500
Welsh Plasma - Medicine	0.970	0.064	0.064	0.203		1.301
Talbot Green - Infrastructure	0.303	1.346	10.633	10.640	19.707	42.629
WBS Fleet Replacement		0.373	1.112	1.285		2.770
WBS Asset Replacement	0.100	0.494	0.121		1.560	2.275
First Floor Ward Ventilation	0.370					0.370
Condition Survey Recommendations	0.250	0.200	0.150			0.600
BECS Blood Mangagement System	0.100	0.200	0.200	1.000		1.500
Total Unapproved Capital Schemes	**23.184**	**14.457**	**50.522**	**15.269**	**21.267**	**124.699**
Total All Wales Capital Plans	**39.613**	**18.044**	**66.322**	**16.108**	**21.267**	**161.354**

8. BALANCE SHEET (Including Hosted Organisations)

The Balance Sheet in NHS Financial Statements is known as the Statement of Financial Position (SoFP). It provides a snapshot of the Trust's financial position including the hosted divisions at a point in time.

The statement shows the Trust's assets and liabilities. As part of the Trust SFIs there is a mandatory requirement to report movement in working capital.

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	Opening Balance Beginning of Apr 24	Closing Balance End of Jul-24	Movement from 1st April Jul-24	Forecast Closing Balance End of Mar 25
Non-Current Assets	**£'m**	**£'m**	**£'m**	**£'m**
Property, plant and equipment	226.135	227.366	1.231	227.366
Intangible assets	10.893	10.894	0.001	10.894
Trade and other receivables	1,316.876	1,310.213	(6.663)	1,310.213
Other financial assets	0.000	0.000	0.000	0.000
Non-Current Assets sub total	1,553.904	1,548.473	(5.431)	1,548.473
Current Assets				
Inventories	31.227	31.466	0.239	31.466
Trade and other receivables	530.547	538.454	7.907	549.166
Other financial assets	0.000	0.000	0.000	0.000
Cash and cash equivalents	20.956	27.646	6.690	16.934
Non-current assets classified as held for sale	0.000	0.000	0.000	0.000
Current Assets sub total	582.730	597.566	14.836	597.566
TOTAL ASSETS	2,136.634	2,146.039	9.405	2,146.039
Current Liabilities				
Trade and other payables	(229.886)	(239.720)	(9.834)	(239.720)
Borrowings	(1.020)	(1.020)	0.000	(1.020)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(338.517)	(589.436)	(250.919)	(589.436)
Current Liabilities sub total	(569.423)	(830.176)	(260.753)	(830.176)
NET ASSETS LESS CURRENT LIABILITIES	1,567.211	1,315.863	(251.348)	1,315.863
Non-Current Liabilities				
Trade and other payables	(3.330)	(3.330)	0.000	(3.330)
Borrowings	(31.785)	(31.785)	0.000	(31.785)
Other financial liabilities	0.00	0.00	0.000	0.00
Provisions	(1,320.849)	(1,069.027)	251.822	(1,069.027)
Non-Current Liabilities sub total	(1,355.964)	(1,104.142)	251.82	(1,104.142)
TOTAL ASSETS EMPLOYED	211.247	211.721	0.474	211.721
FINANCED BY:				
Taxpayers' Equity				
General Fund	0.000	0.000	0.000	0.000
Revaluation reserve	35.956	35.956	0.00	35.956
PDC	155.832	155.924	0.092	155.924
Retained earnings	19.459	19.841	0.382	19.841
Other reserve	0.000	0.000	0.000	0.000
Total Taxpayers' Equity	211.247	211.721	0.474	211.721

9. CASH FLOW (Includes Hosted Organisations)

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The cash-flow forecast is important to enable the Trust to plan for sufficient cash availability throughout the financial year to pay its debts, such as payroll, services provided by other health bodies and private companies. The cash-flow forecast ensures that the Trust has an early understanding of any cash-flow difficulties.

As part of the Brexit emergency planning an additional £4.5m of stock had been purchased by NWSSP and an additional £2.5m of commercial blood products were purchased by WBS, to provide resilience for NHS Wales due to the uncertainty around supply chain reliability because of Brexit.

To aid the Trust's cash flow while the additional stock was being held for Brexit, Welsh Government provided the Trust with additional cash of £7m during 2019-20. WBS did intend to run down the commercial blood stock, however given the ongoing uncertain situation and potential impact on supply chains the Trust continues to hold this stock with assessments ongoing. NWSSP however issued the additional stock and the £4.5m was repaid to WG during February '23.

Cash levels are monitored daily using a detailed cash flow forecast to ensure the Trust has sufficient cash balances to meet anticipated commitments.

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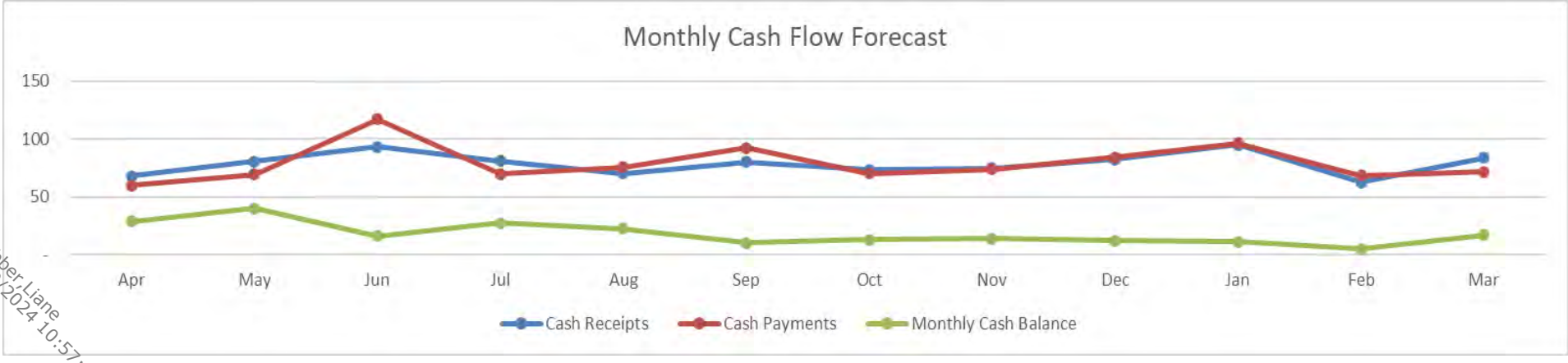
		Apr £'m	May £'m	Jun £'m	Jul £'m	Aug £'m	Sep £'m	Oct £'m	Nov £'m	Dec £'m	Jan £'m	Feb £'m	Mar £'m	Totals £'m
	RECEIPTS													
1	**Income from other Welsh NHS**	50.519	42.117	43.016	40.489	48.599	47.599	47.299	46.099	45.499	46.699	45.499	42.499	545.931
2	**WG Revenue Funding**	10.504	31.147	45.405	20.761	18.500	28.453	20.200	22.529	31.399	42.659	11.399	21.529	304.483
3	**Short Term Loans**													0.000
4	**PDC**							0.000					13.957	13.957
5	**Interest Receivable**	0.179	0.143	0.186	0.158	0.144	0.144	0.144	0.144	0.144	0.144	0.144	0.144	1.818
6	**Sale of Assets**													0.000
7	**Other**	6.657	7.151	4.914	19.701	3.200	3.900	5.600	6.154	5.450	5.800	5.450	5.625	79.603
8	**TOTAL RECEIPTS**	**67.860**	**80.558**	**93.521**	**81.109**	**70.443**	**80.096**	**73.243**	**74.925**	**82.491**	**95.301**	**62.491**	**83.753**	**945.791**
	PAYMENTS													
9	**Salaries and Wages**	25.845	35.256	35.185	35.848	35.635	35.618	35.632	35.625	35.604	35.639	35.618	35.618	417.123
10	**Non pay items**	31.288	30.780	81.237	33.050	38.542	54.602	32.241	36.042	46.537	53.525	29.384	32.156	499.382
11	**Short Term Loan Repayment**													0.000
12	**PDC Repayment**		0.000											0.000
14	**Capital Payment**	2.880	3.178	0.977	0.833	1.500	2.164	2.357	2.429	2.066	7.378	3.543	4.003	33.309
15	**Other items**													0.000
16	**TOTAL PAYMENTS**	**60.013**	**69.214**	**117.399**	**69.731**	**75.676**	**92.384**	**70.230**	**74.096**	**84.207**	**96.542**	**68.545**	**71.777**	**949.813**
17	**Net cash inflow/outflow**	7.846	11.344	(23.878)	11.378	(5.234)	(12.288)	3.013	0.830	(1.715)	(1.241)	(6.054)	11.976	
18	**Balance b/f**	20.956	28.802	40.146	16.268	27.646	22.413	10.125	13.138	13.968	12.253	11.012	4.958	
19	**Balance c/f**	28.802	40.146	16.268	27.646	22.413	10.125	13.138	13.968	12.253	11.012	4.958	16.934	



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DIVISIONAL ANALYSIS

(Figures in parenthesis signify an adverse variance against plan)

Core Trust

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(15.267)	(15.264)	0.003	(41.858)	(41.858)	0.000
RD&I	0.114	0.106	(0.008)	0.394	0.394	0.000
WBS	(7.130)	(7.128)	0.002	(20.961)	(20.961)	0.000
Sub-Total Divisions	**(22.283)**	**(22.286)**	**(0.003)**	**(62.425)**	**(62.425)**	**0.000**
Corporate Services Directorates	(4.199)	(4.197)	0.002	(12.602)	(12.602)	0.000
Delegated Budget Position	**(26.482)**	**(26.483)**	**(0.001)**	**(75.027)**	**(75.027)**	**0.000**
TCS	(0.173)	(0.163)	0.010	(0.635)	(0.635)	0.000
Health Technology Wales	(0.031)	(0.031)	(0.000)	(0.092)	(0.092)	0.000
Trust Income / Reserves	26.686	26.686	0.000	75.700	75.700	0.000
Trust Position	0.000	0.009	0.008	(0.053)	(0.053)	0.000

VCS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**26.222**	**26.515**	**0.293**	**81.403**	**81.403**	**0.000**
Expenditure						
Staff	16.927	17.149	(0.222)	49.069	49.069	0.000
Non Staff	24.562	24.630	(0.068)	74.192	74.192	0.000
Sub Total	**41.489**	**41.779**	**(0.290)**	**123.261**	**123.261**	**0.000**
Total	**(15.267)**	**(15.264)**	0.003	**(41.858)**	**(41.858)**	**0.000**

VCS Key Highlights/ Issues:

The reported financial position for Velindre Cancer Services as at the end of July 2024 was a small underspend of **£0.003m**, and an expected outturn position expected at this stage of **breakeven**.

Income at Month 4 represents a surplus of **£0.293m**. An overachievement on private patient drug income and VAT Savings from delivering drug homecare, which is offsetting the release in a provision for legal costs from last financial year which directly correlates with a reduction in non-pay expenditure.

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VCS have reported a year to date overspend of **£(0.222)m** against staff. Snr Medical costs continue to cause a significant cost pressure to the division which is offsetting the vacancies that

remain across several services despite the recruitment push during 2023-24. The vacancies being carried is above both the vacancy factor and savings target held in the Division.

Non-Staff Expenditure at Month 4 was **£(0.068)m** overspent which is largely due to an increase in facilities management expenses (mainly Postage), the SLA increase in pathology with C&V and the divisional management savings target, partly offset by a release of the legal provision counteracted with income, and other small variances across service areas.

WBS

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**11.646**	**11.727**	**0.081**	**30.747**	**30.747**	**0.000**
Expenditure						
Staff	5.908	6.087	(0.178)	17.042	17.042	0.000
Non Staff	12.868	12.769	0.099	34.666	34.666	0.000
Sub Total	**18.776**	**18.855**	**(0.080)**	**51.708**	**51.708**	**0.000**
Total	**(7.130)**	**(7.128)**	0.002	**(20.961)**	**(20.961)**	**0.000**

Key Highlights/ Issues:

The reported financial position for the Welsh Blood Service at the end of July 2024 was a small underspend of **£0.002m** with an outturn forecast position of **breakeven** currently expected.

Income overachievement of **£0.081m is** due to increased activity on plasma sales, partly offset by underachievement on bone marrow.

Whilst Plasma Sales activity has been increasing deliveries to Randox have now been suspended due to the supplier not making payment. A bad debt provision of £0.366m was created at the end of last financial year however, the debt continued to rise at the start of the financial year prior to the suspension which has now been referred to CCI debt management. Since the referral the Trust has negotiated a re-payment plan with the supplier Randox and the first instalment was received at the beginning of August.

There has been a lack of growth in the bone marrow registry, which was largely impacted during the pandemic, however, is starting to show signs of recovery with significantly more swab tests taking place over the last quarter. The payback from the additional swabs should start to be realised later in this financial year. WBS continue to run campaigns in order to try and grow the panel in sites such as schools and universities, and also raise awareness through advertising on platforms such as social media.

Staff overspend of **£(0.178)m** is due to an increased CIP (savings target), along with advance recruitment and appointments made at risk without identified funding source. Work continues to be underway within WBS SLT to either secure additional funding to support these posts or continue to look into options of migrating staff into vacancies to help mitigate the current risk exposure. There is a focused WBS SLT away day scheduled for the 12th September where this will be discussed, and actions agreed to address the issue.

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Non-Staff reported an underspend of **£0.099m** as at month 4. There are overspends in areas such as room hire costs which are no longer funded by WHSSC, temporary additional security costs at the rear of the building, additional spend within molecular genetics for test kits and the Divisional non pay CIP. Expectation is that security at the site can be removed in the short term. The cost pressures are being offset by underspends in Apheresis harnesses volume and price savings, price savings from bulk purchase of test kits, reduced spend on fuel due to the delay in lease vehicles being introduced, and reduced costs from lower activity on bone Marrow which is a direct correlation with income under performance.

Corporate

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected £m
Income	**1.355**	**1.512**	**0.156**	**4.443**	**4.443**	**0.000**
Expenditure						
Staff	4.541	4.382	0.159	13.884	13.884	0.000
Non Staff	1.013	1.327	(0.314)	3.161	3.161	0.000
Sub Total	**5.554**	**5.709**	**(0.155)**	**17.045**	**17.045**	**0.000**
Total	**(4.199)**	**(4.197)**	0.002	**(12.602)**	**(12.602)**	**0.000**

Corporate Key Highlights / Issues:

The reported financial position for the Corporate Services division at the end of July 2024 was an overspend of **£0.002m**. The Corporate division is currently expecting to achieve an outturn position of **breakeven**.

The Trust continues to benefit from receiving high levels of bank interest as a result of interest rate rises, however a significant amount £1.012m (previously £0.662m) has been set against the Trust revised savings target for 2024-25, which is in addition to the baseline budget of £0.165m.

Staff expectation is that vacancies within the division, will help offset use of agency, the Head of Communications which has been temporarily appointed at risk and the divisional savings target.

A non-pay overspend is again expected and largely relates to divisional CIP target and the increased running costs associated with the hospital estate. Funding was set aside as part of the Trust IMTP to partly support the Estates costs on a non-recurrent basis during 2024-25.

RD&I

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	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**1.435**	**1.404**	**(0.030)**	**4.554**	**4.554**	**0.000**
Expenditure						
Staff	1.129	1.118	0.011	3.630	3.630	0.000
Non Staff	0.192	0.181	0.011	0.531	0.531	0.000
Sub Total	**1.321**	**1.298**	**0.023**	**4.160**	**4.160**	**0.000**
Total	**0.114**	**0.106**	(0.008)	**0.394**	**0.394**	**0.000**

RD&I Key Highlights / Issues

The reported financial position for the RD&I Division at the end of July 2024 was a small **£0.008m** overspend with a current forecast outturn position of **breakeven**.

Clinical Trials and Charitable funds income will fluctuate and is expected be drawn down in line with expenditure.

TCS – (Revenue)

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.028**	**0.028**	**0.000**	**0.028**	**0.028**	**0.000**
Expenditure						
Staff	0.187	0.180	0.007	0.621	0.621	0.000
Non Staff	0.014	0.011	0.003	0.042	0.042	0.000
Sub Total	**0.201**	**0.191**	**0.010**	**0.663**	**0.663**	**0.000**
Total	**(0.173)**	**(0.163)**	0.010	**(0.635)**	**(0.635)**	**0.000**

TCS Key Highlights / Issues

The reported financial position for the TCS Programme at the end of July 2024 is **a £0.010m** underspend with a forecasted outturn position of **Breakeven.**

Escrow bank interest is being brought into the position which is resulting in a year to date surplus position.

HTW (Hosted Other)

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	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
Income	**0.549**	**0.531**	**0.019**	**1.649**	**1.649**	**0.000**
Expenditure						
Staff	0.538	0.530	0.008	1.614	1.614	0.000
Non Staff	0.042	0.032	0.010	0.127	0.127	0.000
Sub Total	**0.580**	**0.562**	**0.019**	**1.741**	**1.741**	**0.000**
Total	**(0.031)**	**(0.031)**	0.000	**(0.092)**	**(0.092)**	**0.000**

HTW Key Highlights / Issues

The reported financial position for Health Technology Wales at the end of July 2024 was **breakeven,** with a forecasted outturn position which will be managed to a **breakeven** position.

HTW is funded directly via WG other than the pay award which is passed through the Trust commissioners in the same way as the core Trust.

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Velindre University NHS Trust

APPENDIX 2

TCS PROGRAMME FINANCE REPORT 2024-25

Period Ending 31st July 2024

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1. INTRODUCTION

1.1 The purpose of this report is to provide a financial update for the Transforming Cancer Services (TCS) Programme for the financial year 2024-25, outlining spend against budget as at 31st July 2024 and the current year-end forecast.

1.2 The TCS Programme financial position is continually monitored and updated, with an update provided regularly to both the TCS Programme Delivery Board and Trust Board.

2. EXECUTIVE SUMMARY

2.1 The summary financial position for the TCS Programme for the year 2024-25 as at 31st July 2024 is provided below. A detailed table of budget, spend and variance for the capital and revenue expenditure is provided in Appendix 1.

Expenditure Type	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Capital	£3.148m	£0	£7.132m	-£7.132m
Revenue	£0.192m	£0.666m	£0.668m	-£0.002m
Total	**£3.340m**	**£0.666m**	**£7.800m**	**-£7.134m**

2.2 The overall forecast outturn for the Programme is an overspend of £7.134m for the financial year 2024-25 against a budget of £0.666m.

2.3 No capital funding has been allocated yet for the projects for financial year, resulting in the aforementioned overspend. A funding request for the nVCC Project has been submitted to WG for c£3.8m and the EW Project funding request will be as part of the EW FBC Addendum.

2.4 The main financial risk to the TCS Programme at present is the lack of funding for the capital projects, which is being mitigated by the aforementioned funding request.

3. BACKGROUND

3.1 In January 2015 the Minister for Health and Social Services approved the initial version of the Strategic Outline Programme 'Transforming Cancer Services in South East Wales'. Following completion of the Key Stage Review in June/July 2015, approval was received from the Minister to proceed to the next stage of the Programme.

3.2 By 31st March 2024, the Welsh Government (WG) had provided a total of £63.295m funding (£60.246m capital, £3.049m revenue) to support the TCS Programme. In addition, the Trust had provided £0.264m from its discretionary capital allocation and £0.512m non-recurrent revenue funding.

3.3 NHS Commissioners agreed in December 2018 to provide annual revenue funding to the Trust to support TCS Programme, with £0.400m provided in 2018/19, increased to £0.420m thereafter.

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3.4 The current funding provided to support the TCS Programme in 2024-25 is £0.663m revenue, with no capital funding allocated as yet. This is outlined in Appendix 2. The sources of funding are summarised below.

Sources of Capital Funding

Initial Allocation (as at 1st April 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Overall Change to Allocation

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Current Allocation (as at 31st July 2024)

Project	WG Capital	Total Funding
Enabling Works Project	£0	£0
nVCC Project	£0	£0
Whitchurch Hospital Site	£0	£0
Total	**£0**	**£0**

Sources of Revenue Funding

Initial Allocation (as at 1st April 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0	£0
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0**	**£0.638m**

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Overall Change to Allocation

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0	£0	£0	£0
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0	£0	£0	£0
Total	**£0**	**£0**	**£0.028m**	**£0.028m**

Current Allocation (as at 31st July 2024)

Project	LHB Commissioners	Trust Reserves	Escrow Interest	Total Funding
PMO	£0.240m	£0.078m	£0	£0.318m
EW Project	£0	£0	£0.028m	£0.028m
nVCC Project	£0	£0	£0	£0
SDT Project	£0.180m	£0.140m	£0	£0.320m
Total	**£0.420m**	**£0.218m**	**£0.028m**	**£0.666m**

4. CAPITAL POSITION

4.1 The current capital funding for 2024-25 is outlined below:

- Enabling Works Project £0m
- nVCC Project £0m
- Whitchurch Hospital Site £0m

Total £0m

4.2 The capital position as at 31st July 2024 is outlined below, with a forecast overspend of £7.132m for 2024-25. This is due to the lack of capital funding being allocated to the projects to date this financial year.

Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Enabling Works Project	£2.288m	£0	£3.368m	-£3.368m
nVCC Project	£0.857m	£0	£3.762m	-£3.762m
Whitchurch Hospital Site	£0.003m	£0	£0.003m	-£0.003m
Total	**£3.148m**	**£0**	**£7.132m**	**-£7.132m**

4.3 A funding request for the nVCC Project has been submitted to WG for c£3.8m, and the EW Project funding request will be as part of the EW FBC Addendum.

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5. REVENUE POSITION

5.1 The revenue funding for 2024-25 is outlined below:

- PMO £0.318m
- Enabling Works Project £0.028m
- nVCC Project £0m
- SDT Project £0.320m

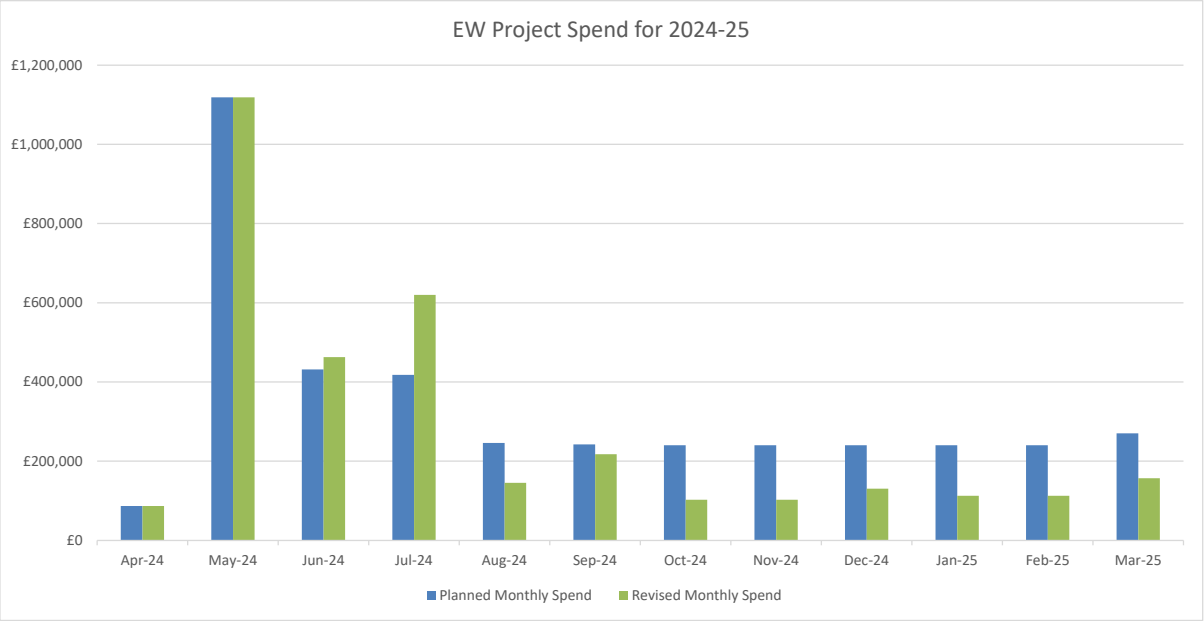
Total £0.663m

5.2 The revenue position as at 31st July 2024 is outlined below, with a forecast overall overspend of £0.002m for 2024-25 against a budget of £0.666m.

Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
PMO	£0.096m	£0.318m	£0.318m	£0
EW Project	£0	£0.028m	£0	£0.028m
nVCC Project	£0.009m	£0	£0.030m	-£0.030m
SDT Project	£0.086m	£0.320m	£0.320m	£0
Total	**£0.192m**	**£0.666m**	**£0.668m**	**-£0.002m**

6. CASH FLOW

6.1 The capital cash flow for the **Enabling Works Project** is outlined below. The actual capital spend to date is £2.288m, with a run rate to date lower than the planned spend.



6.2 The capital cash flow for the **nVCC Project** is outlined below. The actual capital spend to date is £0.857m, with a run rate to date similar to the planned spend.

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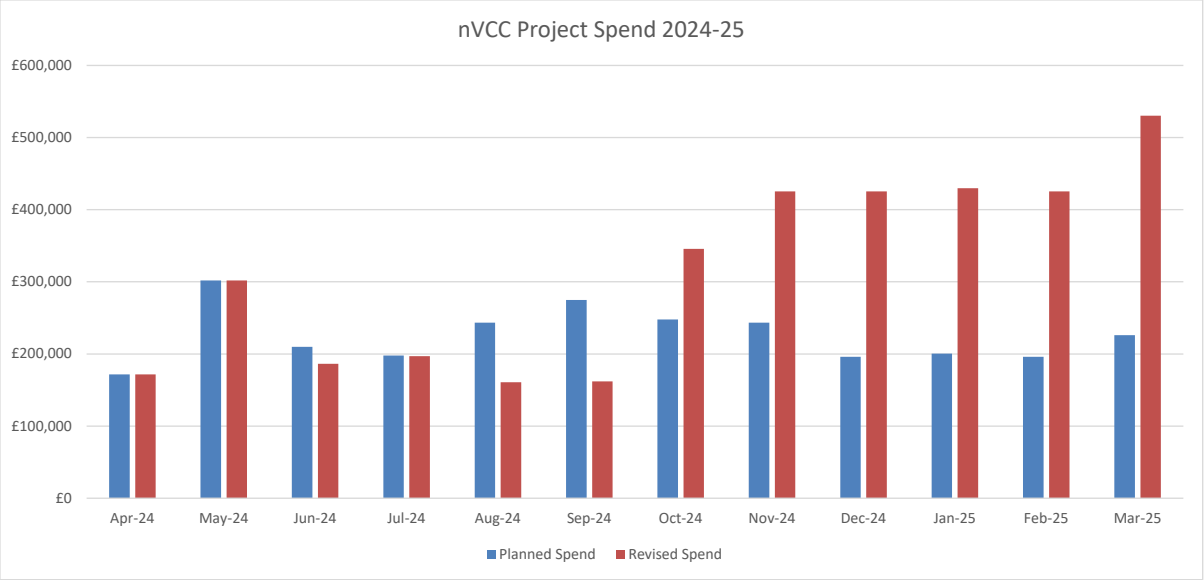

6.3 The cash flow for the remainder of the Programme is not reported as it is not of a material nature.

7. PROJECT FINANCE UPDATES

7.1 A detailed table of budget, spend and variance is provided in Appendix 1.

Programme Management Office

7.2 The current revenue funding for the PMO for 2024-25 is £0.318m, with £0.240m of this provide from NHS Commissioners' funding and £0.078m from the Trust Reserves.

7.3 There is no capital funding requirement for the PMO in 2024-25.

7.4 The revenue position for the PMO as at 31st July 2024 is shown below, with a forecast breakeven position for the year against a budget of £0.318m.

PMO Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.095m	£0.317m	£0.316m	£0
Non Pay	£0.002m	£0.002m	£0.002m	£0
Total	**£0.096m**	**£0.318m**	**£0.318m**	**£0**

7.5 There are currently no financial risks associated with the PMO for 2024-25.

Enabling Works Project

Capital

7.6 There is currently no capital funding for the Enabling Works Project for 2024-25.

7.7 The Project's financial position for 31st July 2024 is shown below. The forecast position reflects an expected overspend of £3.368m for this financial year.

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Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.079m	£0	£0.239m	-£0.239m
Non-Pay	£2.210m	£0	£3.129m	-£3.129m
Total	**£2.288m**	**£0**	**£3.368m**	**-£3.368m**

7.8 The Project spend relates to the following activities:

Enabling Works FBC Project Capital Budget & Spend Summary 2024-25

Description		Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY							
Project 1b - Enabling Works FBC		0	78,682	-78,682	0	239,173	-239,173
Pay Capital Total		**0**	**78,682**	**-78,682**	**0**	**239,173**	**-239,173**
NON-PAY							
EF02	Utility Costs	0	400,000	-400,000	0	480,000	-480,000
EF03	Supply Chain Fees	0	149,824	-149,824	0	291,324	-291,324
EF04	Non Works Costs	0	11,200	-11,200	0	76,200	-76,200
EF05	ASDA Works	0	1,106,849	-1,106,849	0	1,106,849	-1,106,849
EF06	Walters Design & Build	0	523,788	-523,788	0	1,129,588	-1,129,588
EF08	Section 278	0	0	0	0	0	0
EF09	Off Site Habitat	0	-211	211	0	-211	211
EFQR	Quantified Risk	0	0	0	0	100,000	-100,000
EFQS	QRA - SCP	0	0	0	0	0	0
EFRS	Enabling Works FBC Reserves	0	18,255	-18,255	0	-55,079	55,079
Enabling Works FBC Project Capital Total		**0**	**2,209,704**	**-2,209,704**	**0**	**3,128,671**	**-3,128,671**
TOTAL ENABLING WORKS FBC CAPITAL EXPENDITURE		**0**	**2,288,386**	**-2,288,386**	**0**	**3,367,844**	**-3,367,844**

7.9 To date this financial year no capital funding has been provided by WG for the Enabling Works Project. The EW Project funding request will be as part of the EW FBC Addendum, which needs to be submitted to outline the revised scope of the enabling works activities and Payable. The additional works activities are outlined below:

- Water main diversion
- S278 Works Longwood Drive
- HV Intake Room
- Offsite Habitat Creation

7.10 Indicative additional costs for these works were **c£2.9m**, which have been previously reported and this is set out below:

Water Main Diversion	£0.850m inc VAT
S278 Works – Longwood Drive	£1.200m inc VAT
Off Site Habitat Creation	£0.400m inc VAT
HV Intake Room	£0.450m inc VAT
TOTAL	**£2.900m inc VAT**

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7.11 However, latest costings indicate increased requirements for S278 works on Longwood Drive; fees; and offsite habitat creation. As such the increased costs could be up to **c£4.8m** and this will be outlined in the EW FBC Addendum.

7.12 This would increase the EW FBC funding request from c£28.089m to **c£32.9m**. It should be noted that this excludes any QRA or contingency required for these works.

Revenue

7.13 There is currently revenue funding of £0.028m for the Enabling Works nVCC Project for 2024-25. This is provided from the interest earned from the Enabling Works Escrow bank Account for the ASDA works.

7.14 The revenue financial position for the Enabling Works Project for 31st July 2024 is shown below, reflecting a current underspend of £0.028m for the year.

Enabling Works Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0	£0.028m	£0	£0.028m
Total	**£0**	**£0.028m**	**£0**	**£0.028m**

7.15 There is a risk of an underspend of £0.028m for the revenue element of the Enabling Works Project this financial year. However, this will be used to offset the expected revenue overspend in the nVCC Project.

New Velindre Cancer Centre Project

Capital

7.16 There is currently no capital funding for the nVCC Project for 2024-25. A funding request has been submitted to WG for this financial year.

7.17 The Project's financial position for 31st July 2024 is shown below. The forecast position reflects an expected overspend of £3.762m for this financial year.

Enabling Works Capital Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.441m	£0	£2.170m	-£2.170m
Non-Pay	£0.416m	£0	£1.591m	-£1.591m
Total	**£0.857m**	**£0**	**£3.762m**	**-£3.762m**

7.18 The Project spend relates to the following activities:

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nVCC FBC Project Capital Budget & Spend Summary 2024-25

Description	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	112,443	-112,443	0	416,208	-416,208
Project 2d - New Velindre Cancer Centre FBC	0	328,866	-328,866	0	1,754,154	-1,754,154
Pay Capital Total	**0**	**441,309**	**-441,309**	**0**	**2,170,362**	**-2,170,362**
NON-PAY						
nVCC Project Delivery	**0**	**13,043**	**-13,043**	**0**	**63,304**	**-63,304**
Work Packages						
VF01 RDD Process	0	93,263	-93,263	0	449,708	-449,708
VF02 Construction Phase	0	9,075	-9,075	0	503,075	-503,075
VF03 Professional Advisors (Call-off Basis)	0	0	0	0	100,000	-100,000
VF04 Reviews	0	160,000	-160,000	0	240,000	-240,000
VFRS nVCC FBC Reserves	0	140,276	-140,276	0	235,276	-235,276
nVCC Project Capital Total	**0**	**402,614**	**-402,614**	**0**	**1,528,059**	**-1,528,059**
TOTAL nVCC OBC CAPITAL EXPENDITURE	**0**	**856,966**	**-856,966**	**0**	**3,761,725**	**-3,761,725**

7.19 The nVCC FBC was submitted to WG at the end of June 2024. Funding should be released upon the approval of the FBC. The Trust has recently submitted the updated FBC Management Case, which indicated that the Project Delivery costs required for 2024-25 is c£3.8m.

7.20 However, it should be noted that in the financial year 2023-24, the nVCC Project incurred additional costs of c£0.646m associated to achieving Financial Close. The additional costs relate to advisory support. These costs were funded by the EW Project, and it is imperative that this funding is re-provided for the EW Project in 2024-25. The funding needs to be confirmed with WG under separate cover.

Revenue

7.21 There is currently no revenue funding for the nVCC Project for 2024-25.

7.22 The revenue financial position for the nVCC Project for 31st July 2024 is shown below, reflecting a current overspend of £0.00m for the year.

nVCC Revenue Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.009m	£0	£0.030m	-£0.030m
Total	**£0.009m**	**£0**	**£0.030m**	**-£0.030m**

7.23 There is a risk of an overspend of £0.030m for the revenue element of the nVCC Project this financial year. However, this will be offset the expected revenue underspend in the Enabling Works Project.

Whitchurch Hospital Site

7.24 There is currently no capital funding for the nVCC Project for 2024-25.

7.25 The Project's financial position for 31st July 2024 is shown below. This spend relates to legal fees associated with the Whitchurch Hospital Site. The forecast position reflects an expected overspend of £0.003m for this financial year.

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Whitchurch Hospital Site Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Non-Pay	£0.003m	£0	£0.003m	-£0.003m
Total	**£0.003m**	**£0**	**£0.003m**	**-£0.003m**

7.26 To date there is no funding provided by WG for the Whitchurch Hospital Site, however at present the risk to the Programme is low. The associated costs will be reimbursed by WG.

Service Delivery and Transformation Project

7.27 The revenue funding for the Project for 2024-25 is £0.180m from NHS Commissioners' funding and £0.140m from Trust reserves. The resulting budget is £0.320m for this financial year.

7.28 There is no capital funding requirement for the Project in 2024-25.

7.29 The SDT Project revenue position for 2024-25 is shown below, with a forecast breakeven position for the year against a budget of £0.320m.

SDT Expenditure	Year to Date Spend	2024-25 Full Year		
		Budget	Forecast	Variance
Pay	£0.086m	£0.306m	£0.306m	£0
Non-Pay	£0.000m	£0.014m	£0.014m	£0
Total	**£0.086m**	**£0.320m**	**£0.320m**	**£0**

7.30 There are currently no financial risks associated with the Project for 2024-25.

8. KEY RISKS AND MITIGATING ACTIONS

8.1 The main financial risk to the TCS Programme at present is the lack of funding for the capital projects. A funding request for the nVCC Project has been submitted to WG for c£3.8m and the EW Project funding request will be as part of the EW FBC Addendum.

9. TCS SPEND REPORT SUMMARY

9.1 At the end of 2019, a financial model was developed by the TCS Finance Team to provide a spend profile for the TCS Programme. The model allocates reported spend by year to defined deliverables and outputs within each project within the Programme. It also allocates spend to the various resources need to deliver the Programme, such as pay, advisors, suppliers, etc. The output for the model itself is an in-year report providing spend details on a quarterly basis. A cumulative report is also produced for the Programme for its inception to the end of the latest quarter.

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9.2 Appendix 3 provides cumulative report to 31st March 2024. The report for the first quarter of 2024-25 will be published in the August 2024 finance report.

9.3 The cumulative report shows a total spend for the TCS Programme of £68.635m (£63.443m Capital, £5.192m Revenue). The total pay costs for this period were £15.239m.

9.4 The spend to 31st March 2024 for each Project within the Programme is summarised below.

Programme Management Office £2.187m
Project 1 Enabling Works £34.735m
Project 2a nVCC.....£26.221m
Project 2c Whitchurch Hospital Site £0.051m
Project 3a Integrated Radiotherapy Solution.....£0.1.049m
Project 3b Digital Strategy £0.200m
Project 4 Radiotherapy Satellite £0.393m
Project 5 SACT and Outreach £0.002m
Project 6 Service Delivery and Transformation £3.798m
Project 7 Decommissioning £0m

9.5 The spend to 31st March 2024 for each financial year is summarised below.

2014-15 .....£0.328m
2015-16 .....£2.398m
2016-17 .....£6.168m
2017-18 .....£3.909m
2018-19 .....£4.267m
2019-20 .....£2.928m
2020-21 .....£3.924m
2021-22 .....£6.429m
2022-23 .....£17.365m
2023-24 .....£20.918m

9.6 The five deliverables with the highest spend during this period are:

Construction Costs £19.842m
ASDA Works.....£6.660m
Competitive Dialogue £6.196m
Advanced Design and Works £6.016m
Project Control.....£5.198m

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APPENDIX 1: TCS Programme Budget and Spend as at 31st July 2024

TCS Programme Budget & Spend 2024-25

CAPITAL	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Project Leadership nVCC	0	112,443	-112,443	0	416,208	-416,208
Project 1b - Enabling Works FBC	0	78,682	-78,682	0	239,173	-239,173
Project 2d - New Velindre Cancer Centre FBC	0	328,866	-328,866	0	1,754,154	-1,754,154
Capital Pay Total	**0**	**519,991**	**-519,991**	**0**	**2,409,535**	**-2,409,535**
NON-PAY						
nVCC Project Delivery	0	13,043	-13,043	0	63,304	-63,304
Project 1b - Enabling Works FBC	0	2,209,704	-2,209,704	0	3,128,671	-3,128,671
Project 2c - Whitchurch Hospital Site	0	2,772	-2,772	0	2,772	-2,772
Project 2d - New Velindre Cancer Centre FBC	0	402,614	-402,614	0	1,528,059	-1,528,059
Capital Non-Pay Total	**0**	**2,628,134**	**-2,628,134**	**0**	**4,722,806**	**-4,722,806**
CAPITAL TOTAL	**0**	**3,148,125**	**-3,148,125**	**0**	**7,132,341**	**-7,132,341**

REVENUE	Year to Date Budget Jul-24 £	Year to Date Spend Jul-24 £	Year to Date Variance Jul-24 £	Financial Year Annual Budget £	Financial Year Annual Forecast £	Financial Year Annual Variance £
PAY						
Programme Management Office	95,574	94,518	1,056	316,500	316,440	60
Project 6 - Service Change Team	91,256	85,842	5,414	306,246	306,246	0
Revenue Pay Total	**186,830**	**180,359**	**6,470**	**622,746**	**622,686**	**60**
NON-PAY						
Enabling Works FBC	28,434	0	28,434	28,434	0	28,434
nVCC FBC	0	9,355	-9,355	0	30,000	-30,000
Programme Management Office	1,500	1,560	-60	1,500	1,560	-60
Project 6 - Service Change Team	3,532	259	3,273	13,754	13,754	0
Revenue Non-Pay Total	**33,466**	**11,173**	**22,292**	**43,687**	**45,314**	**-1,626**
REVENUE TOTAL	**220,296**	**191,533**	**28,763**	**666,434**	**668,000**	**-1,566**

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APPENDIX 2: TCS Programme Funding for 2024-25

Description	Date	Funding Type	
		Capital	Revenue
Programme Management Office		**£0**	**£0.318m**
Commissioner's Funding	01 April 2024	£0	£0.240m
Trust Revenue Funding	01 April 2024	£0	£0.078m
Enabling Works FBC		**£0**	**£0.028m**
WG Funding - tbc	-	£0	£0
Escrow Bank Account Interest	04 June 2024	£0	£0.028m
New Velindre Cancer Centre FBC		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Whitchurch Hospital Site		**£0**	**£0**
WG Funding - tbc	-	£0	£0
Radiotherapy Satellite Centre	**-**	**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
SACT and Outreach		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Service Delivery, Transformation and Transition		**£0**	**£0.320m**
Commissioner's Funding	01 April 2024	£0	£0.180m
Trust Revenue Funding	01 April 2024	£0	£0.140m
VCC Decommissioning		**£0**	**£0**
No funding requested or provided for this project to date	-	£0	£0
Total		**£0**	**£0.667m**

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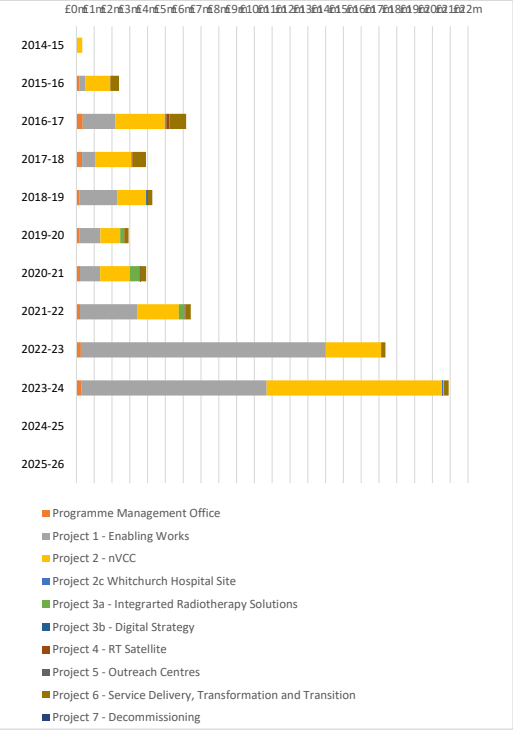
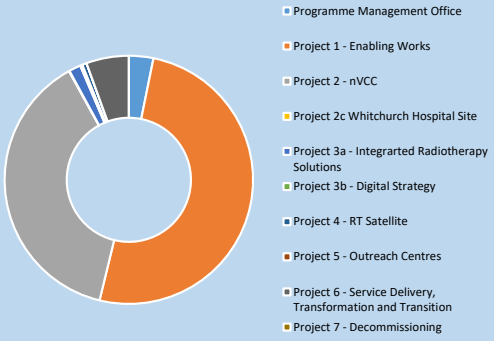
APPENDIX 3: TCS Cumulative Spend Report to 31st March 2024

SUMMARY OF CUMULATIVE TCS SPEND
TO 31 MARCH 2024

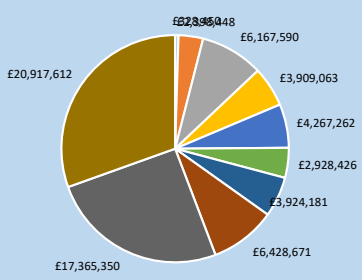
SPEND PER PROJECT PER YEAR



SPEND FOR EACH PROJECT ACROSS ALL YEARS



SPEND FOR EACH YEAR ACROSS ALL PROJECTS



TOTAL SPEND BY PROJECT TO DATE	£68,635,053
Programme Management Office	£2,186,915
Project 1 - Enabling Works	£34,734,803
Project 2 - nVCC	£26,220,533
Project 2c Whitchurch Hospital Site	£50,807
Project 3a - Integrarted Radiotherapy Solutions	£1,049,425
Project 3b - Digital Strategy	£199,786
Project 4 - RT Satellite	£393,293
Project 5 - Outreach Centres	£1,909
Project 6 - Service Delivery, Transformation and Transition	£3,797,583
Project 7 - Decommissioning	-

SUPPLIERS WITH HIGHEST EXPENDTITURE TO DATE

1	Payroll	£15,238,592
2	Walters	£14,593,900
3	Sacyr	£6,009,453
4	Asda	£5,856,199
5	Mott MacDonald	£5,840,369

PROPORATIONAL SPEND FOR EACH DELIVERABLE ACROSS ALL YEARS

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Direct Dial: 029 20 316955
Fax: 01443 843259
e-mail:Matthew.Bunce2@wales.nhs.uk

13 August 2024

Matthew Denham-Jones
Deputy Director of Finance
Health & Social Services Group
Welsh Government

Dear Matt,

Velindre Month 4 (July 2024) Monitoring Return

In line with the guidance issued, please find attached the tables required for Month 4 2024-25.

1. **Table A – Movement of Opening Financial Plan to Forecast Outturn**

   The Velindre core table has been completed in line with the Trust IMTP, NWSSP has then been combined to give the overall Trust Position.

   As included in the 2024-25 to 2026-27 IMTP the Core Trust has a balanced opening financial plan and is currently expected to deliver an outturn position of breakeven.

   Following discussions between Chief Executives, and in order to avoid arbitration, a compromise position was agreed on the LTAs specifically in relation to non-pass through of the full 3.67% uplift funding by two Health Boards and non-recurrent reduction in NICE /HCD income which has led to a financial impact to the Trust for 2024/25 as follows:

   - £318k Reduction in recurrent baseline uplift income compared to plan.
   - £483k Reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed but not expected to be material. This Health Board has given notice that the £483k funding will be removed recurrently in 2025-26 together with activity baseline funding of c£360k.

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The shortfall in LTA income has been replaced through a combination of an increased savings target and pausing previously agreed investment decisions.

Divisional cost pressures above those recognised in the IMTP Financial Plan at this stage will either need to be mitigated, funded from existing budgets in service divisions or require additional savings above the revised target of £2.876m (increase of £0.270m from the £2.606m set at the IMTP planning stage) target already identified.

2. Table A1 – Underlying Position

As per the IMTP Financial Plan the Trust brought a balanced position into 2023-24 and is expected to maintain this position over the course of the 3-year planning period.

In order to retain a balanced position, the Trust will be required to manage all current and new financial risks, deliver the agreed savings target, and mitigate or remove any cost pressures that may emerge over the course of the period.

3. Table A2 – Risks & Opportunities

Risks

There are several financial risks that could impact on the successful delivery of a balanced position for 2024-25 although the majority have now either been reduced in risk or mitigated completely. The Trust is continuing to take appropriate actions to ensure that the remaining risks are appropriately managed and mitigated against. All areas of delivery are risk assessed and where necessary identified risks are included within the Trust Assurance Framework and Trust wide Risk Register. The latest position as at month 4 is provide below.

LTA – (Medium) *(Risk reduced following LTA agreements and some crystallisation of income loss)*

The Trust has undertaken discussions with Commissioners in accordance with a number of important principles: -

- national guidance from WG regarding the principle of pass through baseline uplift funding (which for 2024/2025 was 3.67%).
- working in partnership to support all organisations to thrive and deliver safe services of a high quality.

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The key differences in LHB Commissioner positions relate to the pass through of the Recurrent uplift of 3.67%.

A clause was included within all signed 2023/24 LTAs to proceed with the contract rebase exercise and it was expected that this could be implemented from 2024/25 onwards in line with previously signed agreements. However, LHB Commissioners have not reached consensus on this matter with areas for resolution as follows:

- The baseline year for activity (currently set at 2019/20)
- The allocation adjustment to be applied to maintain cost neutrality at a system level.
- Transfer of Non Specialist services and High Cost Drugs from JCC to LHBs

Consequently, the Trust has had to prepare LTAs on an historic basis, which is not reflective of the population's utilisation of Velindre's services for Commissioners. Further, the lack of agreement regarding the transfer of service has created a contractual risk to the Trust. In order to manage and mitigate this, the Trust has needed to negotiate a second contract with JCC (value £24m) whilst the matter is resolved.

In order to avoid arbitration, discussions between Chief Executives led to a compromise position and the financial impact to the Trust for 2024/25 is as follows:

- £318k Reduction in recurrent discretionary income compared to plan.
- £483k Reduction in non-recurrent income compared to plan with **a further risk to non-recurrent position still to be confirmed but not expected to be material**.

The contract model rebase is still required to align with the new contracting model so that allocations from WG to LHBs are aligned with spend on Velindre's services on local population basis. Discussions with Commissioners will continue in 2024-25 to resolve the matter.

Non-Delivery of Savings - (Low)

The Trust has identified a revised savings target of £2.876m to be achieved during 2024-25. The savings target was originally set to ensure that the Trust had the ability to mitigate against the significant cost pressures within the service, and then increased in order to help support the loss of income from the LTA agreements.

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One Scheme remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

Whitchurch Hospital Site Transfer – Financial Consequences – (Low)

The Trust submitted a paper to the WG Health Strategy Board (HSB) held on 8th March setting out all the cost implications of the land & hospital transfer and future disposal / development. WG HSB approved in principle the proposed approach and funding of the costs. The annual revenue costs are expected to crystallise as a cost pressure when the land is legally transferred to Velindre UNHST from C&VUHB. The official transfer is imminent and is expected to take place in the next couple of months once as we finalise the detail. Once the land is transferred to the Trust, the annual revenue cost pressure would remain on a recurrent basis, until the disposal or development of the residual Whitchurch estate. It is expected that the Trust will need to incur future capital cost to make good and dispose of the site.

The annual costs include site security, utilities and maintenance/upkeep of the Whitchurch hospital and site based on information provided by C&VUHB. These are forecast to be £0.640m (Exc VAT). The Trust doesn't have a formal funding letter yet, however the Deputy Chief Executive NHS Wales confirmed in a letter to VUNHST CEO and Cardiff and Vale LHB CEO on 26 March 2024 that the Health Strategy Board is aware of the on-going revenue costs that are linked to the site which will initially be covered by the Welsh Government but will be offset against any future disposal receipts for the site. The proposed funding model for this arrangement will need to be agreed between WG and VUNHST as the Trust will require revenue funding to cover the annual costs, whereas the proposed funding source is a future capital receipt on disposal. At the Trust CRM in May 2024, WG's Deputy Director for NHS Capital, Estates and Facilities confirmed the Trust should invoice the Capital Finance team for the revenue costs incurred so therefore the risk has been reduced to low.

The site surveys, transaction and disposal costs are estimated at £0.300m (Exc VAT) and the make safe cost for the Whitchurch Hospital is estimated at between £1.65m - £2.73m (Exc VAT) subject to negotiations with WG and Cardiff Council. These costs require agreed capital funding as part of the All Wales Capital Funding Programme.

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Rise in Energy Prices above forecast MTP plans- (High)

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Latest forecast schedule from NWSSP suggests that the Trust energy costs for 2024-25 will be c£1.745m this will leave a shortfall of £0.142m against the budget of £1.603m (£1.040m underlying budget plus £0.563m funding provide by WG) which is held by the Trust.

Management of Operational Cost Pressures – (Low)

There are several cost pressures that are already within the service which are expected to be managed in line with normal budgetary control procedures or through utilisation of the Trust reserve. However, due to the current demands on the service there is a small risk that these current pressures may be beyond divisional control which is being recognised within the table.

In addition, new cost pressures may materialise over the period which may be beyond divisional control or ability to manage through the overall Trust funding envelope.

Opportunities

Vacancy Turnover – (Low)

Further vacancy turnover savings above the savings target and vacancy factor held in divisions.

Emergency Reserve – (Medium)

It is important that the Trust keeps a reserve for emergency cost pressures which may arise over the course of the year, however, if this reserve is not required during 2024-25 then like in 2023-24 the Trust may be in a position later in the year to release this funding on a non-recurrent basis.

Reduction in Energy Prices – (Low)

At this stage the funding received to support the increase in energy prices is expected to be required by the Trust, however whilst unlikely given the latest forecast position from NWSSP if costs were to reduce then an opportunity may crystalise.

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As requested, the pipeline opportunities which are largely savings which would be passed on to our commissioners have been removed so that the narrative is reflective of what is included in the table. **(Action Point 3.1).**

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Table B – Monthly Positions

The Trust position for the period ended July 2024 as reported in table B is a £0.008m underspend, and an outturn forecast position expected of breakdown for 2024-25.

The combined table is produced by adding NWSSP to the Trust Core return.

The DEL and AME depreciation has been updated to reflect the latest non-cash submission which was re-submitted on the 19th July following a thorough review of the calculation. The accelerated depreciation associated with the current VCC site has been included but is subject to n VCC FBC sign off. The asset impairment required in relation to the Asda Enabling Works is still under review, however expected to be charged in 2024-25 in line with the IMTP planning assumptions and will be included in the Enabling Works FBC Addendum and subject to approval.

Monthly position Variance Analysis

Income is in line with the Trust IMTP plans however previous funding re-categorisation between the HB's and JCC has been reversed given that the Contract Rebasing exercise was not agreed as part of the LTA discussions.

The Contract Rebasing exercise was reflective of enacting the new LTA agreements established at the Directors of Finance Forum on 19th July 2019, for Velindre and JCC Cancer Services. This adjustment should be cost neutral to the Trust according to the previously agreed principles, but one Health Board has formally stated that it does not agree with this principle. The contract rebasing provides a more accurate reflection of resource consumption by Commissioners based on the usage of Velindre's cancer services by their respective populations. Discussions on the re-basing exercise are to re-commence with Commissioners during this year.

WG income movement is reflective of the change in depreciation requirement for 2024-25 as highlighted above.

The non-pay expenditure reduction is largely a combination of the increased savings target with further re-alignment to non-pay costs c£0.400m thus reducing the spend, pausing of investment decisions and mitigation of cost pressures. **(Action Point 3.1)**

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Pay & Agency (Table B2)

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Welsh Blood Service Gwasanaeth Gwaed Cymru

Canolfan Ganser Felindre Velindre Cancer Centre

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Of the £0.398m agency spend reported at the end of July, £0.222m relates to Velindre core divisions, with the remaining balance being related to NWSSP.

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. As evident in the tables reliance on Admin and Clerical agency has reduced from last year, but is still required to support vacancies, however the ambition is that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

Variable Pay

Medical staff continue to work extra hours to support additional activity and cover both vacancies and sickness. A review continues to be underway within medical to triangulate activity to additional sessions being worked.

Where possible the Trust will utilise bank staff in order to reduce reliance on agency and the premium costs associated.

4. Covid-19 (Table B3)

The Trust is currently not expected to draw down any covid funding support during 2024-25. However, if at any point in the future the Trust is required to support the LHBs with any further vaccination programme then it is assumed that funding will be provided by WG to support any incurred costs.

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5. **Savings (Table C – C4)**

As highlighted earlier a revised savings target has been set following the conclusion of negotiations on the LTA agreements. An additional £0.270m was required in order to help mitigate the loss in income from the LTA agreements taking the savings target to a revised target of £2.876m.

The private patients scheme remains in amber as Trust is assessing the external expert private patient management support it requires to facilitate delivery of the scheme, however we expect that once the external support contract is signed the income generation will be realised turning the scheme green. If not, a replacement savings scheme will be found, or the Trust can utilise one of the opportunities such as the emergency reserve mitigating any risk. **(Action Point 3.3)**

6. **Welsh NHS Assumptions (Table D)**

Following discussions with the HB's and other NHS Trusts the I&E position should be in agreement for month 4.

As described earlier the Trust has agreement with our commissioners around the financial quantum within the LTAs which realised a loss in income of £801k for 2024-25. The commissioners are however still discussing some of the principles contained with the LTAs to ensure a collective agreement. We expect this to be resolved in the short term. **(Action Point 3.4).**

7. **Invoiced Income (Table E1)**

The Total income for the year is shown within Table E.

8. **SoFP (Table F)**

The table has been completed for month 4 in line with the guidance.

9. **Cash Flow (Table G)**

The cash flow has been completed in line with the guidance for month 4.

10. **PSPP (Table H)**

We are pleased to report that as of July the Trust continues to achieve the 95% target of Non-NHS invoices being paid within 30 days.

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The Trust will continue to work with NWSSP colleagues with the aim of achieving the 95% NHS invoice target during 2024-25.

The 10 day forecast projection outturn will be updated accordingly for the quarter 2 submission **(Action Point 3.5).**

11. Capital Tables (Table I-K)

There are several schemes that are included within the table that are not currently on the Trust CEL, however, are under discussion with WG Capital colleagues with the Trust anticipating that funding will be approved to support these schemes during 2024-25. However, the Trust is currently carrying a significant financial risk of £0.859m spend to July '24 (Forecast £3.762m) in relation to the n VCC Project as well as Enabling Works project with spend to July '24 of £2.289m (Forecast to year end £3.368m), not including the addendum commitments. In addition, the Trust has had to commit further costs in relation to the PwC Governance review recommendations (£0.774m) and early recruitment of essential posts to progress the nVCC project delivery (£1.331m).

The Trust informed WG Capital colleagues at the CRM meeting on the 30th July that there is a potential risk to delivery of the Brachytherapy equipment before the financial year end with the Trust currently exploring storage options such as IP5, therefore the risk has been updated too medium. WG Capital colleagues have also been informed of possible slippage on the funding awarded on the BECS replacement scheme with the expected costs for 2024-25 currently being worked up by service. Schemes that are still subject to receiving funding are risk rated as high.

We have been informed by WG Capital colleagues that the liquid nitrogen scheme which was supported in principle for funding was not approved, so has been removed from the table. The requirement however still remains, and the Trust is hopeful that it can either be supported from Capital year end spends or will be required from next years Capital allocation.

12. EFL (Table L)

This table has been completed in line with the guidance for month 4.

The latest annual capital spend has been updated to align with the Capital spend amount reported in table I **(Action Point 3.6)**

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13. Aged Debtors (Table M)

There are currently no invoices that are older than 17 weeks for Velindre Core Trust.

14. Ringfenced (Table P)

This table has been completed in line with the guidance for month 4.

Th WG annual income allocation column has now been completed for each scheme in line with the anticipated expectation for 2024-25 **(Action Point 3.7).**

15. IFRS 16 (Table Q)

The table has been completed in line with the guidance for month 3.

16. Other

This letter and relevant tables from the MMR will be presented to the Trust Quality, Safety and Performance Committee in September 2024.

Conclusion

I confirm that the financial information reported in the Trust monitoring return is in line with the financial strategy information reported to the Velindre Trust Board.

Should you have any queries please do not hesitate to contact Steve Coliandris in the first instance.

Matthew Bunce
Executive Director of Finance

Velindre UNHS Trust

Carl James
Interim Chief Executive Officer
Velindre UNHS Trust

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Velindre Trust **Period : Jul 24**

Table A - Movement of Opening Financial Plan to Forecast Outturn

This Table is currently showing 0 errors

Line 14 should reflect the corresponding amounts included within the latest IMTP/AOP submission to WG
Lines 1 - 14 should not be adjusted after Month 1

		In Year Effect	Non Recurring	Recurring	FYE of Recurring
		£'000	£'000	£'000	£'000
1	Underlying Position b/fwd from Previous Year - must agree to M12 MMR (Deficit - Negative Value)	0	0	0	0
2	Cost Pressures (Non Covid-19) (Negative Value)	-40 241	-20 268	-19 973	-19 973
3	Planned Expenditure For Covid-19 (Negative Value)	0	0		
4	Allocation Letter Revenue Funding Uplift / (Reduction)/ WG RRL / WG Income Uplift / (Reduction/ Non-Covid)	19 598	18 964	634	634
5	Planned Welsh Government Funding for Covid-19 (Positive Value)	0	0		
6	Other Income Uplift / (Reduction)	18 037	0	18 037	18 037
7	RRL Profile - phasing only (In Year Effect / Column C must be nil)	0	0	0	0
8	Planned (Finalised) Green and Amber Savings Plan	819	539	280	230
9	Planned (Finalised) Net Income Generation	1 277	875	402	402
10	Planned Profit / (Loss) on Disposal of Assets	0	0	0	0
11	Planned Release of Uncommitted Contingencies & Reserves (Positive Value)	0	0		
12		0	0		
13	Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	510	115	395	395
14	**Opening IMTP / Annual Operating Plan**	**0**	**225**	**-225**	**-275**
15	Reversal of Red, Pipeline and Planning Assumption Savings still to be finalised at Month 1	-510	-115	-395	-395
16	Additional In Year & Movement from Planned Release of Previously Committed Contingencies & Reserves (Positive Value)	0	0		
17	Additional In Year & Movement from Planned Profit / (Loss) on Disposal of Assets	0	0		
18	Other Movement in Month 1 Planned & In Year Net Income Generation	405	45	360	360
19	Other Movement in Month 1 Planned Savings - (Underachievement) / Overachievement	-51	-1	-50	0
20	Additional In Year Identified Savings - Forecast	325	50	275	275
21	Variance to Planned RRL & Other Income	0	0		
22	Additional In Year & Movement in Planned Welsh Government Funding for Covid-19 plus virements (Positive Value - additional)	0	0		
23	Additional In Year & Movement in Planned Welsh Government Funding (Non Covid) (Positive Value - additional)	0	0		
24	Additional In Year & Movement Expenditure for Covid-19 (Negative Value - additional/Postive Value - reduction)	0	0		
25	In Year Accountancy Gains (Positive Value)	100	100	0	0
26	Net In Year Operational Variance to IMTP/AOP (material gross amounts to be listed separately)	0	0		
27	Net loss of LTA Income following Commissioner Agreement	-801	-483	-318	-318
28	Reduction in Cost Pressures / Paused Investment Choices	532	179	353	353
29		0	0		
30		0	0		
31		0	0		
32		0	0		
33		0	0		
34		0	0		
35		0	0		
36		0	0		
37		0	0		
38		0	0		
39		0	0		
40	**Forecast Outturn (- Deficit / + Surplus)**	**0**	**0**	**0**	**0**
41	**Covid-19 - Forecast Outturn (- Deficit / + Surplus)**	**0**			
42	**Operational - Forecast Outturn (- Deficit / + Surplus)**	**0**			

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	In Year Effect
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
1	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-3 353	-13 414	-40 241
3	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	1 633	1 633	1 633	1 633	1 633	1 633	1 633	1 633	1 633	1 633	1 633	1 633	6 533	19 598
5	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6	1 503	1 503	1 503	1 503	1 503	1 503	1 503	1 503	1 503	1 503	1 503	1 503	6 012	18 037
7	55	55	55	-18	-18	-18	-18	-18	-18	-18	-18	-19	147	0
8	68	68	68	68	68	68	68	68	68	68	68	68	273	819
9	94	94	94	111	111	111	111	111	111	111	111	111	392	1 277
10													0	0
11													0	0
12													0	0
13				57	57	57	57	57	57	57	57	57	57	510
14	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
15	0	0	0	-57	-57	-57	-57	-57	-57	-57	-57	-57	-57	-510
16	55	55	-110										0	0
17													0	0
18	0	0	0	17	29	51	51	51	51	51	51	51	17	405
19	0	0	-4	4	3	-8	-8	-8	-8	-8	-8	-8	0	-51
20	0	0	15	34	34	34	34	34	34	34	34	34	49	325
21													0	0
22	0	0	0	0	0	0	0	0	0	0	0	0	0	0
23													0	0
24	0	0	0	0	0	0	0	0	0	0	0	0	0	0
25	0	0	0	100	0	0	0	0	0	0	0	0	100	100
26	-50	-52	126	-72	9	5	5	5	5	5	5	6	-47	0
27			-80	-80	-80	-80	-80	-80	-80	-80	-80	-80	-160	-801
28			53	53	53	53	53	53	53	53	53	53	106	532
29													0	0
30													0	0
31													0	0
32													0	0
33													0	0
34													0	0
35													0	0
36													0	0
37													0	0
38													0	0
39													0	0
40	**5**	**2**	**1**	**0**	**-7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**0**
41	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
42	**5**	**2**	**1**	**0**	**-7**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**8**	**0**

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Quality, Safety and Performance Committee

2024-2025 Quarter 1 Trust Quality & Safety Report

DATE OF MEETING	12th September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT
REPORT PURPOSE	DISCUSSION
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Trust-wide & Divisional Quality & Safety Teams
PRESENTED BY	Tina Jenkins, Head of Quality, Safety and Assurance. Viv, Cooper, Head of Nursing and Quality and Peter Richardson, Assistant Director of Quality WBS.
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	This is the Trust's first integrated quarterly Quality & Safety report, produced collaboratively by the three quality hubs: Trust wide; Welsh Blood Service; Velindre Cancer Service. Highlights from the report includes: • The report shows high levels of patient and donor satisfaction. VCC 96% AND WBS 98%. SACT and Pharmacy show lower levels of satisfaction, however low survey completion rates hinder the ability to draw meaningful analysis. • Compliance with Putting Things Right timescales for complaints responses within 30 working days is 87.5% (national target 75%). • One incident in Velindre Cancer Service triggered the Duty of Candour. The incident relates to failure to request clinal investigation and was assessed as potentially causing moderate harm to a patient. The investigation

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	is underway. • No new referrals to the Public Service Ombudsman since October 2023, which is a positive indication of the Trust's handling of concerns process. There are no current open cases, and all improvement plans are completed.

RECOMMENDATION / ACTIONS	To ***DISCUSS*** the Velindre University NHS Trust Quarter 1 Quality & Safety Report.

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)	31st July 2024
Executive Management Board	29th August 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS ***IQ&SG:*** The group endorsed the report and agreed some changes. The group discussed the dilemma regarding low reporting data e.g. Duty of Candour, National Reportable Incidents, and Safeguarding Reports to ensure information is not identifiable, recognising our trust responsibilities around Duty of Quality reporting and transparency. If data suppression took place due to low reporting of numerical data, we would not be able to provide evidence of activity or assurance. The group agreed to ensure narrative to accompany the data is generic to ensure that data is as unidentifiable as possible. This process aligns with data protection principles. ***Executive Management Board:*** New format combining what would have previously been 6 separate reports and the assigned assurance rating was commended and endorsed. A few points of accuracy were raised and subsequently amended. The risks posed by the delay in progressing the development of the Quality Metrics / Quality Outcome Framework was discussed and a clear plan of delivery (including always on reporting) requested by the next meeting.	

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	2024-25 Quarter 1 Trust Quality & Safety Report

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1. BACKGROUND

A new reporting arrangement was agreed at the February 2024 Integrated Quality & Safety Meeting, as follows:

"A quarterly and annual fully integrated quality & safety report will be co-produced by the three quality hubs (led by the Deputy Head of Quality & Safety) providing succinct data driven analysis of key outcomes, activity, learning and improvement during the quarter as well as contextualizing over time. This will meet all legislative requirements i.e Putting things Right Regulations, Mortality Duty of Candour & Duty of Quality. This will amalgamate the current reports each quarter with focus on the 'so what', learning & improvement:

- VCC Divisional Report
- WBS Divisional Report
- Infection Prevention & Control
- Safeguarding and Vulnerable Groups
- Safety Alerts
- Datix standards
- Putting things Right
- Claims, inquests, compliments
- Information Governance
- Health & Safety
- Quality outcome metric overview
- Mortality
- Regulatory compliance
- Assurance visits / inspections
- Learning from external reports"

2. ASSESSMENT AND SUMMARY OF MATTERS FOR CONSIDERATION

The 2024-2025 Quarter 1 Trust Quality & Safety Report is attached. The report provides detail on the Trust's quality & safety activity between April and June 2024. This is the Trust's first fully integrated quality & safety report that has been co-produced by the three quality hubs. The report provides succinct data driven analysis of key outcomes, activity, learning and improvement during the quarter as well as contextualising over time. This will meet the legislative requirements in line with the Putting Things Right Regulations (2011) & Health and Social Care (Quality and Engagement) (Wales) Act (2020), and maintains a strong focus upon learning and improvement, to ensure the continued provision of Safe, Timely, Effective, Efficient, Equitable and Person-Centred Care.

The report also identifies priority areas for quarter 2, including:

- The quality hubs will undertake focused work using the Yorkshire Contributory Factors Framework (a tool that helps map the potential factors that led to a patient safety incident) to identify trend analysis learning from specific incident themes.
- To develop a patient and donor satisfaction survey to gather experience feedback following the concerns process.
- To develop a proportionate investigation template to improve consistency of

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investigations and put staff, patient's and donors wellbeing and feedback at the centre of the process.

- To further develop collaborative working opportunities through the quality hubs to optimise quality and safety outcomes and support learning and continuous improvement.

2.1 Areas for Escalation from the Trust Integrated Quality and Safety Group.

Quality Dashboard - Ongoing delay in progressing with Trust Quality due to competing demands on the BI Team – this was planned to be in place from April 2024 the risks regarding there remains no timescale for further progression of the Quality Metrics / Quality Outcome Framework. Mortality data is being worked through currently but a plan beyond this is awaited (including roll out of Always on Reporting). This is impacting on the overall assurance rating of the Integrated Quality and Safety Group. An action was taken to review the plan and measures that were previously approved at Executive Management Board are still relevant and considering any areas were there may be duplication.

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 ☒

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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.
	Source of Funding: Choose an item
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) The Trust has a requirement to comply with legislations and regulations. These include. *Mental Capacity Act (2005)* *Social Service and Welling Wales Act (2014)* *Putting Things Right Regulations* *Health & Safety at Work Act (1974)* *General Data Protection Regulations (2016)* There is evidence of compliance contained within the report.

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.

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Quality Safety and Performance Committee

VELINDRE UNIVERSITY NHS TRUST PERFORMANCE MANAGEMENT FRAMEWORK REPORT AND SUPPORTING ANALYSIS FOR JULY 2024/25.

Date of meeting	**12TH SEPTEMBER 2024**
PUBLIC OR PRIVATE REPORT	**Public**
IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**
REPORT PURPOSE	**INFORMATION / NOTING**
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**
Prepared by	**Peter Gorin, Head of Strategic Planning and Performance. Rachel Hennessy, Acting Director of Velindre Cancer Services, Sarah Richards, Head of Planning and Performance Services**
PRESENTED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital, Rachel Hennessy, Acting Director VCS, Alan Prosser, Director WBS, Sarah Morley, Executive Director OD & Workforce, Matthew Bunce, Executive Director of Finance**
APPROVED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital**

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EXECUTIVE SUMMARY	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) OVERVIEW** **The report now includes an overview of the development of the Performance Management Framework. For this report, there is a summary of the work packages provided. From the November report, this will be in the format of a clear PMF Plan for each work package, with associated SMART actions. The PMF Plan will also be informed by discussion at the Trust Board Development day in October 2024.** **THE PERFORMANCE HIGHLIGHTS FOR THE PERIOD TO JULY 2024/25 ARE:** **Velindre Cancer Service** **SACT Services:** The June performance was 100% for emergency SACT and 88% for SACT non-emergency. Currently the July position is undergoing validation and is 65%, which is slightly ahead of the June 'unvalidated' position. However, non-emergency performance continues to be challenging. In response to this business continuity plans are still in place. A biweekly VCS SACT demand planning group has been established reporting to a biweekly SACT GOLD, chaired by the Executive Director of Nursing. **Radiotherapy Services:** • Radiotherapy performance for July was 82% for Scheduled, 74% for Urgent, 100% for Emergency and 98% for elective delay. All against a 100% compliance target. Performance continues to be challenging during the Linac replacement programme. **Welsh Blood Service** • WBS met all clinical demand in July and were able to support NHSBT with 70 units of 0- as part of mutual aid. Performance for this metric has remained stable since April, despite recurring staffing pressures within the Collection Teams, including increased sickness and annual leave arrangements affecting capacity. The service remains under pressure in terms of supply matching demand and is working up a resourcing plan to increase collections across Wales. • The recovery plan for bone marrow volunteer recruitment is showing encouraging results again for July since the launch of buccal swab drives in late January 2024. Performance increased with 676 donors added to the panel for July (against a target of 333). • For donors recruited on swab drives during July (who shared their ethnicity), donors from a black, Asian, mixed or minority ethnic heritage made up 15% of the total monthly recruitment (against current population ethnicity data in Wales of 5.8%).

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

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

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

APPENDICES	
1	**Velindre Cancer Services – PMF Supporting KPI Data Graphics and Analysis**
2	**Blood and Transplant Services – PMF Supporting KPI Data Graphics and Analysis**
3	**Trust-wide Services – PMF Supporting KPI Data Graphics and Analysis**
4	**Potential Clinical Quality and Safety measures under development**
5	**Analysis of Current Range of PMF Performance Measures and Level of Statutory Compliance**

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ACRONYMS	
VUNHST	Velindre University NHS Trust
QSP	Quality Safety and Performance Committee
EMB	Executive Management Board
SLT	Senior Leadership Team
PMF	Performance Management Framework
QSF	Quality Safety Framework
KPI	Key Performance Indicators
SPC	Statistical Process Control Charts
SMART	Relating to goal setting – "Specific, Measureable, Achievable, Relevant, Time-based"

1. SITUATION AND BACKGROUND

VELINDRE NHST PERFORMANCE REPORT FOR JULY 2024

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

PMF Development Overview

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Overview of PMF Development Work Packages:

1.1 Analysis of Current Range of PMF Performance Measures and Level of Statutory Compliance

An exercise has been undertaken to show the current level of compliance against the whole range of VCS, WBS and Trust-wide support functions performance measures (KPIs) across statutory/mandatory, best practice/benchmarks and locally determined stretch targets.

The result of this exercise is given in **Appendix 5** which shows that out of the total 111 KPIs (54 statutory; 17 best practice; 40 local) we are compliant with the majority of targets with only 17 areas of non-compliance. The areas of statutory non-compliance are in VCS RT and SACT timeliness and PADR and sickness targets.

However, the Health and Social Care (Quality and Engagement) Wales Act which came into force on 1 April 2023 places a number of additional reporting requirements. The mechanisms to report on these areas are being developed. In particular, the Quality Act requirement for 'always on' reporting on key performance areas.

1.2 Wider inclusion of Quality Metrics into the PMF

Appendix 4 provides an overview of the Duty of Quality & Always On reporting requirements and Trust current levels of compliance. The Quality and BI teams are working to implement the requirements as previously agreed by Executive Management Board (EMB). At time of paper circulation an overview of timings has not been agreed however, this will be further worked on and a verbal update provided in Quality, Safety & Performance Committee (QSP) and also Trust Board. This will then be included in the full project plan for November reporting cycle, however it is expected that progress will have already been made.

1.3 Single Source of the Truth for Data, Mapped to Pathways

It is agreed that regionally this is an important priority and links to actions in the Cancer Improvement Plan 2023-6.

Extract from Cancer Improvement Plan:

"In Wales, data on cancer patients is fragmented and is collected and held by a number of different organisations with varying roles and responsibilities. There is no single organisation that has ownership of the responsibility to use data for patient benefit. This accounts for the high levels of frustration, built up over many years, from a wide range of stakeholders, about the lack of a cancer intelligence function in Wales with responsibility for analysing data at cancer site, population and provider level with sufficient granularity to actually enable service change. The development of innovative digital solutions must be a key component of the recovery of Cancer Services. Minimal progress has been made on delivering the actions set out in the Cancer Information and Intelligence Framework; A Digital Health Strategy for Cancer in Wales 2017-2020. A key component of this strategy was improved data sharing and collection to benefit patients, professionals and the system. Direct patient access or held summaries of their treatment will help enable the balancing of healthcare pathways, activity and decision making between the professional and patient: a key component of the quadruple aim in A Healthier Wales (Welsh Government, 2019)15. Wales urgently needs to make progress in taking forward the actions set out in the Framework and address the deficit in the availability of cancer intelligence to improve care and outcomes. The Wales Cancer Network will lead development of a refreshed Digital Cancer Plan deriving this from the refreshed National Digital Healthcare Plan."

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The Trust is working with Commissioning Health Boards and via the Regional Cancer Board to ensure that the regional is effectively prioritising this development; working effectively with Public Health Wales, Wales Cancer Network and Digital Health and Care Wales on the responsibilities to deliver effective cancer data; taking specific action as a region and individual organisations promptly to address this issue. Again, further details will be provided to EMB, QSP and Trust Board and included in the PMF Plan.

1.4 Inclusion of all Targets

For the next reporting cycle, any metrics without a target will include a target or a date by which the target will be agreed and rationale for delay.

1.5 Exception/ Threshold Reporting

At the Board Development in October, there will be a discussion on how to most effectively start either exception or threshold reporting. This will then be enacted from the November reporting cycle onwards. To inform the discussion, mock ups of the options based on September data will be drafted.

1.6 Future PMF Development Plans

All VCS and WBS Directorates and Trust-wide functions are reviewing their metrics to discuss proposed changes with the Trust Board. This to include any further additional Quality metrics. Any changes to PMF would then be governed via Executive Management Board and Strategic Development Committee into Trust Board.

1.7 PMF Automation

Work is also progressing to 'automate' the production of the PMF performance report to reduce the current level of manual interactions in the current process. This work with the support of Business Information colleagues plus associated transition training will be completed from the November reporting cycle.

2. Cancer Centre Services Overview

Radiotherapy

- 100% of patients requiring emergency radiotherapy treatment began treatment within required timescale (target 100%).
- 82% of patients referred for scheduled radiotherapy treatments began treatment within 21-days of the decision to treat in July. This was an increase in performance from 76% in June 2024.
- Compliance with the 7-day time-to-treatment target for urgent symptom control radiotherapy treatment improved from 72% in June 2024 to 74% in July 2024 against a target of 100%.

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There has been an increase in performance since the extended service contract has been sourced for LA1 1st May 2024, therefore increasing capacity available.

Plans are in place to mitigate the impact of the Linac replacement programme, but this is expected to be challenging for the service.

In addition to capacity challenges, a review of referrals that did not achieve treatment within mandatory target identified trends in relation to change in patient conditions resulting in requirement for patients to be rescanned and re-planned, Linac breakdown, and delay in delineation as a result of staffing capacity.

Longest waits

Scheduled	Number referrals	297
	% within 21 days (target 100%)	243 (82%)
	Longest wait	38 days
	97% (288) patients seen within 28 days*	
Urgent SC	Number of referrals	46
	% within 7 days (target 100%)	33 (74%)
	98% (45) patients seen within 14 days*	

**previous JCCO guidance*

Patients are prioritised and offered the first available appointment in response to the clinical urgency of their pathway- whilst taking into account the patients' needs and in accordance with the access to treatment procedure.

When demand exceeds capacity, all referrals are submitted through escalation where prioritisation and clinical harm assessment is undertaken to ensure that patients are treated in accordance with clinical priority. Where developments/ upgrades of systems continue as part of the IRS programme impacting on capacity, a risk assessment is undertaken identifying appropriate mitigation to reduce the risk of breaching the radiotherapy standards of care.

All failures to meet WG time to radiotherapy standards are investigated at pathway level to identify maximum wait and understand the root cause. Themes coming through as part of the root cause analysis and use to design mitigations where possible.

Service level pathway development identifying best practice and efficiencies is ongoing, this has been integral to the development of care paths.

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Through the All Wales Cancer Performance Management group, it has been established that the three Cancer Centres in Wales have historically utilised inconsistent data definitions for the Emergency Time to Radiotherapy measures. The agreed future definition will include measuring the 24-hour timescale from the point of receipt of the referral to radiotherapy. Velindre Cancer Centre has always adopted this measure.

SACT

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

For the month of June 2024:

- 100% of emergency patients were all treated within the target of 5 days, maintaining the 100% performance of the last 12 months.
- Non-emergency patient performance improved from 76% compliance to 88% compliance, with a reduction in breaches from 107 to 41. The longest patient waited 35 days.
- July 65% ('unvalidated' position)
- All patients within a trial are booked as per the trial timeframes.

Longest Waits Non-Emergency

Wait time	referrals	percentage
0-7 days	132	39.8%
8-14 days	44	13.3%
15-21 days	133	23.1%
22 - 28 days	32	10.7%
29 - 35 days	9	5.1%
36 – 42 days	0	0%
43 – 49 days	0	0%
50 – 52 days	0	0%
Total	**341**	

Daily escalation meetings are taking place and patients are being clinically prioritised and will undergo a harm review if deemed clinically appropriate.

Business continuity plans have been initiated in January 2024 and are still in place. A VCS SACT demand planning group has been established and has developed plans to increase capacity across the service. It reports into the GOLD command meeting chaired by the Executive Director Nursing, to give Executive oversight and support in respect of SACT performance.

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This level of rigour is anticipated to positively impact performance by August/September 2024, with some interim improvements supporting marginal improvement in capacity from late June. Work is continuing with Digital Insight team to develop a 'single source of truth' for each patient pathway as well as understanding the demand for individual components of the service including oral and parental SACT, pharmacy, nursing and booking.

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

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

Pressure Ulcers
There was 1 Avoidable Pressure Ulcer reported for July, the first for 7 months.

Falls
No Avoidable Falls were identified for the 17th consecutive month.

Delayed pathways of care
There was one patient with a delay of 21 days, due to awaiting a package of care to support their discharge home.

Patient Experience
Both Patient experience measures reported 98% and 96% compliance against an 85% target. Responses are anonymous so we do not have significant details to follow up. Key themes link to waiting times in outpatient clinics. There are multiple pieces of work focussing on outpatient improvement including the work linked to SACT GOLD. Volunteers have returned to outpatients in May 2024. Screens are being utilised to communicate length of waits to patients within the area.

1.2 Welsh Blood Service Overview

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All clinical demand was met in July. While O+ blood levels were under pressure on 1st July and A+ in the final week of the month, no alerts for customer hospitals were necessary.

Performance in quality incidents closed within 30 days continues to exceed target (90%) at 97% this month. No adverse events were submitted to the Medicines and Healthcare products Regulatory Agency (MHRA) or the Human Tissue Authority (HTA) in July.

Donor satisfaction continues to exceed the target (95%) reaching 97% in July. 7,827 donors were registered at donation clinics with 3 informal concerns being raised (0.03% of all donors registered). All 3 concerns were managed within the 2-day timescale required under the 'Putting Things Right' guidelines. There were no formal concerns raised in July.

All clinical demand for platelets was successfully met, reflecting strong performance in this area. Platelet wastage, which reached 10%, has significantly improved, achieving the target of 10% in July. WBS is actively analysing issuing data to identify demand trends and make necessary adjustments to platelet production. Additionally, a review of the Platelet Strategy is currently in progress as part of the WBS Futures initiative.

Collection efficiency performance decreased slightly in July (1.13) against a target of 1.25. Performance this month can be attributed to staffing pressures including an increase in staff absence due to sickness and annual leave. Five new staff were recruited to the Bangor Collection Team in July which will support increased resilience going forward.

There were 4 Peripheral Blood Stem Cell (PBSC) collections in July against a target of 7 collections per month. The total cell provision for the service in July was 9 (4 stem cell collections from Welsh donors, and 5 cell imports for the University Hospital of Wales). Performance is expected to be maintained or improve in August and September with 10 stem cell collections planned.

With the launch of the buccal swab 'drives' in late January 2024, the recovery plan for bone marrow volunteer recruitment is building. Overall performance for July was 532 (Cheek Swab) plus 144 (recruited on blood clinic) giving a total of 676 (against a target of 333).

2.1 Workforce and Wellbeing

Sickness

Current rolling sickness absence is 5.22% to July 2024, which is above the Trust Board agreed local stretch target of 4.70% and the Welsh Government Target of 3.54%. A number of interventions to manage sickness are in place to mitigate the risk to staff wellbeing and there has been a downwards trend in sickness absence over the last 12 months. Work is ongoing with service managers to support staff.

PADR's (staff appraisals)

Trust wide PADRs this month is 74% (target 85%). This is an improved performance over the last three months.

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Statutory & Mandatory Training

Statutory and Mandatory training remains above target at 87% (target 85%) and has been consecutively on target for the whole year to date.

A full summary of workforce interventions to mitigate workforce risks and to support effective Supply and Shape of the workforce is summarised in the Supply and Shape Paper April 2024, an updated version will be provided in August 2024

2.2 Patient and Donor Experience

Velindre Cancer Centre uses two patient satisfaction surveys. Performance against 'Would you recommend us?' was 98% and 'Your Velindre experience?' was 96% both set against the 85% target.

The Welsh Blood and Transplant service has maintained a high level of donor satisfaction at 97% which continues to meet the target (95%).

2.3 Digital Services

Steady performance in July 2024, with marginal changes only.

Main area of concern remains the number of significant IT business continuity incidents – the number of incidents in the latest 12-month period has increased to 14, a consequence of a number of outages associated with national, DHCW-managed IT systems. These are being reviewed via the relevant national Service Management Boards, to identify opportunities to prevent re-occurrence.

Target achieved in respect of the % of service requests resolved within SLA – 85% in July 2024. % of incidents resolved within SLA dropped slightly, to 79% in July 2024. Improvement Plan now established for Digital Services 1st and 2nd line support teams.

Reporting arrangements for two indicators are still in development:

- % uptime of critical digital systems which may have direct clinical or business implications – a number of critical systems have been identified as 'in scope' of this indicator. Delivery of routine reporting has been delayed due to competing priorities within the team.

- % of Trust expenditure in digital – to aim was to report this metric from May 2024 (April data) (DIG.73); however, the Digital Services team are waiting on the 2024/25 data to be shared by Finance. The definition for the metric has been agreed with the Finance team.

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The reporting of one further indicator is currently in the process of being established:

- Hours saved through digitisation / automation of paper-based manual processes – publication date TBC.

2.4 Estates Infrastructure and Sustainability

The Estates department has encountered substantial challenges due to prolonged staff absences. Despite this, the team successfully met benchmark compliance for Planned Preventative Maintenance (PPM) across all sites, except for Velindre Cancer Centre, where the transition to a new CAFM system and the introduction of additional PPMs affected performance.

However, the targets for Reactive Maintenance were not achieved during this period. Moving forward, the focus will be on enhancing Reactive Maintenance performance to meet the required benchmarks by planning PPMs and reactive tasks in accordance with deadlines.

Energy prices have decreased following the energy crisis. Team Sigma provide billing & consumption verification for the Trust, alongside comprehensive reporting. Gas and electricity consumption across VUNHST Estate during 23/24 has been lower than baseline 18/19 year. The Trust continues to manage energy consumption with constant monitoring via the Building Management System. Water consumption during 23/24 has increased at VCC. The water consumption increase against the baseline at VCC is due is due to an enhanced flushing regime in line with Water Safety guidelines & Infection, Prevention & Control measures. This action has resulted in an external audit awarding "Substantial Assurance" for water safety, for the first time on site.

The KPIs for fire safety training remains below target figure of 85%. The Trust fire safety manager is working with both the ESR and WOD teams to review the current provision of fire safety training and also to review and streamline the delivery of fire safety training down to five [5] competency levels and remove duplicate competencies. The fire safety manager has continued to work with SLT leads and staff supervisors to emphasise the importance of prioritising attendance at future training events and has run additional sessions through June / July to improve this area of compliance.

Health & Safety

Overall, we have seen a slight increase in incidents this month with an overall number of 10 split between WBS and VCC. We have also received a couple of late reported incidents one of 18 days and another of 6 days. Communication between the safety department and the divisions is taking place to ensure when we have any incidents that they are reported as soon as possible as this could result in late reporting to the HSE if significant enough. We must again highlight the decrease in training for patient manual handling as we don't have the ability to deliver the training currently. Talks are happening to address this soon. In relation to the statistics and language surrounding H&S incidents, this will be included in a paper to EMB for 29th August

2.5 Finance

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The overall position against the profiled revenue budget to the end of July 2024 is underspent by £0.008m and at this stage is currently expecting to achieve an outturn forecast of Breakeven.

The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4HBs and JCC are in agreement to proceed but subject to all HBs agreement the contract rebase. As commissioners were not able to reach a consensus before the 30th June deadline the Trust had to revert back and prepare LTAs on an historic basis.

In order to avoid arbitration, discussions between Chief Executives led to a compromise position and the financial impact to the Trust for 2024/25 is as follows:

- £318k reduction in recurrent discretionary income compared to plan.
- £483k reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed but not expected to be material.

In line with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.269m from the £2.606m which was set at the IMTP planning stage.

Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.875m was required in order to help compensate for the loss of income from the LTA agreements. One Scheme within VCS remains in amber as contract negotiations are ongoing with the supplier, however at this stage is still expected to turn green later in the year.

In order to achieve a balanced financial position, the savings target set for 2024-25 must be achieved, all anticipated income is received, and any new emerging costs pressures are either mitigated at Divisional level or managed through the Trust reserves.

The approved Capital Expenditure Limit (CEL) as of July 2024 is £19.250m. This represents all Wales Capital funding of £17.339m, and Discretionary funding of £1.911m. The Trust reported Capital spend to July'24 of £6.322m and is forecasting to remain within the CEL of £19.250m, subject to the Trust receiving support from WG for the schemes identified at this stage without agreed funding but are in discussion with WG such as the nVCC Capital cost requirement for 2024-25.

During July'24 the Trust (core) achieved a compliance level of 98.3% (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of 96.93% at the end of month 4, and a Trust position (including hosted) of 97.1% compared to the target of 95%.

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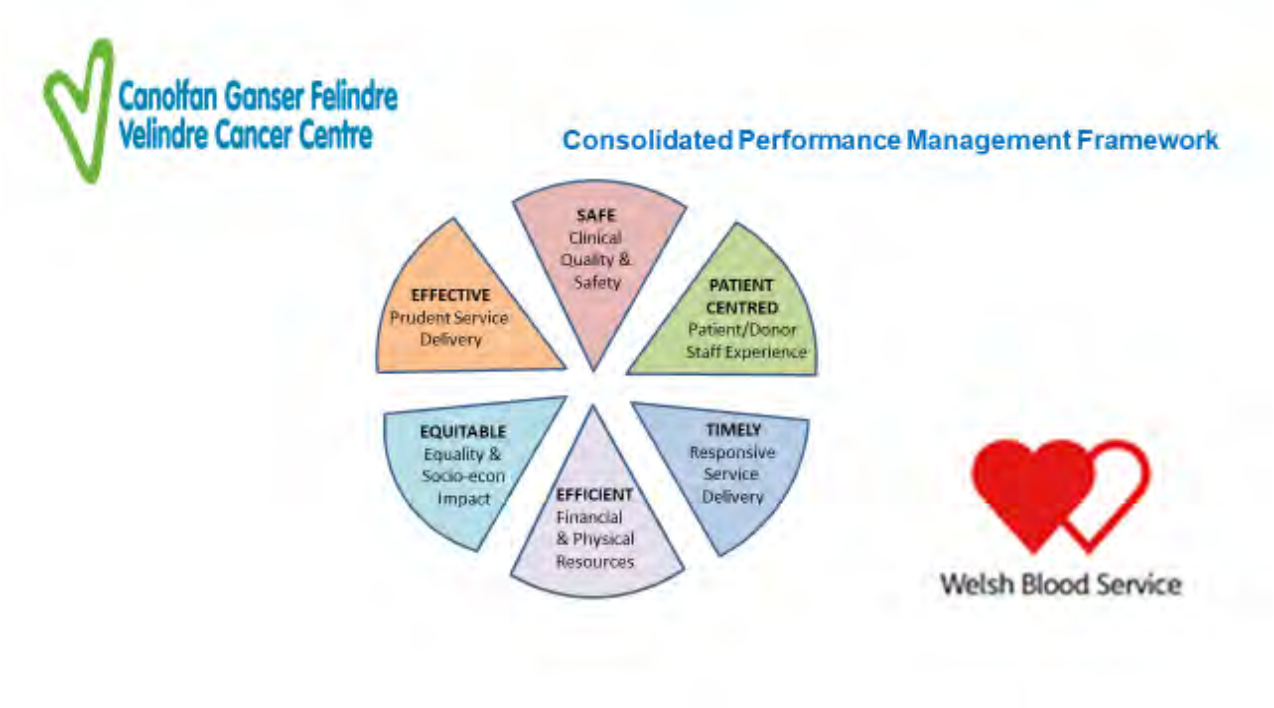
3. ASSESSMENT OF PERFORMANCE AND MATTERS FOR CONSIDERATION
VELINDRE NHST PERFORMANCE SCORECARDS FOR JULY 2024

3.1 The Performance Management Framework (PMF) Scorecards, in this Section, are based on the 'six domains' of the Quality Safety Framework (QSF), namely safe, effective, patient/donor centred, timely, efficient and equitable care.



3.2 Navigating our PMF Performance Report

The following PMF Scorecards incorporate hyperlinks to supporting Key Performance Indicator (KPI) data and analysis, enabling switching between the high-level positions to detailed analysis provided in **Appendices 1 to 3**

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

Quality Safety & Performance (QSP) Committee Scorecard as at July (Month 04) 2024/25

QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Safety	% compliance for staff who have completed the Core Skills and Training Framework Level 1 competencies	National	Monthly	87%	85%	87%	✓	↑	WOD.19
	Number of VCC Inpatient (avoidable) falls	National	Monthly	4	0	0	✓	→	KPV.02
	Number of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	Monthly	2	0	0	✓	↓	KPV.07
	Number Healthcare acquired Infections (HAIs) MRSA Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) MSSA Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) P. aeruginosa Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Klebsiella spp Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) C Difficile	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) E Coli Bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number Healthcare acquired Infections (HAIs) Gram negative bacteraemia	National	Monthly	0	0	0	✓	→	KPV.04
	Number of Velindre Cancer Centre acquired (avoidable) patient pressure ulcers	National	Monthly	1	0	1	✗	→	KPV.01
	% Compliance with World Health Organization 5 moments of Hand Hygiene standard	National	Monthly	100%	100%	96%	✗	→	KPV.08
	Number of National VCS Reportable Incidents recorded with Welsh Government	National	Monthly	0	0	0	✓	→	KPV.60
	Number of WBS Incidents reported to Regulator / Licensing Authority	Local	Monthly	0	0	0	✓	↓	KPI.30
	Number of Health and safety incidents recorded	Local	Monthly	15	0	10	✓	↑↓	H&S.55
	Number of Duty of Candour Incidents recorded	National	Monthly	0	0	0	✓	→	KPV.63
	Number of 'Never Events' recorded	National	Monthly	0	0	0	✓	→	KPV.64
	Carbon Emissions – carbon parts per million by volume	National	Annually	2018/19 C/m3	205.7 C/m3 Dec	137.4 C/m3 Dec	✓	→	EST.06

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QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
Effectiveness	Number of Pathway of Care Delays	National	Monthly	1	0	1	✗	➔	KPV.05
	% Demand for Red Blood Cells Met	Best practice	Monthly	104%	100%	102%	✓	➔	KPI.04
	% Time Expired Red Blood Cells (adult)	Local	Monthly	0.02%	Max 1%	0%	✓	↑	KPI.26
	% Demand for Platelet Supply Met	Best practice	Monthly	133%	100%	122%	✓	↓	KPI.05
	% Time Expired Platelets (adult)	Local	Monthly	20%	Max 10%	0%	✓	➔	KPI.25
	Number of Stem Cell Collections per month	Local	Monthly	6	7	4	✗	↑	KPI.13
	% Rolling average Staff sickness levels	National	Monthly	6.22%	3.54% 4.70%	5.24%	✗	↑	WOD.37
	% Personal Appraisal Development Reviews (PADR) compliance staff appraisal carried out by managers	Prof. Std.	Monthly	73%	85%	74%	✗	↑↓	WOD.36
Patient/Donor/ Staff Experience	% of Patients Who Rate Experience at VCC as very good or excellent	Prof. Std.	Monthly	95%	85%	98% 96%	✓	➔	KPV.11
	% Donor Satisfaction	Local	Monthly	95%	95%	97%	✓	↑	KPI.09
	% of 'formal' VCC concerns responded within 30 working days	Local	Monthly	100%	85%	100%	✓	➔	KPV.12
	% Responses to Formal WBS Concerns within 30 Working Days	Local	Monthly	100%	100%	N/A	✓	➔	KPI.03
Timeliness	Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days	National	Monthly	29% 47%	80% 100%	25% 82%	✗	↓	KPV.14
	Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days	National	Monthly	6% 50%	80% 100%	11% 74%	✗	➔	KPV.15
	Emergency Radiotherapy Patients Treated 80% within 1 Day and 100% within 2 days	National	Monthly	94% 100%	80% 100%	100% 100%	✗	↑	KPV.16

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QSF Domain	QSP Committee Performance Scorecard			Performance as at Month 04 (July 2024)			Compliance against Target or Standard		Data Link
	Key Performance Indicator (KPI)	Target	Reported	Baseline March 23	Target	Actual	In Month Position	Cumulative data trend	
	Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days	National	Monthly	27% 32%	80% 100%	93% 98%	✗	↑	KPV.17
	% Patients Beginning Non-Emergency SACT within 21 days **June position**	National	Monthly	98%	98%	88%	✗	↑↓	KPV.20
	% Patients Beginning Emergency SACT within 5 days **June position**	National	Monthly	100%	98%	100%	✓	↑	KPV.21
	% Antenatal Turnaround Times (within 3 working days)	Best practice	Monthly	96%	90%	95%	✓	↑	KPI.18
	% Turnaround Times (Antenatal -D & -c quantitation) within 5 working days	Best practice	Quarterly	83%	90%	100%	✓	↑	KPI.17
Efficient	Financial Balance – achievement of Trust forecast (£k) in line with revenue expenditure profile	National	Monthly	0	0	£0.008 m	✓	→	FIN.71
	Financial Capital spend (£m) position against forecast expenditure profile	National	Monthly	0	£6.322 m	£6.322 m	✓	→	FIN.73
	Trust expenditure (£k) on Bank and Agency staff against target budget profile	National	Monthly	N/A	£0.138 m	£0.222 m	✗	→	FIN.72
	Cost Improvement Programme £1.3M achievement of savings (£k) in line with profile	National	Monthly	N/A	£0.831 m	£0.831 m	✓	→	FIN.74
	Public Sector Payment Performance (% invoices paid within 30 days)	National	Monthly	95%	95%	97%	✓	→	FIN.60
Equitable	Mean Gender Pay Gap – Annual	Local	Annually	13.45%	5%	13.85%	N/A	N/A	WOD.78
	Diversity of Workforce – % Black, Asian and Minority Ethnic people	Local	Quarterly	5.18%	6%	6.18%	✓	→	WOD.79
	Diversity of Workforce – % People with a Disability within workforce	Local	Quarterly	4.63%	22%	5.79%	✗	→	WOD.80
	% of Workforce declared Welsh Language Listening/Speaking capability	National	Quarterly	89.37%	100%	93.53%	✗	↑	WOD.81

Symbols Key: In Month = Compliant ✓ Non-compliant ✗ Cumulative data trend (15 months) = Improving ↑ stable → fluctuating ↑↓ deteriorating ↓

Webber, Karen
11/09/2024 10:57:44

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 considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒

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	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). Quality and Safety considerations form an integral part of PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Click or tap here to enter text
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	**Choose an item**
	If more than one Well-being Goal applies please list below:
	If more than one wellbeing goal applies please list below: Click or tap here to enter text
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Type of Funding:** **Choose an item** Please explain if 'other' source of funding selected: Click or tap here to enter text **Scale of Change** Please detail the value of revenue and/or capital impact: Click or tap here to enter text

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

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	The Performance Management Framework reports the performance of the organisation across a number of areas but is not the mechanism for managing risks identified within the report.
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*[In this section, explain in no more than 3 succinct points what the impact of this matter is on this risk].*
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	Insert Date
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

Kathryn Jane
17/09/2024 10:57:44

Performance Management Framework supporting KPI Data Graphics and Analysis

SAFETY

KPI Indicator KPV.02

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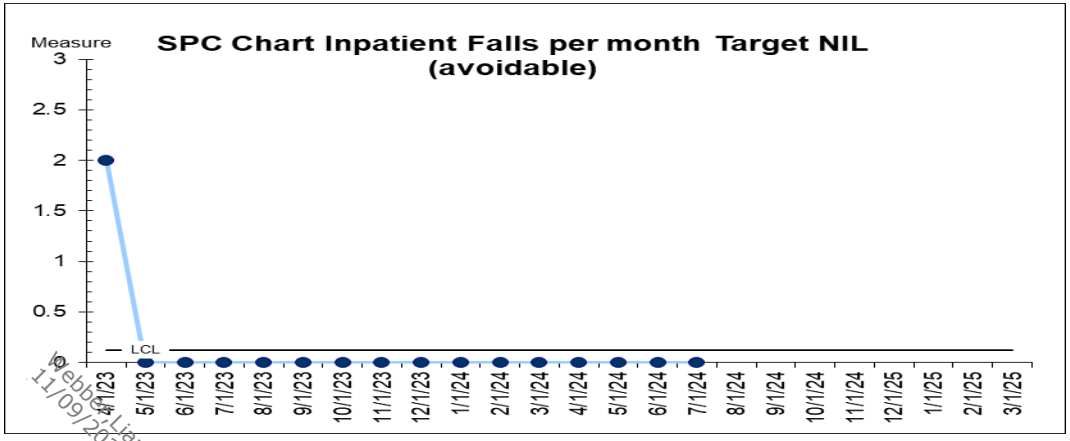
Number of VCC Inpatient Falls per month

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual Number	2	0	3	5	5	3	5	3	6	8	2	5	3	2	3	4
Avoidable Falls	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



Webber,Liane
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SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months.

Performance

No avoidable falls in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

KPI Indicator KPV.01

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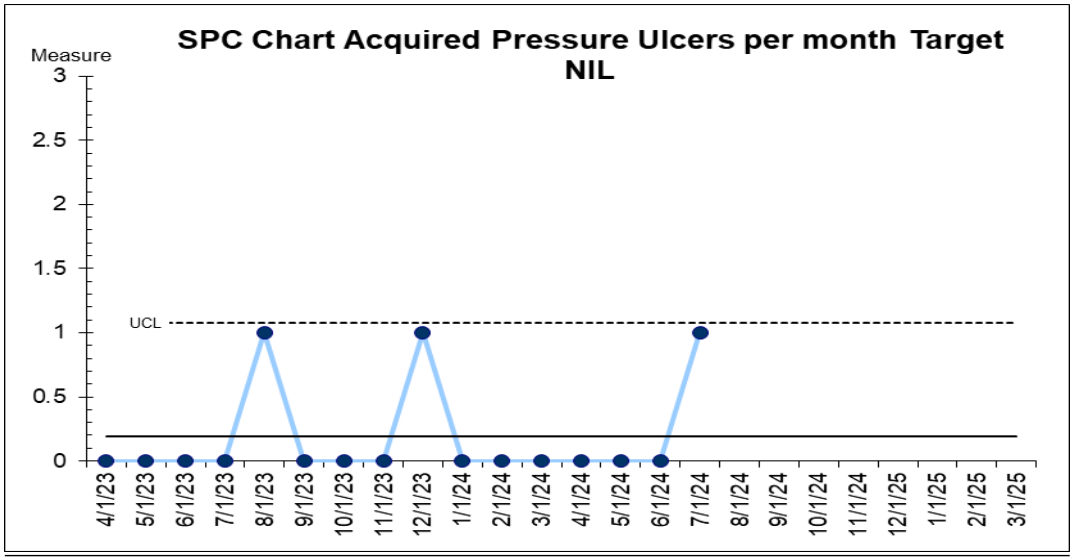
Number of VCC Acquired Pressure Ulcers per month (Inpatients)

Target: 0 Avoidable

SLT Lead: Head of Nursing

Current Performance against Target or Standard

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



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the last 15 months

Performance

There was 1 avoidable pressure ulcer in July 2024.

The learning identified following the investigation was:

- To consider the most appropriate mattress on admission dependent on skin assessment.
- To ensure staff are documenting that they have offloaded patient heels as part of the patient's daily skin care plan and assessment.

The learning has been communicated with the ward nursing team.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Webber, Liane
27/09/2024 10:57:44

KPI Indicator WOD.19

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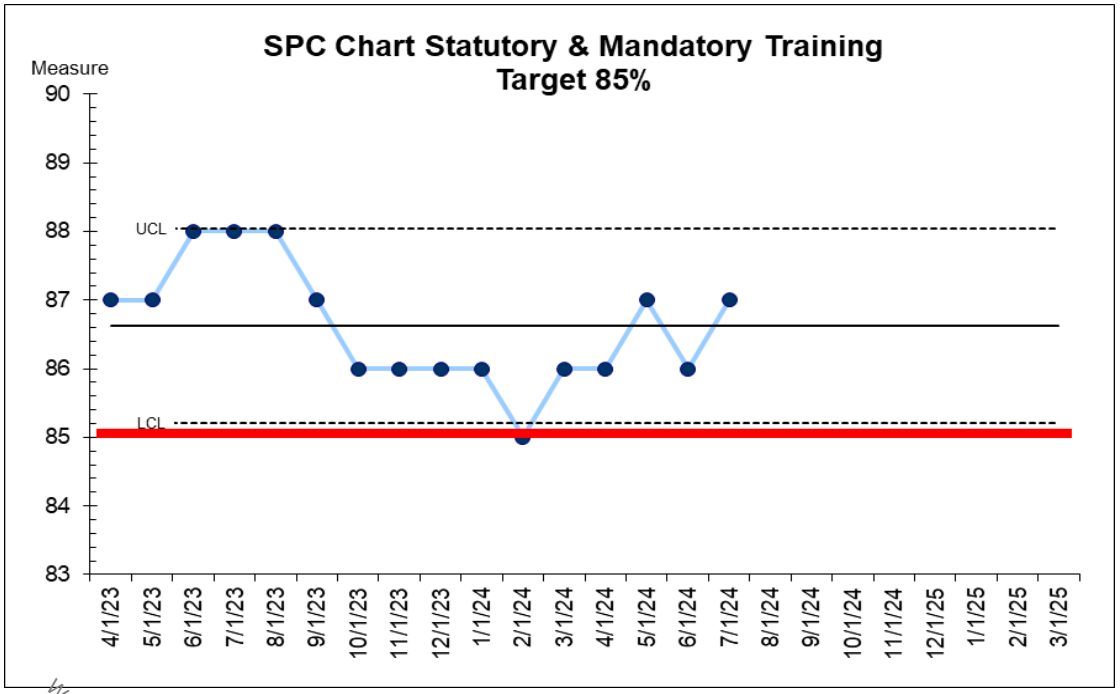
Statutory and Mandatory (S and M) Training Compliance

Target: 85%

SLT Lead: WOD Business Partner

Current Performance against Target or Standard

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



Webber, Lynne
11/07/2024 16:57:44

SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:

- Compliance target is being met

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Improved performance with all areas across the Trust above the target level.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

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

Risks to future performance

Set out risks which could affect future performance

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

KPI Indicator KPV.07

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

Target: NIL

SLT Lead: Clinical Director

Current Performance against Target or Standard

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

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

Performance

Assessment of current performance, set out key points:

On target for the month

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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KPI Indicator KPV.04

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Healthcare Acquired Infections (Inpatients)

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

Current Performance against Target or Standard

Incidence of Healthcare Acquired Infections for the period Oct 2022 to Dec 2023

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

Performance

Assessment of current performance, set out key points:

- RCA for all reported infections in progress
- There is no evidence of VCC transmission in the RCA's to date.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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KPI Indicator KPV.08

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Hand Hygiene % Compliance with WHO 5 moments of hand hygiene by (VCS WBS) Department

Target: 100%

SLT Lead: Clinical Director

Current Performance against Target or Standard

Hand Hygiene Compliance by Clinical Department

VCS WBS Trust	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
VCS Hand Hygiene			100 %	100 %	99%	99.6 %	100 %	99%	100 %	97.5 %	98.9 %	98%	98%	97%	93%	93%
WBS Hand Hygiene			100 %	99.2 %	99%					99.8 %	99%	100 %			100 %	100 %
Trust Hand Hygiene			100 %	100 %	99%		99%	93%	100 %	98.6 %	99.4 %	99%	99%	93%	97%	96%
IPC Validation			100 %	100 %	100 %	99.4 %	100 %	96%	100 %	100 %	99%	99%	93%	87%	91%	95%
Target l00%	0	0	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %

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

Plus Infection Prevention Control Team Validation Audits % compliance

Performance

Assessment of current performance, set out key points:

- Performance is on target

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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KPI Indicator KPV.60

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Number of National Reportable Incidents(NRIs) recorded with Welsh Government in a calendar month

Target: NIL and as a % of Overall Activity (to be agreed)

SLT Lead:

Current Performance against Target or Standard

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

Performance

Assessment of current performance, set out key points:
No incidents met the criteria for NRI in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

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KPI Indicator KPI.30

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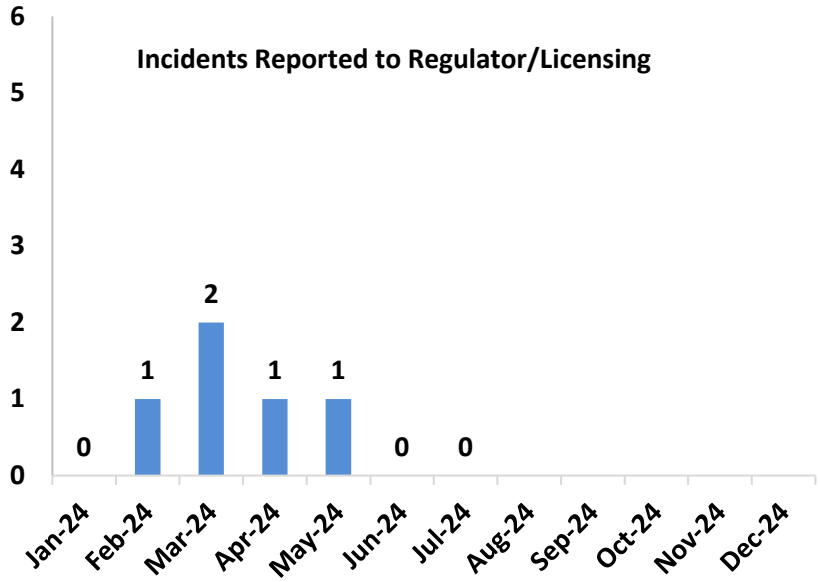
Number of Serious Adverse Blood Reactions & Events (SABRE) Incidents reported to the MHRA in a calendar month

Target: NIL

SLT Lead: Peter Richardson

Current Performance against Target or Standard

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



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Performance

Assessment of current performance, set out key points:
No adverse events were submitted to the MHRA (Medicines and Healthcare products Regulatory Agency) in July.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Lead:
The completion of Corrective Actions and Preventative Actions (CAPA), for SABRE and HTA reports, is monitored via existing processes and reported to the WBS Integrated Quality & Safety Hub. Managers continue to explore opportunities to share learning through formal staff engagement sessions, and a Task & Finish group (reporting to the WBS Integrated Quality & Safety Hub) is working on removal of complexity from the donor eligibility assessment process.	Peter Richardson **Timescale:** Progress is reported Monthly into the WBS Integrated Quality & Safety Hub.

Expected Performance gain – immediate - N/A

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Actions have been/will be introduced as outcome of Root Cause Analysis of these incidents is known.		

Expected Performance gain – longer-term - N/A

Risks to future performance

N/A

KPI Indicator H&S.55

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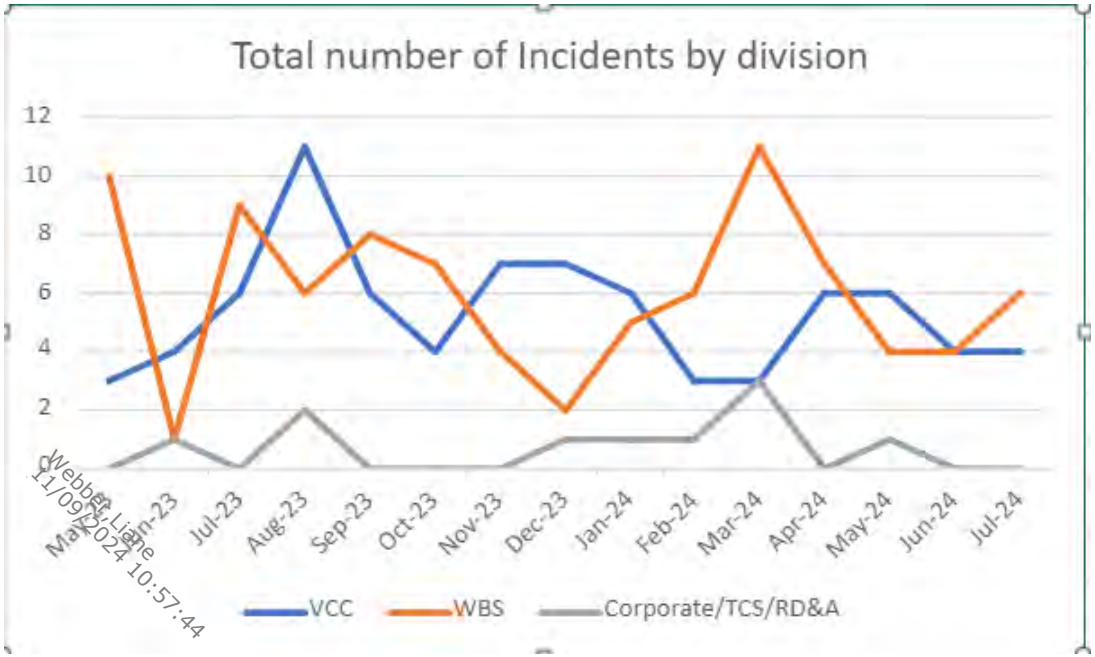
Graph title - Number of staff/contractor/Organisational/patient/donor health and safety H&S incidents by Division

Target: 103

SLT Lead: Lauren Fear

Current Performance against Target or Standard - Level

	May23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24
VCC	3	4	6	9	6	4	7	4	5	3	3	6	6	4	4
WBS	10	1	9	6	8	7	4	2	5	6	11	7	4	4	6
Corporate	0	1	0	2	0	0	0	0	0	0	3	0	1	0	0



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11/09/2024 10:57:44

Performance - Stable

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain

As per the annual report we have identified a target of 103 incidents for the year. We have a base line of 1.98 incidents per week and are currently exceeding our target. Efforts will be made to observe and tackle trends

Service Improvement Actions – tactical (12 months +)

Actions: As above	**Timescale:**

Expected Performance gain

Risks to future performance

Incomplete incident investigation – ongoing monitoring

KPI Indicator EST.06

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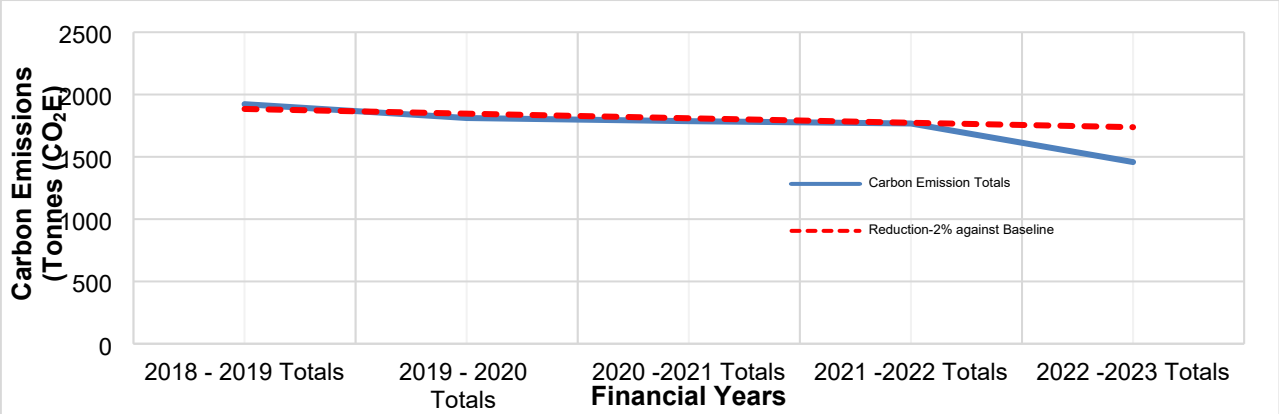
% reduction in Carbon Footprint/Emissions by 2025 against 2018/19 baseline

Target: -16% by 2025

SLT Lead: Asst. Director of Estates

Current Performance against Target or Standard

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



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

Performance

Assessment of current performance, set out key points:

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Ongoing communication and engagement with staff to reduce consumption.

Amendments to the BMS across all sites for better controls.

Integration of Sigma into the billing & consumption verification process to better monitor carbon emissions.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Reduced carbon footprint

Improvement across sites from the capital projects – namely nVCC and Talbot Green Infrastructure.

Risks to future performance

Set out risks which could affect future performance

•

Webber, Jane
11/06/2024 10:57:44

EFFECTIVENESS

KPI Indicator KPV.05

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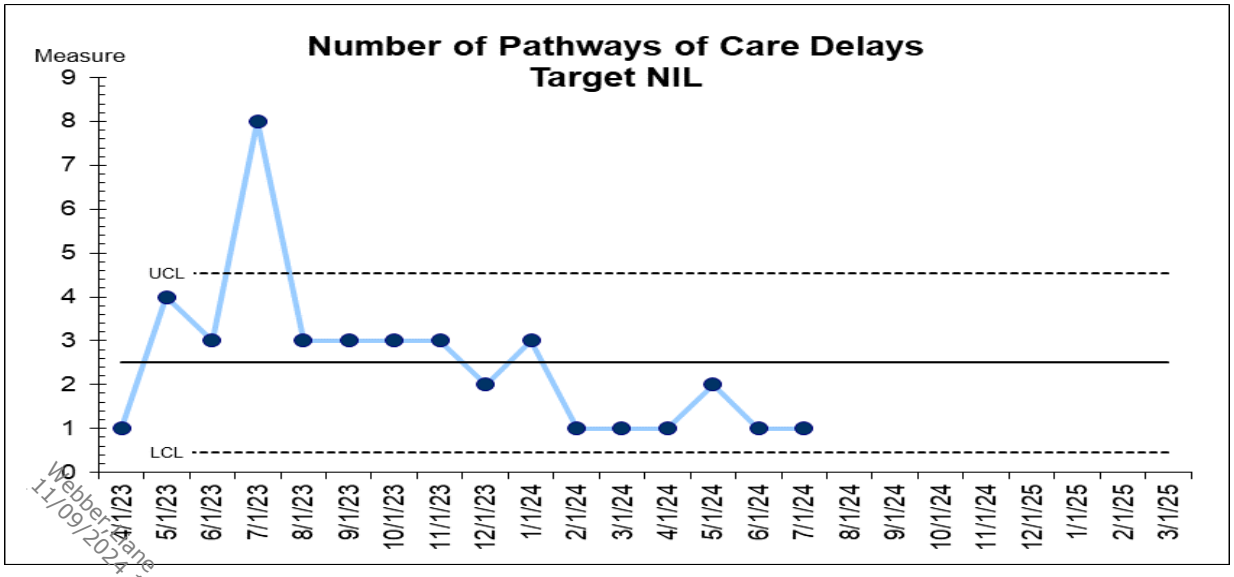
Number of Pathway of Care Delays

Target: NIL

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual PoCDs Number	1	4	3	8	3	3	3	3	2	3	1	1	1	2	1	1
Days Delayed				32	19	43	73		5			19	26		21	21
Target NIL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0



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11/09/2024 10:

SPC Chart Analysis

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

Performance

Assessment of current performance, set out key points:
There was 1 Pathway of Care delay reported in July 2024.

Patient 1: Awaiting package of care to support discharge home, delay of 21 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Data is now being uploaded nationally to the Pathways of Care Delays National system. Individual patient discussions are taking place daily with HB and community teams to progress any delays. It is acknowledged that there are bed pressures across the whole system which impacts on patient discharge/transfer.		Matthew Walters Operational Senior Nurse

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Meeting with Cwm Taf Health board to observe their daily 'Safe to Start' meeting which supports with patient flow and early discharge planning.		Matthew Walters Operational Senior Nurse

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPI.04

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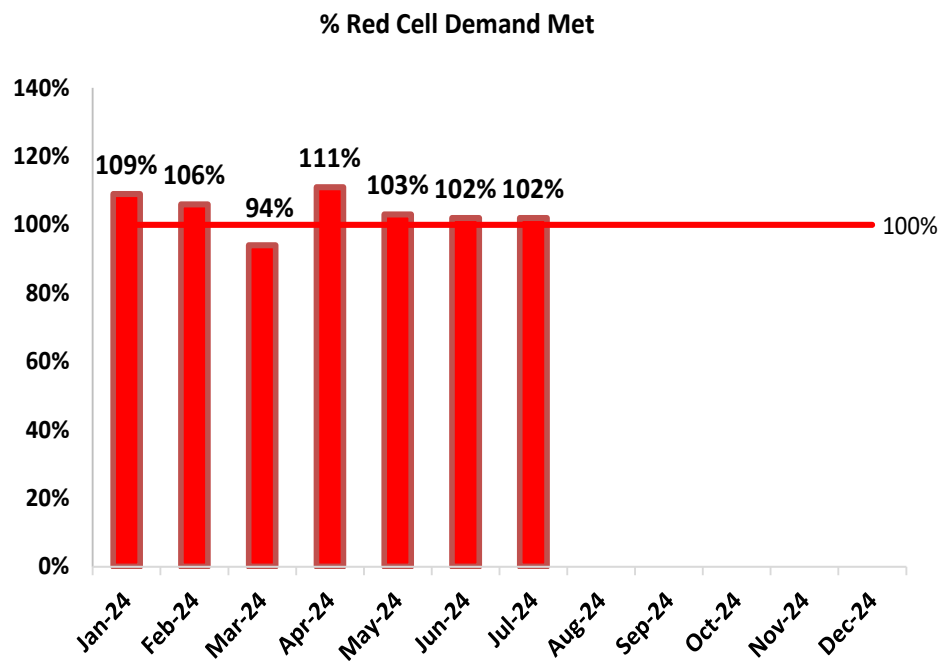
% Red Blood Cell Demand Met as number of bags manufactured as % of Issues to Hospitals

Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	104	97	110	105	102	95	101	107	97	109	106	94	111	103	102	102
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100



Performance

Performance met target in July. The average weekly demand in July was 1445 compared to June average of 1469 units per week.

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

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term N/A

Risks to future performance

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

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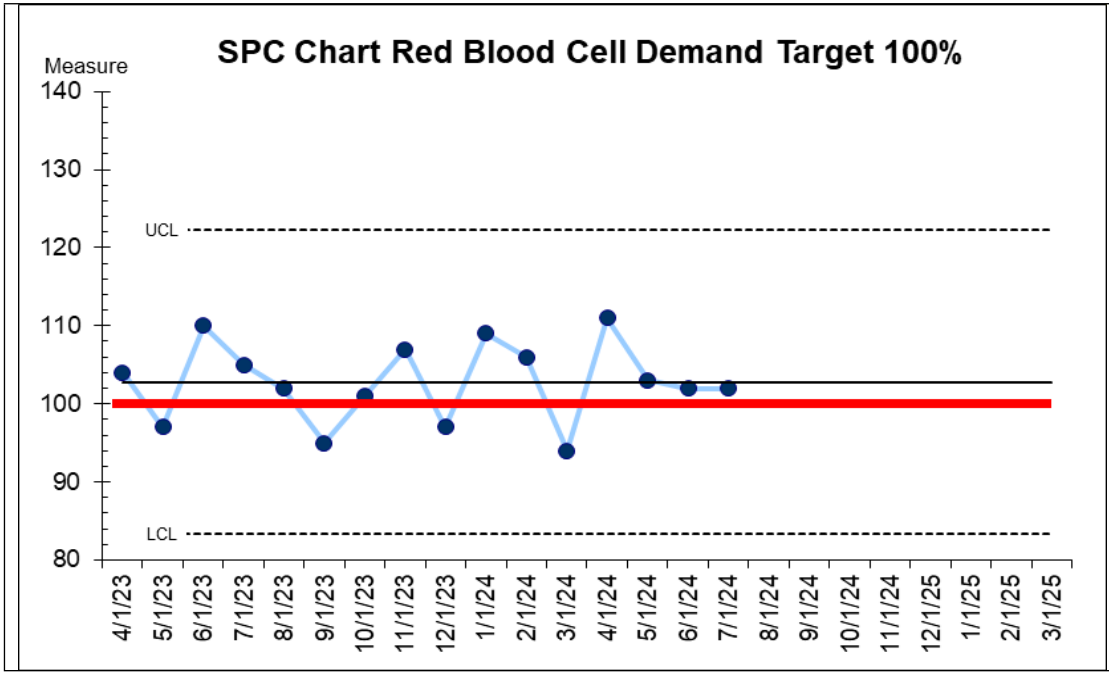

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. Performance continues to fluctuate. However, the overall trend shows performance exceeding target.

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KPI Indicator KPI.26

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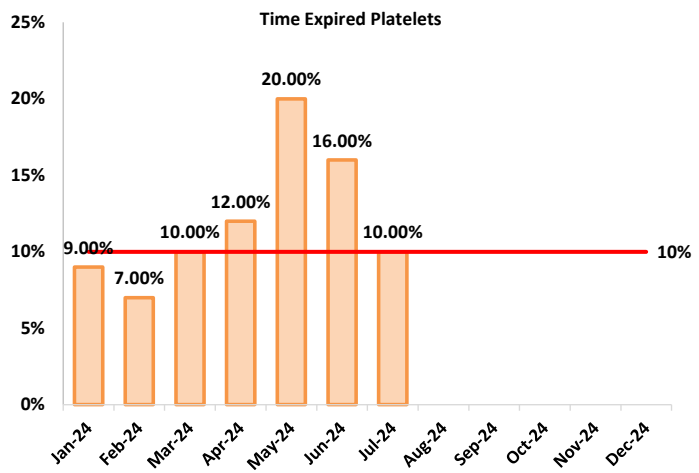
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	10	8	9	12	12	11	11	10	10	9	7	10	12	20	16	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



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

Pebbles Lane 11/09/2024 10:57:44

Performance

Assessment of current performance, set out key points:
At 10%, performance improved in July, meeting target. Platelet demand was higher in the first half of the month which resulted in upwards adjustment in the production. However, the higher demand did not persist into the later part of the month.

WBS will continue to analyse issuing data to identify trends in demand and translate them into adjustments in platelet production.

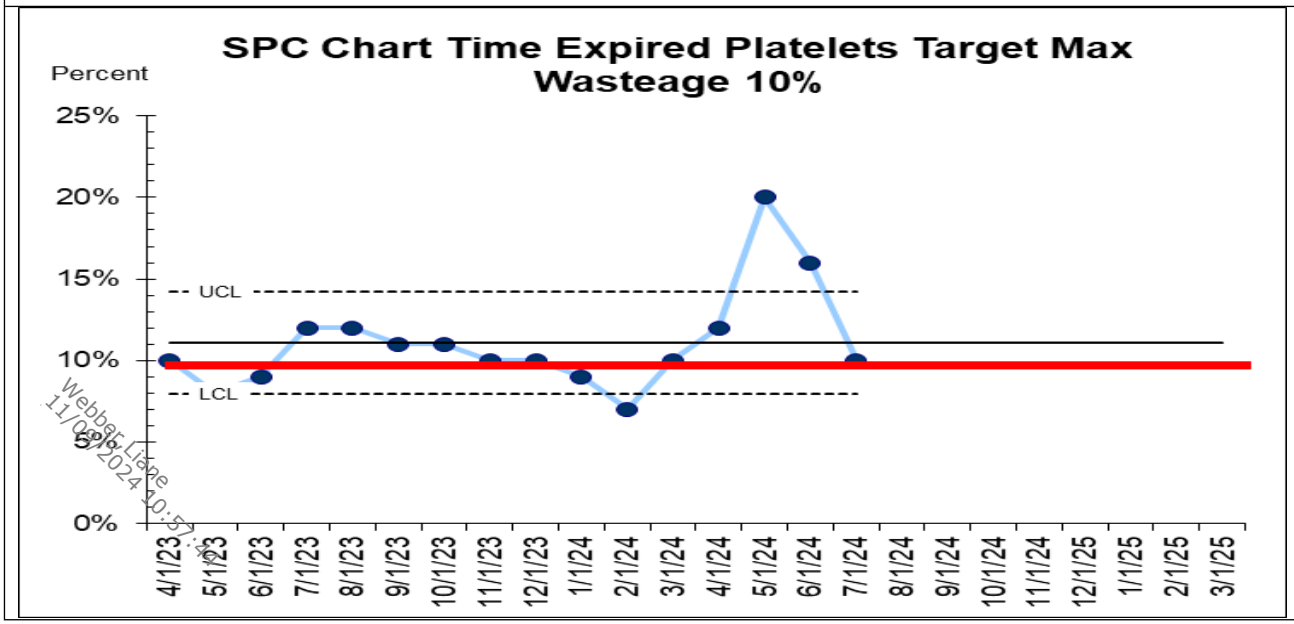
Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus	Q3 2024/25 **Lead:**

	pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	Jayne Davey/ Georgia Stephens
	Expected Performance gain – longer-term. Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance **Set out risks which could affect future performance.** Unexpected increases in clinical need - noting unexpected spike in demand may require imports. Future Bank holidays.	
	**SPC Chart Analysis** The SPC chart which shows an improved performance from Apr. 2023 to Feb 2024. However, there has been recent fall in performance leading to a special cause variation of 20% in May.	

KPI Indicator KPI.05

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Platelet Supply meeting Demand – number of bags manufactured as % the number issued to Hospitals

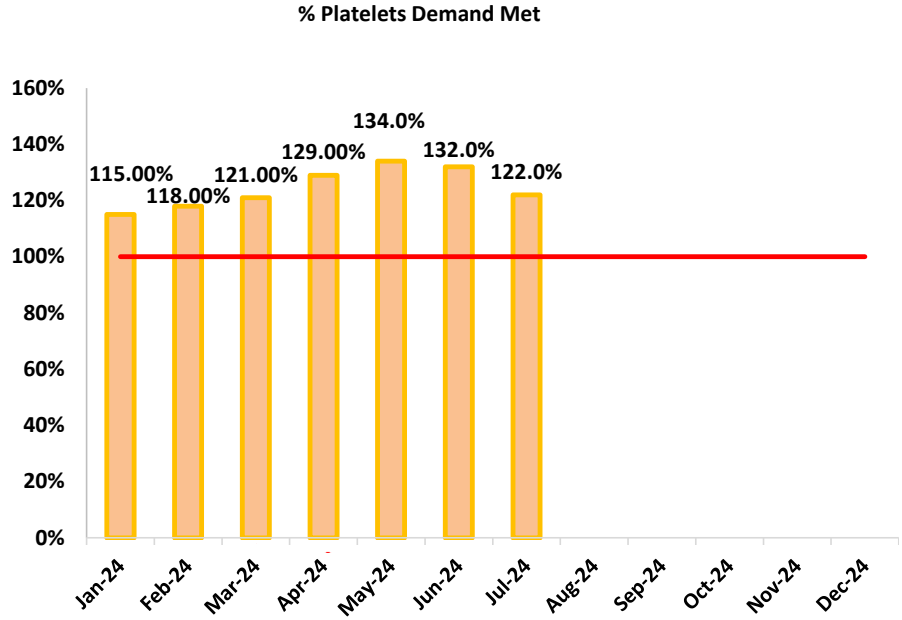
Target: 100%

SLT Lead: Jayne Davey / Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	Jun 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	127	117	114	120	125	121	122	115	125	115	118	121	129	134	132	122
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

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



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Performance

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

Service Improvement Actions – Immediate (0 to 3 months)

Daily monitoring of platelet stock position and assessment of likely demand in the upcoming days. Controlled adjustments in production of pooled platelets to better align overall stock holding to daily demand.	**Lead:** Georgia Stephens **Timescale:** Ongoing – Business as Usual

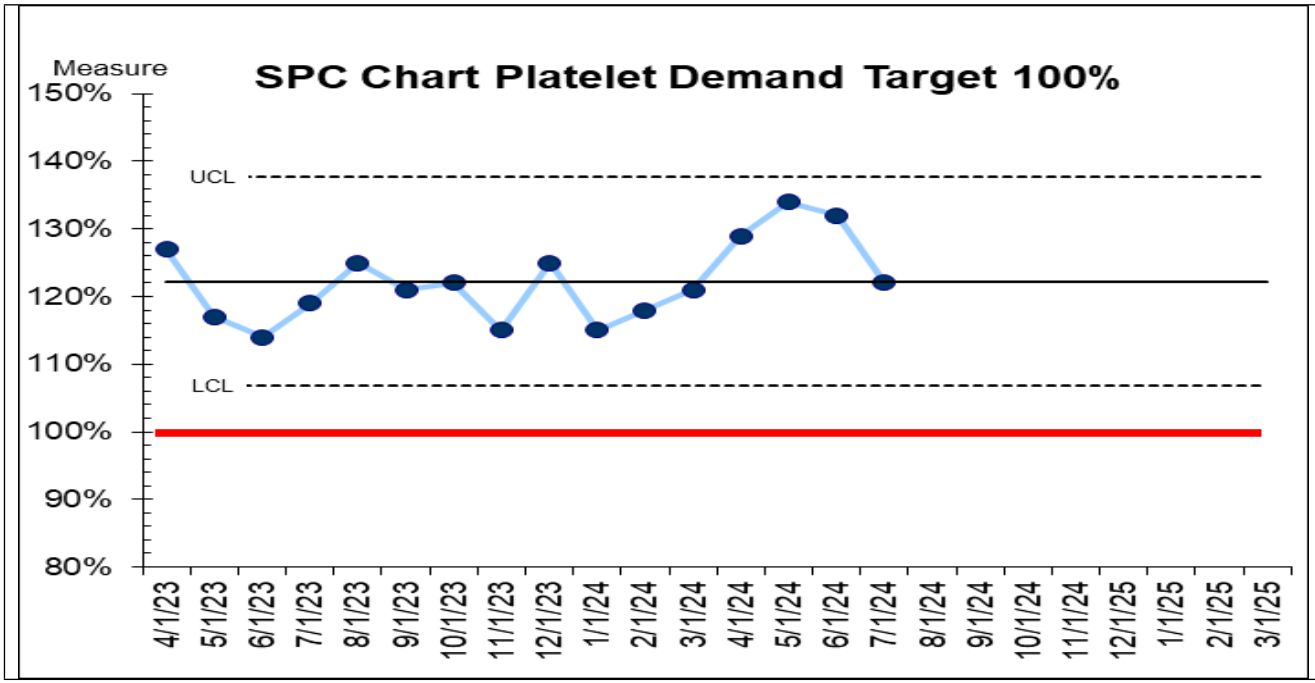
Expected Performance gain - immediate.
Daily agile responses to variations of stock levels and service needs.
Reduced platelet wastage

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	**Timescale:** Q3 2024/25 **Lead:** Georgia Stephens

Expected Performance gain – longer-term.

	Optimised clinic collection plan for Apheresis and a forecasting tool to inform decisions around pooled platelet manufacture.
	Risks to future performance Fluctuations in platelet demand. Advances in clinical practice and patient care which affect the platelet demand (if not communicated to WBS)



SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. The average performance of 120% consistently exceeding the 100% target.

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KPI Indicator KPI.25

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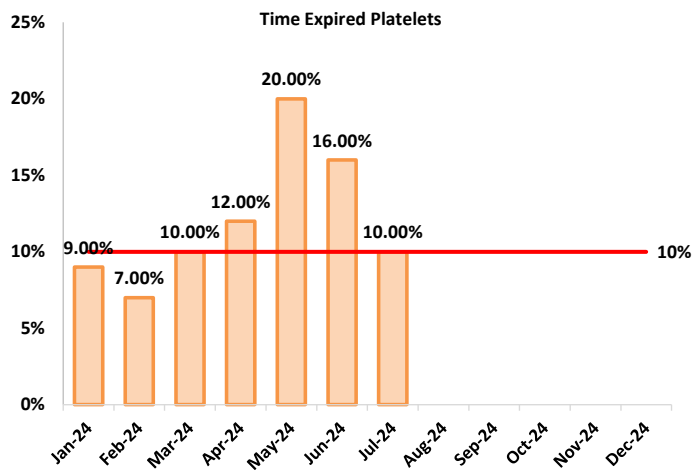
Time Expired Platelets – number of platelets which have time expired as a % of the total number of platelets manufactured

Target: Maximum Wastage 10%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	10	8	9	12	12	11	11	10	10	9	7	10	12	20	16	10
Target Max 10%	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10



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

Pebbles Lane 11/09/2024 10:57:44

Performance

Assessment of current performance, set out key points:
At 10%, performance improved in July, meeting target. Platelet demand was higher in the first half of the month which resulted in upwards adjustment in the production. However, the higher demand did not persist into the later part of the month.

WBS will continue to analyse issuing data to identify trends in demand and translate them into adjustments in platelet production.

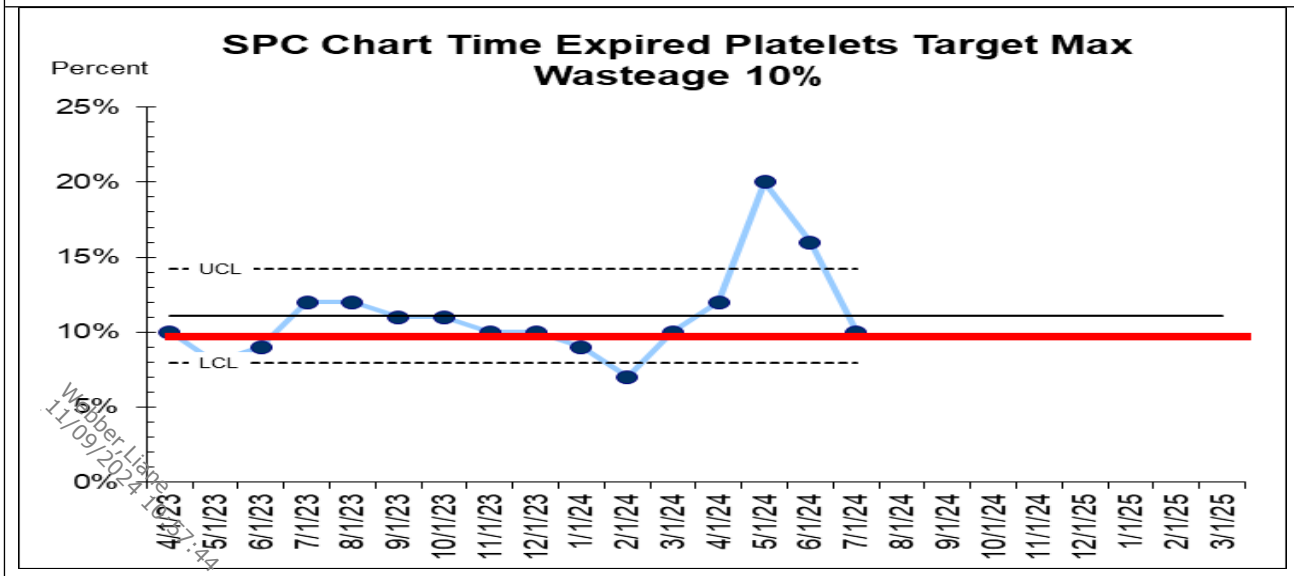
Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:
A workstream for the review of the WBS Platelet Strategy has been initiated under the WBS futures and the Laboratory Modernisation programme. A focus on the balance of apheresis versus	Q3 2024/25 **Lead:**

	pooled platelets, timing of apheresis clinics as well as consideration of a digital tool to enable prediction/requirement for platelet production are included. The workstream meetings have been initiated, work is underway on the scope and prioritisation of work with the revised platelet strategy expected to be delivered in Q3 2024/25	Jayne Davey/ Georgia Stephens
	Expected Performance gain – longer-term. Platelet expiry reduction using a risk-based approach, balancing platelet expiry against ability to supply platelets for clinical needs.	
	Risks to future performance **Set out risks which could affect future performance.** Unexpected increases in clinical need - noting unexpected spike in demand may require imports. Future Bank holidays.	
	**SPC Chart Analysis** The SPC chart which shows an improved performance from Apr. 2023 to Feb 2024. However, there has been recent fall in performance leading to a special cause variation of 20% in May.	

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KPI Indicator KPI.13

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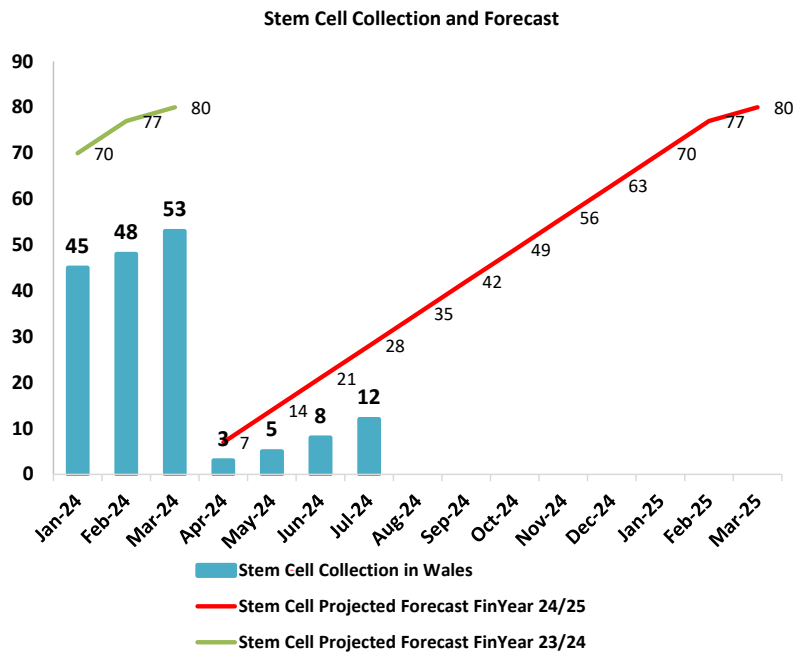
Number of stem cell collections supported year to date. Annual figure 80 per annum reported against cumulative monthly target

Target: 80 per annum

SLT Lead: Deborah Pritchard

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Cumulative Actual	3	6	12	18	21	26	33	35	38	45	48	53	3	5	8	12
Cumulative Target p/a	7	14	21	28	35	42	49	56	63	70	77	80	7	14	21	28



Performance

Transplant centre demand for Stem cell collections was met, but failed to meet collection target, with 4 Peripheral Blood Stem Cell (PBSC) collections July.

The Welsh Bone Marrow Donor Registry (WBMDR) has 10 stem cell collections booked over August/September at the time of writing.

The Service experiences a cancellation rate of ~ 17-25%. This is due to patient fitness and the need for collection centres to work up two donors simultaneously due to a reduction of selected donors able to donate at a critical point in patient treatment.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	
The collection target of 80 in the short-term is under review. An updated recruitment strategy for new donors for the Register has commenced, which is increasing the number of donors on the Registry (see KPI.20). Over time this will increase the number of collections.	**Timescale:** Q4 **Lead:** Deborah Pritchard

Expected Performance gain - immediate. As above

Service Improvement Actions – tactical (12 months +)

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

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

Risks to future performance

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

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KPI Indicator WOD.37

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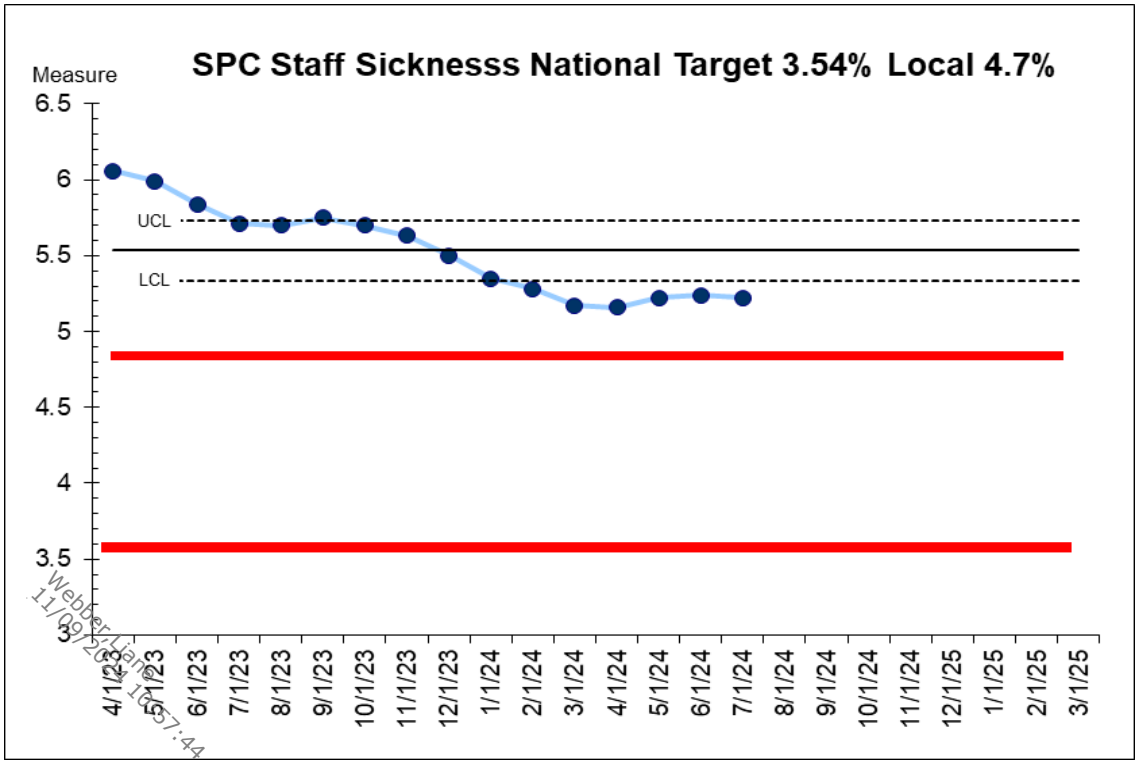
Staff Sickness levels against Target

Target: National 3.54% Local Stretch Target 4.70%

SLT Lead: WOD Director

Current Performance against Target or Standard

Trust Position	May 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	July 24
Actual %	5.99	5.84	5.71	5.70	5.75	5.70	5.63	5.50	5.35	5.28	5.17	5.16	5.22	5.24	5.22
Local target 4.70%	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70	4.70
National Target 3.54%	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54	3.54



Performance

Assessment of current performance, set out key points:

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

Short-term absence remains relatively low across the Trust.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Following feedback from staff engagement sessions in Autumn 2022 the following actions are being taken over the coming 12 months	30/04/2025	Head of OD
• Staff wellbeing support survey • Developing a Menopause friendly culture • Launch benefit platforms (Health Shield, Wage stream etc.) • Reaccreditation of platinum corporate health standards • Implementation of the anti-racist plan	Ongoing	Head of OD and Trust Board

SPC Chart Analysis The SPC chart shows an improving trend over the last 12 months. However, the overall average 5.7% sickness level remains higher than the 4.7% Local target and the 3.54% National target	Quarterly meetings with Wellbeing champions to review ongoing requirements within the organisation		
	Expected Performance gain – longer-term The proactive actions taken to enhance wellbeing and engagement in the workplace offers support to individuals before they even report absent with sickness.		
	Risks to future performance		
	Set out risks which could affect future performance • Not having enough staff available due to sickness absence could impact on delivery of services across the Trust • Staff who feel unsupported during absence may chose to leave the organisation increasing turnover		

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KPI Indicator WOD.36

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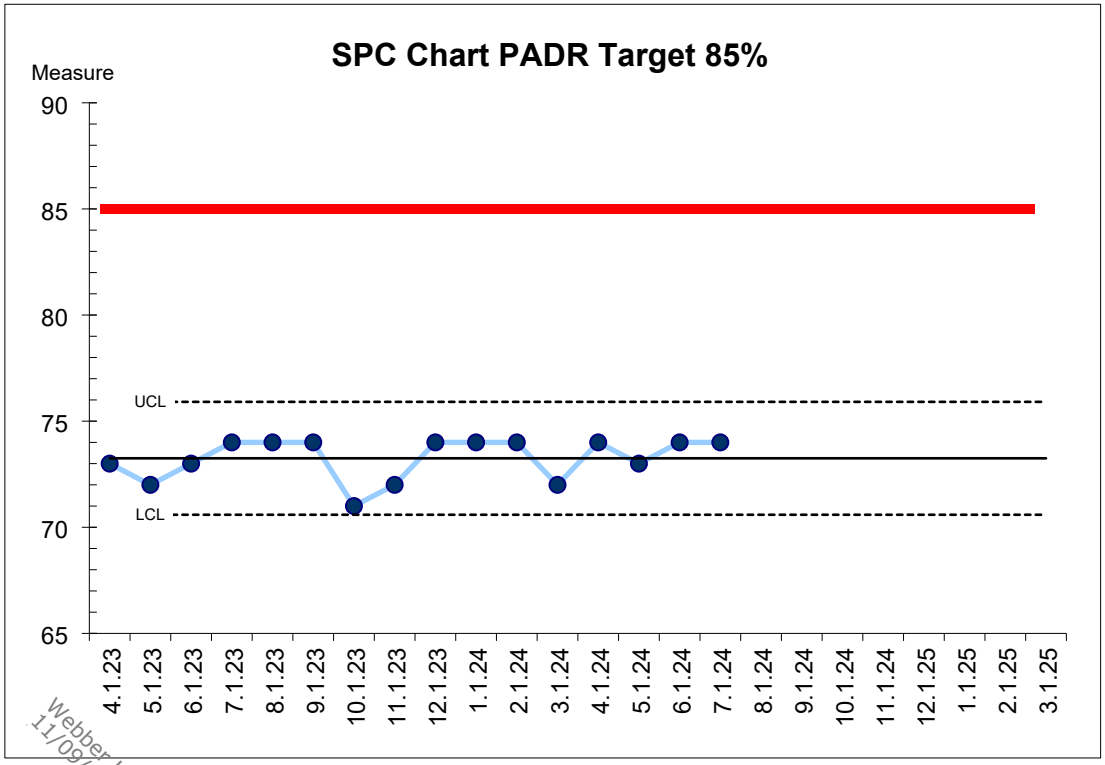
Performance and Development Reviews (PADR) % Compliance

Target: 85%

SLT Lead: WOD Director

Current Performance against Target or Standard

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



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SPC Chart Analysis

The SPC chart shows a stabilising trend over the last 12 months. However, averaging 72%, consistently falling short of the 85% target.

Performance

Assessment of current performance, set out key points:

A full review of the policy, process and procedure is scheduled to take place by the People and OD Team in their work plan for 2024.

The performance trend of departments has been examined over April – June. There are 93 instances of departments falling below 50% (red), covering 39 different departments/teams. 11 teams have coded red on all four months, 7 teams on three of the four.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

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

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Launch a PADR review programme, considering the policy, procedure and current best practice.	April 2025	Head of OD
NHS Wales are currently reviewing the All Wales Capability Policy for management of performance considers.	April 2025	Head of Workforce

Expected Performance gain – longer-term

A review of the current procedure will ensure Staff and Managers are fully aware of Trust expectations to personal performance.

Risks to future performance

Set out risks which could affect future performance

- People have lack of clarity and objectives casing them to be less engaged and motivated in the workplace
- Higher turnover rates due to lack of engagement and motivation

PATIENT & DONOR EXPERIENCE

KPI Indicator KPV.11

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% of Patients that Rate Experience at Velindre at Good or above

Target: 85% | **SLT Lead: Head of Nursing**

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Would you recommend us? %	95	98	96	97	97	95	95	94	95	89	97	96	92	93	98	98
Your Velindre Experience? %	82	68	71	91	94	63	83	87	95	98	94	94	92	96	93	96
Target CIVICA 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

TARGET RATIONALE to ensure consistency
Friends and Family (would you recommend us?) target = good or above (Good + very good)
Very Good 89.80% + Good 8.16% = 97.96%
Your Velindre Experience target = good or above (good + very good +excellent)
Excellent (10/10) 79.59% + Very good (9/10) 10.20% + Good (8/10) 6.12% = 95.91%
Reset Target to CIVICA 85%

Performance

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

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

Survey: VCC - Friends and Family

Create new action

Available Answers	Responses	Score (%)
Very good	88	89.80%
Good	8	8.16%
Neither good nor poor	2	2.04%
Poor	0	0.00%
Very poor	0	0.00%
Don't know	0	0.00%
Total	98	100%

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

Survey: Your Velindre Experience

Create new action

Available Answers	Responses	Score (%)
10 (Excellent)	39	79.59%
9	5	10.20%
8	3	6.12%
7	0	0.00%
6	1	2.04%
5 (Neutral)	0	0.00%
4	0	0.00%
3	0	0.00%
2	1	2.04%
1	0	0.00%
0 (Very Bad)	0	0.00%
Total	**49**	**100%**

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
Outcomes from CIVICA are reviewed monthly and form part of SLT Q&S highlight report and the QSP report	Ongoing	Head of Nursing/SLT
Directorate Reports are provided monthly to enable detailed review and 'You Said We Did' feedback	Ongoing	SLT/Directorate Managers
Directorates to develop plans to increase response rate.	Ongoing	
Q+S team to work with each directorate to provide further analysis on responses		SLT/Directorate Managers
CIVICA working group established with attendees from each directorate		Q+S manager
Q+S team to review the difference in positive percentages for both surveys		

Expected Performance gain – immediate

Introduction of the Civica Implementation group across VCC to increase participation across the teams

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Patient Engagement Hub to work with Q&S team to continue to find new/different ways of engaging patients and seeking feedback. This is currently ongoing.	December 2023	Head of Patient Engagement

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text

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KPI Indicator KPI.09

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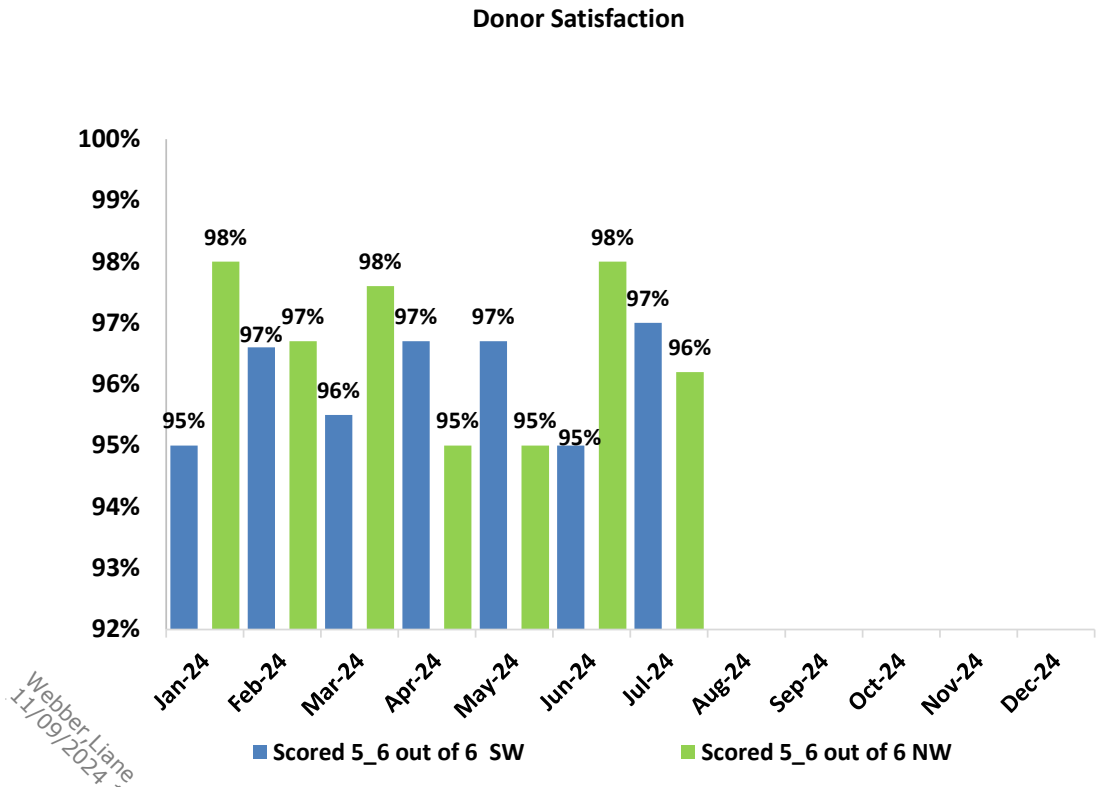
% Donor Satisfaction - donors that scored 5 or 6 out of 6 with their "overall" donation experience after they have been registered on clinic

Target: 95%

SLT Lead: Jayne Davey

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	97	97	97	97	96	94.9	96.7	95.1	95.6	96.3	96.7	96.5	95.1	96.3	95.6	96.9
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95



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Performance

Assessment of current performance, set out key points:
At 96.9%, donor satisfaction increased slightly and remains above target in July. In total there were 1,008 donor survey respondents, 198 from North Wales (scoring a satisfaction rate of 96.2%), and 801 from South or West Wales (scoring satisfaction rate of 97.0%).

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

N/A

Expected Performance gain – longer-term.
N/A

Risks to future performance

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

KPI Indicator KPV.12

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Number VCC formal complaints received under Putting Things Right within 30 days

Target: 85%

SLT Lead: Head of Nursing

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	100	100	100	100	100	100	100	100	100	100	0	100	33	100	71	100
Target 85%	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

Performance

Assessment of current performance, set out key points:

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

Webber,Liane
11/09/2024 10:57:44

KPI Indicator KPI.03

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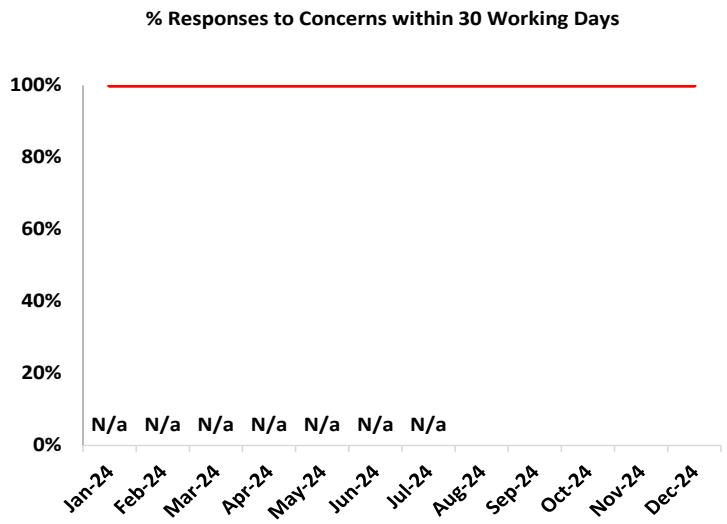
% Formal Concerns responded to under "Putting Things Right" (PTR) within required 30-day Timescale

Target: 100%

SLT Lead: Edwin Massey

Current Performance against Target or Standard

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



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

Performance

Assessment of current performance, set out key points:

The 1 formal concern received in May 2024, related to the number of deferrals on a Donor's record due for closure in July was closed on the 7th of June 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain – immediate

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance.

Closely monitor and have oversight of concerns management in line with PTR to eliminate future risk.

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TIMELINESS

KPI Indicator KPV.14

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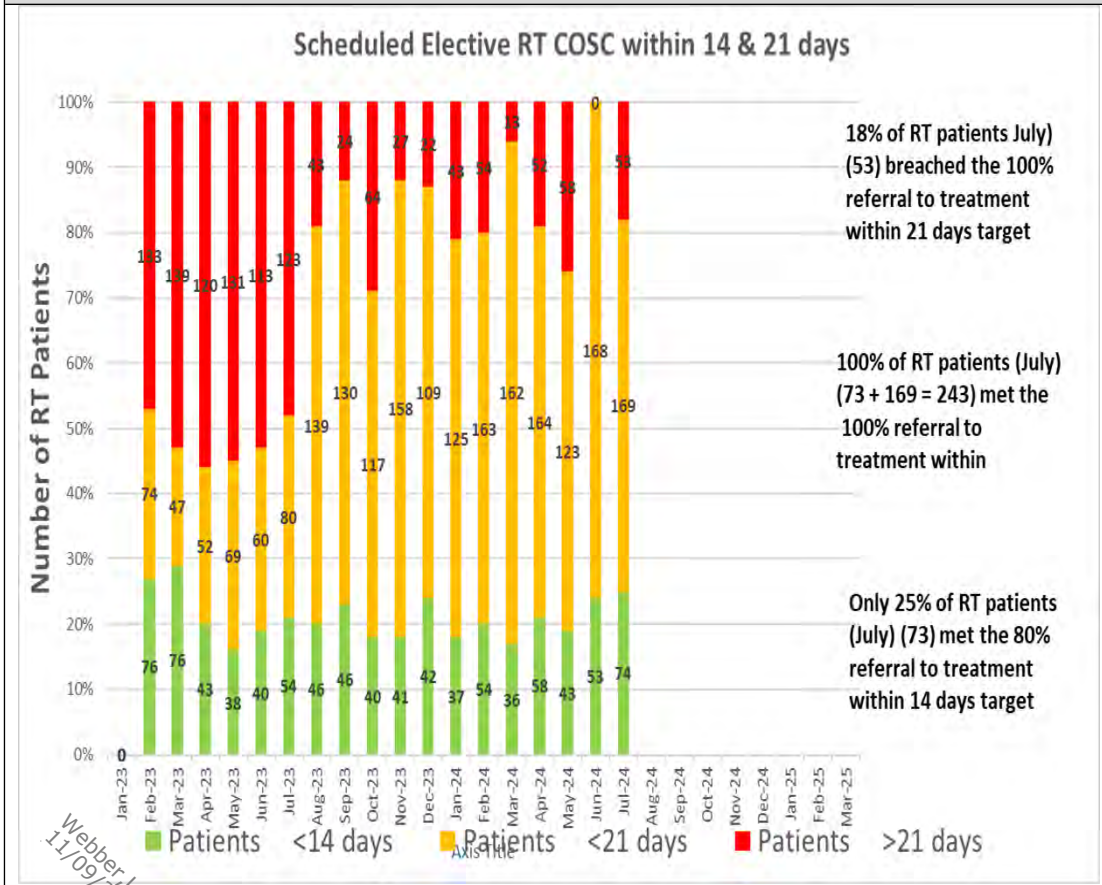
Scheduled Radiotherapy Patients Treated 80% within 14 Days and 100% within 21 Days

Target: 80% within 14 Days and 100% within 21 Days

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



Webber,Liane
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Chart Analysis

The above chart represents the spread of Scheduled RT performance against the 14 and 21 day targets with a significant improvement in >21 day breaches over the last 6 months.

Performance

Assessment of current performance, set out key points:

Ongoing challenges post DHCR in establishing a fully validated position. Validation resources currently insufficient to address range of issues identified.

Number of referrals	297	
treated within 14 days of referral (80% target)	73	25%
treated within 21 days of referral (100% target)	243	82%

Breach reasons:
27 breaches were due to LINAC capacity.
3 breaches were due to booking capacity
26 Breaches were due to pathway management issues. These included 8 for delays in the pathway, 6 for rescans required, 1 where the patient did not attend an agreed appointment, 3 for complex planning and 1 for referral process. The longest wait was 38 days.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve		Lead:
Retraining for clinical teams to ensure categorising of the referrals is correct.	Ongoing	Helen Payne/Tom Rackley
Complete commissioning of LA3 Halcyon unit to extend Varian Halcyon capacity	Complete	Tony Millin
Securing extended service contract for LA1	Ongoing	Tony Millin

Expected Performance gain – immediate

Fully validated position and improvement in performance.

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
IRS implementation group in place to address changes in capacity provision to meet revised patient demand per SST.	April 2026	Tony Millin/ Thomas Rackley/ Helen Payne

Expected Performance gain – longer-term

Changes to patient pathway in line with time to radiotherapy timings

Risks to future performance

Set out risks which could affect future performance

Linac replacement programme which has commenced

KPI Indicator KPV.15

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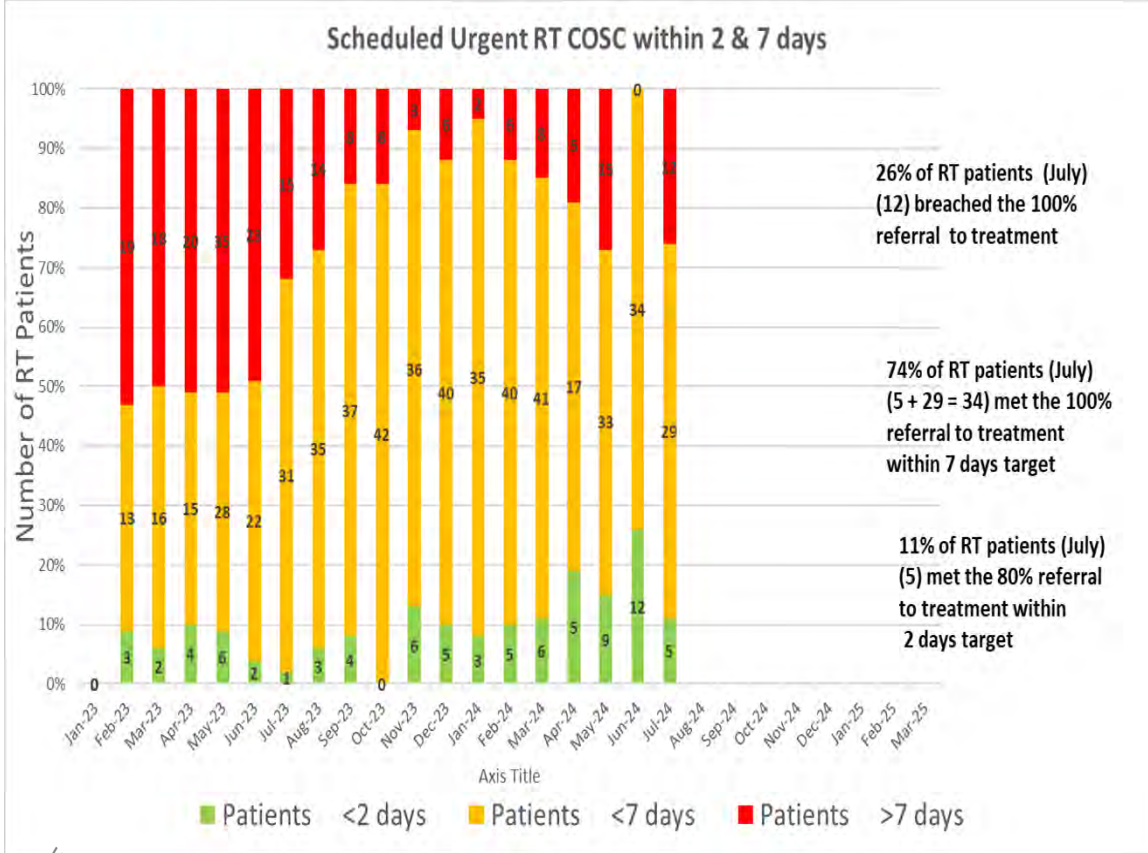
Urgent Symptom Control Radiotherapy Patients Treated 80% within 2 Days and 100% within 7 days

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



Webber, Lisa 11/07/2024 16:57:44

Chart Analysis
The above chart represents the spread of Urgent RT performance against the 2 and 7 day targets with a significant improvement in >7 day breaches over the last 6 months but some recent reduced performance.

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

Number of referrals	46	
treated within 2 days of referral (80% target)	5	11%
treated within 7 days of referral (100% target)	34	74%

Breach reasons:
3 breaches were due to LINAC capacity.
1 breach was due to booking capacity
8 Breaches were due to pathway management issues.
. The longest wait was 20 days.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve:		
Implementation of revised Urgent Symptom Control Definition	**Complete**	Helen Payne/ Thomas Rackley

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance
•

KPI Indicator KPV.16

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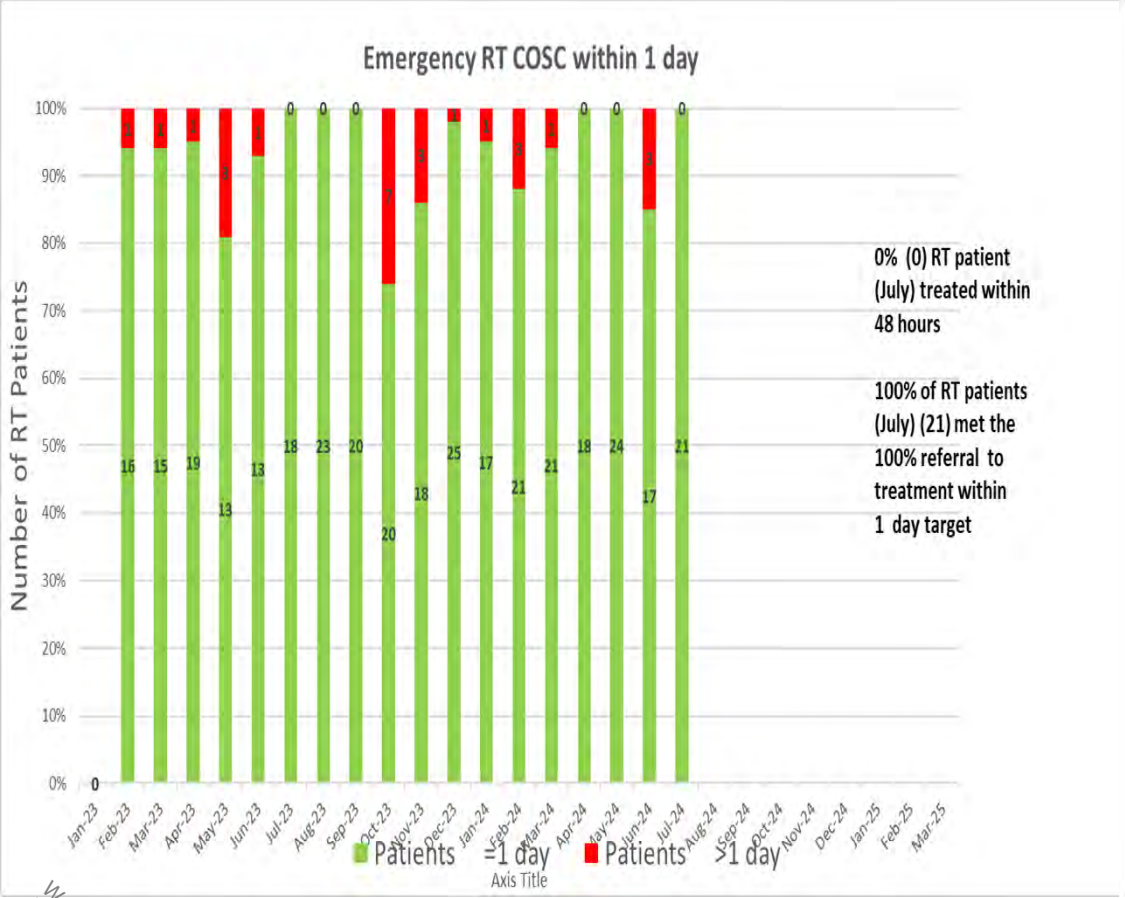
Emergency Radiotherapy Patients Treated Within 1 Day

Target: 80% within 1 Day and 100% within 2 Days

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard



Webber, Jane
11/09/2024 10:57:44

Chart Analysis

The above chart represents the spread of Emergency RT performance against the 1 and 2 day targets with the majority of patients being treated consistently within target.

Performance

Assessment of current performance, set out key points:

Target Achieved

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

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

KPI Indicator KPV.17

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Elective delay Radiotherapy Patients Treated 80% within 7 Days and 100% within 14 Days

Target: 80%

SLT Lead: Head of Radiation Services / Clinical Director

Current Performance against Target or Standard

Elective delay is a new recording category and differentiates between scheduled patients referred in to commence treatment as soon as possible, and those referred whilst on another form of treatment.

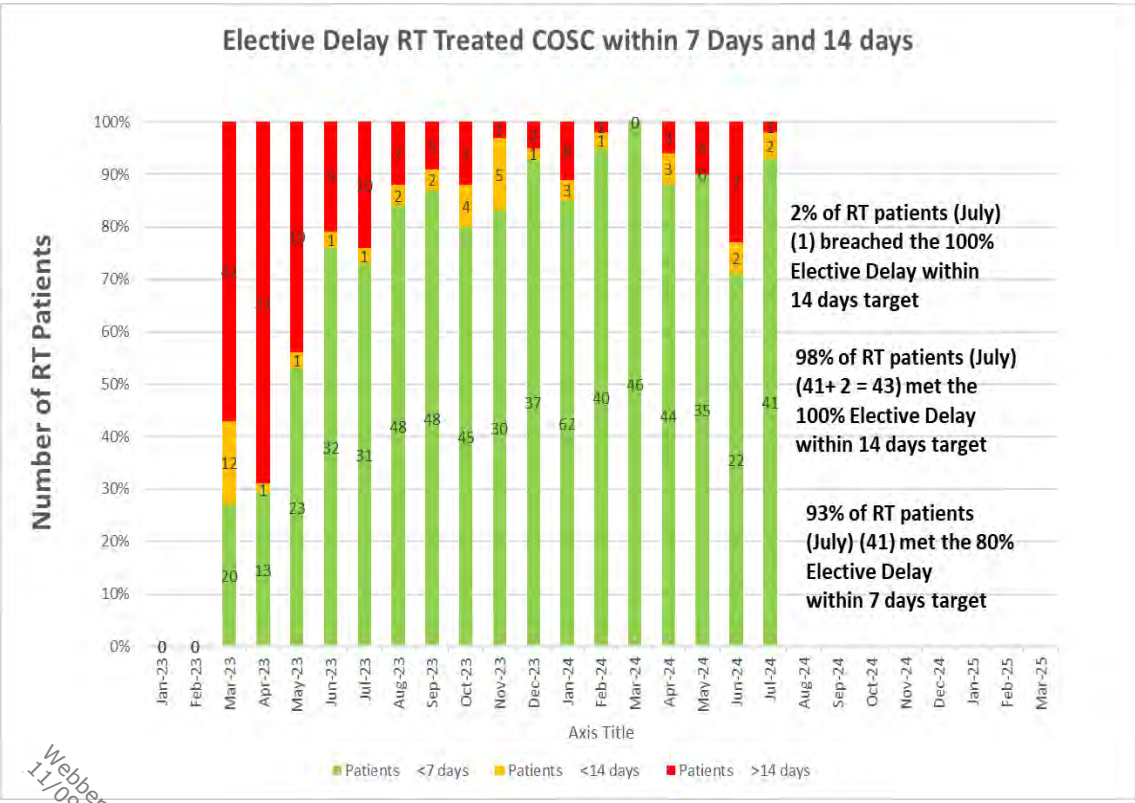

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Chart Analysis

The above chart represents the spread of Elective Delay RT performance against the 7 and 14 day targets with a significant improvement in >14 day breaches over the last 6 months.

Performance

Assessment of current performance, set out key points:

Issues as Scheduled elective patients above

Number of referrals	44	
treated within 7 days of referral (80% target)	41	93%
treated within 14 days of referral (100% target)	43	98%

Breach reasons:
4 were due to Linac Capacity and 1 was due to clinician capacity
4 Breaches were due to pathway management issues. These included
2 were due to replan required, 1 was as a result of patient failing to attend an agreed appointment, and 1 was as a result of the patient being too ill to attend

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve		
•		

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPV.20

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Non-Emergency SACT Patients Treated Within 21-Days

Target: 98%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

	Mar 23	Apr 23	May 23	June 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24
Actual %	98	93	90	90	94	92	90	98	85	90	64	79	91	75	76	88	
Target 98%	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	98	
More than 21 days	8	26	40	40	25	32	35	10	57	29	160	95	33	90	107	41	
Within 21 days	409	343	354	378	370	380	323	414	329	251	283	362	323	271	338	300	

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

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

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

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Performance

June position: 88% Performance – 341patients treated with 41 breaches.

Intent /Days -	22-28	29-35	36-42	43 days +
Non-emergency (21-day target)	32	9	0	0

The longest wait was 35 days.

Breaches – 41 non-emergency patients waited over 21 days. 32 of those patients were treated WITHIN 28 days.

all waits were capacity related.

9 patients waited > 28 days. A clinical harm review process is being led by the Medical Business Manager to identify if harm may have been caused to any patients affected by the extended waits.

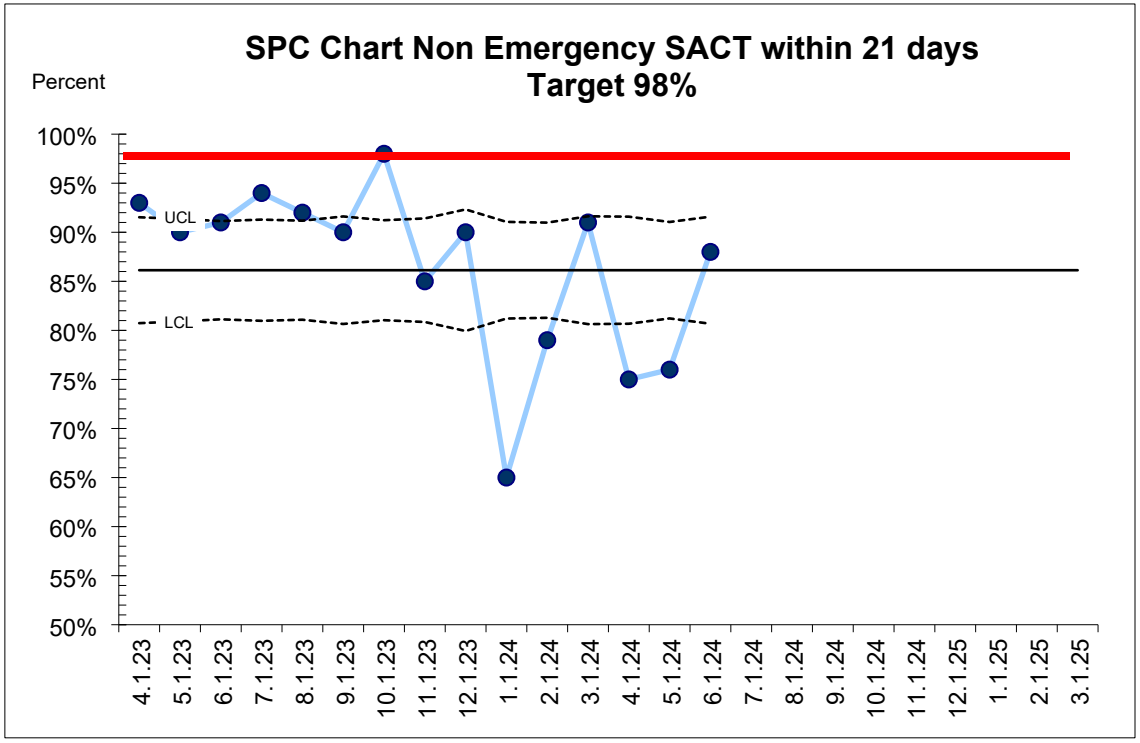
Demand continues in excess of predicted levels.

Pharmacy capacity remains the main challenge to delivering required activity levels to meet demand.

All patients within a Trial are booked within Trial timeframes.

Service Improvement Actions – Immediate (0 to 3 months)

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



SPC Chart Analysis
The SPC chart shows fluctuating performance from January to May 2024.

3) provide cleaning provision from operations to allow for potential release pharmacy staff on weekends to produce additional regimens		

Expected Performance gain – immediate

Not until July 2024

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

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

Webber Liane
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KPI Indicator KPV.21

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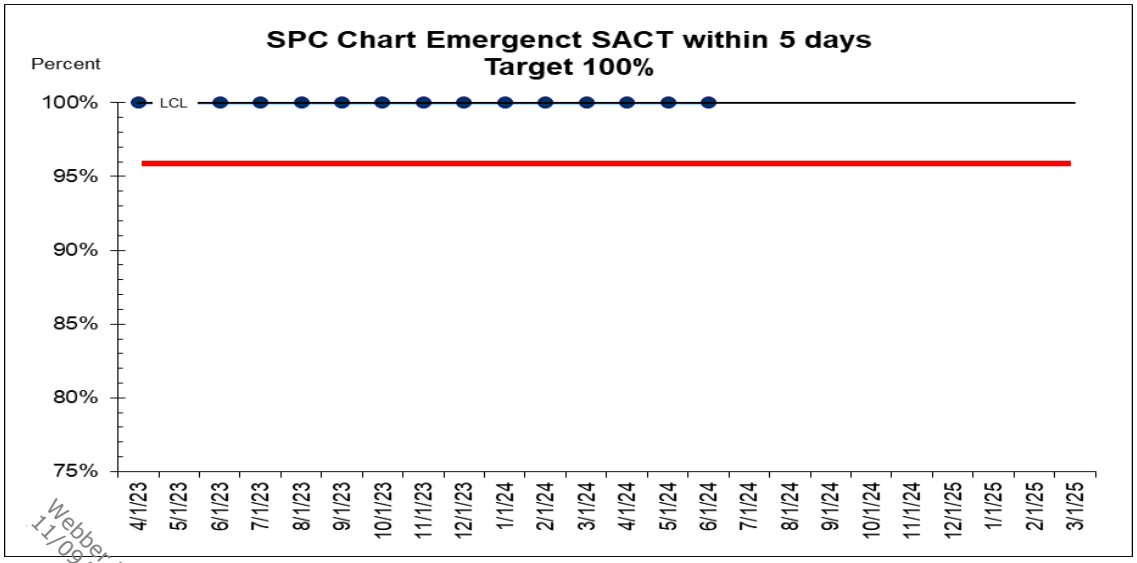
Emergency SACT Patients Treated Within 5 Days

Target: 100%

SLT Lead: Head of Medicines Management and SACT

Current Performance against Target or Standard

VCC	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
Target 100%	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	
More than 5 days	0	0	0	0	2	0	0		1	0	0	0	0	0	0	
Within 5 days	5	0	12	10	5	8	4		7	9	5	2	6	5	8	



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SPC Chart Analysis

The SPC chart shows consistent achievement of target, however note small numbers involved.

Performance

June position:

Target achieved – all 8 patients treated in target.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

		Lead:

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

•

KPI Indicator KPI.18

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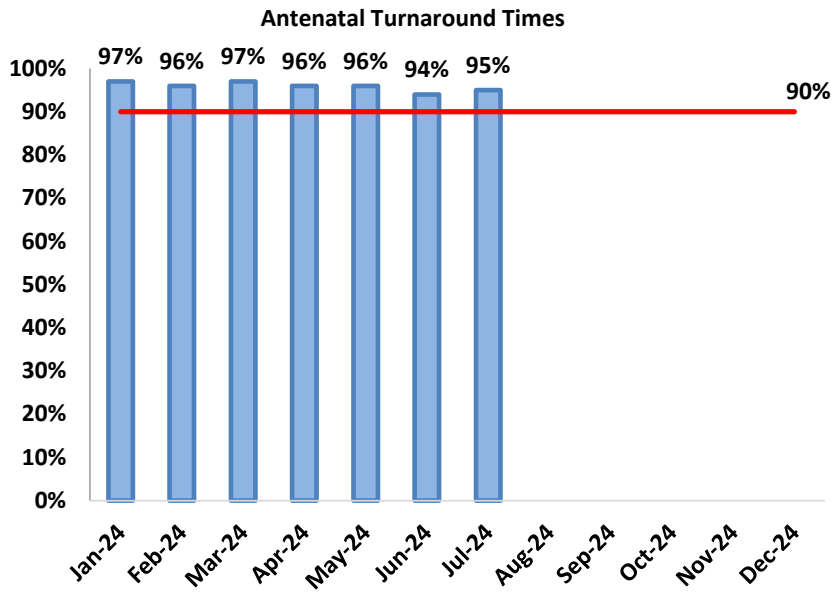
Antenatal Turnaround Times - Patient Results provided to customer Hospitals within 3 working days of receipt of sample

Target: 90%

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	June 24	Jul 24
Actual %	96	95	98	97	96	96	96	92	95	97	96	97	96	96	94	95
Target 90%	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90	90



Performance

Assessment of current performance, set out key points:
At 95% the turnaround time performance for routine Antenatal tests continued to exceed target in July 2024.

Service Improvement Actions – Immediate (0 to 3 months)

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

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

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.
N/A

Risks to future performance

Set out risks which could affect future performance.

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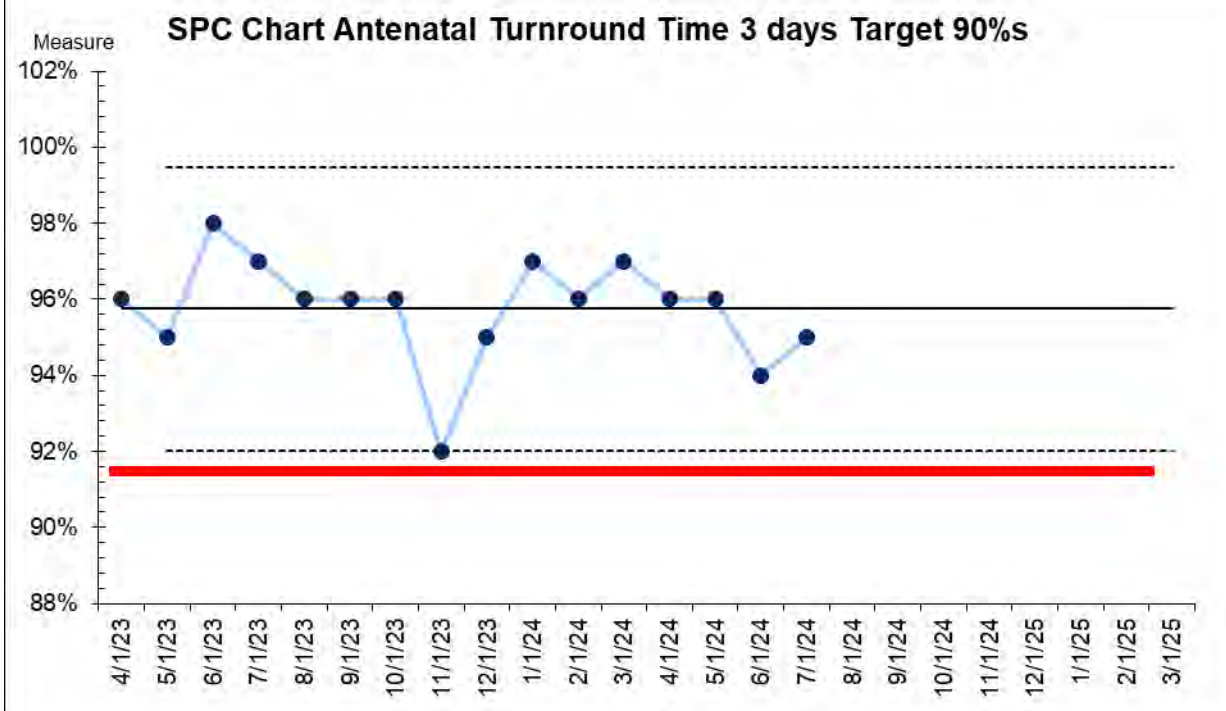

SPC Chart Analysis

The SPC chart shows common cause or normal variation over the 12 month period. However, whilst the performance decreased in November it remained above target, the average performance continued to exceed the 90% target averaging 96%.

Webber,Liane
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KPI Indicator KPI.17

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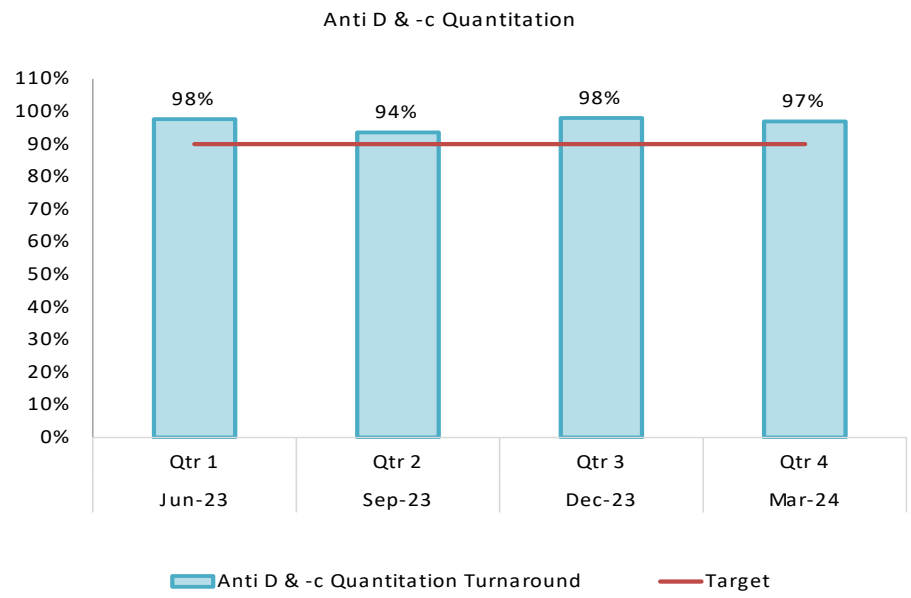
% Antenatal -D & -c quantitation results provided to customer hospitals within 5 working days

Target: 90% per quarter

SLT Lead: Georgia Stephens

Current Performance against Target or Standard

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



Performance

There was continued excellent performance during Quarter 1 which is consistent with 2023-24 performance.

Service Improvement Actions – Immediate (0 to 3 months)

N/A	**Timescale:**	**Lead:**

Expected Performance gain - immediate.

Service Improvement Actions – tactical (12 months +)

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

Expected Performance gain – longer-term.

Risks to future performance

Set out risks which could affect future performance.

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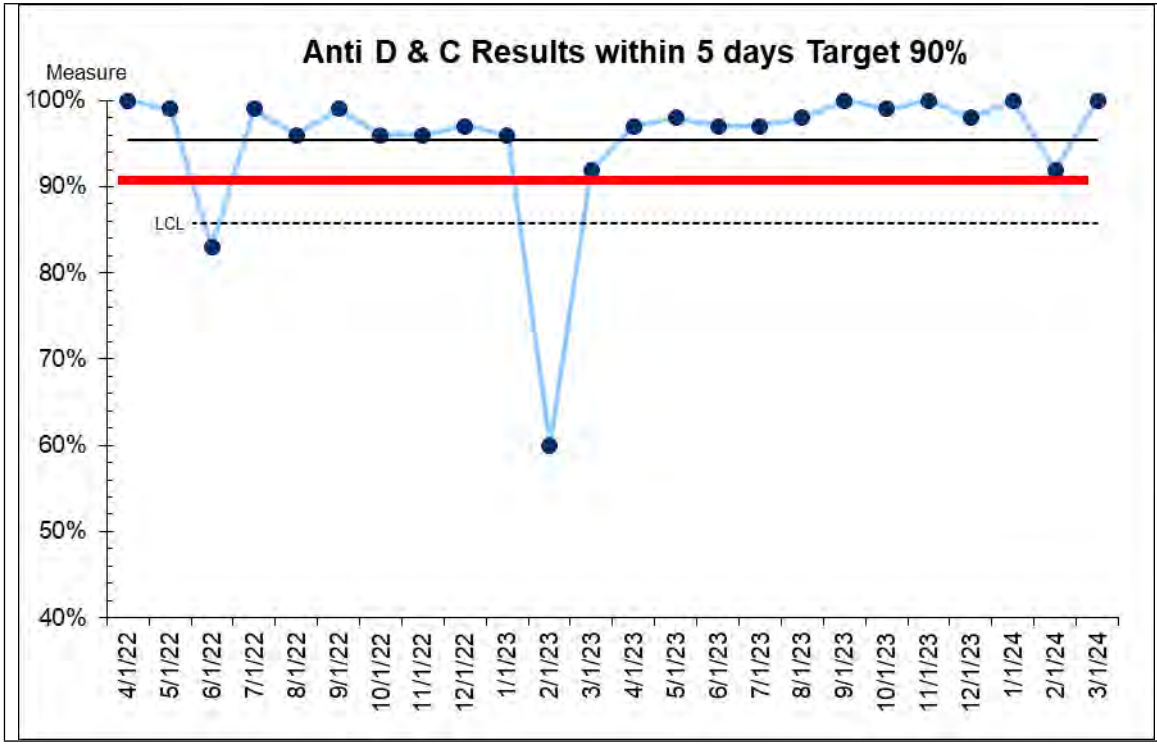

SPC Chart Analysis

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

Webber,Liane
11/09/2024 10:57:44

EFFICIENT

KPI Indicator FIN.71

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Financial Balance – Revenue Position

Target: Net Zero Trajectory

SLT Lead: Director of Finance

Current Performance against Target or Standard

Trust Position (core)	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual (Cumm) £k	30	5	7	8	8								
Target Net Zero		0	0	0	0	0	0	0	0	0	0	0	0

Trust-wide Revenue Position as of July 24

	YTD Budget £m	YTD Actual £m	YTD Variance £m	Full Year Budget £m	Full Year Forecast £m	Year End Projected Variance £m
VCC	(15.267)	(15.264)	0.003	(41.858)	(41.858)	0.000
RD&I	0.114	0.106	(0.008)	0.394	0.394	0.000
WBS	(7.130)	(7.128)	0.002	(20.961)	(20.961)	0.000
Sub-Total Divisions	**(22.283)**	**(22.286)**	**(0.003)**	**(62.425)**	**(62.425)**	**0.000**
Corporate Services Directorates	(4.199)	(4.197)	0.002	(12.602)	(12.602)	0.000
Delegated Budget Position	**(26.482)**	**(26.483)**	**(0.001)**	**(75.027)**	**(75.027)**	**0.000**
TCS	(0.173)	(0.163)	0.010	(0.635)	(0.635)	0.000
Health Technology Wales	(0.031)	(0.031)	(0.000)	(0.092)	(0.092)	0.000
Trust Income / Reserves	26.686	26.686	0.000	75.700	75.700	0.000
Trust Position	0.000	0.009	0.008	(0.053)	(0.053)	0.000

Performance:

The core Trust has reported a nil in-month movement on the position during July'24, which maintains a cumulative year to date position of **£0.008m** underspent and an outturn forecast of **Breakeven.**

The Trust received agreed commitment from HBs to proceed with the contract rebasing at the collective commissioner's group which was reflected in the LTAs issued by the Trust in March, however in April the Trust received letters from 2 HBs which outlined their disagreement with the rebasing proposal. The other 4HBs and JCC were in agreement to proceed but subject to all HBs agreement the contract rebase.

As commissioners were not able to reach a consensus before the 30th June deadline the Trust had to revert back and prepare LTAs on an historic basis.

Following discussions between Chief Executives, and in order to avoid arbitration, a compromise position was agreed on the LTA which has led to a financial impact to the Trust for 2024/25 as follows:

£318k Reduction in recurrent discretionary income compared to plan.

£483k Reduction in non-recurrent income compared to plan with a further risk to non-recurrent position still to be confirmed.

The shortfall in LTA income has been recovered through a combination of an increased savings target and pausing previously agreed investment decisions.

In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.875m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage.

Several new savings schemes were identified, which replaced those schemes that had either failed or not yet progressed. The

	revised target of £2.875m was required in order to help compensate for the loss of income from the LTA agreements. The Trust is reporting a year end forecast breakeven position, however this is based on the assumption that all planned additional income is received, the planned savings targets are achieved, and that all financial risks are mitigated during 2024-25.

Service Improvement Actions – Immediate (0 to 3 months)		
Actions: what we are doing to improve	**Timescale:**	**Lead:**
Expected Performance gain - immediate		
Service Improvement Actions – tactical (12 months +)		
Actions: what we are doing to improve • Recurrent savings plans and delivery to be addressed through Divisional senior leadership teams •	**Timescale:** 31.03.2025	**Lead:** SLT & SMT
Expected Performance gain – longer-term		
Risks to future performance		
Set out risks which could affect future performance		

Webber,Liane
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KPI Indicator FIN.73

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Financial Balance – Capital Expenditure Position

Target: Expenditure in line with Capital Forecast | **SLT Lead: Finance Director**

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

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual(Cum)	31.002	0.416m	2.113m	4.925m	6.322m								
Target £18.500m CEL		0.416m	2.113m	4.925m	6.322m								

Capital Position as of July 2024

	Approved CEL 2024/25 £m	YTD Spend £m	Budget Remaining @ M4 £m	F'cast Spend 2024/25 £m	Year End Variance 2024/25 £m
All Wales Capital Programme					
IRS - Integrated Radiotherapy Solution	5.164	2.042	3.122	5.164	0.000
IRS RSC - Radiotherapy Satellite Centre	11.265	0.854	10.411	11.265	0.000
nVCC Enabling Costs	0.000	2.289	(2.289)	3.368	(3.368)
nVCC Project Fees	0.000	0.719	(0.719)	3.622	(3.622)
nVCC Whitchurch Hospital Site	0.000	0.003	(0.003)	3.636	(3.636)
nVCC Governance Review	0.000	0.140	(0.140)	0.140	(0.140)
nVCC Governance Review Implementation (PW	0.000	0.000	0.000	0.350	(0.350)
WBS TGI	0.000	0.000	0.000	0.363	(0.363)
Digital - WHAIS	0.000	0.000	0.000	0.442	(0.442)
Digital - RISP	0.160	0.000	0.000	0.160	0.000
BECS	0.750	0.000	0.000	0.750	0.000
WBS Electrical Resilience - Backlog Maintenanc	0.000	0.000	0.000	0.350	0.000
WBS Liquid Nitrogen	0.000	0.000	0.000	0.000	0.000
Total All Wales Capital Programme	17.339	6.047	10.382	29.610	(11.921)
Discretionary Capital	1.911	0.275	1.636	1.911	0.000
	19.250	6.322	12.018	31.521	(11.921)

Weaver-Lisa 12/09/2024 10:57:44

The approved 2024-25 Capital Expenditure Limit (CEL) as of July 2024 was £19.250m. This includes All Wales Capital funding of £17.339m, and discretionary funding of £1.911m.

A total of £11.116m is now forecast to be required to support the nVCC enabling, project, Governance review costs and to make good the Whitchurch Site during 2024-25. WG are aware of the total requirement and are looking to put a request to the Minister imminently.

Discussions are ongoing with WG colleagues around securing the funding requirement in relation to WHAIS and the costs associated with the WBS TGI OBC, with WG having supported these projects up to this date.

In addition, the Trust has been awarded funding from WG towards the WBS electrical resilience, however the Trust received confirmation during July that the WBS Liquid nitrogen scheme which was initially supported was not approved by the Minister. The Trust will now be looking to secure funding either from year end capital spend should it become available, or the scheme will be included within next year's IMTP plans with a view to secure funding before the contract ends.

The finance team are in conversation with WG colleagues to ensure that the funding for all of the above Capital Schemes form part of the CEL for 2024-25.

The discretionary allocation of £1.911m represents an increase of 12% on the £1.683m provided during 2023-24.

The discretionary programme was fully allocated from previous decisions other than a £0.100m contingency, however following confirmation of funding towards the WBS Electrical resilience Scheme £0.230m (which was the original funding requirement) has now been released and will be considered for use against priorities schemes. WHAIS (£0.494m) continues to be ringfenced from discretionary with the expectation that if All Wales Capital funding can be secured, then a further £0.494m can be released back into the discretionary pot.

A review of the recent conditions survey of the VCC site is currently underway and will require funding support from the discretionary programme. This is currently estimated to be c£0.160m.

The CEL will be fixed by WG at the end of October, after this point the Trust is expected to manage any slippage on the Capital programme.

Performance to date

The actual expenditure to July 2024 on the All-Wales Capital Programme schemes was £6.047m, this is broken down between spend on the nVCC schemes of £3.151m, the IRS £2.289m, and RSC £0.854m.

The current spend on the Discretionary Capital programme as of July 2024-25 is £0.275m.

Year-end Forecast Spend

The year-end forecast outturn is currently expected to be managed to a breakeven position subject to the Trust securing funds for the nVCC and other projects on WG radar.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Aim to secure funding from WG to support unfunded schemes	30.09.2025	M Bunce

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

- Risk if funding is not secured to support nVCC.

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KPI Indicator FIN.72

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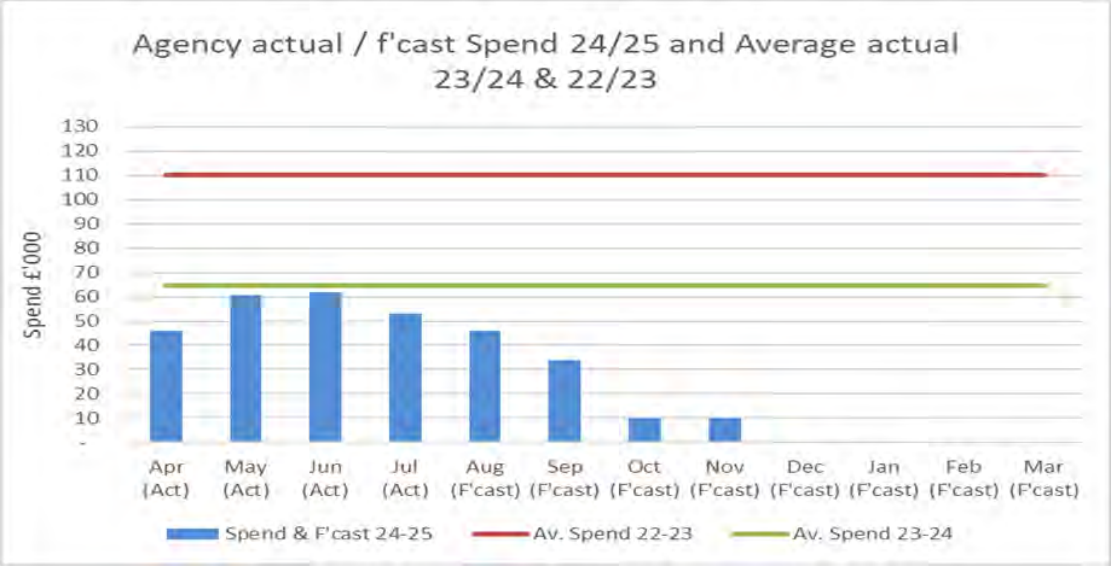
Usage of Overtime Bank and Agency Staff within Budget

Target: Spending within budget | **SLT Lead: Finance Director**

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual £k	1.323	46	107	169	222								
Target (per IMTP) £0.179m Forecast		39	78	117	138	159	179	0	0	0	0	0	0



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Performance

The spend on agency for July'24 was **£0.063m** (June £0.062m) which gives a cumulative year to date position of **£0.222m** and a current forecast outturn spend of circa **£0.322m** (£0.775m 2023/24).

The largest area of agency spend continues to relate to Radiotherapy and Medical Physics to cover vacancies and for the provision of additional capacity.

The Trust has been transitioning the Radiotherapy, Medical Physics, and some of the Estates staff into substantive positions following investment decisions in these areas, with expectation that some agency costs will remain in the short term to support where there continues to be vacancies. The reliance on Admin and Clerical agency is reducing but continues to support vacancies, with the ambition that agency support in this area will cease shortly as posts continue to be filled.

In line with the Value & Sustainability agenda and Finance &Investment Enhanced monitoring arrangements the Trust is aiming to move away from the reliance on agency by the end of quarter 2 as reflected in the IMTP. Whilst this is still the ambition there are some challenges with recruitment in areas such as Medical Physics and Radiotherapy as we establish the Integrated Radiotherapy Solution (IRS) and Radiotherapy Satellite Centre (RSC). In addition, Medical agency is required in the short term to support vacances and increased activity, and an AHP in Radiotherapy cannot be released until the end of November when core staff training is complete. There has also since been an additional ask of facilities for cleaning support within the septic unit which will require short term agency support.

Where possible the Trust will aim to utilise bank staff in order to reduce reliance on agency and the premium costs associated.

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• Actions addressed via Divisional action plans		SLT / SMT

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

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KPI Indicator FIN.74

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Cost Improvement Programme delivery against plan

Target: Savings in line with Forecast CIP | **SLT Lead: Finance Director**

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual Cumm	1.800	0.162m	0.324m	0.497m	0.831m								
Target £2.875m Forecast		0.162m	0.324m	0.497m	0.831m	1.077m	1.334m	1.591m	1.848m	2.105m	2.362m	2.619m	2.875m

Overall VUNHST Cost Improvement Programme £2.875m (previously £2.6M)

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Performance

The Trust established as part of the IMTP Financial Plan a savings target requirement of £2.606m for 2024-25 which equates to 3.1% of the Trusts core LTA income and is required to support the level of investment plans and cost pressures within the system.

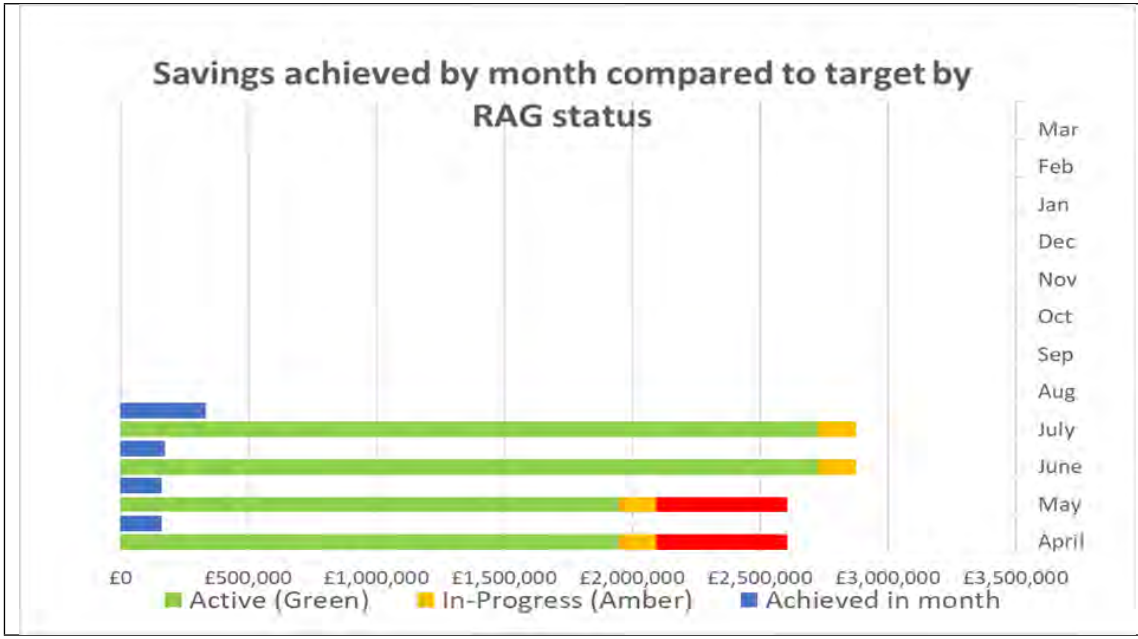
In conjunction with the overall financial plan an in depth review of the Trusts savings plan was undertaken during June and has resulted in a revised savings target of £2.876m being set for 2024-25, which is an increase of £0.270m from the £2.606m which was set at the IMTP planning stage. Several new schemes were identified, which replaced those schemes that had either failed or not yet progressed. The revised target of £2.876m was required in order to help compensate for the loss of income from the LTA agreements.

Of the revised £2.876m total savings target £1.267m (previously at IMTP planning stage £1.302m) is recurrent and £1.608m (IMTP £1.304m) is non-recurrent, with £1.193m (IMTP £1.179m) being categorised as actual saving schemes and the balance of £1.682m (IMTP £1.427m) being via income generation.

The Divisional share of the revised overall Trust savings target has been allocated to VCS £0.939m (32%) (Previously per IMTP £0.939m (36%)), WBS £0.569m (20%) (IMTP £0.650m (25%)), RD&I £0.230m (8%) (IMTP £0.230m 9%)) and Corporate £1.137m (40%) (IMTP £0.787m (30%)).

The WBS savings target was reduced from £650k to £569k in year due to the inability to enact savings schemes against a number of services constraints, not least the Infected Blood Enquiry. In addition, most of the replacement schemes that were found are non-recurrent in nature. It is therefore extremely important that work continues in the Division to implement recurrent savings plans to ensure that a balanced position can be carried into 2024-25.

The private patients scheme remains in amber as the Trust is assessing the external expert private patient management support it requires to facilitate delivery of the scheme, however we expect that once the external support contract is signed the income generation will be realised turning the scheme



green. If not, a replacement savings scheme will be found, or the Trust can utilise one of the opportunities such as the emergency reserve mitigating any risk.

It is extremely important that divisions review their current savings schemes, and where delivery may not be achieved, alternative schemes are implemented to ensure that the savings target is met for 2024-25.

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KPI Indicator FIN.60

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Public Sector Payment Performance Target Non NHS Invoices paid within 30 days

Target: 95%

SLT Lead: Finance Director

Current Performance against Target or Standard

Trust Position	23/24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Capital & Revenue Invoices	97	96	97	96	97								
Target 95%	95	95	95	95	95	95	95	95	95	95	95	95	

Performance

During July'24 the Trust (core) achieved a compliance level of **98.3%** (June 95.2%) of Non-NHS supplier invoices paid within the 30-day target, which gives a cumulative core Trust compliance figure of **96.9%** at the end of month 4, and a Trust position (including hosted) of **97.1%** compared to the target of 95%.

Service Improvement Actions – Immediate (0 to 3 months)

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

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
Work between Finance, NWSSP and the service will continue throughout 2024-25 in order to maintain performance.	31/03/2025	M Bunce

Expected Performance gain – longer-term.

Ensured compliance

Risks to future performance

Set out risks which could affect future performance

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EQUITABLE

KPI Indicator WOD.81

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% of Workforce who have declared Welsh Language Listening/Speaking capability

Target: 100%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Ma y 24	Jun 24	July 24
Actual %	-	89.70	-	-	90.19	-		90.59			92.50			93.53	
Target %	-	100 %	-	-	100 %	-		100 %			100 %			100 %	

Trust

Welsh Language (Listening/Speaking)

30-Jun-24

Welsh Language (Listening Speaking)	Count	Headcount	%
0 - No Skills / Dim Sgiliau	1181	1763	66.99%
1 - Entry/ Mynediad	238	1763	13.50%
2 - Foundation / Sylfaen	69	1763	3.91%
3 - Intermediate / Canolradd	43	1763	2.44%
4 - Higher / Uwch	55	1763	3.12%
5 - Proficiency / Hyfedredd	63	1763	3.57%
Capability Stated	1649	1763	93.53%
Not Stated	114	1763	6.47%
Grand Total	**1763**	**1763**	**100%**

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Performance

Assessment of current performance, set out key points:

- Welsh Language declaration 'not stated' recorded quarterly
- Target agreed as 0% non-declaration

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
- insert text

KPI Indicator WOD.78

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Mean Gender Pay Gap – Annual

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
Actual %	13.85	-	-	-	-	-	-	-	-	-	-	-	
Target TBA%	TBA	-	-	-	-	-	-	-	-	-	-	-	TBA

Trust Gender Pay Gap 31st Mar 2024		
Gender	Mean Hourly Rate	Median Hourly Rate
Male	£23.60	£19.13
Female	£20.33	£17.95
Difference	£3.27	£1.18
Pay Gap %	13.85%	6.15%

Mean Gender Pay Gap – 13.85% as at March 2024. This will be updated in March 2025. There is no target set, other than the objective to remove pay gaps within the time of the Strategic Equality Plan, ie by March 2028.

Performance

Assessment of current performance, set out key points:

- Gender pay gap position recorded as at March 2023
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

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KPI Indicator WOD.79

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Diversity of Workforce – % Black, Asian and Minority Ethnic people

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	My 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Ma y 24	Jun 24	July 24
Actual %	-	4.56	-	-	5.45	-		5.62			5.96			6.18	
Target TBA%	-	TBA	-	-	TBA	-									

Trust
Ethnic Origin
30-Jun-24

Ethnic Origin	Headcount	%
Asian	56	3.18%
Black	23	1.30%
Chinese	13	0.74%
Mixed	17	0.96%
Not Stated	28	1.59%
Other	15	0.85%
Unspecified	71	4.03%
White	1540	87.35%
Grand Total	**1763**	**100%**

BAME % **6.18%**

Performance

Assessment of current performance, set out key points:

- Staff ethnic origin recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

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KPI Indicator WOD.80

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Diversity of Workforce – % People with a Disability within workforce

Target: TBA%

SLT Lead: Director of Workforce and OD

Current Performance against Target or Standard

Trust Position	Ma 23	Jun 23	July 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	Ma y 24	Jun 24	July 24
Actual %	-	4.9	-	-	4.9	-		5.33			5.74			5.79	
Target TBA%	-	TBA	-	-	TBA	-									

Trust
Disability
30-Jun-24

Disability	Headcount	%
No	1457	82.64%
Not Declared	45	2.55%
Prefer Not To Answer	14	0.79%
Unspecified	145	8.22%
Yes	102	5.79%
Grand Total	**1763**	**100%**

Performance

Assessment of current performance, set out key points:

- Staff disability recorded quarterly
-

Service Improvement Actions – Immediate (0 to 3 months)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain - immediate

Service Improvement Actions – tactical (12 months +)

Actions: what we are doing to improve	Timescale:	Lead:
• insert text	XX/XX/XX	AN Other
•	XX/XX/XX	AN Other

Expected Performance gain – longer-term

Risks to future performance

Set out risks which could affect future performance

- insert text
-

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APPENDIX 4

Clinical Outcome Quality and Safety KPIs being considered/developed for PMF Scorecards 2023/24

QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	Type	Target
Safety			
VCS	Number & rate per 100k comparison of Velindre acquired (avoidable) patient pressure ulcers	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison of VCC Inpatient (avoidable) falls	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison of Potentially (avoidable) Hospital Acquired Thromboses (HAT)	National	NIL / Rate per 100k TBA
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) MRSA	National	NIL / 20 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) MSSA	National	NIL / 20 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) P. aeruginosa	National	NIL / Rate per 100k TBA (10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) Klebsiella spp	National	NIL / Rate per 100k TBA (10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) C Difficile	National	NIL / 25 per 100k TBA(10% reduction on 2017/18)
	Number & rate per 100k comparison Healthcare acquired Infections (HAIs) E Coli	National	NIL / 67 per 100k TBA(10% reduction on 2017/18)

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QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	**Type**	**Target**
	Number & rate per 100k comparison Healthcare acquired (HAIs) Gram negative bacteraemia	National	NIL / Rate per 100k TBA(10% reduction on 2017/18)
	Number of 'Never Events' recorded and reported.**(now included)**	National	NIL
	Number of National Serious Untoward Incidents (SUIs) recorded with Welsh Government	National	NIL
	NICE Guidance compliance with relevant cancer standards	Best practice	100%
Effectiveness			
VCS	% RT patient mortality within 30 days of first definitive treatment.**(now included)**	National	< 0.5% TBA
	% SACT patient mortality within 30 days of first definitive treatment .**(now included)**	National	< 1.0% TBA
	VCC Inpatient Mortality .**(now included)**	National	< 1.0% TBA
	Antibiotic usage Compliance with the principles of 'Start Smart then Focus'.	Best Practice	= or < 55% of WHO 'access category'
	Patient Reported Outcome Measures (PROMS)	National	TBA
	% treatments carried out Close to Home	Best Practice	TBA
	Turnover rate for Nurse and Midwifery registered staff leaving NHS Wales	National	Improvement against 2019/20 baseline
Experience			
VCS	Patient Reported Experience Measures (PREMS)	National	TBA

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QSF Domains	Executive Management Board PMF Scorecard.		
	Potential KPI under Consideration	Type	Target
Timely			
VCS	% Outpatients seen within 30 minutes of scheduled time (revised methodology)	Local	100%
Efficient			
VCS	% of Clinical episodes coded within one month post episode discharge end date	National	95%
	% of Clinical coding errors corrected by the next reporting month following identification	National	90%
Equity			
VCS	Equity of patient access to treatment (RT, SACT and Therapies)	Local	TBA
	The Workforce Race Equality KPI's are not going to be available to us until at least June next year as they are dependent on the national implementation of the Workforce Race Equality Standard (WRES)	National	TBA

Duty of Quality & Always On reporting requirements and VUNHST compliance 23.08.24

Duty of Quality

'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.

Examples of evidence to be used to assess the duty of quality and the extent of any improvement in outcomes includes …. '. The report then lists the requirements as in column 1 below:

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Duty of quality requirement	VUNHST compliance	Comment
Existing performance, outcome and delivery indicators and measures from the quality management system	Currently reporting on statutory KPIs	Work in progress to develop Quality metrics for each area – phased approach
Patient Reported Outcome Measures and Patient Reported Experience Measures (PROMS and PREMS)	Patient & donor experience results presented No specific PROMs in place / reported on	PROMS development in progress Could start to present Prostate PROMS in the PMF as this data is being collected
Mortality data	SACT 30 day mortality is in our PMF, Not yet capturing Radiotherapy Mortality Reporting on the MES in patient deaths via IQSG report and quarterly integrated Q&S report	VCC team is working to capture Radiotherapy mortality data
Information contained within the Once for Wales Concerns Management System such as incidents and concerns.	Reporting within PMF, in IQSG report and quarterly integrated Q&S report and annual PTR reports	
Patient and staff stories	Taking place at QSP	Could build % compliance into our PMF / QOF
Strategic decision-making that has been driven by the Health and Care Quality Standards	QIAs undertaken re any strategic decisions made. Information re this was provided in the Trust's Duty of Quality Annual Report 2023/24 Not captured currently in PMF / QOF	Could build % compliance into the PMF eg consider a quarterly % score where we list the strategic decisions that been made and whether they have all had a QIA undertaken
Reports following external reviews or inspections by inspectorate and licensing bodies.	Reports from any external review / inspections are captured on AMAT as well as the recommendations required Progress against the actions are reviewed at IQSG and are reported in the IQSG report, Integrated Q&S report	Not currently captured on the PMF, but we could look to develop this eg % compliance
Consideration of the recommendations and implications of significant national reports, for example, following national inquiries.	Takes place - mainly via the appropriate group eg Safeguarding, and then IQSG, into EMB then QSP, or directly into EMB. Recommendations proposed for VUNHST (ie recommendations that we ourselves advise) are not currently tracked on AMAT, but could and should be	Could consider presenting compliance with actions from any inquiries in the PMF/QOF

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APPENDIX 5

Analysis of Current Range of PMF Performance Measures (KPIs) & Level of Statutory Compliance (average/usual level)

VUNHST Services	Statutory / Mandatory KPIs		Best Practice / Benchmark KPIs		Locally Determined / Set KPIs	
Velindre Cancer Services (VCS) KPIs Safety (18); Effective (8); Patient Experience (3); Timely (8); Efficient (7)	Measuring in PMF & compliant	23	Measuring in PMF & compliant	5	Measuring in PMF & compliant	8
	Measuring in PMF & non-compliant	8 (see below) 2	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 44 VCS KPIs		**31**		**5**		**8**
Welsh Blood Services (WBSS) KPIs Safety (8); Effective (11); Donor Experience (7); Timely (4); Efficient (9)	Measuring in PMF & compliant	10	Measuring in PMF & compliant	12	Measuring in PMF & compliant	6
	Measuring in PMF & non-compliant	1 (see below) 3	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 39 WBS KPIs		**11**		**12**		**6**
Trust-wide Services (CORP) KPIs Safety (11); Effective (5); Staff Experience (3); Timely (45; Efficient (10); Equity (4)	Measuring in PMF & compliant	10	Measuring in PMF & compliant	0	Measuring in PMF & compliant	21
	Measuring in PMF & non-compliant	2 (see below) 3	Measuring in PMF & non-compliant		Measuring in PMF & non-compliant	5 (see below) 4
	Measures currently absent from PMF	Quality Act (see below) 1	Measures currently absent from PMF		Measures currently absent from PMF	
Total 38 CORP KPIs		**12**		**0**		**26**
Grand Total VUNHST 111 KPIs		**54**		**17**		**40**

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Notes

1 Quality Act 2023

2 VCS RT and SACT Statutory timeliness targets plus PADR and Sickness targets

3 WBS and Trust-wide PADR and Sickness targets

4 Trust-wide Health & Safety and Fire Training Local Stretch Targets

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

QUALITY, SAFETY AND PERFROMANCE COMMITTEE

TRUST RISK REGISTER UPDATE

DATE OF MEETING	12 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The main objectives of this report are to: • share the current extract of risk registers for risks scoring 12 and above for Quality/Safety and 15 above for all other domains; • to allow the Quality, Safety and Performance Committee (QSP) to have effective oversight and assurance of the way in which risks are being managed across the Trust; • Update QSP with a summary of activity related to the status of the risks and

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	associated movement. This paper will be shared with the Public Audit Committee and Trust Board.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to: • **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above. • **NOTE** the on-going developments of the Trust's risk framework. • **NOTE** the work underway to improve organisational management of risk reporting.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
WBS SLT	7 August 2024
VCC SLT	8 August 2024
EMB Run	29 August 2024
THIS PAPER TAKES INTO CONSIDERATION THE FEEDBACK FROM VCC AND WBS SENIOR LEADERHSIP TEAMS ON THEIR RESPECTIVE RISKS.	

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR				2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.			

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APPENDICES

1	Trust Risk Domains
2	Trust Risk Register – July (data validated in August 2024)

1. SITUATION

1.1 Risk

This report informs the Quality, Safety and Performance Committee of the status of reportable risks in line with the Board approved risk appetite levels and provides an update on progress on the development of the Trust's risk framework.

The baseline information is provided by the Velindre Cancer Service (VCS) and Welsh Blood Service (WBS) monthly risk analysis reports, which have been validated by their Senior Leadership Teams (SLT).

The timing of this report means that the validated data for August is not currently available. The VCS SLT is reviewing the August data on 5 September and WBS SLT on 11 September. Therefore, an updated version of this paper will be prepared including validated data for August for the consideration of the Public Audit Committee and Trust Board.

Trust risks are categorised into 11 domains noted in Appendix 1.

Risks reported in this paper are:

1. risks in the safety/quality domain with a risk level of 12 and above;
2. risks in the non-safety domain risk level of 15 and above.

2. ASSESSMENT

2.1 Trust Risk Register

For the reporting period, there is a total of 14 risks to report in line with the Trust's risk appetite. This includes:

- 9 risks with a current score of 12 or above, reported in the safety/quality domain. 1 on the Welsh Blood Service (WBS) register, 8 on the Velindre Cancer Service (VCS) register.
- 4 other risks with a current score over 15 or above. Two each on the VCS and WBS registers and one on the Transforming Cancer Services register.

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Further detail on the risks escalated to the Trust Risk Register can be viewed in Appendix 1.

2.2 Welsh Blood Service – based on July 2024 data and analysis by the WBS Senior Leadership Team on 7 August 2024

Key changes since the July reporting cycle:

- Following robust feedback by the WBS Senior Leadership Team and the Executive Board, risk 3362 “Risk to quality as a result of the failure of the WBS External Nitrogen Storage Tank leading to complete loss of liquid nitrogen” is being reviewed and its status re-categorised as a new risk rather than accepted risk.
- Risk 3193 “There is a risk to Financial Sustainability as a result of a failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform, leading to a degradation of critical WBS (NHS Wales) blood supply chain activities” and 3197 “There is a risk to Quality as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degradation of critical WBS (NHS Wales) supply chain activities” have been reviewed and the current risk scores reduced to a score of 10 on the basis that whilst funding is still unclear, the procurement will go ahead therefore the likelihhod of this risk materialising is lower.

2.3 Velindre Cancer Service – based on July 2024 data and analysis by the VCS Senior Leadership Team on 8 August 2024

Key changes since the July reporting cycle:

- Risk 3392 (Workforce domain) “There is a risk to the Dietetic delivery as a result of reduced staffing due to vacancies, leading to a potential impact on patient care” has been reduced to 12 and therefore isn’t reported on the Trust Risk Register.

2.4 Project and programme risk reporting

The new Velindre Cancer Centre project recently reviewed its risk profile and mitigation strategy. The updated position was approved by the Project Board at its August meeting. A meeting to align the project’s approach to Trust risk reporting is planned for early September. Further meetings to establish the alignment of programme risk reporting, specifically Velindre Futures and Welsh Blood Service Futures and Transforming Cancer Services, will take place in mid-September.

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The Transforming Cancer Services risk noted in Appendix 1 is under review.

3. KEY MATTERS - Summary of Actions Taken/ In Plan from Recent Governance Cycle

3.1 All Wales Datix module

Whilst the workstream has met regularly, in the update received 31 July, the Once for Wales Central Team considers there to be a lack of alignment across Wales in the terminology, matrices and workflow used within the risk management area.

The team is also of the opinion that the new Datix module achieves the specification established by the programme and anticipates that the opportunity to further refine the module will naturally arise as it is utilised fully by NHS Wales organisations.

With this in mind, the Programme Board recommended that all health bodies should prepare readiness reports with a plan to migrate to the Datix Cymru Enterprise Risk Management functionality (Risk Module), configured as established in the Demo System, from the 1st April 2025.

A meeting of organisational risk leads and Directors of Corporate Governance will take place in early September to map out the proposed approach for confirming individual organisational appetite to proceed.

3.2 Internal Improvements as part of the wider Governance, Assurance and Risk Programme

3.2.1 A newly developed Velindre Fundraising risk register was considered by the Trust's Charitable Funds Committee on 5 September. A meeting to map the alignment of the register with Trust Board risk reporting is scheduled for mid-September.

3.2.3 Following the appointment of the new Trust Risk and Assurance manager, we are re-establishing the Trust wide network to improve Trust risk reporting. Four key areas of focus over the next month include:

- a review of risk domains descriptors – to improve organisational understanding and aid accurate reporting;
- reviewing the procedure for de-escalating and closing risks;
- reviewing the procedure for management of long-term risks;
- an agreed template for future risk reporting.

3.2.4 In addition, an audit of all open risks will be undertaken when the new Risk and Assurance Officer starts in post in October 2024. The work will start with a data cleanse exercise focusing on each risk to assess issues such as inactivity, target dates last recorded review etc.

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3.2.5 A benchmarking exercise comparing current and historic Trust risk reports against those compiled by other NHS Wales organisations is underway.

3.2.6 All improvements will be captured in phase two of the Governance, Assurance and Risk Programme as part of the Building our Future Together initiative. Any changes or improvements will be considered in the context of the current Risk Policy and supporting documents, and their approval will be subject to internal governance.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to

- **NOTE** the risks in the quality and safety domain with a score of 12 and risks in other domains with a score of 15 and above.
- **NOTE** the on-going developments of the Trust's risk framework.
- **NOTE** the work underway to improve organisational management of risk reporting.

3 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains.
	Safe ☒

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	Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation. The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	No - Include further detail belowNo - Include further detail below
	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.There are no specific legal implications related to the activity outlined in this report.

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4 RISKS

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

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Appendix 1: Trust risk domains.

Risk domains
Quality
Safety
Compliance (Regulatory)
Research and Development
Reputation
Performance and Service Sustainability
Financial Sustainability
Workforce
Partnerships
Information Governance /GDPR
Environment

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

ID	DIRECTORATE		RISK OWNER	RISK TITLE	INHERENT RATING	CURRENT RATING	TARGET RATING	RATING CHANGE SINCE LAST REPORTING PERIOD	RISK OPENED	REVIEW DATE	PROGRESS SINCE LAST REPORTING PERIOD	OUTSTANDING ACTIONS
Velindre Cancer Centre												
12+ Risks in the Quality and Safety domains												
3337	SACT & Medicines Management	Safety/ Quality	RH	There is a risk that patients are missed as a result of multiple lists being used to manage booking leading to clinical harm	16	12	8		13.02.2024	16.09.2024	09/07/2024 - demo of single patient list taking place week commencing 08/07/2024 to assess and identify any additional work required prior to roll out 01/08/2024 - single patient list remains in building stage. Digital colleagues working closely with the booking team and wider SACT scheduling team to ensure the list is fit for purpose. Daily escalation meetings remain in place. Unscheduled list is completed on a weekly basis to mitigate against the risk 16/08/2024 - Digital colleagues and bookings team continue to work closely. List is in testing phase	No further actions noted on Datix

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											with a few amendments to make. it is felt once the digital team have all they need to build the list it will take 2 weeks for the list to be ready for roll out. In the meantime, daily escalation meetings continue and the unscheduled list is actioned regularly	
3338	SACT & Medicines Management	Safety/ Quality	RH	There is a risk that unable to meet demand for SACT service provision as a result of lack of pharmacy capacity leading to delay in patient treatment	16	20	12		13.02.24	09.09.24	02/07/24 - Pharmacy expansion Parenteral Product plan approved by SLT and Gold. Supporting paper outlining Pharmacy 04/07/24 - Efficiencies similarly developed and approved. Joint Pharmacy and Nursing paper presented to EMB August. 09/07/24 - business case scrutiny applications submitted for consideration at next panel (July 19) in anticipation of EMB approval to reduce	No further actions noted on Datix

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

											recruitment timeframe. MaH service expansion progressing as plan, however further capacity required (through additional staffing resource) to meet demand. Continue to progress plan.	
3366	Integrated Care	Safety	KB	There is a risk to the safety of staff due to lack of storage and cleaning space in the Therapies department resulting in an increased trip, slip or falls risk within the shared therapies storage, kitchen and corridor area.	8	12	4		04.04.24	30.08.24	Ongoing capital planning bid to relocate storage. Staff advised to use cups with lids when carrying hot drinks in the room and throughout the department. 2 person maximum sign to be re-instated on the door to the kitchen/store room Large signage to inform staff i.e.. “all spillages must be cleaned immediately”. This is just to re-enforce the existing guidance located by the door. An additional sign may be better placed on the opposite wall next to the window.	No further actions noted on Datix

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

											When using the ladder to access stock items on the shelves a 'buddy' must be present, and stock moved out the way rather than overreaching because they are unable to get the ladder close to the item they are trying to retrieve. (I'll put a poster together for this which can be circulated to the team and displayed in the room). Ongoing capital planning bid to relocate storage.	
3230	Operation Service and Delivery (Medical Records)	Safety	AMS	There is a risk to patient safety as a result of variation and multiple access routes for new referrals to Velindre Cancer Centre. The impact will be an inability and timeliness to ascertain accurate patient referral information which may impact/delay the delivery of patient care	12	12	4		09.10.2023	30.09.2024	01/07/24 - Risk reviewed by the Outpatient Management Group. VCC Service Improvement Team has established links with the C&V Service Improvement Team. Links with the Digital Team to agree technical solution of managing the sending and receipt of the pro forma (such as action point).	Explore options for short term central management of new patient referrals New Patient Waiting List to be developed to supporting the monitoring of referrals, which will include appointments booked, attended and waiting. Explore options for an electronic solution to manage and audit new patient referrals

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

											Discussions underway.	
2465	Medical	Quality/ Safety	RH	There is a risk to patient safety, caused by the duplication of information, excessive use of email and a lack of alternative communication methods for the processing of clinical information.	16	12	4		05.11.2021	29.11.2024	15/07/24 - Head of Ops in post. Key priority to review audit recommendations and establish T&F group to take forward outstanding actions	T&F group to be established Audit reviewed Action plan developed for outstanding actions
2187	Radiation Service	Quality/Safety	RW	There is a risk to patient safety due to inadequate staffing within the Radiotherapy Physics Department and the need to balance core duties with developmental tasks.	25	12	8		14.09.2020	29.11.2024	*No actions taken since last report. Review due in November 2024.*	Complete comprehensive 5 year workforce plan to determine the workforce requirements through the multiple stages of IRS implementation, the opening of the satellite centre and the transfer of services to nVCC. Re-advertise IRS implementation lead for the development of novel techniques.
3293	Radiation Service	Quality	IK	There is a risk to Quality, Performance and Service as a result of any delay in the new Velindre Cancer Centre (nVCC) leading to capacity at the current site not being sufficient to meet the demand, resulting in increased waiting time for radiotherapy, failure to meet All Wales time to radiotherapy metric and reduced patient experience.	20	12	4		21.12.2023	04.09.2024	Monitoring of capacity and demand. Development of breast escalation process to ensure patients are prioritised as per clinical need. Unlimited extended working hours on treatment machines and other areas of the department in	No further actions noted on Datix

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

											response to demand. Limited extended working hours on treatment machines and other areas of the department in response to demand. Limited to safe staffing, skills mix and age and configuration of the fleet. Agency radiographers in place to support additional hours. Unlimited replacement of new linear accelerators on current site. Policies and procedures on how to manage Radiotherapy scheduling and delays. Development of detailed transition plan to be implemented through NVCC project. Once plan is in place to assure operational service commence 2027, risk review may reduce current risk assessment.	
3431	Medical	Quality	CM	There is a risk that insufficient time to undertake an appropriate clinical assessment ahead of patients receiving their	20	20	4		24.07.2024	30.09.2024	*No update since last reporting cycle, however review is not due until 30.09.2024*	No further actions noted on Datix

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

				SACT for Skin/Melanoma, as a result of a significant gap between the demand and capacity in place for Pre SACT Assessments may lead to sub optimal clinical care for patients receiving SACT, missed/incomplete/incorrect or delayed patient related administration which can affect patient care and safety, poor patient experience for patients and an impact on the wellbeing of clinical staff.								
15+ Risks in other domains												
2705	Operation Service and Delivery	Safety	MD	There is a risk to public and staff safety as a result of CCTV/Door access system failure at Velindre cancer Centre leading to assurance of functionality, as recording units' failure with no warning	15	15	2		08.09.22	01.02.2025	Intevo System operational, however there are several cameras not working presently Functionality of the system operating normally. Camera functionality is being assessed to ascertain number of cameras inoperable against number of cameras required in priority areas	Audit of CCTV being undertaken Digital, Ops and estates to create SOP to overcome out of hours authorised access to node rooms
3247	Medical	Workforce		There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	16	16	9		08.11.23	30.09.24	One additional consultation room provided. One virtual hub provided. Capital monies requested to deliver two further consultation	Fully review of demand and utilisation of capacity within OPD. Business case to be developed to obtain funding to covert accommodation to

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											rooms submitted, outcome awaited.	delivery an additional four consultation rooms Clinic templates to be reviewed to manage patient flow
Welsh Blood Service												
12+ Risks in the Quality and Safety domains												
2274	WBS	Quality/ Safety	AP	There is a risk to **quality and safety** as a result of extensive manual workarounds due to outdated legacy IT systems, leading to increased risk of incorrect test results and patient harm.	16	12	4		31.10.22	24.12.24	Next review date 24.12.2024	Discovery and planning Transformation Workstream: process redesign and system configuration Data workstream: migration of legacy data Application workstream: build of environments, database and interfaces
15+ Risks in other domains												
3350	WBS	Service Sustainability	AP	There is a risk to **performance and service sustainability** due to the Welsh Blood Service transport function being unable to deliver services due to operating an ageing fleet of commercial vehicles	15	15	12		04.03.24	14.08.24	Update due outside of reporting period	Review risk
3306	WBS	Performance and Sustainability	AP	There is a risk of **loss of performance and sustainability**, as a result of a loss of electrical supply leading to a loss of service and production at Welsh Blood services Llantrisant.	20	15	5		15.1.24	26.07.24	Review risk position.	Programme of works and design has been agreed. Now gathering total costs for the work.

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TRUST RISK REGISTER

v01 September Governance Cycle
Quality Safety and Performance Committee

Transforming Cancer Services												
15+ Risks in the Quality and Safety domains												
3227	TCS	Financial sustainability	DP	There is a risk to **financial sustainability** as a result of changes during the design development process leading to a design which costs more overall, increasing project costs.	8	16	8		16.10.23	31.10.23		Costs have exceeded the proposed CAPEX and Value Engineering has been undertaken and shared with WG / Treasury. Commercial bootcamp is scheduled for 10/10/23 to try to finalise commercial position on various issues Ongoing

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST ASSURANCE FRAMEWORK UPDATE

DATE OF MEETING	12 September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mel Findlay, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The main objective of this report is to provide the Quality, Safety and Performance Committee with the opportunity to review the updates on the Trust Assurance Framework and the actions planned for the next period. This paper will be shared with the Public Audit Committee and Trust Board.

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RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to: • **NOTE** the current status and on-going

	development of the Trust Assurance Framework.

COMMITTEE / GROUP WHO HAVE RECEIVED OR CONSIDERED THIS PAPER PRIOR TO THIS MEETING	
COMMITTEE OR GROUP	**DATE**
EMB Run	29 August 2024
The Executive Management Board reviewed the strategic risks	

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

Level 7	Level 6	Level 5	Level 4	Level 3	Level 2	Level 1	Level 0
ASSURANCE RATING ASSESSED BY EXECUTIVE SPONSOR			2 – Comprehensive actions have been identified and addressed. The cause of the performance issue has been identified and is being actively managed.				

APPENDICES	
1	Strategic Risks
2	Trust, Assurance and Risk Framework August 2024

1. SITUATION

1.2 Trust Assurance Framework

The Trust Assurance Framework (TAF) was established in 2020. A dashboard was developed to record movement to TAF and support ongoing management of strategic risks by nominated Executive Leads.

The Trust Assurance Framework template was reviewed and updated further in consultation with the Audit Committee in early 2024. A refreshed Trust Assurance Framework, detailing eight strategic risks, was approved by Trust Board in March 2024.

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The eight strategic risks are included as Appendix 1.

2. ASSESSMENT

Trust Assurance Framework

At the Quality, Safety and Performance Committee in July 2024, TAF 05 Digital – *"There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security."* was discussed at length as a deep dive exercise providing an opportunity to discuss matters raised.

The mapping between the IMTP and the Trust Assurance Framework has been reviewed and considered as part of the template. The tracking of the performance against these objectives, in line with the standard IMTP quarterly reporting, will be included in the next reporting cycle.

The longer term "Phase 2" approach re-orientate the Trust Assurance Framework according to strategic objectives. The template and approach for this will be outlined and considered by the Governance, Assurance and Risk group in October, for agreement in November in order to allow the development of the 2025-2028 Integrated Medium Term Plan and Trust Assurance Framework to progress on this basis during Quarter 3 and 4.

Summary of Actions Taken/ In Plan

	Matter raised through recent governance cycle	Action Taken/ In plan	Timeframe
1	Populate refreshed TAF on Power BI template	Work completed in background on Power BI and refreshed information to be populated from March reporting cycle.	Although issue with lack of risk/assurance resource continues, it has been possible to progress the development work is complete and there is a usable version of the dashboard on SharePoint. Next steps are to migrate the dashboard through the Power Automate Exporting Tool.

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			Expect to be available to start migration by November.
3	Alignment to Integrated Medium Term Plan goals and then tracking of progress as part of first line of defence assurance.	Full update in paper in section 2.2 above	Phase 1 – July reporting cycle. Phase 2 – aligned to 2025/6 Integrated Medium Term Plan development
4	Deep dive of two risks at Quality, Safety & Performance Committee going forwards	Following reporting of refresh framework of strategic risks, this will recommence from the next reporting cycle.	TAF 05 Complete – included in July reporting cycle. New TAF risk to be considered for deep dive.
5 a-c	Governance, Assurance & Risk programme of work development	a. Alignment to Integrated Medium Term Plan annual review b. Embedding through Divisional Leadership and senior management as a valuable management tool c. Trust Board collective time to ensure strategic risks play a central role in how the Trust Board operates it's core functions and responsibilities. This may include further Board development time etc.	July 2024 - in line with completion of current phase and refresh of Governance, Assurance & Risk programme of work.

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6	Tracked changes	Tracked changes will be highlighted more clearly to show recent updates. In addition, the cover paper will be developed to include clearer commentary of key changes.	July reporting cycle – This will be automated based on migration to Power BI template as per improvement action 1 above.
7	Risk Score Trend	Review of approach to managing updated on Risk Score Trend to be reviewed by Executive Management Board	September Executive Management Board

3 SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to **NOTE** the current status and on-going development of the Trust Assurance Framework.

4 IMPACT ASSESSMENT

RELATED TRUST STRATEGIC GOAL(S)	Please indicate whether or not any of the matters outlined in this report impact the Trust's strategic goals. Please indicate here
Please tick all relevant goals: . Outstanding for quality, safety and experience ☒ . An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ . A beacon for research, development and innovation in our stated areas of priority ☐ . An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ . A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC TRUST ASSURANCE FRAMEWORK RISK	06 - QUALITY & SAFETY06 - QUALITY & SAFETY

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QUALITY AND SAFETY IMPLICATIONS / IMPACT	Tick all relevant domains. Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Cantered ☒ The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). The risk register and associated risk framework are imperative to quality and safety in the organisation. The risk register and associated risk framework are imperative to quality and safety in the organisation.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED	There are no socio economic impacts linked directly to the current risks in paper.
TRUST WELL-BEING GOAL IMPLICATIONS/IMPACT	There are no direct well-being goal implications or impact in the current risks in this paper.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT	There is no direct equality impact in respect of this paper, however each risk will have an impact assessment where appropriate.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report

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3 RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes
WHAT IS THE RISK?	The strategic Risks outlined in the TAF are informed by the Trust's active management and reporting of its operational risks.
WHAT IS THE CURRENT RISK SCORE	n/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	Consideration of the impact of the actions outlined in this paper on the current scoring of the strategic risks will be managed by the Executive Management Board at its monthly Run meetings.
BY WHEN?	Ongoing
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix	

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Appendix 1 – Trust Strategic Risks

01	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.
02	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.
03	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.
04	There is a risk of failure to meet or exceed service expectations without the prevalence of a positive working environment, which is characterised by effective values and behaviours, systems and processes
05	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security
06	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.
07	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.
08	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.

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SECTION 1

RISK ID	01	RISK TITLE	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Rachel Hennessey	Alan Prosser	Anne Carey	RISK THEME	Service Capacity		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Blood stock planning and management function between WBS and Health Boards. This includes active engagement with Health Boards in Service Planning including the established annual Service Level agreement,. The overall annual collection plan based on this demand and the active delivery of blood stocks management through the Blood Health Plan for NHS Wales and monthly laboratory manager meetings.	Director WBS	X			E	Annual Service Level Agreement meetings with Health Boards to review supply. Benchmarking against National and International standards. Annual Blood Health Team review of Health Board supply and prudent use of blood Annual Integrated Medium Term Plan (IMTP) review of previous 3 year demand trend to build resilience to inform and predict any surge demand.	Not Assessed	Senior Leadership Team, COO and EMB Review, QSP committee and Board.	Not Assessed	Welsh Government Quality, Planning and Delivery Review.	Not Assessed
C2	Operational Blood stock planning and management function in WBS. Delivered through annual, monthly and daily resilience planning meetings. Underpinned by the UK Forum Mutual Aid arrangements. Regular meetings with UK Blood Services on position of Blood Supply.	Director WBS	X			E	System pressures can be flagged at an early stage and appropriate action taken through Department Head review with escalation to Senior Leadership Team and Director.	PA	Performance Report to Senior Leadership Team and EMB Review, QSP committee and Board. National Red Cell and Platelet shortage plans	PA	Welsh Government Quality, Planning and Delivery Review Internal Audit, Wales Audit Office, regulator audits.	PA
C3	Continuity of core service delivery functions supporting Transfusion, Transplantation and Welsh Bone Marrow Donor Registry (WBMDR).	Director WBS	X			E	Business Impact Assessments across service functions identifying Maximum Tolerable Period of Disruption. Contingency equipment, Managed service contracts for critical suppliers, Planned Preventative Maintenance, Additional inventory for contingency of critical supply items. Business Continuity Plans for response. On call provision for Senior Leadership Team and core service functions.	PA	Escalation through VUNHST Business Continuity command structure if system pressures not resolved, invoke Service Level Agreements if appropriate or Technical Agreement with other UK Services.	PA	Invoke UK Blood Services Memorandum of Understanding (MoU) Escalation to Welsh Government Emergency Preparedness, Resilience and Response (EPRR) for Health, Local Resilience Forum - Strategic Coordinating Group. Internal Audit, Wales Audit Office, regulator audits.	PA
C4	Delivery of business as usual core services and capacity to support strategic programmes of work.	Director WBS, VCS	X			E	Implementation group for programmes mapping the interdependencies and pressures. Regular touch point meetings with Senior Leadership Team to review capacity to deliver key programmes of work.	PA	Highlight and performance reports to Senior Leadership Team and EMB to review.	PA	QSP committee and Board and external stakeholders if required. Internal Audit, Wales Audit Office, regulator audits.	PA
C5	National Policy decisions/ Directives that are introduced including Regulatory requirements to ensure the safety of services. (Advancements in medicines to improve patient safety).	Director WBS, VCS	X			E	Horizon scanning and representation at key forums including UK Forum, Joint Professional Advisory Committee (JPAC) for UK blood services, The UK advisory committee on the Safety of Blood, Tissues and Organs (SaBTO). Regular liaison with Blood Policy and Tissue, Cells and Organs Policy team in Welsh Government.	Not Assessed	Trust wide clinical and scientific board. Senior Leadership Team and EMB Review.	Not Assessed	QSP, SDC	Not Assessed
C6	SEW- VUNHST cancer demand modelling programme with HBs and WGDU in place, continues to provide high level assurance on demand projections.	Director VCS	X	X		PE	SE Wales Group	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed
C7	Demand and Capacity Plan for each service area of VCS	Director VCS	X	X		PE	Service area operational planning meeting	Not Assessed	Performance Report - SLT, EMB, QSP and Board	Not Assessed	Welsh Government Quality, Planning and Delivery Review	Not Assessed

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND

Wednesday 10.5.2...

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

SECTION 5

SMART ACTION PLAN

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

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE	VELINDRE CANCER SERVICE
Strategic Goal 1 Outstanding for quality, safety and experience	**1. Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) 2. Implementation of Integrated Radiotherapy Solution Programme by 2026/27 3. Implementation of Outreach Programme by 2025-26 4. Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services 5. Implementation of Regional Acute Oncology Delivery Model and Network Structure 6. Implementation of ePMA for Use by Velindre Cancer Services 7. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services 8. Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC) 9. Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes 10. Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables 11. Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25 12. Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy 13. Ensure the Viability of the Neuro- Oncology Service 14. Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping).**	**1. Project close and Radiotherapy Satellite Unit to 'go-live'. 2. Progress phase 3 objectives 3. Complete 4. Develop contingency plan to address scenario in which national implementation on of the TrAMs model is delayed beyond the opening of nVCC. 5. Complete 6. Project close following successful implementation. 7. Project close following successful implementation. 8. Develop plan to facilitate transition of brachytherap y service to nVCC. Develop interim business case for radiotherapy as part of contingency planning to address potential delays to wider infrastructure project to include commissioni ng a fourth linear accelerator, outsourcing,7-day working,etc. 9. Complete 10. Full programme implemented. Undertake post- implementation on programme review 11. Complete 12. Complete 13. Complete 14. Complete**	**1. Complete 2. Project close 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Deploy workforce plan for operational and facilities services. Draw down identified funding from FBC to enable recruitment to necessary posts. 9. Complete 10. Complete 11. Complete 12. Complete 13. Complete 14. Complete**
	15. Implement Recommendations from Peer Review of SACT Treatment Helpline 16. Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics 17. Implement New Molecular Radiotherapy Treatments at VCS 18. Review the Radiation Protection Service Resource to Enable Dynamic Response to National, Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources 19. Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme 20. Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services 21. Develop and Implement Model for Clinical Leadership and Supporting Governance Structure 22. Design, Commission and Deploy Revised Patient Transport Model 23. Implement Pathway Improvement Programme 24. Undertake Digitisation of Medical Records 25. Implementation of New Services / Delivery Models 26. Implement DHCR Phase 2 by 2024/25 27. Implementation of Consolidated Document Management System Across VCS 28. Respond to Low / Limited Audit Assurance Findings 29. Implementation of Centre for Collaborative Learning	**15. Complete 16. Complete 17. Determine resource implications of the introduction of new Molecular Radiotherapy treatments at VCS in anticipation of NICE approval. Actively engage with commissioners. 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Undertake evaluation of new models. 24. Establish project group. Identify service improvement s / opportunities for change. Identify additional resource requirements Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 25. Develop solutions for, develop service model for delivery of, identify resource implications and develop business cases to secure funding, where appropriate, to facilitate: Implementation on of new Internal Mammary Node (IMN) service, axillary radiotherapy service and partial breast radiotherapy service Implementation on no new extreme hypofractionation for prostate / SABR prostate service. Implement SABR treatments for new indications. Expansion of stereotactic radiosurgery (SRS) service. Palliative radiotherapy service. 26. Complete 27. Complete 28. Complete 29. Phased implementation on work to commence (initial proposals aligned to nVCC Full Business Case agreed).**	**15. Complete 16. Complete 17. Complete 18. Complete 19. Complete 20. Complete 21. Complete 22. Complete 23. Complete 24. Undertake post-project evaluatio 25. Complete 26. Complete 27. Complete 28. Complete 29. Complete**
	WELSH BLOOD SERVICE	WELSH BLOOD SERVICE	WELSH BLOOD SERVICE

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Strategic Goal 1 Outstanding for quality, safety and experience	**1. Implement improved donor interaction by 2026/27. 2. Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model and its ambition by 2026/27. 3. Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) 4. Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25. 5. Revised blood collection clinic portfolio by 2025/26. 6. Introduce clinically led collection team model by 2024/25 7. Develop and implement a platelet strategy by 2025/26. 8. To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system. 9. Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26 10. Procure new Blood Establishment Computer System (BECS) contract. 11. Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs SaBTO) recommendations on blood donor testing to reduce the risk of transmission of Hepatitis B infection as required 2024/25. 12. Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26. 13. Implementation of Foetal DNA typing by 2024/25.**	**1. Complete introduction of a donor experience hub. Complete implementation on of a Customer Relationship Management t (CRM) System. Implement omni-channel software 2. Implement recommended strategies for maintaining growth of the registry such as collecting 3rd party cellular products or ATMP Starting materials. Continue to progress with the WBMDR replacement software project 3. Begin to implement new strategy 4. Complete 5. Complete development of options for introduction of a new fixed donation venue/complete review of existing blood donation venues 6. Complete 7. Development of the collection strategy for apheresis and whole blood platelet collection Development of the Horizon Scanning for fluctuations for optimal platelets supply. Development of the strategy to improve the on-shelf availability of all platelet types: Including expanding donor panel. Research and development of new components 8. Complete deployment (Q1) 9. Complete Data Migration (Q1).Training (Q1). Go Live (end of Q1) 10. New Contract Award (Q1).New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECs solution 11. Part of standard activity post implementation. 12. Implement Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) strategy (Qtr 1). Substances of Human Origin (SoHo) Regulations – develop strategy for WBS. 13. Scope expansion of service. 14. Implement new NAT strategy.**	**1. Implement tailored pathways for donors and advocates. New donor app implementation and create content. 2. Continue to implement recommended strategies for the expansion of stem cell collection services. Implement new WBMDR software. 3. Complete 4. Complete 5. Complete 6. Complete 7. Complete 8. Complete 9. Complete 10. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28). Continue supporting existing BECS solution. 11. Part of standard activity post implementation. 12. Substances of Human Origin (SoHo) Regulations – WBS Strategy to be in place 13. Complete 14. Complete**
	15. Introduction of West Nile Virus (WNV) Testing. 16. Assess and implement the recommendations of the Infected Blood Inquiry (IBI). 17. Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. 18. Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. 19. Develop a sustainable workforce model which provides leadership, resilience and succession planning by 2025/26.	**15. Complete 16. Complete 17. Commence supply of frozen recovered plasma for fractionation from Q1 Receipt of first fractionated product from Q3. 18. Develop Full Business Case (FBC). 19. Implement recommend actions of review of workforce planning across WBS. 20. Implementation recommendations from the Inependent Blood Inquiry**	**15. Complete 16. Complete 17. Source Plasma TBC depending on policy decision and business case support. 18. Construction commence s - three- year programme 19. TBC**

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SECTION 1

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

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: PE

Overall Trend in Assurance THIS WILL HAVE A GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
1.3	Performance data and measures to clearly track progress against objectives				X	PE	Linked through performance framework insight; new performance management	E	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	PA
2.1	Blood - core blood services commissioning arrangements			X		E	Commissioning contracting reporting in place with LB partners; regional/national	E	Strategic Development Committee/ Quality Safety	PA	Regulatory scope re MHRA tbc; clear stanadards for services understood and	E
3.1	Local Partnership Forum		X	X		E	Feedback from LPF; proven to be effective	E	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office	E
4.1	South Wales Collaborative Cancer Leadership Group system model to provide leadership across region			X		PE	Agreed to model for next phase	NE	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	PA
5.1	Partnership Board arrangements with partner Health Boards model;			X		E	Agreed to model for each organisation	PA	Strategic Development Committee/ Quality Safety	PA	Wales Audit Office/Welsh Government	E
5.2	Partnerhsip with other stakeholders e.g. WAST, HEIW and University partnerships.		X			E	Good working relationships with regular communication	E	HIW	E	QSP	E
5.3	Effective regional /national commissioning of Trust services		x			PE	Regional commissioning groups in place and effective	PA	EMB; Strategic Development Committee; Quality, Safety		Wales Audit Office/Welsh Government	

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Across the models of working in strategic partnerships, there are common themes of control effectiveness – with the models largely in place, further development required on the ways of working/work programmes and even further development required on the reporting mechanisms	First line and second lines of defence assurance are in place to a certain extent	1.9; 1.7; 1.8
Establishment of new commissioning national commissioning function (WHSSC/EASC) regarding blood service commsissioning and specialsit cancer commissioning	Replace of CCLG not in place yet so no regioanl assurance regarding strategic alignment etc	1.9
Agreement of need for improved regionsal cancer commissiong (core services)		1.6; 1.8
Need for improved data/quality metrics to track perforamance	Provision of improved metrics to EMB; QSP and Trust Board	1.3; 1.4

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.4	Phase 1 complete. Development of Phase 2 of PMF with additionalperfromance measures/quality metrics commenced - delivery dates require firming up. Phase 2 elements commenced with a range of new quality indicators proposed for WBS and wider quality dimensions - approved by EMB in May 2024 - for consideration by SDC in May 2024. Progress made on provision of outcome measures/resource utilisation dashboard for all Site Specific Teams in VCS and resource utilisation (may 2024)	Carl James	Design stage commenced and a revised programme has been developed to support the delivery of phase 2.	14/05/2024	Anticipated it will reduce level of risk by providing additional insight on quality of services	The level of assurance should increase
1.5	Development of Value Based Healthcare programme to	Matt Bunce	Programme established and staff on-boarded. Progress	11/04/2024	Anticipated it will reduce level of risk by providing	The level of assurance should increase
1.6	CCLG: formation of SE Wales Cancer Programme to evolve from CCLG	Carl James (will act as liason)	1. CEO agreement to Cancer programme sept 23 2. CEO lead identiifed 3. Programme Manager and resources partially identied 4. Commencement of programme (tbc). Still no commencement date. Further regional discussions at the regional summit on 6 june 2024	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments and the quality of cancer services	The level of assurance should increase
1.7	WG review of NHS Wales strategic management / accountability arrangements will potentially identify how strategic alignment across the healthcare system can be stregthened. When completed the Trust will review and identify any actions which strengthen alignement	Carl James	Trust received request to feed into the review process. Review in progress - NHS organisations have not received any further information at this stage. No further update received on the findings of the national review	14-May-24	Unknown at this state	The level of assurance should increase
1.8	Trust included in SE Wales regional strategic planning programme (for wide range of services i.e. not only cancer (e.g. diagnostics etc)	Carl James	Chief Executive/Executive Director of Transformation/Executive Medical Director attended regional workshop to discuss shape of programme/strategic aligment on 6th December 2023. Regional programme working through implementation phase. Regional clinical summit on 6 June 2024 to discuss future regional plans	14-May-24	Anticpated it will reduce the level of risk regarding strategic mis-alignment between the Trust/partners and the wider healthcare system.	The level of assurance should increase
1.9	Establishment of new national commissioning body (bringing WHSSC/EASC together)	Welsh Government	Implementation of new commissioing body well progressed. New Commissioning Body established and LIVE	14/05/2024	Anticipated it will reduce level of risk by providing strengthening regional partnership arrangments	Action complete: increased level of assurance increased as national body with clear commissioning scope and powers

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27

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Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	**Working with our Health Partners:** **The Trust works with a wide range of partners including health, local authorities, emergency services and the voluntary/charity sector.** **Our Agreed Programmes of Work:** **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.** **1. Delivering the Fundamental Cornerstones of Healthcare Provision:** **• Implementing the requirements of the Health and Social Care (Quality and Engagement) (Wales) Act 2021, the National Quality and Safety Framework and the National Clinical Framework to provide services of the highest possible quality** **• Delivering services that meet the national clinical quality and safety standards and provide an excellent experience** **• Treating patients as quickly as possible** **• Providing blood and blood products to our partner Health Boards to support the provision of treatment and care to people across Wales** **• Developing agile and flexible capacity plans which allow us to respond quickly to changes in demand for our services** **• Supporting the health and well-being of our staff who have been working in extremely challenging circumstances for the past three years** **• Workforce redesign – optimising multi-professional patient / donor cantered care predicated on co-production and top of licence working**		
	2. Improving Population Outcomes and Reducing Inequalities: **• Improving access to our services to increase uptake and reduce inequalities and ill-health** **• Strengthening our decision-making to consciously address poor outcomes and inequalities in the communities we serve** **• Working with our health partners where it is clear and compelling that we can add value and make a difference**		
	3. Regional Working, Partnerships and Collaboration to Improve Outcomes **• Work with Local Health Board partners to strengthen our support the delivery lead of improved cancer outcomes for patients in South East Wales** **• Develop the Velindre@ research hub philosophy across all LHB partners in South East Wales** **• Further develop the Blood Health Oversight Group work programme to improve the prudent use of blood and blood products across Wales** **4. Delivery of Transformation Programmes** **Non-surgical Tertiary Oncology Services:** **• Implementing the final phase of the Acute Oncology Service regional model** **• Continue to improve pathways for unscheduled care patients** **• Delivery of the Cardiff Cancer Research Hub** **• Implementation of the Integrated Radiotherapy Solution in 2025** **• Construction and delivery of the new Velindre Cancer Centre in Whitchurch, Cardiff in 2027**		
	Blood and Transplant Services **• Laboratory Modernisation programme:** **• Refurbishment of the Talbot Green facility by 2027** **• Plasma for Fractionation: developing the case for change and delivery of the Programme**		

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SECTION 1

RISK ID	03	RISK TITLE	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Sarah Morley			RISK THEME	Workforce Supply and Shape		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		PE
C1	Trust People Strategy, approved in May 2022, clearly noting the strategic intent of Workforce Planning - 'Planned and Sustained Workforce'	Sarah Morley	X			E
C2	Workforce Planning Methodology approved by Executive Management Board	Susan Thomas	X			E
C3	Workforce planning - skills development	Susan Thomas	X			PE
C4	Workforce Planning embedded into our Inspire Programme to develop Mangers and leaders in WP skills	Susan Thomas	X			PE
C5	Additional workforce planning resources recruitment to support development of workforce planning approach and facilitate the utilisation of workforce planning methodology	Susan Thomas	X			PE
C6	Educational pathways in place for hard to fill roles in the Trust to support the recruitment of new skills and development of new roles	Susan Thomas	X			PE
C7	Widening access Programme in train to support development of new skills and roles	Susan Thomas	X			PE
C8	Workforce analysis available via ESR and Business Intelligence support	Susan Thomas	X			PE
C9	Hybrid Workforce Programme established to assess implications for planning a workforce following COVID and learning lessons will include technology impact assessments.	Sarah Morley			X	E
C9	Monthly dashboard reports are provided to divisional SLTs to monitor performance, identify and manage any issues. Hotspot areas are identified and managead accordingly, such as establishment of Task and Finish Groups.	Susan Thomas	X	X	X	E

SOURCES OF ASSURANCE

ID	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Tracking key outcomes and benefits map – aligned to Trust People Strategy	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports	PA
C2	Staff Feedback	PA	Trust Board reporting against Trust People Strategy	PA	To be completed as per compliance/reg tracker update	IA
C3	Provide operational managers with skills and capabilities to undertake effective	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C4	Evaluation sheets	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C5	Staff Meeting to feedback on implementation plan	IA	Supply and Shape paper to EMB then QSP	PA	Wales Audit Workforce Planning National Review	IA
C6	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports	IA
C7	Education and Training Steering Group	PA	Supply and Shape paper to EMB then QSP	PA	Internal Audit Reports - Education Strategy Audit	IA
C8	Performance reports monthly to operational managers with improvemnt plans/actions set out.	PA	Performance reporting to Executives and Trust Board	PA	Internal Audit Reports - Education Strategy Audit	IA
C9	Agile Project and Programme Board - see comments below - programme now closed - updates on any future work progammes via EMB	PA	Policies and proceedures to be imbedded with Hybrid Working Principles	PA	Internal Audit	PA
C9	Regular monitoring at SLTs, where workforce dashboards monitor performance, identify and manage issues.	PA	Regular performance reports and Suply and Shape paper are submitted to EMB and QSP	PA	External Audit Reports - Managing Attendance at Work, Recruitment and Retention and Edication Strategy Audit (ongoing)	PA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Gaps are evident in understanding agreed service models – both internally and regionally		
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	INTIAL RISK RATING	CURRENT RISK RATING	TARGET RISK RATING	RISK TREND
3247	There is a risk to health and wellbeing of the medical workforce caused by the lack of consultation rooms and the overbooking of clinics due to high demand the impact will be increased workload and increased patient waiting times.	16	16	9	No shift in risk rating
3001	There is a risk to safety as a result of work related stress leading to harm to staff and to service delivery.	16	12	9	Risk has decreased from initial rating.

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	The Healthy and engaged workplan to be implemented to support worforce capacity within the Trust	Sarah Morley	PA	COMPLETE	The Healthy and Engaged workplan 2024-25 was agreed at the Healthy and Engaged Steering Group on 09.03.2024. The Healthy and Engaged Workforce Steering Group reports quarterly to EMB.	14.05.2024		Impact on assurance level was updated in the Supply and Shape paper presented to QSP on 09.05.2024.
1.2	Establish Hybrid working arrangements as a core way in which the Trust undertakes some of its work.	Sarah Morley	PA	COMPLETE	The Hybrid Working project is presenting the details of a desk top booking approach to EMB in January 2023. This business case will then be further developed following EMB feedback. The Hybrid Working Toolkit has been developed in draft and will be finalised and published in February 2023.	21/12/2023	This programme of work is now completed - a close down report was taken to EMB in August 2023. An review of our infrastructure to support Hybrid Working is now being discussed, led by Estates	
1.3	Participate in the NWSSP International nurse recruitment Project	Sarah Morley	IA	COMPLETE	International nurse recruitment has commenced to recruit 17 WTE nurses by December to commence in March 2024. Progress is monitored via EMB. International nurses take up post on 25.03.2024	21/12/2023	13 overseas nurses have been recruited and onboarded and will start in March 2024.	
1.4	Develop and Implementation Plan for the People Strategy	Susan Thomas	PA	COMPLETE	A plan to implement the People Strategy will be presented to EMB in December.	21/12/2023	Presented to EMB Shape	
1.5	Development of a Strategic workforce plan	Susan Thomas	IA	Sep-24	Development of a Strategic workforce plan aligned to the Clinical Services Strategy is ongoing - a draft version of the plan will be presented following agreement of the clinical service strategy. Workforce models will be developed inline with the Clinical and Scientific Strategy	14/05/2024	The Clinical & Scietific Strategy is still under dvelopment. Work underway in the interim is described in the Workforce Supply & Shape Paper was presented to QSP Committee in May 2024	
1.6	Development of a Trust Retention Plan	Susan Thomas	IA	Jun-24	Retention plan is bening developed by the newly appointed Retention Lead. Retention plan updated to EMB monthly. Paper on the plan to be presented to EMB in May	14.05.2024		
1.7	Review Exit Interview Process	Susan Thomas	IA	COMPLETE	The Exit interview process has been rewritten. There is a new dashboard and automated process and engagement sessions have been delivered. A new procedure will be submitted to EMB	20.03.2024		

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Planned ans Sustained Workforce** **Right people right place right time** **1. Implement the Education Strategy Implementation Plan 24/25** **2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model** **3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism** **4. Attraction and Retention** **5. Agree a plan for the Widening Access Programme** **6. Ongoing recruitment Marketing Campaigns for hard to fill roles** **7. Working with Comms Trust wide recruitment campaign in place** **8. Evaluate the International nurse Recruitment Programme** **9. Develop a Nurse retention plan**		
	Skilled and Developed Workforce Achieving Excellence through our staff **1. Component caring and capable workforce Deliver the Trust Training Plan 24/25 – clear KPIs to support evaluation** **2. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model** **3. Developing our academic profile Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre for Learning and Innovation** **4. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology** **5. Working with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology**		

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SECTION 1

RISK ID	04	RISK TITLE	There is a risk of failure to meet or exceed service expectations without the prevelance of a positive working environment, which is characterised by effective values and bahaviours, systems and processes	STRATEGIC GOAL	2 -An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Sarah Morley			RISK THEME	Organisational Culture		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X								
C1	Trust Strategies and enabling strategies (including people, RD&I and Digital) launched November 2023 to provide clarity and alignment on strategic intent of the Organisation	Carl James	X			E	Working group led by CJ	PA	Trust Board reporting on strategy and controls via cycles of business	PA	To be completed as per compliance/ reg tracker updates	PA
C2	Developed Capacity of the Organisation – set out in the Education Strategy and implementation plan to support the educational development of the Organisation to support the Trust direction	Susan Thomas	X			PE	Education and training steering group	IA	Trust Board reporting on strategy and controls via cycles of business	IA	To be completed as per compliance/ reg tracker updates	IA
C3	Management and Leadership development in place to provide a infrastructure to develop compassionate leadership and managers established via the creation of the Inspire Programme with development from foundations stages in management to Board development	Susan Thomas	X			PE	Education and training steering group	PA	Highlight Report to EMB from Education and Training Steering Group on a quarterly basis	PA	Internal Audit Reports	IA
C4	Values to be reviewed and Behaviour framework to be considered	Susan Thomas	X			PE	Healthy and Engaged Steering Group and Education and Training Steering Group	PA	Reported through EMB Shape to Strategic Development Committee	IA	Internal Audit Reports	IA
C5	Communication infrastructure in place to support the communication of leadership messages and engagement of staff	Lauren Fear	X			PE	Healthy and Engaged Steering Group	IA	Reported through EMB to QSP	IA	Internal Audit Reports	IA
C6	Health and Wellbeing of the Organisation to be managed –with a clear plan to support the physical and psychological wellbeing of staff	Susan Thomas	X			PE	Health and Wellbeing Steering Group	PA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C7	Governance arrangements in place to monitor and evaluate the implementation of plans	Lauren Fear	X			PE	Workforce and OD steering groups and internal governance	PA	Steering Groups' highlight reports to Executive Management Board	PA	Internal Audit Reports	IA
C8	Performance Management Framework in place to monitor the finance, workforce and performance of the Organisation	Carl James	X			PE	PMF Working Group	PA	Exucutive Management Board	PA	Internal Audit Reports	IA
C9	Service models in place to provide clarity of service expectations moving forward	Susan Thomas	X			PE	SLT Meetings	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA
C10	Aligned workforce plans to service model to ensure the right workforce is in place	Cath O'Brien	X			PE	SLT Meetings and Educationa and Training Steering Group	IA	Supply and Shape paper to EMB then QSP	IA	Internal Audit Reports	IA

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE DETAILING WHY THERE IS NO ASSOCIATED ACTION.
Each of the controls requires further development and progression, the plans for which are at varying levels of maturity		
Requires a cohesive and holistic Organisation alignment between performance management, service improvement, leadership behaviours and people practices to deliver the desired culture		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

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SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Implement a routine of conversations with staff and members of the Executive Team, Divisional Senior Leadership Teams and Extended Leadership Team.	Sarah Morley	PA	Jun-24	The four leadership teams have a established a working group to implement the 'Working Together to Build our Future' ongoing series of discussions across the organisation. These bagan in September 2023 and will act as a temperature check on how staff are feeling on the ground about the organisation both in routine arrangements and also the changes that are taking place around them. These conversations will also provide the opportunity to talk about the Trust Strategy. Themes from the first eight weeks of conversations have been fed back via a video message. A summary of the themes and proposed actions will be presented to EMB in May 2024. This paper also proposes that the conversations continue as routine in person and virtually.	14/05/2024	The outputs from the WT Sessions are being mapped into the Refresh of the Building Our Future Together Organisational Development Approach. New Sessions are now being scheduled which will cover staff across the bases in Wales	
1.2	Consider fedback from Trust data on the culture of the organisation in a holistic overview in order that the Executive Team and Board can evaluate interventions in place and the forward plan to ensure a positive and effective culture.	Sarah Morley	PA	Jul-24	Data is being triangulated to understand the current climate within the organisation. A plan is being developed to ensure that appropriate interventions are in place or being introduced to support a positive and supportive cultre within the organidation. Many elements of employee voice are being considered as part of this work. results of the NHS Staff survey have begun to be distilled to further develop our work programme	14/05/2024	We received the Trust level data from the 2023 staff survey with the more detailed dahsboards following in May. This data will be used to over lay with other feedback. The areas of data have been mapped onto the current workstreams and management groups to ensure that this will enusre action is taken under the appropriate workstream.	
1.3	A staff engagement project to understand levels of staff engement and also review the Trust Values	Sarah Morley	PA	COMPLETE	A first report against the review of the Trust values was presented to EMB in December 2022. It was decided at that meeting that a broader piece of work was needed to ensure that Trust values were bulit on the culture the organisation was striving to achieve to deliver its ambitions under the Destination 2033 strategy. a 2nd Phase of engagement activity has been underway with staff, patients and donors. Further opportunities will be provided for Executive management Board and Trust Board to shape this work in November and December 2023.	21/12/2023		
1.4	Promotion of the Speaking Up Safely Framework	Sarah Morley	PA	COMPLETE	The initial task and finish group to establishe the Speaking up Safely Framework in Velindre has been completed. Communication and governance processes are in place.	14/05/2024	Initial programme completed - ongoing work to trianguate with wider cultural work	

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 2 **An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations**	**Healthy and Engaged Workforce** **Our staff will feel valued and supported and promote a culture of true inclusivity, fairness and equity across the workforce.** **1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence** **2. Implement the Values and Behaviour framework project** **3. Triangulate culture work, staff feedback themes and leadership work to deliver an aligned Culture Programme of work that addresses Organisational issues reflects our values and allows staff to speak up freely** **4. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working** **5. Deliver an action plan 24/25 commitment in the Trust Anti- Racist Action plan** **6. Monitor Welsh Language Standards, working with Divisions on improvement plans** **7. Implement the WL Culture plan** **8. Update all WOD related policies and procedures** **9. Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA**		
	People Function Cultural Development – People and Relationships Model **1. Develop an engagement plan for the function to support the engagement and alignment with service development** **2. Implementation of the holistic People and Relationships model** **3. Engagement and Commitment from EMB** **4. Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback**		

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SECTION 1

RISK ID	05	RISK TITLE	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	STRATEGIC GOAL	ALL	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Carl James			RISK THEME	Digital Transformation		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

Overall Level of Effectiveness: RATING **PE**

Overall Trend in Assurance THIS WILL BE A GRAPH

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
	Trust Risk Register associated risk on Datix. (see section 4)			X		E						
C1	Trust Digital Strategy - Published Oct '23	Carl James	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C2	Active work ongoing to leverage existing and deliver on new technologies – e.g. LIMS, IRS, BECS, EPMA	Chief Digital Officer		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C3	Training & Education packages to develop internal capabilities – including for exec and Board	Chief Digital Officer	X			PE	Staff feedback - KLAS Survey	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C4	Training & Education packages for donors, patients	Chief Digital Officer	X			PE	Patient and Donor feedback	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed
C5	Ring-fencing digital advancement in Trust budget – benchmark 4%	Chief Digital Officer	X			E	Review of proposals via EMB/Board Digital IMTP	IA	EMB Shape / EMB Run	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	IA
C6	Specifically development of digital resources capacity and capability	Chief Digital Officer	X			PE	Review of proposals via EMB/Board Digital Programme Board	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/ Centre for Digital Public Services	PA
C7	Digital inclusion in wider community	Chief Digital Officer	X			E	Tracking key outcomes and benefits map – aligned to Trust Digital Strategy Joint plan with Digital Communities Wales	PA	EMB Shape	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit / Digital Communities Wales	PA
C9	Prioritisation and change framework to manage service requests	Chief Digital Officer	X			PE	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C10	Levels of unsupported applications/ legacy systems	Chief Digital Officer			X	PE	Trust Digital governance reporting Digital Programme Board	PA	EMB Shape / EMB Run / Cyber Action Plan	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C11	Trust digital Governance	Carl James		X		E	Trust Digital governance reporting - WBS Futures - Velindre Futures - Digital Programme Board IMTP	PA	EMB Shape	IA	Wales Audit OfficeSIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C12	Framework of lead and lag indicator reporting into Trust digital governance structure, integrated into wider performance framework	Chief Digital Officer			X	PE	Review via Divisional SMT/SLT	PA	EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	PA
C13	Cyber Assurance Controls in place	Chief Digital Officer		X		E	Review via Divisional SMT / SLT/ Cyber Security eLearning (Stat. & Mand)/ Board Development Sessions.	PA	EMB Shape / EMB Run	PA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit/WG/CRU as competent authority for NIS	PA
C14	Digital transformation is guided by an agreed digtial architecture.	Chief Digital Officer	X	X		PE	Digital Programme Board Digital Design Authority being established	IA	EMB Shape	IA	SIRO Reports/ Strategic Development Committee/ QSP Committee/ Internal Audit	Not Assessed

GAPS IN CONTROLS	GAPS IN ASSURANCE	ASSOCIATED ACTION REFERENCE/ RATIONALE
Agreed Digital Inclusion plan - C4,C7 - This has now been agreed by EMB/SDC and is no longer a gap in control	Assurance Arrangements for Digital Architecture will need to be established -	
Digital architecture needs to be developed to guide digital transformation activities - Digital Design Authority is in the process of being set up	Data and Insight prioritisation as this becomes part of the Digital Services team -	
C9 - Change Advisory Board needed		

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK	RISK TREND
92	There is a risk to COMPLIANCE as a result of the inadequate oversight of supplier contracts, procurement governance etc., leading to difficulties in complying with internal governance for contract management, renewals and procurement activity.	12	Risk trend is increasing with capacity constraints in the procurement teams supporting the Trust
R022 (EPMA)	There is a risk that there will not be a resource available from the Pharmacy team to both lead and support the evaluation panel activities (before and during) from a clinical perspective, caused by staff shortages, resulting in slippage of timescales in publishing and awarding the supplier	16	Lead Digital Pharmacist in place - risk closed from TAF
3193/3197 (BECS)	There is a risk to QUALITY as a result of failing to secure sufficient funding for the delivery of a new Blood Establishment Computer System (BECS) contract and software platform leading to degredation of critical WBS (NHS Wales) supply chain activities	15	Outline Business Case at EMB/SDC in April '24

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R008 (WHAIS)	There is a risk that the LIMS solution will not support the required interactions between WHAIS and WBMDR because commercial H&I solutions are not designed to support an integrated donor registry. If no workaround is identified this would prevent WHAIS from being able to maintain its current HSCT clinical services.	20	Part of the remit of the WHAISIT project group is to carefully plan the implementation activities to minimise impact and disruption. This includes identifying the future relationship between WHAIS and WBMDR. Appropriate requirements will be stimulated in the URS.
2651	There is a risk to Financial Sustainability as a result of the introduction of a new interfacing policy by MAK-System for devices connected to ePROGESA, leading to organisational cost pressures, reputational damage and/or delays in realising IMTP and other strategic benefits.	12	Additional funding needs to be made available for a Blood Establishment Computer System re-procurement through to 2027

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
1.1	Establishment of a Digital Programme, including key controls for digital inclusion and digital architecture	Chief Digital Officer	PA	Complete	Digital Programme has now been established from Oct '23 Now meets on a bi-monthly basis	May-24	As the Programme continues to develop the overall level of risk should reduce by reducing the likelihood scores	The level of asurance should increase.
1.2	Create the Trust Digital Reference Architecture to support C14 and others	Chief Digital Officer	IA	Feb-23	Digital Programme has now been established from Oct '23. This includes a Digital Design Authority to oversee the reference architecture. The Digital Strategy has now been published and a draft insfrastructure strategy (reference architecture) is available.	May-24	Terms of reference for the Digitial Programme include the creation of Digital Design Authority which is in the process of being stood up in Q4 23/24. Digital Design Authority is still to formally meet.	The level of asurance should increase.
1.3	Approve the Digital Inclusion plan so that it can be used as the control point	Chief Digital Officer	IA	Complete	Plan approved at EMB/SDC Quality Impact Assessment Completed and Approved	May-24	improvement in the position on C7	The level of asurance should increase.
1.4	C13 - Embed new Head of Cyber Security	Chief Digital Officer	IA	Complete	Head of Cyber Security has been appointed from Dec '23	May-24	Dedicated post now in place to lead on cyber - will still be a single point of failure - Request into Trust reserves for a second post - no funding decision provided	C13 to move to Effective
1.5	C9 - Prioritisation framework needs to be established for the Data and Insight Service	Chief Digital Officer	IA	Jun-24	Data and Insight formative paper presented at April EMB Shape / Strategic Development Committee	May-24	Will contribute to reduction in likelihood of risk	C9 would move to Effective
1.6	Identify external benchmark / standards for the Digital Services (e.g. ISO27001 ./ ITIL)	Chief Digital Officer	IA	May-24	Will start with identification of standards for Digital Service (through new ITSM tool) and Cyber Security IT Infrastructure Library (ITIL) will form the basis of standards for Digital Service Cyber Essentials will be used for Cyber plan alongside Cyber Resilience Unit review	May-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Develop an implementation plan for the Digital Strategy to sit between the strategy and IMTP, including investment	Chief Digital Officer	IA	Jun-24	To be reviewed at May EMB	May-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice
1.7	Introduce a Change Advisory Board (CAB) to manage digital changes to service.	Chief Digital Officer	IA	Jun-24	Scope fror CAB has been established and will meet for the first time in May	May-24	Will contribute to reduction likelihood of risk	Assurance controls should better represent best practice, around C9

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 5 **A sustainable organisation that plays it part in creating a better future for people across the globe**	**2. "Agile" Delivery Squads introduced to Digital target operating model** **3. "Agile" Delivery Squads introduced to Digital target operating model** **4. New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare** **5. Robotic Process Automation (RPA)** **6. Digital Inclusion - digitally connect our donors, patients, and carers and staff to our services 24/7** **7. New Trust-Wide Network** **9. Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach – Cyber Security Strategic Development Plan (CSSDP)** **11. Introduce new Digital Training Platform**	**1. ongoing development of call centre solution and support** **2. Scale model to new areas** **3. Complete** **4. Further PROMS development by Value Intelligence Centre** **5. Complete** **6. Further development of the Digital Inclusion Plan** **7. VUNHST headquarters on new network** **8. Introduction of further ITSM best practice** **9. Further development of the CSSDP** **10. Complete** **11. Complete** **12. Common / User device experience for nVCC**	**1. Transition to nVCC** **2. Complete** **3. Complete** **4. Ongoing** **5. Complete** **6. Further development of the Digital Inclusion Plan** **7. New Velindre Cancer Centre on new network** **WBS Talbot Green on new network** **8. Complete** **9. Further development of the CSSDP** **10. Complete** **11. Complete** **12. Transition to nVCC**
	13. Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre **14. Performance Management Framework (Quality Measures) dashboard** **16. National Data Resource roadmap** **17. Trust wide Data and Insight plan** **18. New Velindre Cancer Centre (nVCC) digital enablement** **19. Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services** **20. Digital enablement of the integrated Radiotherapy Solution Programme by 2026/27** **21. Implementation of electronic prescribing and medicines administration (ePMA) for Use by Velindre Cancer Services** **22. Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)** **24. Upgrade Video Consultation platform to support Pathway Improvement Programme**	**13. WBS Donor system** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems delivered by Velindre Scrutiny of ProjectCo Digital systems** **19. Project close following successful implementation.** **20. Progress phase 3 objectives.** **21. Project close following successful implementation.** **22. Project close and Radiotherapy Satellite Unit to 'go-live'** **23. Complete** **24. Complete**	**13. Complete** **14. Further PMF dashboard development** **15. Complete** **16. Scale NDR roadmap** **17. Complete** **18. Design and implementation of nVCC Digital infrastructure and systems &Transition of digital into nVCC** **19. Complete** **20. Complete** **21. Complete** **22. Complete** **23. Complete** **24. Complete**

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	25. Undertake Digitisation of Medical Records 26. Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure 27. Electronic Patient Record – Phase 2 28. VCS Service Changes – Other digital activities in support of the VCS plan 29. WHAIS Digital: Implement a new Laboratory Information Management System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26. 30. WBMDR Digital: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27 31. BECS Procure new Blood Establishment Computer System (BECS) contract and implement digital system. 32. NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS). 33. WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system 34. Plasma for Medicines: Digitally enable the Plasma for Medicines programme 36. Foetal D: Digital enablement of Foetal DNA typing. 37. Live Connectivity: Introduce live connectivity for the blood collection teams 38. Donor Interaction and Appointments: Digitally enable improved donor interaction by 2026/27.	25. Undertake options appraisal. Develop supporting business case(s).Initiate phased delivery of the project. 26. Complete 27. Complete 28. Complete 29. Complete Data Migration (Q1).Training (Q1).Go-Live (end of Q1). 30. Continue to progress with the WBMDR replacement software project. 31. New Contract Award (Q1). New BECS implementation starts. Complete analysis and testing of Semester Patch and implement. Continue supporting existing BECS solution. 32. Go Live with new NEQAS system. Close Project. 33. Final deployment activity (Q3) 34. Adapt digital systems (BECS) to work with the Plasma for Medicines model once agreed 35. Close down DHCW service 36. Scope expansion of service. 37. Complete 38. Complete introduction of a donor experience hub. Complete implementation of a Customer Relationship Management (CRM) System. Implement omni-channel software	25. Undertake post-project evaluation 26. Complete 27. Complete 28. Complete 29. Complete 30. Implement new WBMDR software. 31. BECS Implementation (Q1 - Q4) + (Q1 – Q3 2027/28) Continue supporting existing BECS solution. 32. Complete 33. Complete 34. Complete 35. Complete 36. Complete 37. Complete 38. Implement tailored pathways for donors and advocates. New donor app implementation and create content.

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SECTION 1

RISK ID	06	RISK TITLE	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	STRATEGIC GOAL	1 - Outstanding for quality, safety and experience	RISK SCORE TREND	No change to risk score since previous reporting period. The actions
RISK LEADS	Lauren Fear			RISK THEME	Organisational and Clinical Governance		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)	Lauren Fear		X		E						
C2	Annual Assessment of Board Effectiveness	Emma Stephens			X	E	Annual Board Effectiveness Survey Annual Self- Assessment against the Corporate Governance in Central Governance Departments: Code of Good Practice 2017	6	Audit Committee Trust Board	6	Internal Audit Reports Audit Wales Structured Assessment Programme / Reports Joint Escalation & Intervention Arrangements	6
C3	Board Committee Effectiveness Arrangements	Lauren Fear	X			E	Internal Audit Review	4	Audit Committee Trust Board	4	Internal Audit of Board Committee Effectiveness Audit Wales Structured Assessment Audit Wales Review of Quality Governance Arrangements	4
C4	Board Development Programme	Lauren Fear	X			PE	Programme established	4	Trust Board in Board Development	4	Specialist external input as required, for instance on Socio-economic Duty	4
C5	Quality of assurance provided to the Board	Lauren Fear	X			PE	Quality of Board papers and supporting information effectively enabling the Board to fulfil its assurance role.	4	Trust Board assessment via formal annual and additional effectiveness review exercises	4	Internal Audit Reports. Audit Wales Structured Assessment Programme/Reports	4
C6	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	X			PE	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect	4	Governance, Assurance & Risk Steering Group and Trust Board in Board Development input	4	Benchmarking input	4
C7	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework	Lauren Fear	X			NE	Exercise to be completed	1	Trust Board in Board Development	1		

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SMART ACTION PLAN

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

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1.0	Develop and implement formal Governance, Assurance and Risk Programme as part of Trust wide Organisational Development programme of work.	Lauren Fear	4	Jun-24	Governance, Assurance and Risk (GAR) Programme of work consisting of 20 projects across the spectrum of work progressing well through 2023/24, final analysis of progress to be confirmed and agreed in February 2024 Board Development session. August 2024 update: Phase 2 GAR refresh underway. Initial	30.8.24	Impact to be asseessed when programme delviered	
2.0	Refresh of Trust Assurance Framework risks	Lauren Fear	6	Complete	Project TAF 2.0 within the GAR Programme is due to complete in January 2024 Trust Board, risks then to be reviewed on a monthly basis and reported through governance routes accordingly	11.4.24	Requirement for C7 to be put in place	
3.0	Revised reporting mechanism to be developed	Lauren Fear	4	Jun-24	Project TAF 3.0 within the GAR Programme is undertaking a review of the reporting mechanism and aligning with appropriate committees, currently EMB Shape, Strategic Development Committee, Audit Committee and Trust Board. Work has taken place to initiate regular review and process within senior teams. Good progress made however further embedding required with Senior Leadership Teams.	11.4.26	Impact to be asseessed when delviered	
4.0	Trust Assurance Framework will be mapped through Governance Cycle	Lauren Fear	6	Complete	Work is complete to map Trust Assurance Framework through governance cycles, at present the TAF is received at appropriate committees, EMB Shape, Strategic Development Committee, Audit Committee and Trust Board	11.4.27	Requirement for C7 to be put in place	Impact measures to be confirmed as part of GAR programme.
5.0	External benchmarking of Governance, Assurance & Risk best practice as part of the Governance, Assurance & Risk programme of work	Lauren Fear	4	Jun-24	Full cross-reference of Governance, Assurance and Risk work into TAF 06 in this respect August 2024 update - Risk benchmarking underway. TAF benchmarking to be completed in September for GAR group	11.4.28	Impact to be asseessed when programme delviered	
6.0	Cross-reference of Integrated Medium Term Plan objectives to strategic objectives in the Trust Assurance Framework to be completed and agreed with Trust Board	Lauren Fear	1	May-24	To be discussed in February 2024 Trust Board development session to then incorporate into reporting from April onwards	11.4.29	Impact to be asseessed when delviered	Detail has been incorporated below. Further SMART actions to be considered by the Governance, Assurance and Risk group at its next meeting in October 2024.

SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 Outstanding for quality, safety and experience	**Our Strategic Delivery Framework provides us with a structured approach to the translation and delivery of our strategic goals and priorities within the organisation** **Trust Purpose and Vision, aligned to** **• Trust Strategic Goals** **• VCS Strategy and Priorities and Service Plans** **• WBS Strategy and Priorities and Service Plans** **• Support Functions Strategies and Plans**		
	Building our Future Together 'Destination 2033' BOFT is an organisational development approach which is designed to identify and develop the leadership, culture, behaviours, processes and systems that we want to be. **BOFT Programme** **1. Ensure that we are organised appropriately to support delivery of strategy, which has the safety and quality of care for our patients and donors as its golden thread** **2. Provide a way of working and shape to the organisation which enables us to maintain focus** **3. Ensuring accountability and ownership is in the right place, supported by effective structures, and is empowering for those delivering and those leading the delivery of high quality services today and shaping our services for the future** **4. Draw together our organisational developments with a common sense of purpose** **5. Improve our effectiveness, efficiency and value based approach** **6. Develop the mechanisms which enable us to prioritise where and when we focus our efforts** **7. Provide continued confidence and clarity to our staff that we are set up in a way in which ensures we can collectively deliver on the organisation's ambition** **8. Support realistic, authentic and compassionate leadership**		
	9. Re-assessing inter-related areas of work to ensure that together they provide the mechanisms to achieve our objectives **• Prioritisation & Co-ordination Arrangements** **• Values & Culture** **• Internal Staff Communication & Staff Engagement** **• Governance Risk and Assurance** **• Performance Management** **• Leadership Development** **• Value Based Healthcare** **• Quality Framework** **• Ways of Working** **• Clinical & Scientific Arrangements**		

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SECTION 1

RISK ID	07	RISK TITLE	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Jacinta Abraham	Nicola Williams	Chief Operating Officer	RISK THEME	Patient Outcomes		

SECTION 2

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
C1	Trust Risk Register associated risk on Datix. (see section 4)			X								
C2	Capacity and demand planning and forecasting	Interim Director VCS / COO	As per TAF 01 C12									
C3	Multiprofessional Workforce Planning	Interim Director VCS / Director OD & Workforce	X	X		NE	Velindre Cancer Service Senior Leadership Team	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C4	Quality and safety monitoring (Via PMF)	Interim Director VCS / Exec Director Strategic Tranformation, Planning and Digital / Exec Director Nurisng, AHP & HCS			X	NE	VCS Quality & Safety Group / VCC SLT / Intergrated Quality and Safety Group	NE	Executive Management Board	NE	Quality, Safety and Perfromance Committee	NE
C5	Pathway delivery programme/Service Improvement Programmes: focus on delivery against national optimum pathways, reduction in variation, quality & safety priorities (via the Safe Care Collaborative), realignment of roles and responsibilities ensuring patients remain at centre of service delivery (also see TAF 01)	Interim Director VCS / COO	X			PE	Pathways Programme VCS/ VCS Quality & Safety Group / VCS Senior Leadership Team	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C6	Effective processes in place to capture patient experience, ensuring effective listening and learning	Interim Director VCS / Exec Director Nursing, AHP & HCS			X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C7	Mortality review process and monitoring	Interim Director VCS / Exec Medical Director			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C8	Patient reported outcome monitoring (SST level to Board)	Interim Director VCS / Exec Medical Director / Exec Director Finance			X	NE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	NA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C9	Velindre Oncology Acadamy establishment	Exec Director Nursing, AHP & HCS	X	X		NE	VOA Implementation Group	IA	Executive Management Board	NA	Quality, Safety and Perfromance Committee	NA
C10	Clinical audit process and systems in place	Head of Nursing / CD VCS / Exec Medical Director	X	X	X	PE	Velindre Cancer Service Senior Leadership Team/Intergrated Quality and Safety Group	IA	Executive Management Board	IA	Quality, Safety and Perfromance Committee	IA
C11	Quality & Safety Tracker (improvement monotoring)	Interim Director VCS / Exec Director Nursing, AHP & HCS		X	X	PE	VCS Quality & Safety Group / VCS SLT	PE	Integrated Quality & Saefty Group / Executive Management Board	PE	Quality, Safety and Perfromance Committee	PE

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

DATIX RISK REF	RISK TITLE	CURRENT RISK RATING	RISK TREND
2187	Radiotherapy Physics Staffing There is a risk of the radiotherapy physics team being unable to complete core and developmental tasks due to inadequate staffing. This staff group is key in ensuring quality and safety of radiotherapy treatments. This may result in - patient treatment delay - Radiotherapy treatment errors.- key projects not keeping to time e.g. commissioning of essential systems - suboptimal treatment - either due to lack of planning time or lack of developmental time	15	Risk Stable

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2465	Number of emails medics are receiving, especially those related to clinical tasks.	16	Risk Stable
2579	There is a risk to performance and service sustainability as a result of training curriculum changing to include acute oncology leading to inability to secure the required number of Palliative Care Trainees	15	Risk Stable
2515	There is a risk that staffing levels within Brachytherapy services are below those required for a safe resilient service. This may result in a lack of resource to develop the service, investigate incidents and cover for absences. This may impact on the quality of care due to a reduction in resilience and development of the service	15	Risk Stable
2612	Acute Oncology Service (AOS) Workforce Gaps	15	Risk Stable

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
Actions also aligned with TAF 01 re capacity and demand mapping and service reconfiguration								
A1	An electronic mechanism to be introdcued to monitor compliance with relevant national standards and guidance, including NICE, delivery plans and national frameworks.	Interim Director VCC	0	Sep-24	Q-pulse being procured. Options appraisal to be undertaken to consider Blue light, Q-Pulse and AmAT systems and agree on which system would be the most effective and efficient	22.3.24	Change will reduce risk through having enhanced mechanisms to implement new clinical changes in a timely manner	Enhanced control and assurance
A2	AmAT Quality & Safety Tracker to be fully embedded as the tracker across VCS	Interim Director VCC	2	Mar-24	AmAT rolled out and all open improvement plans moved across onto the system. Some teams require ongoing support to keep tracker live and up to date.	22.3.24	Change will reduce risk by having effective mechanisms to ensure that identified quality and safty improvements have been implemented and had the desired impact	Enhanced control and assurance
A3	Intergrated Quality and Safety dashboards to be developed that align with PMF	Exec Director Transofrmation, planning, performance and	2	Aug-24	Initial quality, safety and outcome metrics& implementation plan agreed	22.3.24	Should reduce risk	Enhanced control and assurance
A4	Value Based Healthcare patient reported outcome plan to be fully delivered (PROM measures across all SSTs agreed and electronic system implemented)	Exec Medical Director / Exec Finance Director	2	Mar-26	Working Group established within VCS, Lead by the VBHC Team Programme plan in place to procure and implement a digital PROMS solution. Anticipated procurement within Q3 of 24/25. Work underway with clinical teams to agree SST specific PROM sets where national PROMS have not been set. The programme is collaborating with WCN on this. When PROMS data is collected digitally it will be available within the data warehouse for analytical and reporting purposes, including at Board level. This is expected in Q4 24/25 for the areas which will have PROMS deployed	17.5.24	Should long term reduce risk	Enhanced assurance
A5	Single electronic patient referral system into the Cancer Service to be developed and implemented	Interim Director VCS / Head of Operations VCS	1	Mar-25	Work commenced	22.3.24	Reduce risk	Enhanced control
A6	Overall review of booking systems (including SACT) to be undertaken and revised processes implemented	Interim Director VCS / Head of Operations VCS / Head of Nursing	1	Sep-24		22.3.24	Reduce risk	Enhanced control
A7	Recommendations from SACT treatment helpline peer review to be fully implimented	Interim Director VCS	1	Sep-24	SACT telephone helpline report received and action plan developed	22.3.24	Change will reduce risk by further enhancing safety of the SACT Telephone helpline	Enhanced control
A8	Transformational multi professional workforce plans across all areas of the cancer service	Director OD & Workforce	1	Mar-26	Opportunities for mult-professional consultant posts being considered	22.3.24	Reduce risk	Enhanced control
A9	Finalise the delivery of BI solution to ensure robust service level to board mortality data monitoring in line with legislative and best practice standards	Exec Director Transofrmation, planning, performance and digital	1	Jun-24	Data tool in development, system validation issues identified	22.3.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced control and assurance
A10	Implement a robust mortality review and reporting infrastructure that includes reviewing how and for what cases mortality reviews are undertaken and outcomes reporting	Exec Medical Director / Exec Finance Director	1	Aug-24	Benchmarking undertaken and Trust process have been reviewed based on benchmarking outcomes and review of national standards	15.5.24	Change will reduce risk by having robust mortality monitoring leading to further reviews and identification of further areas for improvement	Enhanced assurance
A11	Fully roll out the Q-Pulse system across all services at VCS and Trust	Interim Director VCS & Director Corportae Governance	1	Mar-25	Project group being established, project leads identified. Trust wide Q-Pulse system procured	22.3.24	This enhanced document management system will reduce risk by having far greater governance in respect of SOP's, policies procedures, guidelines etc	Enhanced control and assurance
A12	Implementation of the patient engagement framework	Director Corporate Governance e	2	Mar-25		22.3.24	Reduce risk	Enhanced control and assurance
A13	Fully embed a robust Clinical & Scientific infrastructure including establishment of a robust multi-professional Clinical & Scientific Board	Exec Medical Director / Exec Director Nursing, AHP &	2	Aug-24	Clinical & Scientific Board established. Terms of Reference endorsed by EMB. Long Term Management Support to be secured.	15.05.2024	Risk will reduce by having enhanced strategic clinical and scientific direction supporting effectve prioritisation and decision making.	Enhanced control
A14	Develop the Clinical & Scientific Strategy with a clear deliverable implementation plan	Exec Medical Director / Exec Director Nursing, AHP & HCS	1	31/06/2024	Strategy under development following extensive engagement. Draft strategy will be developed to commence consultation in may 2024. Long Term Management Support to be secured to drive forward delivery of the startegy (same post as one described above)	15.05.2024	Risk will be reduced by having clear clinical and scientific direction informed by research, national standards and patient / donor requirements	Enhanced control
A15	Undertake a review of the manaement of inpatients with altered airways - including a regional working group and commissioning of an external peer review	Head of Nursing / CD VCS	0	Aug-24	Regional working group established and proposals due to VCC SLT & EMB in May 2024.	15.05.2024	Risk will reduced by ensuring robust safety wrap in respect of patients with altered airways	Enhanced control

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SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27

Strategic Goal 1 Outstanding for quality, safety and experience	**Clinical Quality and safety Priorities:** **1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience.** **2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice.** **3. To Integrate Clinical Audit within VCS Quality and Safety function** **4. Development of robust Site- Specific Quality Metrics** **5. To improve incident and risk management.** **6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System** **7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service.** **8. 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.** **9. Review and improvement of donor selection and screening processes** **10. Introduction of all Wales foetal D Screening for RhD negative pregnant women.** **11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results.** **12. Achieve JACIE accreditation for the WBMDR** **13. Commencing rollout of live connectivity of the BECS at community- based donation clinics** **14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact** **15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.** **16. Implement an outcome recording system for patients (digital PROMS)**		
	The Quality Impact Assessment (QIA) focuses on Three Main Areas: **1. Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care.** **2. Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients.** **3. Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care**		
	Strategic Equality Plan and Equality Impact Assessments (EQIA) **• Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps** **• Objective 2: Engage with the community** **• Objective 3: Communicate with people in ways that meet their needs** **• Objective 4: Ensure service delivery reflects individual need**		

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SECTION 1

RISK ID	08	RISK TITLE	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	STRATEGIC GOAL	1 -Outstanding for quality, safety and experience 5 - A sustainable organisation that plays it part in creating a better future for people across the globe	RISK SCORE TREND	No change to risk score since previous reporting period
RISK LEADS	Matthew Bunce	Carl James		RISK THEME	Financial Sustainability and Long-Term Value		

RISK SCORE (see definitions tab)

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

SECTION 3

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

KEY CONTROLS / **SOURCES OF ASSURANCE**

ID	Key Control	Owner	Preventative	Mitigating	Detective	Control Effectiveness Rating	1st Line of Defence	Assurance Rating	2nd Line of Defence	Assurance Rating	3rd Line of Defence	Assurance Rating
FSLTV1	Divisional Financial Outturn	Head of Financial Planning & Reporting and Head of Finance Business Partner / Budget Holders			X	E	Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV2	Quarterly Finance Reviews	Deputy Director of Finance / Head of Finance Business Partnering			X	PE	Directorate Level Budget holders, reports and training	not assessed	Divisional Finance Reports and Performance; Finance Business Partners	PA	Internal Audit / External Audit	PA
FSLTV3	Divisional Performance Review	Executive Director of Finance / Deputy Director of Finance			X	PE	Divisional Senior Leadership Teams, reports	not assessed	Executive Finance Reports; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV4	Executive and Trust Board Reporting	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; QSP Committee; Trust Board	PA	Internal Audit / External Audit	PA
FSLTV5	Statutory and Mandatory Financial Reporting (inc. Annual Accounts)	Executive Director of Finance			X	E	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team; MMRs; Welsh Costing Returns; Audit Committee; Trust Board	PA	Welsh Government / NHS Executive (FP&D) / External Audit	PA
FSLTV6	Finance and Investment: Enhanced Monitoring	Executive Director of Finance			X	PE	Executive Budget Holders / Programme SROs	not assessed	Trust Board Finance Reporting; Senior Finance Team	PA	Internal Audit / External Audit	PA
FSLTV7	Collective Commissioners Review	Deputy Director of Finance		X		PE	Directorate Level Budget holders, reports and training	not assessed	Collective Commissioning Group LTA reporting	IA	LHB Commissioners	IA
FSLTV8	Investment Appraisal	Executive Director of Finance / Executive Director of Strategic Transformation, Planing & Digital	X			PE	Executive Budget Holders / Programme SROs	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Strategic Development Committee; Trust Board; WG Better Business Cases; HM Treasury Greenbook	not assessed	LHB Commissioners / Welsh Government / Internal Audit / External Audit	IA
FSLTV9	Financial Strategy / Medium Term Financial Plan / Budget Setting	Executive Director of Finance	X			E	Executive Budget Holders / Programme SROs	not assessed	Trust Board and Committees	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV10	Scheme of Delegation and Delegated Financial Authority	Executive Director of Finance	X			PE	Oracle Financial System Controls; Budget holders; Executive budget holders; Programme SROs	not assessed	Trust Board and Committees; Delegated Financial Limits	PA	Internal Audit / External Audit	IA
FSLTV11	Value Based Healthcare programme	Executive Director of Finance / Executive Medical Director	X			PE	Value Based Healthcare project leads; VBH programme SROs	not assessed	Value Based Healthcare steering committee / Executive Management Board	PA	LHB Commissioners / Welsh Government / Internal Audit / External Audit	PA
FSLTV12	Procure to Pay monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Requisitioners / Budget Holders	not assessed	Finance P2P reporting; Expense reporting; Expenses and Purchasing / Credit Card policy; Losses and Special Payments reporting	PA	Internal Audit / External Audit	PA
FSLTV13	Debtors / Cash monitoring	Deputy Director of Finance / Head of Financial Operations			X	E	Budget Holders; Private Patients lead; reports	not assessed	Debtors Reporting; Senior Finance Team;	PA	LHB Commissioners / Welsh Government (External Financing Limit) / Internal Audit / External Audit	PA
FSLTV14	Discretionary Capital Financial Planning and Reporting	Deputy Director of Finance / Head of Financial Planning and Reporting			X	E	Budget Holders; Heads of Division; Divisional Directors	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board; Fixed Assets Register Reporting	PA	Internal Audit / External Audit	PA

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FSLTV15	Major Capital Programmes monitoring	Chief Executive			X	PE	Executive Budget Holders / Programme SROs; Scheme of Delegation and Governance Framework	not assessed	Capital Planning and Delivery Group; Strategic Capital Board; Executive Management Board	IA	Internal Audit / External Audit	IA
FSLTV16	Counter Fraud	Deputy Director of Finance / Head of Financial Operations		X		E	Budget Holders, reports and training	not assessed	Counter Fraud Reports; Audit Committee	PA	Internal Audit / External Audit	PA
FSLTV17	Tax management	Deputy Director of Finance / Head of Financial Operations			X	E	Budget holders, requisitioners, reports and training	not assessed	Financial Operations Team; VAT working group	PA	External Advisory (EY) / Internal Audit / External Audit / HMRC	PA
FSLTV18	Procurement	Executive Director of Finance / Deputy Director of Finance / Head of Procurement	X			PE	Exec Directors, Divisional Directors, Budget Holders, reporting and training	not assessed	Procurement Compliance reporting; Audit Committee	PA	Internal Audit / External Audit	IA

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

SECTION 4

ASSOCIATED OPERATIONAL RISKS - According to risk appetite

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

SECTION 5

SMART ACTION PLAN

Action Ref	Action Plan	Owner	Assurance Level	Due Date	Progress Update	Date of Update	Impact of Changes on Risk	When the action is complete, detail the impact on assurance level/control
F1	Development of VBH programme of work to identify areas of unwarranted variation and actions to improve	EDoF / EMD / COO	4	Ongoing	VBH Programme of work under way overseen by the VBH Steering Group. Opportunity Pipeline presented at April 2024 EMB Shape identified 4 potential initiatives to take forward. These require further development including identification of Senior Responsible Officers to take accountability at Exec level to oversee the development and delivery.	22.04.24	Identification of opportunities to reduce unwarranted variation and improved allocation and utilisation of resources will support financial sustainability	tbc
F2	Continuous improvement of Finance and Investment Enhanced Monitoring reporting including identification of Savings Opportunities; Disinvestments and Choices and clear line of sight with Welsh Government Value and Sustainability Board agenda	EDoF / DDoF	4	Ongoing	Pharmacy review has been conducted and will be presented to Exec Management Board early in 2024. Following this a review of medicines management governance (including financial aspects), will be conducted by September 2024. Finance and Investment Enhanced Monitoring reporting continues with key risks highlighted regarding Long Term Agreements.	22.04.24	Identification of opportunities for new savings initiatives and disinvestments / choices will support financial sustainability	tbc
F3	Development and review of Financial Control Procedures	EDoF / DDoF	6	Ongoing	Capital financial control procedure approved by Audit Committee. Financial Control Procedure update plan and pipeline for review in development.	22.04.24	Strengthened control procedures will support risk mitigation	tbc
F4	Development of Investment Appraisal process and prioritisation framework	EDoF / EDoSTP&D / DDoF / DDoP	4	Sep-24	Presentation made to April 2024 EMB Shape for the development of criteria for assessing investment opportunities. This included Strategic Fit, Deliverability and Value and Sustainability. Next steps are to develop criteria aligned to the 3 areas identified.	22.04.24	Alignment of investment with strategic priorities will demonstrate goal congruence and increase the likelihood of securing funding for projects / initiatives	tbc
F5	Identification of business development and external funding opportunities	EDoF / EDoSTP&D / EMD / DDoF	4	Jun-24	Cardiff Cancer Research Hub market engagement exercise completed. Programme plan drafted and in the process of being reviewed. Private patient cash collection and pricing continues to be developed and progress being made in the backlog of cash collection.	22.04.24	Attracting external / alternative sources of income will decrease pressure on WG allocation of funds	tbc
F6	Develop Scheme of Delegation and Governance Framework for the nVCC	EDoF / DDoF	4	Jun-24	Scheme of Delegation and Governance Framework was approved in June-23 by the Trust Board. A Scheme of Delegation and Governance Framework is being developed for nVCC, which will integrate findings from DLA Piper and PwC reviews. Progress to be taken forward through the nVCC Taskforce established in April 2024.	22.04.24	Mitigate the risks of non compliant procurement and improve budgetary control procedures by ensuring clear accountability for spend.	tbc

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SECTION 6

IMTP PRIORITY IMPROVEMENT ACTIONS - that Mitigate Trust Assurance Framework Strategic Goal Key Risks

IMTP 2024.25 to 2026.27 Service Area	2024.25	2025.26	2026.27
Strategic Goal 1 **Outstanding for quality, safety and experience**	Value & Sustainability In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements through EMB Shape. The Trust will continue to review and integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. More specifically, this will include: • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach. Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre 1. Pre-op anaemia programme: This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10 procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).		
	2. Training, Engagement and Communication: Creating, sharing and delivering developmental content to staff at all levels to build confidence and understanding of the principles of VBHC. This includes generating case studies of value in action projects within VUNHST (Velindre University NHS Trust) across both the Welsh Blood Service and the Velindre Cancer Service. Through close collaboration with the Welsh Value in Health Centre we will pursue opportunities for shared learning and spread of improvements in practice. 3. Technical Development: Ensuring that linked data sets (e.g. activity, outcomes, and use of resources) are accessible to services to inform decision making. This takes the form of information tools such as dashboards which will be iterated to meet service needs and to incorporate future data feeds, for example blood transfusion data and patient reported outcome measures (PROMS). 4. Data Maturity: This theme focuses on ensuring that the accuracy and completeness of data within patient IT systems is sufficient to enable meaningful analytics. Working with service		
	5. Data Driven Sense Making and Action Planning This takes all the above information and applies financial, workforce and data analytical capabilities to provide actionable information for services to apply through the Value Intelligence Cycle. By applying analytics prior to, and after changes to services are made, the impact of interventions can be assessed enabling further refinement to processes and services provided. Areas of intervention include identifying and reducing unwarranted variation in the provision of care. 6. Digital PROMs Platform: To enable the systematic collection of patient reported outcome measures (PROMs) to capture and understand the quality of life and symptom burden that our patients experience. For most patients, this will take the form of a structured questionnaire sent periodically to their mobile phones. The responses to the questions will be stored on the patient's electronic health record and form part of their medical history to support with the management of their care. This PROMs system will be part of a suite of patient facing apps within the Digital Services' portfolio. Roll out will include work to support patients that are not familiar with using their phones in this way, and use of alternative methods for completion for those who do not have this technology to hand.		
	7. Patient Outcomes: To achieve shared decision making, our patients need meaningful information on the outcomes that they should expect from different treatment options. To understand the outcomes of treatment for our patients, we need to agree the questions to be asked. This ensures consistency across pathways and the ability to analyse aggregated data to assess the benefits or the negative side-effects that treatments can have. These parameters are already agreed nationally for some cancer sites, e.g. Lung Cancer. The Value Intelligence Centre is working with our Clinical Teams, the Welsh Cancer Network, and the Welsh Value in Health Centre to agree validated PROMs tools (sets of questions to capture Patient Reported Outcome Measures) for different types of cancer and when to send them on a national basis. These will be used to inform the consultations of the patients completing the form as well as, in aggregate being used to help future patients understand typical outcomes from different treatments using real-life locally gathered data 8. Food Mission: Velindre's Food Mission sets a long-term ambition to provide our people with access to affordable, healthy food with an objective to source 70% of Velindre's food from Welsh, environmentally friendly or globally responsible providers by 2035. It is expected that this will improve the wellbeing of patients, donors, staff, and their families. Further, it will support the delivery of Velindre's wider Value Based Healthcare, Workforce and Sustainability Strategies, the Trust's Wellbeing Objectives, and its ambition to reach Net Zero by 2030.		
	Estates and Sustainability Plan 'Estates Excellence' The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in. 1. Provide an estate which enables the delivery of high quality clinical services 2. Provide a safe and high quality estate which gives patients, donors, staff and partners a great experience 3. Provide healthy buildings which support and enhance individual well-being 4. Minimise the impact of our estate on the environment 5. Maximise the benefit and social value our estate can provide to our staff, patients, donors and the communities we serve Estates Actions • Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs • Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces • Investing additional resources in the maintenance of the existing estate to maintain a Category B • Implementing our estates, digital, workforce and sustainability strategies • Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles • Identifying innovative ways to adopt renewable energy sources to service our requirements • Identifying facilities we can share the use of with other public bodies and wider partners		

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	• Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets • Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services • Delivering a number of transformative capital programmes which have sustainability at their centre of design: • Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 • Refurbishment / development of new outreach facilities by 2024/2025 • Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 • Opening of the new Velindre Cancer Centre by 2025		
	Sustainability Actions		
	• Major refurbishment of the Welsh Blood Service, Llantrisant site, by 2025		

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RISK DESCRIPTORS			
RISK NUMBER	RISK THEME/TITLE	DRAFT RISK DESCRIPTION	RISK OWNER
01	Service Capacity	There is a strategic risk of failure to deliver timely, safe, effective and efficient services for the local population leading to deterioration in service quality, performance or financial control as a result insufficient capacity and resources.	Cath O'Brien Rachel Hennessey Alan Prosser
02	Partnership Alignment	There is a strategic risk of failure to align our strategic objectives and intent with system partners, including within the health and social care system, third sector and industry partners which could result in an inability to deliver required change to achieve our medium to long term objectives.	Carl James Nicola Williams Jacinta Abraham
03	Workforce Supply and Shape	There is a strategic risk of an optimised workforce supply and shape in order to effectively deliver quality services and achieve our medium to long term objectives.	Sarah Morley
04	Organisational Culture	There is a strategic risk of failure to have a positive working environment and high levels of staff engagement through the embedding of appropriate values and behaviours in effective systems and processes.	Sarah Morley

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05	**Digital Transformation**	There is a strategic risk that the Trust fails to sufficiently consider, optimise the opportunities and effectively manage the risks of new and existing technologies, including considerations of Artificial Intelligence and Information Security	**Carl James**
06	**Organisational and Clinical Governance**	There is a strategic risk that the organisational and clinical governance arrangements do not provide appropriate mechanisms and culture to achieve our medium to long term objectives.	**Lauren Fear**
07	**Patient Outcomes**	There is a strategic risk that Velindre Cancer Service patient outcomes / experience may be adversely affected due increasing service demands, the need for significant service delivery transformation to meet the rapidly changing and complex treatment regimes, staffing challenges, and lack of consistent quality, outcome and mortality metrics.	**Nicola Williams** **Jacinta Abraham** **Cath O'Brien**
08	**Financial Sustainability**	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive.	**Matt Bunce**

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DEFINITIONS

CONTROL EFFECTIVENESS

Effective	Control in implemented/ embedded; working as designed; with associated sources of assurance	E
Partially Effective	Some aspects of control to be implemented/ embedded; some aspects therefore not yet operating as designed; and may be gaps in associated sources of assurance	PE
Not yet Effective	Significant aspects of control be implemented/ embedded; significant aspects therefore not yet operating as designed; and gaps in associated sources of assurance	NE

ASSURANCE RATING		
Positive assurance	the assuring committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity	PA
Inconclusive assurance	the assuring committee has not received sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy	IA
Negative assurance	the assuring committee has received reliable evidence that the current risk treatment strategy is not appropriate to the nature and / or scale of the threat or opportunity	NA
Not Assessed	Assessment of the assurance arrangements is pending.	Not Assessed

Total IMTP 2024/25 Quarterly Actions Delivery	
BRAG Rating	**Progress Categories Definitions**
BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale

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YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

LEVELS OF ASSURANCE DESCRIPTORS

First Line of Defence functions that own and manage risk	**Second Line of Defence** functions that oversee or specialise in risk management	**Third Line of Defence** functions that provide independent assurance
Self-Assurance	**Internal oversight/**specialist control teams, such as**:**	**Internal Audit** (provides assurance to the Board and senior management. This assurance covers how effectively the organisation assesses and manages its risks and will include assurance on the effectiveness of the first and second lines of defence); and **external oversight**, such as:
Risk and control management as part of day-to-day business management Staff training and compliance with policy guidance Teams take responsibility for their own risk identification and mitigation	Quality & Safety IT Governance (corporate/Clinical)	External Audit Regulators & Commissioners Wales Audit Office reviews Stakeholder reviews Scrutiny from public, Parliament, and the media
Examples of assurance	***Examples of assurance***	***Examples of assurance***
Management Controls / Internal Control Measures *Local management information / departmental management reporting* *Divisional / Departmental performance reviews, mandates, outcomes frameworks, objectives (Clinical and Nonclinical services)* *Operational planning / Business Plans - Delivery Plans and Action Plans* *Governance statements / self-certification* *Local procedures*	*Board, Committee and Management Structures which receive evidence from* *Finance reports* *KPI's and management information* *Quality, Safety and Risk reports* *Training records and statistics* *Performance reports*	*Recent internal audit reviews and levels of assurance* *External Audit coverage* *Inspection reports / external assessment e.g. HIW / NHS Wales other regulator and Commissioner compliance reviews* *Patient Feedback / Patient experience feedback* *Staff surveys / feedback* *Comparative data, statistics, benchmarking*

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Exceptions reporting *Targets, Standards and KPIs* *Incident Reporting* *Staff Training Programmes*	*BAF, VUNHS risk register* *Policies and Procedures including Risk Management Policy* *Compliance against Policies*	

STRATEGIC GOALS
1 - Outstanding for quality, safety and experience
2 - An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations
3 - A beacon for research, development and innovation in our stated areas of priority
4 - An established 'University' Trust which provides highly valued knowledge and learning for all
5 - A sustainable organisation that plays it part in creating a better future for people across the globe

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

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

RISK SCORE

LIKELIHOOD MATRIX					
LIKELIHOOD (*)					
LIKELIHOOD SCORE	**1**	**2**	**3**	**4**	**5**
DESCRIPTOR	**RARE**	**UNLIKELY**	**POSSIBLE**	**PROBABLE**	**EXPECTED**
Frequency: How often might it/does it happen	Not expected to occur for 10 years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

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Probability: Will it happen or not?	Less than 0.1% chance	01.-1% chance	1-10% chance	10-50% chance	Greater than 50% chance

[redacted]

RISK RATING MATRIX - IMPACT X LIKELIHOOD					
RISK MATRIX	**LIKELIHOOD(*)**				
CONSEQUENCE(**)	**1- Rare**	**2- Unlikely**	**3 - Possible**	**4 - Probable**	**5 - Expected**
1 -Negligible	1	2	3	4	5
2 - Minor	2	4	6	8	10
3 -Moderate	3	6	9	12	15
4 - Major	4	8	12	16	20
5 - Catastrophic	5	10	15	20	25

IMPACT MATRIX

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

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RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
06	Performance and Service Sustainability *Business objectives/projects* *Service/business interruption*	Failure to achieve minor objective No or minimal service issue	Failure to achieve significant/key objective Minor impact on service	Failure to achieve multiple significant/ key objectives. Moderate impact on service	Failure to achieve crucial objectives. Major impact on service	Gross failure to achieve multiple crucial objectives Service failure

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

RISK DOMAINS		Impact, consequence score (severity levels) and examples.				
		1	2	3	4	5
		NEGLIGIBLE	MINOR	MODERATE	MAJOR	CATASTROPHIC
		has occurred in a Research Study that is not a Clinical Trial of an Investigation Medicinal Product.	Procedural requirements, and/or Good Clinical Practice (GCP) has occurred in a Clinical Trial of an Investigational Medicinal Product (CTIMP) but it is neither "critical" nor "major".	Request for provision of corrective action & preventive action plan (CAPA) updates at periodic intervals	Early re-inspection to determine adequate progress is observed in implementing a corrective action & preventive action (CAPA) plan Request for provision of corrective action & preventive action (CAPA) plan updates at periodic intervals For actions in relation to pending or future clinical trials (for example, suspension or revocation)	example, other competent authorities, other government departments or UK NHS Research Ethics Committees Meetings with senior representatives from the inspected organisations to review the implications of the critical findings, the organisation's proposed actions and the actions Infringement Notice Referral to the MHRA Enforcement Group for investigation with a view to criminal prosecution
10	**Safety** *Impact on safety of patients, staff or public (physical or psychological harm)*	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a number of patients or donors	Major injury leading to long-term incapacity /disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days RIDDOR/agency reportable incident Mismanagement of patient or donor care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects RIDDOR/agency reportable incident An event which has an effect on a large number of patients or donors
11	**Workforce and OD** *Human resources/ organisational development/ staffing/ competence*	Short term low staffing level that temporarily reduces service quality (<1day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence

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				Low staff morale Poor staff attendance for mandatory/key training	competence (>5 days) Loss of key staff. Very low staff morale Very poor staff attendance mandatory/ key training	Loss of several key staff Very poor staff attending mandatory training /key training on an ongoing basis

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

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

SUMMARY STATEMENTS OF 7 LEVELS

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

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Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

POLICY MANAGEMENT REVIEW AND COMPLIANCE STATUS: AS AT AUGUST 2024

DATE OF MEETING	12/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Fay Sparrow, Freedom of Information & Compliance Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The purpose of this report is to provide the Quality, Safety & Performance Committee with assurance on the continuing progress that is being made, and to provide an update on the timeline for policy compliance. As of August 2024,there were **108** policies under review of which **3** have been archived. Of the remaining **105** policies under review, **71 (67.62%)** are in date and **34 (32.38%)** have passed their review date. Of the **34** policies that have passed their review date, **9 (26.47%)** are classified as All Wales Policies. Since the appointment of the permanent Freedom of Information Officer (FCO) at the end of September 2023, policy compliance has risen by **18%.**

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RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to: a) **NOTE** the contents of the report and the progress that has been made in respect of the Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. b) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/08/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board: a) **REVIEWED** the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee. b) **NOTED** the level of assurance in relation to Trust-wide Compliance and the plans for improvement. c) **ENDORSED** the **Policy Management Review Compliance Status Report** for submission to the September 2024 Quality, Safety and Performance Committee.	

7 LEVELS OF ASSURANCE	
If the purpose of the report is selected as **'ASSURANCE',** this section **must be** completed.	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes

ACRONYMS	
WOD	Workforce and Organisational Development
FCO	Freedom of Information and Compliance Officer

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APPENDICES	
Appendix 1	Workforce and Organisational Development status August 2024
Appendix 2	Planning Performance and Estates status August 2024
Appendix 3	Health and Safety status August 2024

Appendix 4	Quality and Safety status August 2024
Appendix 5	Digital status August 2024
Appendix 6	Infection Prevention and Control status August 2024
Appendix 7	Information Governance status August 2024
Appendix 8	Corporate Communications status August 2024
Appendix 9	Schedule of policies currently within their review date

1. SITUATION

1.1 The purpose of this report is to provide **ASSURANCE** to the Quality, Safety & Performance Committee on the continuing progress that has been made on the current policy compliance status and the timeline for the remaining policies outside of their review date be reviewed and proceed through the approval process.

1.2 Since the appointment of the permanent Freedom of Information Officer (FCO) at the end of September 2023, collaborations with the divisions has increased policy compliance by **18%**. However, it must be noted that as part of the continuous life cycle of a policy, there will never be a fixed static point, during the last four months further policies fell outside of their review date.

The Quality, Safety and Performance Committee is asked to:

a) **NOTE** the contents of the report and the progress that has been made in respect of Policy Compliance Status for those policies that fall within the remit of the Quality, Safety and Performance Committee.

b) Receive **ASSURANCE** that progress is being managed via the Executive Management Board.

2. BACKROUND

2.1 The Document Control Register is regularly reviewed with collaborative engagement undertaken with each of the respective policy leads on a regular basis. The purpose of the ongoing collaborative engagement exercise is to confirm and validate the following:

- Clarification on the status of existing policies.
- A risk assessment of policies passed their review date.
- Monitoring and updates of the review and approval status of policies currently outside their review date.

2.2 The importance of planning the review of the policy ***in advance*** of its review date is to ensure it remains in date and has been highlighted to each of the policy leads during the audit review. The Document Control Register has been updated to incorporate a trigger point to help facilitate this.

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3. ASSESSMENT

3.1 As of August 2024,there were **108** policies under review of which **3** have been archived. Of the remaining **105** policies under review, **71 (67.62%)** are in date and **34 (32.38%)**

have passed their review date. Of the **34** policies that have passed their review date, **9 (26.47%)** are classified as All Wales Policies.

3.2 Table 1 highlights the number of policies within each division and the number of policies both within and outside of their review dates.

Table 1: *Progress as at August 2024*

Directorate/Department	Policies outside of review date		Policies within review date (Inc. All Wales)	Total policies within the division
	All Wales	Trust		
Workforce & Organisational Development	1	17	28	**46**
Planning, Performance & Estates	0	2	12	**14**
Infection Prevention & Control	2	0	10	**12**
Health & Safety	0	3	7	**10**
Quality & Safety	1	2	6	**9**
Digital	2	1	4	**7**
Information Governance	2	0	4	**6**
Corporate Communications	1	0	0	**1**
TOTAL	**9**	**25**	**71**	**105**

3.3 Since the last reported position to the Quality, Safety & Performance Committee in May 2024, **3** policies have been archived.

Table 2: *Archived policies between May – August 2024*

Directorate/ Department	Policy Title	Status
Quality and Safety	International Health Partnership Related Activity Policy (QS31)	Archived – Discussion between Deputy Director of Nursing and WOD – no longer required.
Workforce & Organisational Development	Homeworking Policy (WF45)	Archived - Captured within Flexible Working Policy (WF23)
Workforce & Organisational Development	COVID 19 Extraordinary Ad Hoc Home Working Policy and Guidance for Managers and Staff (WF45a)	Archived - Captured within Flexible Working Policy (WF23)

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3.4 **Document Management System**

The Trust has completed a contract for the provision of a new electronic Quality Management System. The new system is an updated version of Q-Pulse, which is being introduced in each Division to meet their specific needs.

There is a phased approach to the implementation with the VCC and WBS working with the system providers to put a detailed project plan for each Division. As Corporate Governance will only be using the Document Management module in the first instance, implementation within VCC and WBS is progressing ahead of Corporate Governance.

Due to staffing constraints within the Corporate Governance Team progress with the initial system configuration for the Document Management Module has been delayed, but it is expected that work will recommence in October 2024.

Subject to the Q-Pulse implementation within the VCC and WBS, it is anticipated that the Q-Pulse Document Management Module for Trust wide Policies will be completed by October / November 2025.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 Policy compliance has risen by **18%** since the appointment of a permanent Freedom of Information and Compliance Officer (FCO) at the end of September 2023, with Workforce & Organisational Development (WOD) remaining the division with the largest number of policies that have passed their review date.

4.2 **Appendices 1-8** provide an update on all policies outside of their review date (including All Wales) and, where possible, an estimated timeline for review.

4.3 **Appendix 9** provides the policies covered by this report that are within their review date.

5. MPACT 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	☐

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RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	A robust and clear governance framework for the management of policies is essential to minimise risk to patients, employees and the organisation itself; therefore, the Trust has developed a system to support the development or review, approval, dissemination and management of polices.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Yes
	Through better decision making, the duty will improve the outcomes for those who suffer socio-economic disadvantage. The Duty will contribute towards a fairer and more prosperous Wales.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A More Equal Wales - A society that enables people to fulfil their potential no matter what their background or circumstances
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents has an associated EIA. The EIA will be refreshed when GC01 is due for review.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

6. RISKS

6.1 The appointment of a permanent FCO ensures a continual review cycle of the policies and compliance with GC01 Policy and Procedure for the management of Trust Wide Policies and Other Trust Wide Written Control Documents.

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

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APPENDIX 1 – Workforce and Organisational Development

Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Review Due	Comments / Input from WOD
WF12	Version 2	Study Leave Policy, Procedure & Guidelines	Head of Workforce	Executive Director of OD and Workforce	Nov-13	Assigned to VD for review Q3
WF 13	Version 1	Adverse Weather Policy	Head of Workforce	Executive Director of OD and Workforce	Mar-21	Changed to procedure – Policy Review report required to go through governance approval process to change
WF 16	Version 3	Welsh Language Policy	Head of Workforce	Executive Director of OD and Workforce	May-22	Assigned to Welsh Language Manger for review Q3
WF 18	Version 2	Alcohol, Drugs & Substance Misuse Policy	Head of Workforce	Executive Director of OD and Workforce	Jun-22	Endorsed by EMB August 2024 – QSPC September
WF 19	Version 2	Policy for Employing Ex-Offenders and people with a criminal record	Head of Workforce	Executive Director of OD and Workforce	Jan-21	Assigning in progress - to be completed by September 2024
WF 21	Version 1	Close Personal Relationships in the Work Place	Head of Workforce	Executive Director of OD and Workforce	Feb-21	Assigning in progress - to be completed by September 2024
WF 22	Version 2	Professional Registration Policy	Head of Workforce	Executive Director of OD and Workforce	Jun-22	Endorsed by EMB August 2024 – QSPC September
WF 28	Version 4	Recruitment of Locum Doctor Policy	Head of Workforce	Executive Director of OD and Workforce	Apr-17	Assigning in progress - to be completed by September 2024

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WF 29	Version 1	Maternity, Paternity, Adoption and Parental Leave Policy	Head of Workforce	Executive Director of OD and Workforce	Aug-18	Assigned to GS for review Q3
WF 30	Version 1	PADR Policy	Head of Workforce	Executive Director of OD and Workforce	May-20	Endorsed by EMB August 2024 – QSPC September
WF 31	Version 3	Sabbatical Leave Policy for Consultant Medical Staff	Head of Workforce	Executive Director of OD and Workforce	Jan-21	Assigning in progress - to be completed by September 2024
WF 40	Version 2	Supporting Staff who are Carers	Head of Workforce	Executive Director of OD and Workforce	May-22	Assigning in progress - to be completed by September 2024
WF 43	Version 2	Mental Health, Wellbeing & Stress Management Policy	Head of Workforce	Executive Director of OD and Workforce	Jan-21	Changed to procedure – Policy Review report required to go through governance approval process to change
WF 46	Version 2.1	Supporting Transgender Policy	Head of Workforce	Executive Director of OD and Workforce	Aug-22	Assigning in progress - to be completed by September 2024
WF 49	Version 2	Shared Parental Leave Policy	Head of Workforce	Executive Director of OD and Workforce	Dec-21	Assigned to GS for review Q3
WF 54	Version 2	Violence, Domestic Abuse & Sexual Violence Workplace Policy & Procedure	Head of Workforce	Executive Director of OD and Workforce	Jul-23	Assigning in progress - to be completed by September 2024
WF 56	Version 5	Smoke Free Policy	Head of Workforce	Executive Director of OD and Workforce	Jun-22	Assigning in progress - to be completed by September 2024
WF 17 All Wales Velindre Adopted	Version 2	Policy on Reimbursement of Removal and Associated Expenses	ALL WALES	Executive Director of OD and Workforce	Jun-21	Pending update from Welsh Partnership Forum Business Committee

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APPENDIX 2 – Planning, Performance and Estates

Policy Reference	Version	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
PP 02	Version 1	Security Policy	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Jan-22	Endorsed by EMB June 2024 – QSPC September
PP16	Version 1	Cleaning Manual	Operations Manager	Chief Operating Officer	May-10	Draft cleaning standards are with Welsh Gov for approval, expecting draft copy in Autumn to feed into this policy.

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APPENDIX 3 – Health and Safety

Policy Reference	Version	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
QS 30	Version 7	Lone Working Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Mar-23	To go through governance approval process to change to procedure
QS 36	Version 7	Workplace Equipment Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	May-23	To go through governance approval process to change to procedure
QS 24	Version 4.1	Medical Devices & Equipment Management Policy	Medical devices officer	Director of Strategic Transformation, Planning & Digital	Jan-24	Out for consultation before proceeding through approval

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APPENDIX 4 – Quality and Safety

Policy Reference	Version	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
QS 25	Version 4	Preceptorship Policy for Newly Registered Nurses and Allied Health Care Professionals	Clinical Educators WBS & VCC AHP Preceptorship Lead	Executive Director of Nursing, AHPs and Health Sciences	Nov-23	Aiming to review and submit to PNF end of Aug and submit to QSPC in Q3.
QS 02	Version 2.1	Management of Safety Alerts and Important Notifications Policy	Quality, Safety and Assurance Manager	Executive Director of Nursing, AHPs and Health Sciences	Jan-24	Reviewing EQIA – looking to submit In Q3
QS17 All Wales Velindre Adopted	Not indicated	Consent to Examination or Treatment - All Wales	ALL WALES	Executive Medical Director	Jul-22	Revised Model Policy received via All Wales Consent to Treatment Group for adoption by the Trust. Being prepared for submission to QSPC

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APPENDIX 5 – DIGITAL

Policy Reference	Version	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
IG 10	Version 1	Staff Mobile Phone Policy	Head of Digital Delivery	Director of Strategic Transformation, Planning & Digital	Mar-12	Endorsed EMB in June subject to completion of EQIA – submit to QSPC November
IG 03 All Wales Velindre Adopted	Version 2	Email Use Policy	ALL WALES	Director of Strategic Transformation, Planning & Digital	Jun-18	Under review by IGMAG. Being progressed with the Trust's Head of Information Governance.
IG 07 All Wales Velindre Adopted	Version 3	Internet Use Policy	ALL WALES	Director of Strategic Transformation, Planning & Digital	Jan-23	Under review by IGMAG. Being progressed with the Trust's Head of Information Governance.

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Appendix 6 – Infection Prevention and Control

Version	Policy Title	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
IPC 03 All Wales Velindre Adopted	Version 1	Aseptic Non Touch Techniques (ANTT)	ALL WALES	Executive Director of Nursing, AHPs and Health Sciences	Jul-21	Endorsed EMB in July – submit to QSPC September
IPC 05 All Wales Velindre Adopted	Not Indicated	NHS Scotland National Infection Control Manual (NIPCM)	ALL WALES	Executive Director of Nursing, AHPs and Health Sciences	Apr-24	Scottish manual updated Jan 2024 - need to review Trusts and go through Governance

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Appendix 7 – Information Governance

Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
IG 04 All Wales Velindre Adopted	Version 2	Information Security Policy	ALL WALES	Executive Director of Finance	Jan-23	Under review by IGMAG. Being progressed with the Trust's Head of Information Governance.
IG 09 All Wales Velindre Adopted	Version 2	Information Governance Policy	ALL WALES	Executive Director of Finance	Jan-23	Under review by IGMAG. Being progressed with the Trust's Head of Information Governance.

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Appendix 8 – Corporate Communications

Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
GC19 All Wales Velindre Adopted	Version 1	Social Media Policy	Assistant Director of Communications and Engagement	Director Corporate Governance and Chief of Staff	Jan-18	Draft recommendation period ended 31/5/24 – DPO providing overview prior to IGMAG.

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Appendix 9 – Policies within their review period

Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 52a All Wales Velindre Adopted	Version 5	Redeployment Procedure (Excluding OCP Redeployments)	Head of Workforce	Executive Director of OD and Workforce	Aug-25	*Review and updates completed Changed from policy to procedure Previously known as Redeployment Policy (Exc OCP Redeployments)*
Workforce & OD	WF 05	Version 4	Equality & Diversity Policy	Equality & Diversity Manager	Executive Director of OD and Workforce	Sep-25	
Workforce & OD	WF 44	Version 3	Working Time Regulations	Head of Workforce	Executive Director of OD and Workforce	Sep-25	*Statutory Legislation*
Workforce & OD	WF 34	Version 5	Incremental Credit Procedure for Staff starting or re-joining the NHS	Head of Workforce	Executive Director of OD and Workforce	Oct-25	*Completed.* *Change from Policy to Procedure*
Workforce & OD	WF 04b	Version 1	Disclosure and Barring Service Checks Procedure	Head of Workforce	Executive Director of OD and Workforce	Jan-26	
Workforce & OD	WF 04	Version 1	Recruitment & Selection Policy	Head of Workforce	Executive Director of OD and Workforce	Jan-27	-
Workforce & OD	WF 35	Version 5	Annual Leave and Bank Holiday Policy	Head of Workforce	Executive Director of OD and Workforce	Jan-27	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 53	Version 5	Redundancy and Security of Employment Policy	Head of Workforce	Executive Director of OD and Workforce	Jan-27	
Workforce & OD	WF 01 All Wales Velindre Adopted	Version 1	Respect and Resolution Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	All Wales review done – currently going through the internal governance process for Trust Adoption
Workforce & OD	WF 02 All Wales Velindre Adopted	Version 40	Disciplinary Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*New approach to the review of All Wales Policies and Procedures agreed by Welsh Partnership Forum Business Committee. The core element of this new approach is to move away from using a review date as a prompt for review of an existing policy, to recognise key prompts for review and to provide an option for a transactional review where changes/updates to an existing policy are more administrative than material. All Wales W&OD policies remain extant until replaced by an updated version approved by the Welsh Partnership Forum. NHS Wales Employers will issue this schedule on a quarterly basis as confirmation of policies remaining extant to provide clarity and support organisations from a governance and assurance perspective.*

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 08 All Wales Velindre Adopted	Not Indicated	Managing Attendance at Work Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 09 All Wales Velindre Adopted	Version 21	Capability Policy and Procedure	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 14 All Wales Velindre Adopted	Not Indicated	Special Leave Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 23 All Wales Velindre Adopted	Version 2	Flexible Working Policy and Procedure	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 24 All Wales Velindre Adopted	Not Indicated	Procedure for NHS Staff to Raise Concerns (Whistleblowing)	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 26 All Wales Velindre Adopted	Not Indicated	Reserve Forces Training and Mobilisation Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 27 All Wales Velindre Adopted	Not Indicated	Secondment Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 36 All Wales Velindre Adopted	Not Indicated	Menopause Guidance	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 50 All Wales Velindre Adopted	Not Indicated	Pay Progression Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 51 All Wales Velindre Adopted	Not Indicated	Upholding Professional Standards in Wales (Medical Staff Only)	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 52b All Wales Velindre Adopted	Version 15	NHS Wales Organisational Change Policy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed in March 2024 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 07 All Wales Velindre Adopted	Not Indicated	Protocol on Collective Consultation on Proposed Redundancy	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 10 All Wales Velindre Adopted	Not Indicated	Accessing NHS Pension and Retirement Policy (incorporating 2015 Scheme)	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 15 All Wales Velindre Adopted	Not Indicated	Employment Break Scheme	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 20 All Wales Velindre Adopted	Version 3	Exit Policy & Procedure	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 38 All Wales Velindre Adopted	Not Indicated	NHS Wales Model Voluntary Early Release Scheme	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Workforce & OD	WF 42 All Wales Velindre Adopted	Not Indicated	All Wales NHS Dress Code - Free to Lead, Free to Care	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Workforce & OD	WF 47 All Wales Velindre Adopted	Version 1	NHS Wales Consistency of National T&C's (AFC) Band Outcome Following merger of Organisations	Head of Workforce	Executive Director of OD and Workforce	Extant Reviewed on 8 June 2023 by Welsh Partnership Forum Business Committee	*As above re All Wales*
Planning, Performance & Estates	PP 01	Version 4	Fire Safety Policy	Fire Safety Manager	Executive Director of Strategic Transformati on, Planning & Digital	May-27	
Planning, Performance & Estates	PP 03	Version 3	Environmental Policy	Trust Sustainabi lity Manager	Executive Director of Strategic Transformati on, Planning & Digital	Sep-26	Currently undergoing EQIA

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Planning, Performance & Estates	PP 04	Version 2	Asbestos Policy	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Nov-25	
Planning, Performance & Estates	PP 05	Version 4.1	Control of Contractors	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Nov-25	Currently under review.
Planning, Performance & Estates	PP 06	Version 3	Business Continuity & Emergency Planning Policy	Head of Validation and Risk Management	Chief Operating Officer	Jul-26	
Planning, Performance & Estates	PP 08	Version 2	Waste Management Policy	Trust Sustainability Manager	Executive Director of Strategic Transformation, Planning & Digital	Sep-26	Currently undergoing EQIA
Planning, Performance & Estates	PP 09	Version 2	Water Safety Policy	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Nov-25	
Planning, Performance & Estates	PP 10	Version 2	Medical Gas Piped Systems Policy	Assistant Director of Estates	Chief Executive	Mar-27	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Planning, Performance & Estates	PP 11	Version 2	Operational Policy for High Voltage Electricity Supply Systems using a contractor as the Authorised Person (HV)	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Mar-27	
Planning, Performance & Estates	PP 12	Version 2	Operational Policy for High Voltage Electricity Supply Systems	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Mar-27	
Planning, Performance & Estates	PP 13	Version 2	Electrical Low Voltage Policy	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Mar-27	
Planning, Performance & Estates	PP 14	Version 2	Ventilation Policy	Assistant Director of Estates	Executive Director of Strategic Transformation, Planning & Digital	Mar-27	
Infection, Prevention and Control	IPC 15	Version 2	Control and Management of Multi Drug Resistant Bacteria	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Dec-24	EMB July 2024 endorsed the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December 2024 for the national policy review and consultation to be completed.

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Infection, Prevention and Control	IPC 00	Version 7	Framework Policy for Infection Prevention and Control	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Mar-27	
Infection, Prevention and Control	IPC 01	Version 5	Viral Gastro Enteritis (including Norovirus) Policy & Addendum	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Mar-25	
Infection, Prevention and Control	IPC 04	Version 5	Decontaminatio n Policy	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Mar-25	
Infection, Prevention and Control	IPC 07	Version 4	Methicillin Resistant Staphylococcus Aureus (MRSA)	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	May-25	.
Infection, Prevention and Control	IPC 10	Version 6	Hand Hygiene Policy	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Nov-25	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Infection, Prevention and Control	IPC 11	Version 5	Specimen Collection, Handling and Transport Policy	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Mar-27	
Infection, Prevention and Control	IPC 13	Version 7	Policy for the Prevention and Control of Transmissible Spongiform Encephalopathies (Creutzfeldt-Jakob Disease) Minimising the Risk of Transmission	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Mar-26	
Infection, Prevention and Control	IPC 18	Version 4	Tuberculosis Management	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Dec-24	
Infection, Prevention and Control	IPC 21	Version 4	Infection Prevention and Control Policy for the Management of Respiratory Infections and Addendum	Head of Infection Prevention and Control	Executive Director of Nursing, AHPs and Health Sciences	Sep-25	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Health and Safety	QS 09	Version 7	Management of Latex and Latex Allergy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jan-27	
Health and Safety	QS 14	Version 8	Safer Manual Handling Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jan-27	
Health and Safety	QS 15	Version 8	Management of Violence & Aggression Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jan-27	
Health and Safety	QS 18	Version 8	Health Safety & Welfare Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jul-25	Policy was revised to align with legislation.
Health and Safety	QS 26	Version 6	Safe Use of Display Screen Equipment & Appendices	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jan-27	
Health and Safety	QS 33	Version 5	Control of Substances Hazardous to Health (COSHH)	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Jan-27	
Health and Safety	QS35	Version 4	Safe Use of Sharps Policy	Health and Safety Manager	Director of Strategic Transformation, Planning & Digital	Oct-26	Policy transferred from IPC to H&S September 2023 Revised policy approved by Committee Chair's Urgent Action on 25/10/2023.

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Quality & Safety	QS 01 All Wales Velindre Adopted	Version 2	National Policy on Patient Safety Incident Reporting and Management	Quality & Safety Manager	Executive Director of Nursing, AHPs and Health Sciences	Extant	All Wales - approved by QSP in November 2023
Quality & Safety	QS 03	Version 3	Handling Concerns Policy	Head of Quality, Safety and Assurance	Executive Director of Nursing, AHPs and Health Sciences	Nov-26	
Quality & Safety	QS 04a	Version 9	Compensation Claims Policy	Claims Manager	Executive Director of Nursing, AHPs and Health Sciences	Nov-26	
Quality & Safety	QS 08	Version 3	Policy for the management of Safeguarding Allegations/ Concerns about Practitioners and those in a position of trust	Head of Safeguarding and Vulnerable Groups	Executive Director of Nursing, AHPs and Health Sciences	May-26	
Quality & Safety	QS 12	Version 3	Safeguarding & Public Protection Policy	Head of Safeguarding and Vulnerable Groups	Executive Director of Nursing, AHPs and Health Sciences	May-26	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Quality & Safety	QS 19	Version 4.8	Ionising Radiation Safety Policy	Head of Radiation Protection Services	Executive Medical Director	Mar-26	
DIGITAL	IG 05	Version 4	Software Policy	Head of Digital Delivery	Director of Strategic Transformati on, Planning & Digital	Jul-25	
DIGITAL	IG 06	Version 4	Anti-Virus Policy	Head of Digital Delivery	Director of Strategic Transformati on, Planning & Digital	Jul-25	
DIGITAL	IG 11	Version 2	Data Quality Policy	Head of Digital Delivery	Director of Strategic Transformati on, Planning & Digital	Jul-25	
DIGITAL	IG 14	Version 2	Information Asset Policy	Head of Digital Delivery	Director of Strategic Transformati on, Planning & Digital	Jul-25	
Information Governance	IG 01	Version 2	Records Management Policy	Head of Informatio n Governan ce	Executive Director of Finance	Jul-25	
Information Governance	IG 02	Version 2	Data Protection & Confidentiality Policy	Head of Informatio n Governan ce	Executive Director of Finance	Jul-25	

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Directorate/ Department	Policy Reference	Version Number	Policy Title	Policy Lead	Accountable Executive Lead	Policy Review Date	Comments
Information Governance	IG 08	Version 2	Freedom of Information Act Policy	Head of Information Governance	Director Corporate Governance and Chief of Staff	Jul-25	
Information Governance	IG 13	Version 2	Confidentiality Breach Reporting Policy	Head of Information Governance	Executive Director of Finance	Jul-25	

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Refresh and Update of the Trust Well-Being Objectives

DATE OF MEETING	12.09.24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	DISCUSSION

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	**Owen Barnett**, Trust Environment Officer
PRESENTED BY	**Phil Hodson**, Deputy Director of Planning & Performance
APPROVED BY	**Lauren Fear**, Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The primary objective of the Well-being of Future Generations (Wales) Act (WBFGA) is to improve the social, economic, environmental and cultural well-being for the Welsh People. The purpose of the Act is to encourage the public bodies listed in the Act to think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach. Each public body listed within the Act, which includes the Trust, must ensure that the they are

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	committed to sustainable development. This must include assurance that the Trust is: • Setting and publishing objectives ("well-being objectives") that are designed to maximise its contribution to achieving each of the well-being goals, and • Taking all reasonable steps (in exercising its functions) to meet those objectives. The purpose of the Trust objectives is to demonstrate how the Trust will work to achieve the vision for Wales set out in the well-being goals. As a named body under the Act, the Trust originally developed its Trust Well-being objectives in 2015. However, there is now a requirement for the Trust Well-Being of Future Generations Objectives to be reviewed and updated. This is a statutory obligation due to the amendment in the legislation. Under the Act, all named public bodies must review their current objectives to ensure they are still compliant, whenever an amendment is made. The Act has had a minor amendment, changing the word 'fair' to 'decent' under A Prosperous Wales.

RECOMMENDATION / ACTIONS	The Trust Well-Being of Future Generations Objectives were developed in April 2015, in line with the requirements under the legislation. Following the approval of the Velindre University NHS Trust Destination 2033 Strategy and supporting strategies (service and enabling), together with a slighted change in the WBFGA legislation, there is a requirement to review the WBFGA objectives. This presents an opportunity to refresh the objectives and ensure tight alignment with the Trust strategies. The Quality, Safety & Performance Committee are asked to:

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	1. **NOTE** the current Trust Board approved Trust Well-Being Objectives 2. **NOTE** the engagement and consultation process which has been undertaken to receive feedback on the existing Trust Well-Being Objectives 3. **DISCUSS & ENDORSE** the suggested changes to the Trust Well-Being Objectives 2 & 3, following extensive engagement and consultation both internally & externally

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB Shape	14.08.23
EMB Shape	16.10.23
EMB Shape	22.01.24
EMB Shape	19.02.24
Velindre Cancer Centre Senior Leadership Team	07.03.24
Welsh Blood Service Senior Management Team	10.04.24
Local Partnership Forum	08.03.24
Strategic Development Committee	19.06.24
Quality, Safety & Performance Committee	12.09.24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS EMB SHAPE 14.08.23 – The EMB agreed to discard option three and to review options one and two to ensure alignment with the Trust's Destination 2023 Strategic Goals. EMB Shape & SDC have approved the Trust refresh proposal.	

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

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APPENDICES	
Appendix 1	Questionnaire for staff, patients & donors and stakeholders
Appendix 2	Trust Well-Being Objectives Questionnaire Feedback Analysis
Appendix 3	Trust Well-Being Objectives

1. SITUATION

1.1 The primary objective of the Well-being of Future Generations (Wales) Act is to improve the social, economic, environmental and cultural well-being for the Welsh population. The purpose of the Act is to encourage the public bodies listed in the Act to think more about the long-term, work better with people and communities and each other, look to prevent problems and take a more joined-up approach.

1.2 To make sure all listed under the Act are working towards the same vision, the Act puts in place seven well-being goals.

1.3 Each public body listed within the Act – which includes the Trust – must carry out sustainable development. This must include a) setting and publishing objectives ("Well-Being Objectives") that are designed to maximise its contribution to achieving each of the well-being goals, and b) take all reasonable steps (in exercising its functions) to meet those objectives.

1.4 The purpose of the objectives shows how the Trust will work to achieve the vision for Wales set out in the well-being goals. As a named body under the Act, the Trust developed our Trust Well-being objectives in 2015.

2. BACKGROUND

2.1 The Trust WBFGA Objectives require review/refresh. This is a statutory obligation due to the amendment in the legislation. Under the Act, all named public bodies must review their current objectives to ensure they are still compliant, whenever an amendment is made. The Act has had a minor amendment, changing the word 'fair' to 'decent' under A Prosperous Wales.

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2.2 A paper was taken to EMB on August the 14th to promote discussion on the preferred way forward. The paper sets out the need to;

Plan: Development of a review plan which will include:

- **Review**: Performance against the current WBFGA objectives. S.W.O.T & P.E.S.T.L.E analyses can be found alongside a KPI Mapping document which includes progress of the Trust & Divisions towards meeting the Trust's Well-Being Objectives.

- **Review:** Engagement (with the Trust Board; patient/donors; staff; other partners/service users). Full details of this plan, communications tracker and the questionnaire can be found in the attached Appendix 1, 2 and 3.

- **Consideration:** Evaluation of the WBFGA in respect of their ability to improve health and well-being i.e., their impact. Evaluation of the feedback included in Appendix 4.

3. ASSESSMENT

3.1 A comprehensive engagement exercise has been undertaken to capture feedback on the existing WBFGA objectives and the Trust-wide and Divisional progress towards meeting these Well-Being Objectives. This has included engagement with our staff, our Divisional Leadership Teams, our Executive Management Board and with our service users via a variety of communication methods, including an online questionnaire.

3.2 Following this engagement exercise it is suggested that that the QSP consider an amendment to Trust Well-Being Objective 2 from '*improve the health and well-being of families across Wales by striving to care for the needs of the whole person',* to *'improve the health and well-being <u>of our staff and of people across Wales</u> by striving to care for the needs of the whole person'*.

3.3 It is further suggested that the QSP consider an amendment to Trust Well-Being Objectives 3 from *'create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of deliver'* to *'create new, highly skilled, <u>jobs in Wales</u> and attract investment by increasing our focus on research, innovation and new models of delivery'.*

3.4 The QSP should be reassured that the Trust's Well-Being Objectives will be reviewed regularly (annually) to assess their importance, relevance and effectiveness.

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3.5 In addition, it is noted in this paper for clarity that Velindre University NHS Trust is not responsible for public health.

4. SUMMARY OF MATTERS FOR CONSIDERATION

4.1 **NOTE** the current and previously approved Trust Well-Being Objectives.

4.2 **NOTE** the engagement and consultation process undertaken to gather intelligence on the Trust's current Well-Being Objectives.

4.3 **DISCUSS & ENDORSE** the suggested changes to the Trust Well-Being Objectives 2 & 3, following extensive engagement and consultation both internally & externally.

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*	09 - Future Direction of Travel
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 ☐

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	The purpose of this paper is to outline to approach to support the refresh and review of the Trust Well-Being Objectives. There are no quality and safety implications at this stage of the process.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not yet completed (Include further detail below why)
	A socio-economic duty assessment will be completed for the approach outlined within this piece of work.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not yet completed - Include further detail below why
	The purpose of this paper is to outline to approach to support the refresh and review of the Trust Well-Being Objectives. However, there will be a requirement to undertake an Equality Impact Assessment.
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.

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6. RISKS

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

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Velindre's Well-Being Objectives Refresh

21 Dec 2023

Adfywio Amcanion Llesiant Felindre

21 Rhag 2023

* Required

Velindre University NHS Trust is refreshing its Well-Being Objectives.

The Well-Being of Future Generations (Wales) Act 2015 places a duty on public bodies, including the NHS, to carry out sustainable development. Public bodies must set and publish 'Well-Being Objectives' that are designed to maximise the organisation's contribution to achieving each of the Well-Being Goals outlined in the Act.

The Objectives are important as they stage the road map to improving the social, economic, cultural and environmental well- being of Wales.

Velindre currently has seven wellbeing objectives which were introduced in 2015. These objectives should play an important role in everything we deliver as a Trust, therefore it is important the objectives are relevant to us all.

* Angenrheidiol

Mae Ymddiriedolaeth GIG Prifysgol Felindre yn adfywio ei Hamcanion Llesiant.

Mae Deddf Llesiant Cenedlaethau'r Dyfodol (Cymru) 2015 yn rhoi dyletswydd ar gyrff cyhoeddus, gan gynnwys y GIG, i gynnal datblygiadau cynaliadwy. Rhaid i gyrff cyhoeddus osod a chyhoeddi 'Amcanion Llesiant' i sicrhau cyfraniad mwyaf posibl y sefydliad at gyflawni pob un o'r Nodau Llesiant yn y Ddeddf.

Mae'r Amcanion yn bwysig gan eu bod yn gosod y llwybr ar gyfer gwella llesiant cymdeithasol, economaidd, diwylliannol ac amgylcheddol Cymru.

Ar hyn o bryd, mae gan Felindre saith amcan llesiant a gafodd eu cyflwyno yn 2015. Dylai'r amcanion chwarae rôl bwysig ym mhopeth a wnawn fel Ymddiriedolaeth, felly mae'n bwysig bod yr amcanion yn berthnasol i bob un ohonom.

We need your input!

We want to hear your thoughts on the Well-Being Objectives outlined below. We want to know how relevant you believe each objective to be to our work at Velindre.

We would also welcome any general comments or feedback you may have relating to each objective. Are there areas within each objective that should be strengthened? Or maybe there are areas you believe are less relevant than others. Is there anything we should add that doesn't currently feature?

Please 'rate' each Well-Being Objective based on how important you believe it is that Velindre achieves the objective:

1 thumb - *Not important*
4 thumb - *Neither important nor not important*
7 thumb - *Very important*

Mae'ch angen chi!

Rydym am glywed eich barn chi ynglŷn â'r Amcanion Llesiant isod a pha mor berthnasol yw pob amcan i'n gwaith yn Felindre.

Yn ogystal â hynny, rydym yn croesawu unrhyw sylwadau neu adborth cyffredinol sydd gennych mewn perthynas â phob amcan. A ddylem gryfhau unrhyw feysydd yn yr amcanion? Efallai bod ambell faes yn llai perthnasol nag eraill. A ddylem ychwanegu unrhyw beth sydd ddim yno ar hyn o bryd?

Ar gyfer pob Amcan Llesiant, nodwch ba mor bwysig yw hi, yn eich barn chi, fod Felindre'n cyflawni'r amcan hwnnw:

1 thumb – *Ddim yn bwysig*
4 thumb – *Ddim y naill ffordd na'r llall*
7 thumb – *Pwysig iawn*

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Not important > Very important	Ddim yn bwysig > Pwysig iawn
1. Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways * 2. Improve the health and well-being of families across Wales by striving to care for the needs of the whole person * 3. Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery * 4. Deliver bold solutions to the environmental challenges posed by our activities * 5. Demonstrate respect for the diverse cultural heritage of modern Wales * 6. Bring communities and generations together through involvement in the planning and delivery of our services * 7. Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well- being *	1. Lleihau anghydraddoldeb iechyd, ei gwneud yn haws i gael y gofal iechyd gorau posibl pan fydd ei angen a helpu i atal salwch trwy gydweithio â phobl Cymru mewn ffyrdd newydd * 2. Gwella iechyd a llesiant teuluoedd ledled Cymru trwy ymdrechu i ofalu am anghenion y person yn ei gyfanrwydd * 3. Creu cyfres newydd o swyddi medrus iawn a denu buddsoddiad trwy ganolbwyntio'n fwy ar ymchwil, arloesi a modelau newydd o gyflawni * 4. Datrys y problemau amgylcheddol a achosir gan ein gweithgareddau mewn ffordd feiddgar * 5. Dangos parch i dreftadaeth ddiwylliannol, amrywiol y Gymru fodern * 6. Dod â chymunedau a chenedlaethau ynghyd trwy eu cynnwys yn y gwaith o gynllunio a darparu ein gwasanaethau * 7. Cryfhau enw da rhyngwladol yr Ymddiriedolaeth fel canolfan rhagoriaeth ar gyfer addysgu, ymchwil ac arloesi technegol, a hynny wrth wneud cyfraniad parhaol at lesiant y byd hefyd *
## Additional feedback Thinking about your scores from above, please tell us: 8. Are there any topics contained within the objectives that you believe shouldn't be a priority for the Trust? 9. Are there any areas linked to wellbeing that aren't covered in the existing objectives that should be included?	## Rhagor o adborth Wrth ystyried eich atebion uchod, dywedwch wrthym, yn eich barn chi: 8. Oes unrhyw destun yn yr amcanion na ddylai fod yn flaenoriaeth i'r Ymddiriedolaeth? 9. A ddylem ni gynnwys unrhyw feysydd sy'n gysylltiedig â llesiant ac sydd ddim yn rhan o'r amcanion presennol?
## Bringing the objectives to life We're keen to ensure the objectives are easy for staff to recall. In no more than three words, tell us what you believe each objective is trying to achieve. 10. Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways	## Rhoi bywyd i'r amcanion Rydym yn awyddus i wneud yn siŵr fod yr amcanion yn hawdd i'r staff eu cofio. Mewn tri neu lai o eiriau, nodwch beth mae pob amcan yn ceisio ei gyflawni, yn eich barn chi. 10. Lleihau anghydraddoldeb iechyd, ei gwneud yn haws i gael y gofal iechyd gorau posibl pan fydd ei angen a helpu i atal salwch trwy gydweithio â phobl Cymru mewn ffyrdd newydd

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11. Improve the health and well-being of families across Wales by striving to care for the needs of the whole person	11. Gwella iechyd a llesiant teuluoedd ledled Cymru trwy ymdrechu i ofalu am anghenion y person yn ei gyfanrwydd
12. Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery	12. Creu cyfres newydd o swyddi medrus iawn a denu buddsoddiad trwy ganolbwyntio'n fwy ar ymchwil, arloesi a modelau newydd o gyflawni
13. Deliver bold solutions to the environmental challenges posed by our activities	13. Datrys y problemau amgylcheddol a achosir gan ein gweithgareddau mewn ffordd feiddgar
14. Demonstrate respect for the diverse cultural heritage of modern Wales	14. Dangos parch i dreftadaeth ddiwylliannol, amrywiol y Gymru fodern
15. Bring communities and generations together through involvement in the planning and delivery of our services	15. Dod â chymunedau a chenedlaethau ynghyd trwy eu cynnwys yn y gwaith o gynllunio a darparu ein gwasanaethau
16. Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well- being	16. Cryfhau enw da rhyngwladol yr Ymddiriedolaeth fel canolfan rhagoriaeth ar gyfer addysgu, ymchwil ac arloesi technegol, a hynny wrth wneud cyfraniad parhaol at lesiant y byd hefyd

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Trust Well-Being Objectives Refresh: Online Survey Feedback Analysis

	Internal Questionnaire - English	Internal Questionnaire - Welsh	External Questionnaire - English	External Questionnaire - Welsh
Number of Respondents	48	1	18	0
1. Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways	**This Objective's average score is 6.72 / 7.** 90% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work.	**This Objective's average score is 6.00 / 7.**	**This Objective's average score is 6.44 / 7.** 88% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 6% of respondents said that this Well-Being Objective was 'not important'.	N/A
2. Improve the health and well-being of families across Wales by striving to care for the needs of the whole person	**This Objective's average score is 6.74 / 7.** 98% of respondents said that this Well-Being Objective was 'highly important' or 'very important' to the Trust's work. 2% of respondents said that this Well-Being Objective was 'neither important nor not important'.	**This Objective's average score is 6.00 / 7.**	**This Objective's average score is 6.78 / 7.** 100% of respondents said that this Well-Being Objective was 'highly important' or 'very important' to the Trust's work.	N/A
3. Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery	**This Objective's average score is 5.87 / 7.** 82% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 17% of respondents said that this Well-Being Objective was 'neither important nor not important'.	**This Objective's average score is 5.00 / 7.**	**This Objective's average score is 6.56 / 7.** 100% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 6% of respondents said that this Well-Being Objective was 'not important'.	N/A
4. Deliver bold solutions to the environmental challenges posed by our activities	**This Objective's average score is 6.07 / 7.** 87% of respondents said that the is this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 11% of	**This Objective's average score is 7.00 / 7.**	**This Objective's average score is 5.56 / 7.** 71% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 18% of	N/A

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	respondents said that this Well-Being Objective was 'neither important nor not important'. 2% of respondents said that this was 'not important'.		respondents said that this Well-Being Objective was 'neither important nor not important'. 12% of respondents said that this Well-Being Objective was 'not important'.	
5. Demonstrate respect for the diverse cultural heritage of modern Wales	**This Objective's average score is 6.00 / 7.** 83% of respondents said that the is this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 11% of respondents said that this Well-Being Objective was 'neither important nor not important'. 6% of respondents said that this Well-Being Objective was 'not important'.	**This Objective's average score is 6.00 / 7.**	**This Objective's average score is 5.78 / 7.** 71% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 18% of respondents said that this Well-Being Objective was 'neither important nor not important'. 12% of respondents said that this Well-Being Objective was 'not important'.	N/A
6. Bring communities and generations together through involvement in the planning and delivery of our services	**This Objective's average score is 6.22 / 7.** 89% of respondents said that the is this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 9% of respondents said that this Well-Being Objective was 'neither important nor not important'. 2% of respondents said that this Well-Being Objective was ' not important'.	**This Objective's average score is 5.00 / 7.**	**This Objective's average score is 5.83 / 7.** 77% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 12% of respondents said that this Well-Being Objective was 'neither important nor not important'. 12% of respondents said that this Well-Being Objective was 'not important'.	N/A
7. Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well-being	**This Objective's average score is 5.41 / 7.** 66% of respondents said that the is this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 26% of respondents said that this Well-Being Objective was 'neither important nor not important'. 8% of respondents said that this Well-Being Objective was 'not important'.	**This Objective's average score is 6.00 / 7.**	**This Objective's average score is 6.56 / 7.** 95% of respondents said that this Well-Being Objective was 'important', 'highly important' or 'very important' to the Trust's work. 6% of respondents said that this Well-Being Objective was 'neither important nor not important'.	N/A

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8. Are there any topics contained within the Objectives that you believe shouldn't be a priority for the Trust?	Overall, there were no overriding Objectives/themes that respondents felt shouldn't have been a priority for the Trust. Most respondents (12%) felt the Objectives were important. Others (18% and 14% respectively) felt that "people" and "well-being" should be given more priority.	N/A	Overall, there were no overriding Objectives/themes that respondents felt shouldn't have been a priority for the Trust. Most respondents (50%) felt that the Objectives were important.	N/A
9. Are there any areas linked to wellbeing that aren't covered in the existing objectives that should be included?	Overall, the overriding suggested theme concerned "staff" (52% of respondents suggested that this was missing from the current Well-Being Objectives). Most of the other suggestions referred to staff and staff well-being in a variety of different ways.	"Specifically improving the provision of public transport to our site. Encourage staff, visitors and users of our services to use public transport to come to site"	Overall, there were several key themes that respondents felt were missing from the Trust's Objectives. 30% said "patients", 20% said " treatment" and 20% said "family members".	N/A
10. In no more that 3 words, tell us what you believe Objective 1 is trying to achieve:	Most popular words: "Access" (26%) and "healthcare" (14%).	"Fairer care"	Most popular words: "health" (33%), "innovate" (17%) and "health inequalities" (17%).	N/A
11. In no more that 3 words, tell us what you believe Objective 2 is trying to achieve:	Most popular words: "Holistic care" (17%) and "person" (12%).	"Consider the whole person"	Most popular words: "holistic" (50%), "holistic care" (17%) and "wellness" (8%).	N/A
12. In no more that 3 words, tell us what you believe Objective 3 is trying to achieve:	Most popular words: "investment" (10%), "workforce" (10%) and "future" (8%)	"Improving staff skills"	Most popular words: "new" (17%), "radiotherapy patients" (8%) and "ground-breaking" (8%).	N/A
13. In no more that 3 words, tell us what you believe Objective 4 is trying to achieve:	Most popular words: "sustainability" (10%), "green" (10%) and "innovation" (8%)	"Reducing environmental impact"	Most popular words: "awareness" (17%), "greener care" (8%) and "environmentally innovative" (8%).	N/A

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14. In no more that 3 words, tell us what you believe Objective 5 is trying to achieve:	Most popular words: “inclusive” (12%), “diversity” (10%) and “Welsh culture” (7%)	“History and future of Wales”	Most popular words: “diversity” (25%), “cultural diversity” and “equality” (8%).	N/A
15. In no more that 3 words, tell us what you believe Objective 6 is trying to achieve:	Most popular words: “community” (18%), “collaboration” (10%) and “patient” (10%)	“Community participation”	Most popular words: “opinions” 17%), “engage the population” (8%) and “collaborative” (8%).	N/A
16. In no more that 3 words, tell us what you believe Objective 7 is trying to achieve:	Most popular words: “research” (8%), “good” (8%) and “future” (5%)	“Improving Velindre’s status”	Most popular words: “care” (25%), “health improvement” (13%) and “excellence” (13%).	N/A

Trust Well-Being Objectives Refresh: Anecdotal Feedback	
Via email	“I’ve reviewed these and whilst they are appropriate objectives, I feel that there is very little that is applicable to the improvement of the health and wellbeing of employees. There is no reference to how these relate to fair work objectives of the Act”
Staff intranet	“I would like to see Yammer (like Facebook for internal staff only) deployed to enable staff to create groups for hobbies and sharing information such as baking, travel, book clubs, walking, LGBT, metal health etc to help with wellbeing and collaboration across VC”
Staff intranet	“I would like to see visible mental health first aiders situated around VCC, also a walking group in the warmer months to boost our mental health”
Via staff engagement	“More focus on staff well-being”

Trust Well-Being Objectives Refresh: Further Planned Engagement	
Local Partnership Forum	Attending PLF Meeting in March to field questions – Friday, 8th March

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Trust Well-being Objectives

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Reduce health inequalities, make it easier to access the best possible healthcare when it is needed and help prevent ill health by collaborating with the people of Wales in novel ways

Improve the health and well-being of families across Wales by striving to care for the needs of the whole person

Create new, highly skilled jobs and attract investment by increasing our focus on research, innovation and new models of delivery

Deliver bold solutions to the environmental challenges posed by our activities

Demonstrate respect for the diverse cultural heritage of modern Wales

Bring communities and generations together through involvement in the planning and delivery of our services

Strengthen the international reputation of the Trust as a centre of excellence for teaching, research and technical innovation whilst also making a lasting contribution to global well-being

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Digital Services Annual Report 2023/2024

DATE OF MEETING	12/09/2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	David Mason-Hawes, Head of Digital Delivery
PRESENTED BY	Carl Taylor, Chief Digital Officer
APPROVED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	The attached Digital Services Annual Report seeks to review progress in respect of the delivery of the Digital Strategy, via a summary report on the objectives of the 2023/24 Digital IMTP and a review of progress against the risks set out in the Trust Assurance Framework. The report also sets out the end of year position in respect of Digital Services operational risks and IT business continuity incidents, as well as a summary of overall performance across the

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	Digital Services Performance Management Framework measures. The report covers the period April 2023 to March 2024 inclusive.

RECOMMENDATION / ACTIONS	This report is presented to the Quality, Safety & Performance Committee to provide **ASSURANCE** in respect of the ongoing delivery of the Digital Services 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**
Executive Management Board – Run	29/08/2024

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Presented to EMB Run under the consent agenda – accepted.

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 4 - Increased extent of impact from actions

APPENDICES	
Appendix 1	Digital Services Annual Report (April 2023 – March 2024)

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1. SITUATION

The Digital Services Annual Report, attached as Appendix 1, sets out the end of year position in respect of progress against the 2023/4 digital objectives set out in the Trust Integration Medium Term Plan (IMTP) The report also sets out key risks and provides a summary update of significant IT business continuity incidents across the Trust for the period April 2023 to March 2024 inclusive.

It is presented to the Quality, Safety & Performance Committee for **ASSURANCE**.

2. BACKGROUND

Appendix 1 sets out the end of year position in respect of the Digital IMTP for 2023/24. A summary 'RAG' rating is shown to provide a high level view on progress against each of the deliverables as at 31/03/2024.

3. ASSESSMENT

Good progress continues to be made against the wide range of digital IMTP objectives. Digital Services and service-side resources / capacity continues to be the primary challenge in respect of some objectives.

Of the 43 objectives set out in the 2023/24 IMTP, 23 have been flagged as 'completed'. A number have been rolled over into the 2024/25 plan, to reflect the ongoing nature of those projects / programmes.

There were 12 significant IT business continuity incidents in the period April 2023 to March 2024 inclusive.

For full details please refer to the full report in Appendix 1.

'Level 4' has been selected in respect of compliance with the '7 Levels of Assurance' framework. This rating has been selected on the basis that actions / plans are in place to deliver the digital elements of the Trust IMTP, with some objectives already achieved. However, it is recognised that there remain some aspects where the delivery approach is yet to be agreed or where projects / programmes carry ongoing risks where full mitigation(s) are yet to be established.

4. SUMMARY OF MATTERS FOR CONSIDERATION

No immediate matters for consideration / action.

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The report is presented to the Quality, Safety & Performance Committee to provide assurance in respect of the delivery of the Digital IMTP and risk / incident management and the ongoing support of the Quality, Safety & Performance Committee to deliver the Digital IMTP and wider Digital Programme is greatly appreciated.

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*	05 – Digital Transformation | Failure to Embrace New Technology
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☐ Effective ☒ Equitable ☐ Efficient ☒ Patient Centred ☐
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are 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: n/a
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	The Digital Services team continue to manage risks relating to "digital inflation" and the increasing move towards the provision of commercial digital services via a revenue model. The digital services IMTP includes objectives to set a clear plan for recruitment of staff into the team and the enhancement of Trust IT infrastructure and networking services. The financial implications for these are yet to be fully assessed and it is recognised the current financial climate makes the challenge of creating the required capacity to deliver across all objectives more difficult.
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 on progress in terms of the delivery of the Trust digital programme and associated objectives. There are no aspects of the update that change or introduce changes that impact upon equality and/or patient identifiable information.

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	All digital risks are actively managed and recorded in DATIX and/or Project RAID logs as required.
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	

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Velindre University NHS Trust

Digital Services Annual Report

(April 2023 – March 2024)

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1. Introduction

1.1 The Digital Services Annual Report covers the period April 2023 to March 2024.

1.2 The report seeks to provides an update on the following key areas:

1.2.1 Digital Programme Update

- An 'end of year' summary of progress against the digital services objectives in the 2023/24 Trust Integrated Medium Term Plan (IMTP)

1.2.2 A summary of progress in respect of Digital Services performance, as reported via the Trust Performance Management Framework (PMF).

1.2.3 A summary of key digital risks within the organisation as at 31/03/2024.

1.2.4 A summary of the significant IT business continuity incidents that occurred through the reporting period April 2023 to March 2024.

2. Digital Programme Update

2.1 The Digital Strategy[1] was published at the start of the 2023/24 financial year. The strategy is one of four 'enabling' sub-strategies within the organisation and sets out a vision for digital services across the Trust over the next 5-10 years.

2.2 New governance arrangements were established in 2023/24, to facilitate the delivery of the many projects and programmes that underpin the successful achievement of the aims and objectives set out in the strategy. A new Digital Programme Board has been established, to provide strategic oversight of the digital programmes and projects being delivered across Velindre University NHS Trust (VUNHST). Work is already underway to establish supporting governance and processes, to receive and consider 'new demand' requests and to develop an assurance process for the design and deployment of new digital services – it is expected that these arrangements will be deployed in Q1 – Q2 2024/25.

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[1] Digital Excellence: Our Strategy | 2023 – 2033
https://velindre.nhs.wales/destination-2033/how-we-will-achieve-our-vision/sub-strategies/digital-strategy/

2.3 **2023/24 Digital IMTP – End of Year Position**

A table showing the 'end of year' position in respect of all the digital objectives within the Trust 2023/24 Integrated Medium Term Plan (IMTP) is included as **Appendix A**.

2.4 As in previous years, the 2023/24 has been an extraordinarily busy year for the Digital Services team. The Digital IMTP set out 43 objectives for the 2023/24 financial year, covering all aspects of the service. The objectives within the Digital IMTP are expected to achieved alongside Business As Usual (BAU) activities.

2.5 Of the 43 objectives set out in the 2023/24 Digital IMTP, 25 (58%) were fully completed. Nearly all other objectives were underway, with completion due in the 2024/25 financial year. Key achievements and progress from the 2023/24 financial year are summarised below:

2.5.1 Improvements to Critical Systems

The Trust operates a number of systems that are categorised as 'critical' to clinical and business operations across the Trust. A number of these services are subject to programmes of work to enhance the digital capabilities of the service areas they support.

A new IT service has been procured to replace the legacy IT systems in place within the **Welsh Histocompatibility and Immunogenetics Service (WHAIS)** – a contract was awarded to Thermofisher, to deploy its H&I IT system into the Transplantation service. Implementation is underway and due to complete in early 2025/26.

The Velindre Cancer Centre (VCC) became the first organisation in Wales to implement full **electronic test requesting for Radiology**. This service went live in June 2023 and supports improved operational efficiency, reduced error rates and improved data quality – all with the aim of improving the overall experience for patients being treated at VCC.

Major upgrades were delivered to a number of departmental services, including the **Chemocare** platform that is used to manage the delivery of chemotherapy treatments to patients in VCC and the **Treatment Helpline** – an in-house application used in the cancer center to provide support to patients undergoing chemotherapy treatment, which was completely re-written by the Digital Services software development team and released for use by the service in Q3 2023/24, introducing new functionality to ensure advice provided via the helpline adheres to current clinical best practice and guidance.

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2.5.2 Improving our IT Infrastructure / Cyber Security

Work remains ongoing to deliver the full scope of the new **Integrated Radiotherapy Service** (IRS), which will provide world-leading radiotherapy services for patients

being treated by the cancer centre, including those seen at the new satellite site in Nevill Hall, due to open in February 2025. However, significant progress has been made through 2023/24 to establish the IT infrastructure needed to power this new cutting-edge service. An offsite data centre facility has been delivered through joint working between the Digital Services team, the supplier (Varian) and their 3rd party IT partner Quadris. The commissioning of the new radiotherapy equipment will take place through 2024/25 and beyond, eventually extending to the new Velindre Cancer Centre once that site opens. However, the establishment of the required IT infrastructure was a major milestone for the programme.

Alongside the work to stand up the offsite data centre for the IRS, the Trust is working up plans to deploy an entirely new network across all Trust sites. The first deployment of a new HPE Aruba network will be at the Radiotherapy Satellite Centre in Nevill Hall, before seeking to deploy the new network infrastructure across the WBS and then eventually into the new Velindre Cancer Centre. Work to establish a new network design was completed to plan 2023/24, procurement and implementation activities, starting with the RSC, will be taken forward in 2024/25.

The Digital Services team made significant progress through 2023/24 to remove 'legacy' hardware from active service. This includes the removal of 'end of life' server equipment and the maintenance and management of those services that remain in use. Ensuring the Trust maintains a fully supported IT estate is crucial to (i) ensuring Trust digital services remain performant and resilient and (ii) to ensure the organisation's cyber security posture is maintained. This work included the removal of systems utilising the (out of support) Windows 7 operating system – this work was completed in Q4 2023/24.

Following a prolonged period without a member of staff in post, the Trust successfully appointed a new Cyber Security Manager in December 2023. The focus of their work is to re-establish and take forward the work programme to deliver the Cyber Security Strategic Plan. Simulated phishing campaigns were re-started in Q4 2023/24, to identify and test the relative vulnerability of staff to such attacks and guide future staff training / communications activities.

2.5.3 Digital Maturity

As part of a national exercise, coordinated by Digital Health & Care Wales, Velindre took part in an external digital maturity assessment in March 2023. The Healthcare Information and Management Systems Society (HIMSS) offer a range of assessments, enabling organisations to benchmark themselves against other equivalent services across the UK and worldwide. Their Electronic Medical Record Adoption Model (EMRAM) assessment seeks to assess the digital capabilities and maturity of an organisation, to establish a clear view of where an organisation stands and to aid with the development of a towards full adoption of digital health records. VUNHST was assessed as HIMSS Level 1, a score that was replicated across other

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organisations within NHS Wales – the planned implementation of ePMA and the establishment of a Clinical Data Repository are required to step up to higher maturity levels. The assessment also identified opportunities for how and where local digital enablement works could focus, to improve the usability of Trust digital systems.

The Trust committed to and signed the Digital Inclusion Charter in 2023/24. This charter sets a range of expectations for how the organisation should consider digital inclusion when designing and implementing new digital systems and services. The Digital Inclusion plan is due to be signed off in May 2024. The workplan to embed charter into BAU and project / programme development is ongoing.

2.5.4 Workforce Development / Digital Literacy

Within the Digital Services team, numerous staff are pursuing postgraduate academic qualifications, to improve the leadership capacity and capability across the team, but also to support and inform succession planning.

- One member of the team graduated from the NHS Digital Academy in April 2023. This NHS England initiative recruits one cohort per year and in recent years, five Welsh Government-funded spaces have been made available to NHS Wales staff.

- A similar postgraduate (PgDip / MSc.) course has now been established in Wales. The MSc. Leading Digital Transformation is now in its 3rd year. Two members of staff within the Digital Services team are currently on this course, the first is due to graduate in 2024 and another in 2025.

- One member of the team is undertaking an Open University MSc. in Computer Science, part-funded by the Trust. Graduation is planned for 2025.

- Alongside the development of existing staff, innovative ways of bringing in new talent are also being taken forward. The Trust currently has two digital apprentices in the team. Funding options to appoint more are being explored, particular into areas that are difficult to recruit or where they relate to new and emerging technologies (e.g. cloud, cyber security).

Work to further develop the digital literacy and confidence of the wider workforce is still yet to be started at scale. Some smaller enabling projects have been completed, such as the adoption of a new digital learning platform (LMS365). The use of this platform is expected to grow over the next few years, as it becomes the default platform for the delivery of training for Trust digital systems and services. However, significantly more work is needed across areas such as Microsoft Office 365, to ensure the Trust and its staff are getting the most out of these applications and the Trust is achieving true value for money.

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2.5.5 Ongoing Projects

Of those projects that have extended into the 2024/25 year, there are a number of key areas to highlight:

Good progress has been made with regards to the procurement of a new **Blood Establishment Computer System** (BECS) platform. Supplier engagement days were taken forward in early 2023/24, to support work to develop the user requirements specification through the latter part of the year. Procurement activities were extended into 2024/25, to allow further time to refine the business and case and confirm funding arrangements for any new platform.

A significant amount of work is still required to ensure the **Digital Health & Care Record**, originally deployed into VCC in November 2022, fully support VCC operational and clinical processes. The scoping of the next phase of its development is due to be completed in 2024/25.

Major national system implementations, such as the **Radiology Information Services Programme** (RISP) and the **electronic Prescribing and Medicines Administration** (ePMA), have been rescheduled. RISP is due to be implemented into VCC in May 2025, dates for ePMA are yet to be finalised – subject to clarification re: national funding arrangements and local service planning / capacity.

2.6 Data & Insights

2.7 In Q4 2023/24, a new role – the Assistant Director of Data & Insights – was created. This role was filled in January 2024. One of the first actions following the appointment to this role was to formally bring together the two divisional Data & Insight teams (formerly often referred to as 'Business Intelligence' – BI) under the leadership of the AD of Data & Insights. In doing so, the Data & Insight team also formerly became part of the corporate Digital Services team.

2.8 The AD of Data & Insights commenced a review of current Data & Insights arrangements across the Trust in Q4 2023/24. This review will consider both ways of working / business processes for managing Data & Insight demands within the Trust and the structures, roles, capacity and capabilities within the Data & Insight team to deliver the Data & Insights agenda. This review will report back to the Divisional SLTs and Executive teams in Q2 2024/25.

2.9 Since the Data & Insight team were not part of the wider Digital Services function at the start of the 2023/24 year, objectives for Data & Insight are not captured within the 2023/24 Digital IMTP. The 2024/25 Digital IMTP does now reflect the wider scope of the Digital Services team and includes a range of deliverables for the Data & Insight team. Progress in respect of the delivery of these objectives will be presented via the twice-yearly updates and in the annual report for the 2024/25 financial year.

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3. Digital Services Performance

3.1 As at 31st March 2024, there were five measures reported within the Trust Performance Management Framework (PMF) – these were:

- % Compliance against National Cyber Security Centre (NCSC) '10 Steps to Cyber Security' standards
- Number of significant IT business continuity incidents in rolling 12-month period (see section 5).
- % User satisfaction with Digital Service Desk
- % Digital Service Desk *requests* resolved within agreed response times (SLA)
- % Digital Service Desk *incidents* resolved within agreed response times (SLA)

Performance in respect of the Digital Service Desk measures remained relatively stable through 2023/24, but without significant improvement. Performance against the three measures was generally just under target, averaging around 92/93% for user satisfaction (target = 95%) and 80-82% for request and incident resolution (target = 85%). An IT Support Improvement Plan is due to be developed and rolled out through 2024/25, with the aim of improving the performance of the Digital Service Desk further.

Compliance with the NCSC '10 Steps to Cyber Security' standards stood at 88% at the start of the 2023/24 financial year. This annually reported measure is next due to be refreshed in June 2024. However, as noted above the appointment of a Cyber Security Manager in December 2023 now allows the Trust to more effectively take forward its cyber security agenda.

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4. Digital Services Risks

As at 31st March 2024, the Trust is in a positive position in respect of its management of the strategic risks set out on the Trust Assurance Framework (TAF – risk 5). The overall level of effectiveness is rated as 'partial effectiveness', with actions / plans in place to improve the effectiveness rating. Of the controls in place for the 14 individual risks captured within the risk assessment, 5 are rated as 'effective'; the remaining 9 risks are rated as 'partial effectiveness'.

There are seven open actions captured within the assessment – one is overdue, relating to the intention to create a digital reference architecture so that new digital projects conform to recognised local and national data/information, technical and interoperability standards. This work is scheduled to be completed in Q2 2024/25 and is linked to the establishment of a new Digital Design Authority, part of the wider governance for the Digital Programme.

The Digital Delivery team manage a range of operational risks pertaining the day-to-day operations and the use of Trust digital systems. These are managed by the Digital Delivery team. As at 31st March 2024 there were 23 active (open) risks on the operational digital services risk register. The current breakdown of risks based on 'current' risk rating/score is:

Risk Rating	***No. of Risks***
Significant	15
Moderate	5
Low	3
Grand Total	**23**

All of the above risks have a score of 12 or less. Many relate to individual cyber security risks associated with ongoing use of legacy infrastructure and other IT services across the Trust. Work is underway to remediate these risks – for example, via the removal of the last Windows 7 devices in use across the VCC Radiotherapy Department (work was completed Q4 2023/24). Other risks cover areas such as digital staffing / capacity, digital contractual arrangements and operational issues with Trust digital systems.

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The Digital Programmes team are currently accountable for the delivery and/or management of digital risks within the following major digital transformation projects:

- Welsh Blood Service (WBS) – Futures – Digital Modernisation
    - Blood Establishment Computer System (BECS)
    - Welsh Histocompatibility & Immunogenetics Service IT (WHAIS IT) system
    - Laboratory Information Management System 2.0 (LIMS2.0)
- Velindre Cancer Service (VCS) – Futures
    - Radiology Information System Programme (RISP)
    - Electronic Prescribing and Medicines Administration (ePMA)
    - Integrated Radiotherapy Solution (IRS)
    - Radiotherapy Satellite Centre (RSC)

5. Significant IT Business Continuity Incidents

In the period April 2023 to March 2024 inclusive, there were 12 significant IT business continuity incidents.

Full details of these are presented in the twice-yearly report that is presented to the Quality, Safety and Performance Committee, including details of any preventative action(s) taken following the incident. A summary of the incidents that occurred in the 2023/24 financial year is shown below.

Date	Description	National / Local Incident
02/03/2024	Welsh Clinical Portal unavailable	National
30/01/2024	Disruption to VUNHST telephony services	Local
22/11/2023	Loss of Wi-Fi Service at VCC	Local
17/11/2023	Loss of ePROGESA functionality on Collection Teams	Local
16/11/2023	Interruption of Prometheus service (Welsh Bone Marrow Donor Registry)	National
15/09/2023	WBS website unavailable	Local
05/09/2023	VCC power outage	Local
20/08/2023	VCC power outage	Local
09/08/2023	VCC PSBA network failure	National (external)
31/07/2023	Konica printing issues (VCC)	Local
26/04/2023	VCC telephony issues	Local
13/04/2023	Synapse (Radiology system unavailable	Local

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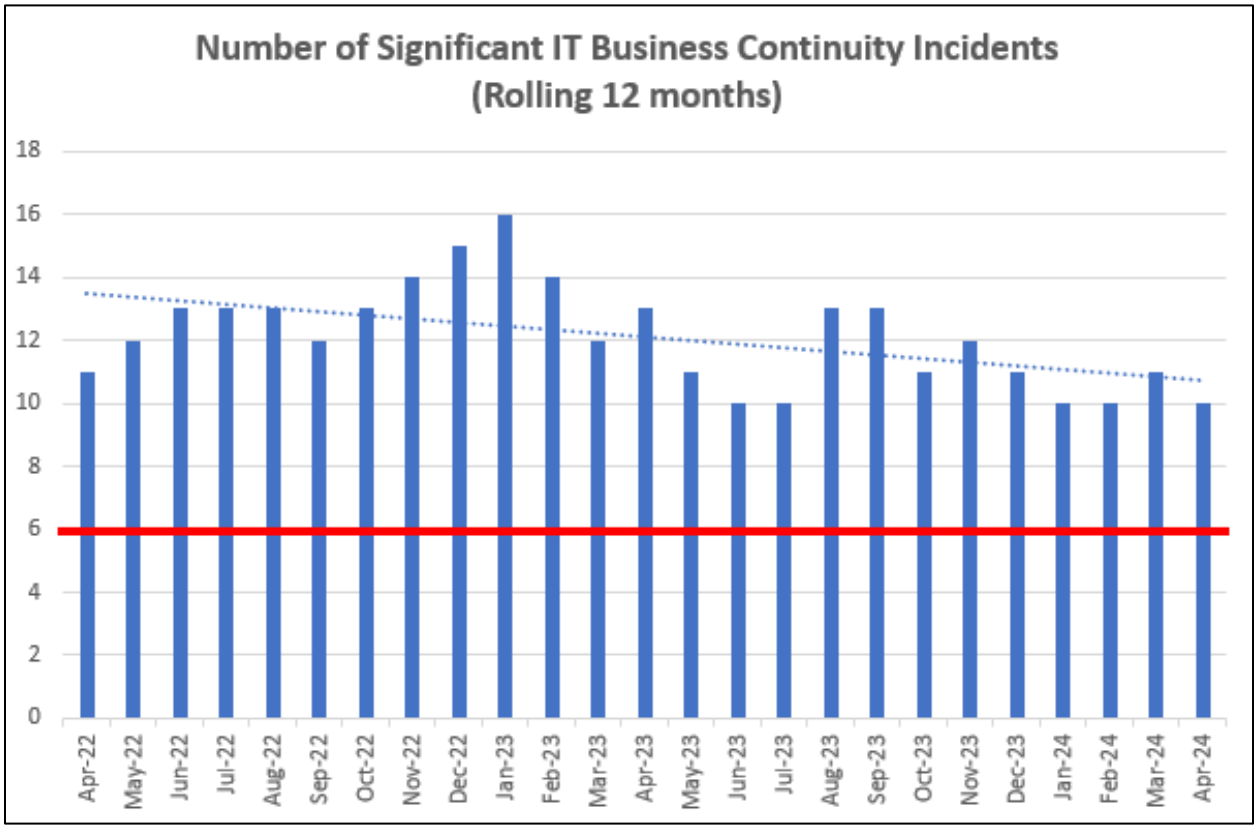
As work progresses to improve the performance and resilience of local IT infrastructure, it is anticipated that the ongoing downward trend in the number and frequency of significant IT business continuity incidents will be maintained. As reported via the Trust Performance Management Framework, there continues to be a steady improvement in respect of the PMF-reported score for the rolling 12-month trend in significant IT business continuity incidents. Work to remove Windows 7 devices from VCC was completed in Q4 2023/24 – remaining devices cannot be removed due to lack of alternative deployment options. Significant legacy IT infrastructure removed from the Radiation Physics service in Q4 2023/24, with more planned in early 2024/25 – this is largely a consequence of (i) in-house work to virtualise the server infrastructure and (ii) the establishment of the off-site data centre for the Integrated Radiotherapy Solution. Work remains ongoing to remove other legacy IT infrastructure in use across the Welsh Blood Service and the Velindre Cancer Centre. This work is ongoing, but alongside other measures, it is hoped this will contribute to further improvements in performance.



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Appendix A – Digital IMTP 2023/24 | End of Year Position

Objective	Target Completion Date	Benefits	RAG Status	Update
Ensuring Our Foundations (Digital Strategy – Theme 1)				
VCC Digital Health & Care Record Phases 1b & 2	Q1 – Q4	Improved patient experience. Increased clinical and operational efficiency.	DELAYED (2024/25)	DHCR Phase 1 still yet to be formally closed. Work ongoing to remediate data quality / operational challenges from initial deployment – being managed under 'business as usual'. Scoping workshop to be held in Q1/Q2 2024/25 to explore ongoing development requirements.
Blood Establishment Computer System (BECS). - Procure new contract & commence implementation	Q1 – Q4	Improved donor experience. Increased operational efficiency.	DELAYED (2024/25)	OBC approved in Trust Board and Prior Information Notice (PIN) issued (May 24). Supplier engagement sessions scheduled for late-June / early-May. Formal procurement due to commence in September 2024.
Electronic Prescribing (ePMA) - Procurement / Contract Award (Q3) - Commence Go-Live (Q4)	Q1 – Q4	Improved patient experience. Improved clinical and operational efficiency.	DELAYED (2024/25)	Preferred supplier identified following procurement. Discussions ongoing as to timing of VCC implementation of ePMA.
WHAIS IT System for WTAIL. - Procure new contract & commence implementation	Q1 – Q4	Increased WBMDR activity & income. Improved operational efficiency. Improved staff recruitment & retention.	**COMPLETED**	Successful bidder (VH Bio) confirmed in Q3 2023/24. Implementation commenced in March 2024. Implementation anticipated to run until Q2 2025/26.

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Objective	Target Completion Date	Benefits	RAG Status	Update
Radiotherapy Satellite Centre - Procurement / Readiness	Q1 – Q4	Improved patient experience. Delivery of SACT and radiotherapy treatment closer to home.	**COMPLETED**	Service design for IT infrastructure ongoing. No issues to escalate at this stage. Trust-wide network design work has completed – purchase of first suite of new networking equipment completed in Q4 2023/24, for deployment in 2024/25. The RSC is anticipated to be the first major deliverable in respect of the digital enablement of the new facility.
Integrated Radiotherapy Solution (IRS). - Offside Data Centre - Workflow Redesign	Q1 – Q4	Improved patient experience. Improved operational and clinical efficiency.	DELAYED (2024/25)	Offsite data centre established. Work broadly progressing to plan; however, complex requirements for integration of VCC services with national (DHCW-managed) solutions remain a concern – work ongoing to identify and test. This work will extend into 2024/25. Digital Services supporting wider IRS work programme as required.
Radiology Informatics System Procurement (RISP) – local implementation. - Pre-Implementation Planning	Q1 – Q4	Improved patient experience. Improved operational and clinical efficiency.	**COMPLETED**	Programme in national 'build' phase – local implementation planning underway. Go-live timelines under review, following supplier delays, associated with national 'build' phase.

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Objective	Target Completion Date	Benefits	RAG Status	Update
Replace digital solution for the Welsh Bone Marrow Donor Registry (WBMDR). - User research (Q2) - Commence implementation (Q3)	Q1 – Q4	Increased operational efficiency.	DELAYED (2024/25)	Prior Information Notice (PIN) issued to market – initial supplier engagement days held in September 2023. Supplier engagement ongoing to determine implementation approach. Timelines for commencement of procurement / implementation yet to be finalised.
Chemocare v6 Upgrade			**COMPLETED**	Upgrade delivered in March 2023, v5 switched off April 2023.
Printer Management Establish new management arrangement and governance for VUNHST printer estate	Q1 2023/24	Improved operational efficiency. Reduced costs.	DELAYED (2024/25)	Legacy invoicing issue now improved. Plans in place to establish contract for a new managed print service in July 2024.
Telephony Procure and implement new / replacement Trust-wide telephony solution	Q1 – Q4	Reduced operational costs. Increased IT support / infrastructure resilience. Improved support for hybrid working.	DELAYED (2024/25)	Migration of VCC to new SIP platform completed in Q3 2023/24 – significant cost avoidance (approx. £100k per annum) and improved service performance / resilience anticipated. Full rollout of new telephony platform to be delivered in 2024/25.
IT Infrastructure Establish Digital Infrastructure Strategy and delivery programme, including 'cloud first' strategy	Q3	Fully costed IT infrastructure roadmap and delivery plan.	**COMPLETED**	IT Infrastructure Strategy completed – revised by Digital Programme Board in Q3 2023/24. Work ongoing to communicate strategy to wider organisation and update IT infrastructure roadmap / workplan.

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Objective	Target Completion Date	Benefits	RAG Status	Update
IT Service Management Tool Implement new IT Service Management (ITSM) / Digital Service Desk management tool.	Q3	Reduced response timelines through Increased automation. Improved operational efficiency. Improved staff satisfaction with Digital Service Desk (PMF)	DELAYED (2024/25)	Procurement of new ITSM tool completed in January 2024 – rollout commenced March 2024. Initial go-live scheduled for Aug/Sep 2024.
Pilot new end user device performance monitoring tool → full implementation subject to business case	Q3	Improved IT infrastructure resilience. Quicker remediation of IT support issues through early identification & automation.	**COMPLETED**	Pilot completed in Q2 2023/24. Development of business case placed on hold due to cost pressures and desire to explore opportunities available via new IT Service Management (ITSM) tool in the first instance.
Digital Inclusion (Digital Strategy – Theme 2)				
Digital Platform Establish technical capability and baseline current capabilities.	Q3	Identification of opportunities and challenges in respect of delivery of Trust digital programme.	**COMPLETED**	External consultancy – Perago – brought in to review current arrangements, landscape review and roadmap reported back to VUNHST. Work completed in Q2.
Increase rates of virtual consultations (VCC). - Pilot new service delivery model (Q2) - Implement new service delivery model (Q4)	Q4	Improved patient experience – choice of appointment types. Improved operational efficiency.	**DEFFERED**	Service mapping workshop undertaken to explore opportunities to improve 'AA' platform and increase adoption in VCC. Engagement session held with consultant team in 2023 to review opportunities for engagement with SSTs. However, an assessment of Microsoft Office 365 virtual appointments platform to be undertaken by national programme team. As such, further work to grow adoption placed on hold until review reports back.

Webster, Liane
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Objective	Target Completion Date	Benefits	RAG Status	Update
Insight Driven Services (Digital Strategy – Theme 3)				
Transfer of Business Intelligence teams into Digital Services.	Q4	Improved operational efficiency. Improved resilience, reduced turnaround time for BI request. Ability to fully utilise BI toolset, development of self-service portals etc.	**COMPLETED**	New Assistant Director of Data & Insight due to commence work January 2024, with plans for immediate transfer of VCC and WBS Business Intelligence functions into their line management. Wider Organisational Change Process (OCP) due to commence in late-2023/24 / early 2024/25 following review of current services.
Implement PSA Tracker	Q3	Improved patient experience. Reduction in volume of in-person follow-up attendances in Urology.	**COMPLETED**	Pilot deployment went live in March 2023. Scoping work ongoing to plan for implementation of the national (fully integrated) version of the platform.
PROMS / PREMS – scoping / implementation.	Q3	Improved patient experience.	DELAYED (2024/25)	Consultancy support established; initial proof of concept / pilot complete in VCC. Business Analyst appointed, to support scale-up of Value Based Healthcare work – to work alongside and advise new Head of Value Based Healthcare. Full work plan in development.
Safe & Secure Services (Digital Strategy – Theme 4)				

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Objective	Target Completion Date	Benefits	RAG Status	Update
Cyber Security Recruit additional cyber technical expertise	Q1	Increased protection for Trust digital systems and services. Increased cyber security resilience.	**COMPLETED**	New Cyber Security Manager commenced work in December 2023. Work programme to improve cyber security posture re-commenced. Risk on Trust risk register closed. Option of sharing resources / services with other NHS Wales organisations also being explored.
Cyber Security Enhance network infrastructure and end user monitoring capabilities.	Q2	Increased protection for Trust digital systems and services. Increased cyber security resilience.	DELAYED (2024/25)	Some progress continues to be made. However, significant improvements delayed whilst Cyber Security Manager role has remained unfilled. Work has recommenced following successful recruitment of new Cyber Security Manager in December 2023. Actions against Cyber Security Strategic Delivery Plan now being taken forward, significant progress anticipated in 2024/25.
Cyber Security Review data backup and recovery arrangements.	Q2	Increased protection for Trust digital systems and services. Increased cyber security resilience.	DELAYED (2024/25)	Progress made to standardise arrangements across WBS and VCC in 2023/24. A further review of the overall backup strategy is planned for late-2023/24.
Cyber Security Pilot new tools to support monitoring capability.	Q3	Increased protection for Trust digital systems and services. Increased cyber security resilience.	**COMPLETED**	Pilot completed.
A Digital Organisation (Digital Strategy – Theme 5)				

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Objective	Target Completion Date	Benefits	RAG Status	Update
Digital Programme Establish Digital Programme.	Q1 – Q4	Clear delivery roadmap and delivery programme for VUNHST digital services. Clearly established governance arrangements for delivery of VUNHST digital transformation programme.	**COMPLETED**	Digital Programme Board met in early October 2023. Supporting governance / processes being developed.
Digital Services Capacity & Capability Build the capacity and capability of Digital Services team. - Take forward Phase 2 of the Digital Services Recruitment Strategy. - Develop and implement new Target Operating Model	Q1	Increased capacity to deliver Digital Programme to agreed timescales. Clear delivery model for execution of digital projects, delivery of industry-standard approach for digital transformation.	DEFERRED	Review of Digital Services structures and Target Operating Model commenced, due to report back in Q1/Q2 2024/25.
Implement Electronic Radiology Test Requesting	Q2	Reduced errors. Increased operational and clinical efficiency.	**COMPLETED**	Implemented in August 2023
Digitising Medical Records – develop business case.	Q1 – Q4	nVCC readiness. Increased operational and clinical efficiency.	DEFERRED (2024/25)	Discussion re: pre-nVCC digital priorities due to be held with VCC SLT in Q4 2023/24. 2024/25 VCC / Digital IMTP to include intention to scope digitisation of medical records project, with aim to implement solution(s) in 2025/26.

Webber,Liane
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Objective	Target Completion Date	Benefits	RAG Status	Update
Robotic Process Automation Scoping Establish funding route to support RPA Recruit RPA Lead	Q1 – Q4	Increased operational efficiency. Significant staff time savings through automation of routine / high volume tasks. Potential cost (financial) savings.	**COMPLETED**	Initial scoping completed. RPA Developer appointed – due to commence work early November 2023.
Robotic Process Automation Establishment of PoCs / pilots. Establish RPA service (non-clinical workflows only).	Q1 – Q4	Increased operational efficiency. Significant staff time savings through automation of routine / high volume tasks. Potential cost (financial) savings.	DELAYED (2024/25)	RPA Developer in post. Automations already being delivered in non-clinical service areas (e.g. WBS DCC, SACT) using Microsoft tools. Procurement of Blue Prism Cloud RPA platform delayed into Q1 2024/25.
Office 365 Re-establish Office 365 project.	Q1	Increased staff productivity and operational efficiency.	DELAYED (2024/25)	Delayed due to capacity and competing work priorities.
Implement Digital Inclusion Charter.	Q3	Strategic intent to ensure digital inclusion at heart of Trust digital initiatives.	COMPLETED	Digital Inclusion Charter signed. Digital Inclusion plan signed off in May 2024. Workplan to embed charter into BAU and project / programme development ongoing.
Initiate 'Digital Enabled Workforce' Programme (Induction/Access/ Skills), including establishment of Digital Champions.	Q2	Establish capacity to further develop and improve Trust digital maturity.	DELAYED (2024/25)	KLAS digital usability survey completed – feedback provided to Trust in September 2023. Work yet to commence to scope wider programme and enablement of digital champions.

Webber,Liane
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Objective	Target Completion Date	Benefits	RAG Status	Update
Baseline assessment of current digital workforce capability.	Q2	Identification of opportunities and challenges in respect of delivery of Trust digital programme.	COMPLETED	Perago baseline review completed. KLAS digital usability survey completed – feedback provided to Trust in September 2023. HIMSS digital maturity assessment completed. Both explored elements of current workforce capabilities. Outputs to be used to inform wider digital literacy programme for staff.
Deliver Desk / Room booking IT platform, to support delivery of VUNHST Hybrid Working.	Q4	Improved operational efficiency. Improved estate management. Improved staff morale.	**WITHDRAWN**	Pre-procurement activity completed; business case developed. Placed on hold due to financial constraints. Alternative options being considered – e.g. utilise Office 365.
Establish 'Live' connectivity for WBS Collection Teams – PoC → Full Implementation.	Q3	Reduction in manual / paper-based processes. Improved compliance with risk / incident reporting. Live view of WBS donation activity for reporting, demand management etc.	**COMPLETED**	Pilot commenced with 'West' Collections Team – positive feedback. Pilot to be extended across all Collection Teams in 2024/25.
WBS Laboratory Device Integration / Automation. - Agree interface development strategy & delivery plan (Q4)	Q4	Improved operational efficiency. Reduction in data quality errors.	DELAYED (2024/25)	Work ongoing.
Software Development Re-platform WBS Appts. System.	Q3	Improved stability of IT service. Ability to integrate Appts. System into national IT services (e.g. NHS Wales app) via API.	DELAYED (2024/25)	Work ongoing, go-live scheduled for July 2024.

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Objective	Target Completion Date	Benefits	RAG Status	Update
Software Development Re-platform VCC Treatment Helpline.	Q1	Increased stability of IT service. Improved usability of VCC Treatment Helpline software. Future proofing.	**COMPLETED**	Implemented in August 2023
Working In Partnership (Digital Strategy – Theme 6)				
BAU support for externally deployed solutions (Welsh Infected Blood Support Scheme (WIBSS), Appts. System – Healthcare Research Wales etc.)	Q1 – Q4	Reputational management. Income streams.	**COMPLETED**	
Explore commercial opportunities for in-house developed systems	Q3	Potential income streams.	**COMPLETED**	No commercialisation activity planned for 2023/24. Two in-house developed systems currently deployed outside VUNHST under SLA.
Digital Services staff to join Intensive Learning Academy (USW).	Q2	Staff recruitment & retention. Access to emerging digital talent.	**COMPLETED (ONGOING)**	Two VUNHST members of staff undertaking MSc. Leading Digital Transformation @ USW. Other graduate and undergraduate placement opportunities being explored.
Grow Digital Apprenticeship capacity in Digital Services.	Q1	Improved resilience. Staff motivation / recruitment & retention.	DEFERRED (2024/25)	Two IT Undergraduate Trainees already in the team. Financial constraints have limited opportunity to introduce digital apprenticeships in time for 2023 undergraduate intake.

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Objective	Target Completion Date	Benefits	RAG Status	Update
HIMSS EMRAM Digital Maturity Assessment.	Q2	Identification of digital priorities for improvement / investment. National assessment of Trust digital services.	**COMPLETED**	Assessment completed in March 2023. Final report presented to VUNHST by HIMSS in Q1 2023/24. VUNHST assessed as HIMSS Level 1. Implementation of ePMA and establishment of a Clinical Data Repository required to step up to higher maturity levels.

Webber,Liane
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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Communications and Engagement Annual Report

DATE OF MEETING	12 September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Choose an item
REPORT PURPOSE	ENDORSE FOR APPROVAL
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	JON ELLIS, INTERIM HEAD OF COMMUNICATIONS LISA MILLER, HEAD OF PATIENT ENGAGEMENT ANDREW HARRIES, INTERIM HEAD OF DONOR ENGAGEMENT
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	The Communications and Engagement Annual Report (Appendix 1) provides the Quality, Safety and Performance Committee with a summary of the key activities delivered by the Communications and Engagement team over the past twelve months. The Committee is asked to endorse the Communications and Engagement Annual Report in advance of the Trust Board's

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	consideration for **APPROVAL** on 26 September 2024.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **ENDORSE** the Communications and Engagement Annual Report in advance of the Trust Board's consideration for **APPROVAL** on 26 September 2024.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	**04/09/24**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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

APPENDICES	
Appendix 1	Communications and Engagement Annual Report

Webber,Liane
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1. SITUATION

Effective communications and engagement support is key to the Trust's successful delivery of its work. Our communications and engagement activities must aim to be purposeful, effective, and accessible with the needs of our audiences and stakeholders at the heart of everything we do.

This document provides the Quality, Safety and Performance Committee with a summary of some, not all, of the activities delivered over the past 12 months to support the Trust's communications and engagement with:

- staff,
- donors,
- patients and their carers,
- volunteers,
- community engagement and communications in relating to the new Velindre Cancer Centre project.

2. BACKGROUND

It was agreed that a Communications and Engagement Annual Report should be complied as part of the Trust's annual reporting cycle.

3. ASSESSMENT

The Communications and Engagement Annual Report, available as Appendix 1, summarises some of the key activities the Trust has undertaken over the past twelve months in this area of work. This includes:

1. how we have supported the process of bringing our vision, purpose, and values to life
2. communications and engagement with our stakeholders, and
3. supporting our Armed Forces.

The team would like to thank all our colleagues across the Trust who have supported the Communications and Engagement team during the reporting period as we aim to deliver high-quality, purpose driven communications and engagement. We recognise that without their support, this would not be possible.

4. SUMMARY OF MATTERS FOR CONSIDERATION

The Quality, Safety and Performance Committee is asked to **ENDORSE** the Communications and Engagement Annual Report in advance of its consideration for **APPROVAL** by the Trust Board.

Webster, Liane
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5. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report directly support the achievement of 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*	02 - Partnerhips Working / Stakeholder Engagement
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☐ Effective ☐ Equitable ☒ Efficient ☐ Patient Centred ☒
	The Communications team across the Trust has a key role in supporting clinical colleagues to deliver safe services, sharing relevant messages and updates on current service delivery. The Patient Engagement team can play a key role in supporting the organisation to test its assumptions that we are delivering equitable and patient centred services via engagement with the Patient Cared Partnership Board and the Velindre Voices forum.

Webber,Liane
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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 An EQIA was undertaken in support of the Patient Engagement Strategy and implementation plan.
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	A Wales of Cohesive Communities - Attractive, viable, safe and well-connected communities. If more than one Well-being Goal applies please list below: All goals.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	**Choose an item** **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.

Webber,Liane
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ARE THERE RELATED RISK(S) FOR THIS MATTER	**Choose an item**

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	

Webber,Liane
11/09/2024 10:57:44

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

Communications and Engagement Annual Report 2023-24

Webber, Liane
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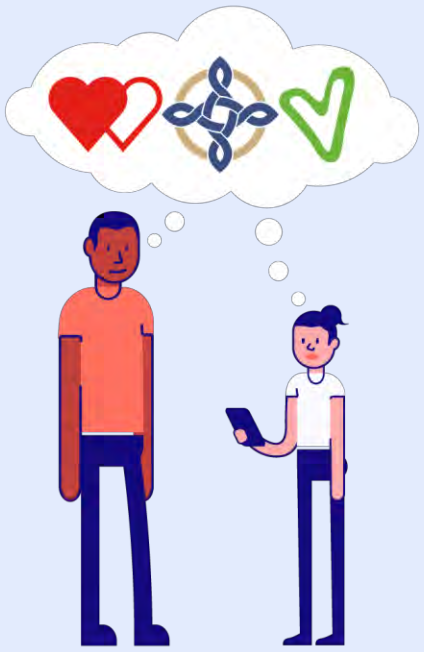

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Foreword

I am proud to present this 2023/24 annual report which showcases some of the ways in which the Trust's Communications and Engagement teams have supported the Trust's work over the past 12 months.

The past year has been a busy one for the Trust. We launched our new ten-year strategy, *Destination 2033* and four enabling strategies to help us realise our ambitions across digital, workforce, sustainability, and estates. We also developed a new set of organisational values that were created in partnership with staff, service users and partners to help guide our behaviours as Velindre employees.

We have achieved a great deal in a short space of time and the communications and engagement team have been beside us every step of the way, ensuring our stakeholders' voices are heard and helping to share our stories with all who are interested.

The team has also demonstrated an admirable commitment to professional development, with a number going through the Trust's very own leadership and development programme, *Inspire.*

While much has happened in the past 12 months, the next year promises to be just as exciting for the Trust. I look forward to seeing the quality of our communications content and engagement work improve further, focused on the needs of our internal and external audiences, especially our staff, patients and donors.

Lauren Fear
Director of Corporate Governance and Chief of Staff

Webber,Liane
11/09/2024 10:57:44

Bringing our vision, purpose, and values to life...

Our communications and engagement activity is always aligned with the Trust's purpose, vision and values as we strive to support the organisation on its journey to *Destination 2033*.

Every opportunity is strategically assessed to ensure our activity contributes to the Trust's ambitions.

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Ein pwrpas:
Gwella bywydau

Our purpose:
To improve lives

Ein gweledigaeth:
Gofal ardderchog, dysgu ysbrydoledig, pobl iachach

Our vision:
Excellent care, inspirational learning, healthier people

Ein gwerthoedd:
Gofalgar, parchus, atebol

Our values:
Caring, respectful, accountable

Webber, Liane
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Internal communications and engagement

Informing, involving, improving and celebrating

This year has seen us deliver a step change to the way we inform and celebrate our collective engagement. A new focus on improving systems to capture information, greater collaboration with our management teams to recognise their information needs, and understanding what it means to work in our organisation today have been priorities for the year.

We have achieved this by:

1. Supporting the launch of our organisational strategy

In 2023, the Trust launched its strategy: Destination 2033. The new strategy supports the Trust to deliver excellent care, provide inspirational learning and contribute towards making people healthier. The communications and engagement team were involved from the outset, delivering a comprehensive suite of staff and external stakeholder engagement to ensure the contents of the strategy was informed by our staff, our service users, and our partners.

2. Discussing, agreeing and launching our new values

Following a comprehensive period of engagement to understand the values that resonated most with our staff and service users, the communications team supported the launch of a new set of values that capture what is important to us and how we should all behave.

Caring — We are always kind, supportive, approachable and show compassion to all.

Respectful — We seek to understand other people's perspectives. We are always open and transparent.

Accountable — We always take personal responsibility for what we do and how we do it.

Webber, Anna
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3. Celebrating Excellence

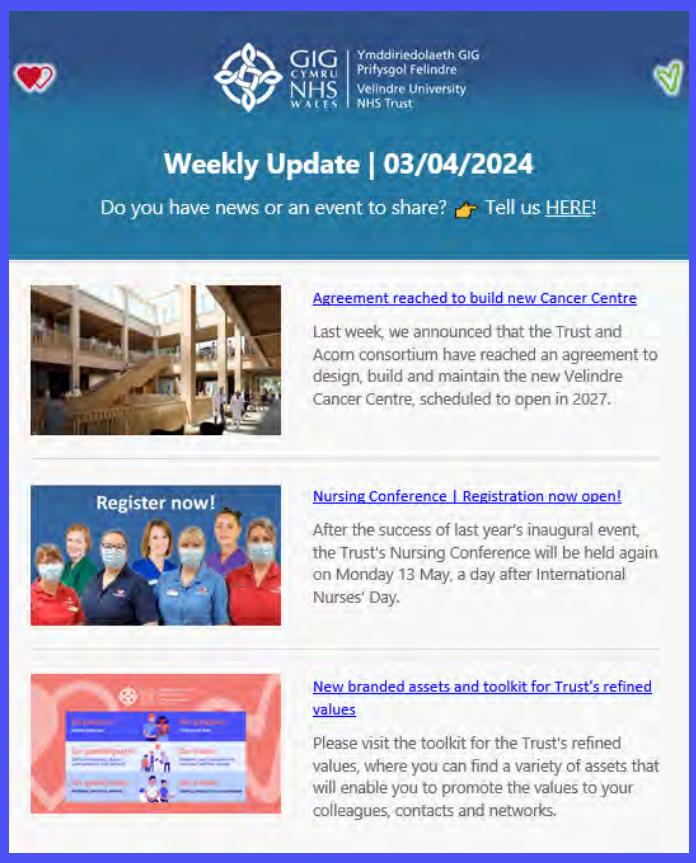
The Velindre Employee Excellence awards were a great success, with a record 183 nominations received across the defined categories – double the number of nominations received the previous year. The communications team ran an extensive campaign to encourage nominations by showcasing previous award winners and driving traffic to bespoke intranet pages designed for the occasion. In total, the Employee Excellence pages of the intranet received more than 4,250 views in the three months prior to and after the awards event.

4. The Trust's Wall of Thanks

2023 saw the launch of the Trust's Wall of Thanks, an internal platform to showcase the positive feedback received on a daily basis from our service users. The dedicated Wall of Thanks area of the intranet quickly became a popular destination for sharing uplifting words of gratitude received from patients and donors, with more than 2,500 views during the year. In total, 113 positive comments and compliments were received and shared relating to Velindre Cancer Centre, and 90 relating to the Welsh Blood Service.

5. Informing each other

During the year, we sent weekly newsletters to every member of staff to update them on activity across the Trust. In addition, the Welsh Blood Service and Velindre Cancer Centre sent bespoke weekly newsletters to their employees each week to provide a more localised update for staff at each of our services. We have consolidated systems that empower staff to inform us about their news with a total of 266 notifications received over the 12 months!



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6. Working Together to Build our Future

Everyone should feel safe and have the opportunity to thrive at work.

That's why, in the autumn of 2023, we launched the Working Together initiative, bringing Trust staff together to focus on a series of wide-ranging questions in face-to-face and virtual sessions. We wanted to better understand what it feels like to work for the Trust today and find ways of improving the way we connect and support each other in delivering for our patients and donors.

We talked about:

- how can we create safe, accessible, honest opportunities to discuss the things you and/or your teams find challenging at work?
- how do you feel about what's achievable for us as a Trust in the future and how we check in with each other to review the position regularly
- how do you think we can maintain the conversation and engagement between us all in a way that helps build trust within our organisation.

Gweithio Gyda'n Gilydd
Working Together

Chaired by either the Executive Director of Workforce and Organisational Development or the Director of Corporate Services and Chief of Staff, the activities were designed and supported by the Working Together Steering Group which included representatives from the Trust's services. The initiative was developed in a way that is aligned with and complementary to other staff wellbeing and engagement initiatives such as Speaking Up Safely, Staff Values and NHS Wales Staff Survey. Informal feedback was shared regularly with the Executive Board and the Extended Leadership Group.

13 sessions were held from mid-September until the end of December. 423 members of staff attended the sessions in total. 29 attended face to face sessions, 394 attended virtual sessions. A new framework to govern the development of our internal engagement is in development, informed by the findings of the Working Together sessions.

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7. Getting involved with the new Velindre Cancer Centre project

Un Peth Bach

Un Peth Bach (Just One Thing) was designed to break down some of the key topics of interest in relation to the new Velindre Cancer Centre into manageable bitesize chunks, supported by weekly online polls and pop-up engagement sessions. Ten topics, 144 poll responses and 350 staff interactions ensured that staff voices were heard loud and clear.

Staff design sessions

Creating space for staff to review, feedback and influence the design of the new Velindre Cancer Centre was fundamental to ensuring that the new building meets the needs of staff. A series of workshops and drop-in sessions enabled teams to closely review floorplans and make suggestions for improvements. The plans were updated and refined based on this input, with an ongoing cycle of engagement.

Webber,Liane
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8. Bringing volunteers back to Velindre Cancer Service

A key priority for the 2023/2024 was the reintroduction of volunteers into Velindre Cancer Centre (VCC), in line with our practices pre-COVID.

The Trust recognises the unique and important contribution volunteers make in complementing the services it provides, and a new framework has been developed to ensure volunteers are recruited, trained and supported in a safe and inclusive way.

A user friendly recruitment and role development process, along with a bespoke training programme are now in place, delivered in partnership with our teams at the cancer centre. Recruitment commenced during the reporting period with volunteers scheduled to return to VCC during June 2024.

The Trust was awarded a grant by the Wales Council for Voluntary Action (WCVA) which supports its ambitious plan for volunteer services. This will allow us to measure the social value from volunteering activities and the impact upon the volunteers themselves.

Data: 1 June 2023 - 31 May 2024

A summary of our year in **numbers**

1) Social media

274 posts	**231** posts	**86** posts
1,599 comments	**1,865** mentions	**715** mentions
16,563 reactions	**2,036** likes	**273** likes
2,804 shares	**610** retweets	**96** retweets
55,013 engaged users	**6,789** engagements	**1,446** engagements
5.75% engagement rate	**2.44%** engagement rate	**2.55%** engagement rate
876 net new followers	**145** net new followers	**272** net new followers
2,097,140 impressions	**347,230** impressions	**56,307** impressions

Popular posts

2) Website

Top website page views

52,009 Velindre Cancer Centre

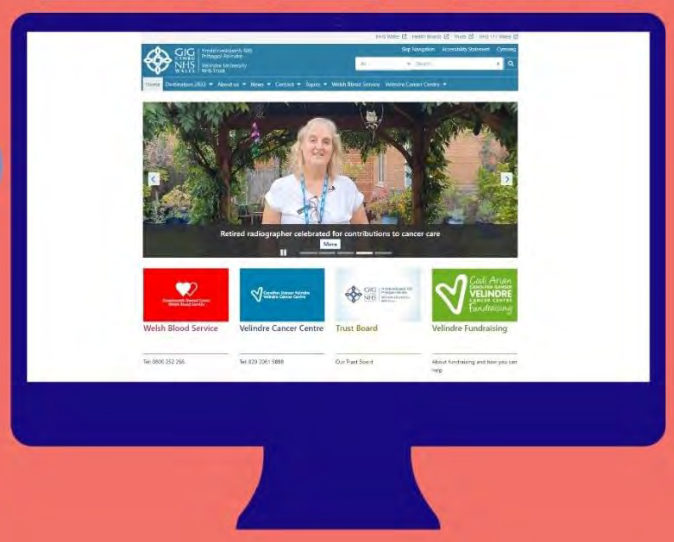
13,856 Working for the Trust

9,519 Trust vacancies

285,000 website views

77,766 users

97 secs avg session time



55 news articles

Top 5 common themes
- Awards/accreditations
- Clinical trials/research
- Launches
- Corporate updates
- WBS campaigns

3) Intranet news and publishing

692 news items (posts and links)	**768** news items (posts and links)
29 staff trained to edit intranet	**28** staff trained to edit intranet
52 staff newsletters	**52** staff newsletters

266 **News Capture Forms completed** by staff from across the Trust.

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External Communications and Engagement

Sharing our work with our communities of interest

Better systems supporting the capture of our news and achievements has in turn allowed us to focus on sharing those with a wider range of stakeholders – particularly patients, donors, supporters, media and the wider public. The remainder of this document provides insight on some, and far from all of the campaigns and opportunities on which we have collaborated with internal and external partners over the past 12 months.

1. Shining a light on awareness days

Awareness days provide an opportunity to focus on the different services we provide as a Trust. These days give us an opportunity to hear from experts across the organisation who are able to explain how their teams support our patients and donors.

- Acute Oncology Services awareness week – developed a suite of filmed content to help raise awareness of the importance of acute oncology services.
- World Cancer Day – delivered a comprehensive suite of social media content to showcase some of the faces behind cancer care at Velindre. Three days of social media activity generated 1,300 positive engagements. On the same day, Welsh Blood Service (WBS) promoted the new age range for bone marrow donors changing to 16-45, the campaign was supported by Emma Capps in the USA, after she received a lifesaving donation from a stem cell donor living in Wales.

- National Cancer Clinical Nurse Specialist (CNS) day – filmed interviews with four clinical nurse specialists discussing the contribution their roles make to our patients.

Webber,Liane
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- National Healthcare Estates and Facilities Day - produced filmed content for internal and external platforms to celebrate the non-clinical roles across our services that help ensure patients, donors and staff can receive and deliver care in safe and pleasant environments
- World Blood Donor Day – in June 2023, WBS featured twins Frankie and Jax. Their mother Jodie shared the story of complications during and after pregnancy resulting in the need for blood for baby Jax. Both boys have now fully recovered. The post reached 444,636 accounts.

- World Bone Marrow Donor Day – in September 2023, the WBS promoted the story of Kirstie and Taisha. After a search of over 40 million volunteer bone marrow donors from Registries across the world, fifteen-year-old patient Taisha Taylor found an incredibly rare match just 30-minutes' drive from her home.

2. Supporting our nurses

Velindre University NHS Trust's second nursing conference took place in May this year, aligned with International Day of the Nurse. The event, which took place in the Cardiff City Stadium, brought together registered nurses, health care support workers and Clinic Collection Assistants (CCAs) from across the Trust to celebrate past successes and get excited about future achievements. To support the event, the communications team ran a series of promotional activity across internal channels to generate interest in the event, resulting in 130 attendees on the day – up from 105 the previous year.

The team provided comprehensive communications support at the event, including vox pop filming and post-event content not only to celebrate but also to enable those unable to attend because of their working commitments to learn and share what was a fabulous occasion.

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3. Showcasing research

In 2023 the Trust employed its first ever communications officer dedicated to promoting research and innovation across the organisation. During the year, our team produced multiple packages of content to promote high-profile clinical trials and research activities, including:

- ARISTOCRAT – BBC coverage secured to announce the recruitment of the first patient in Wales onto the ARISTOCRAT clinical trial, a trial which explores whether a cannabis-based oral spray can help patients with brain cancer.
- FAKTION – content produced to promote a clinical study to investigate if we could safely combine standard hormone therapy with AstraZeneca's AKT inhibitor capivasertib to improve patient outcomes. In December 2023, the USA's Federal Drug Agency (FDA) announced it will license the treatment for use in patients with ER positive, HER2 negative advanced breast cancer.

4. Explaining our Nantgarw Support Unit

Our Nantgarw Support Unit is a valuable service that delivers anti-cancer medication in a light, warm and friendly setting away from the Cancer Centre. By delivering medication from the unit we have been able to increase the number of patients we treat each week, while offering patients the opportunity to receive their care in a safe and convenient setting. The communications team supported the pharmacy team by developing a suite of content, including a flyer and an explainer video, to promote the Support Unit and showcase its features to patients who may not be familiar with the facility.

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5. Supporting high-profile media productions: Rhod Gilbert: A Pain in the Neck

Rhod Gilbert: A Pain in the Neck was an intimate and inspiring documentary that followed Velindre Patron, Rhod Gilbert, through an emotional 18 months as he confronted his illness. Much of the documentary was filmed at Velindre Cancer Centre and the communications team worked closely with the production company to support filming activity across the site. The documentary was broadcast in late 2023 as part of Channel 4's Stand up to Cancer campaign.

6. Building the new Velindre Cancer Centre

In March, the Trust announced that the final agreement has been reached between the Trust and Acorn consortium to design, build and maintain the new Velindre Cancer Centre (nVCC). The announcement was a key milestone in the nVCC project and the communications team worked closely with the Acorn consortium to produce an announcement pack that was shared with all local and wider stakeholders.

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7. Celebrating 75 years of the National Health Service

In July 2023, the NHS celebrated turning 75. A Trust wide campaign included Welsh Blood Service content aimed at encouraging blood donors to 'give before they go' on holiday. The campaign was supported by the launch of the new JD Cymru Leagues and Adran Leagues season and continued to promote sign-ups to the Welsh Bone Marrow registry. The campaign reached a total of 200,586 accounts across social media.

8. Promoting changes to tissue and cell donation in Wales

In September 2023, as part of a four-nation agreement, the Welsh Government announced that restrictions preventing some LGBTQ+ people from donating tissue, surgical bone and stem cells will be lifted in Wales. Following a review by the FAIR (For the Assessment of Individualised Risk) steering group, a UK-wide collaboration including representatives from all UK blood services, medical, scientific and academic experts, LGBTQ+ groups, as well as a selection of patients, donors and their families. Working closely with the Welsh Government, the NHS Blood and Transplant teams and other organisations involved with donation and transplant, during the reporting period, the Welsh Blood Service worked together to change the eligibility questions asked during the tissue and cell donation process and further promote the introduction of fairer eligibility criteria to tissue and cell donation.

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External engagement

1. Delivering our patient engagement strategy

During 2023, the patient engagement team has focussed on developing improved working relationships with patients, carers and the public. This led to the development and implementation of Velindre Voices, and the development of strategic and operational relationships with external stakeholders including Llais, cancer charities, third sector organisations and national organisations such as the Wales Council for Voluntary Action (WCVA), Genomics Partnership Wales and many more.

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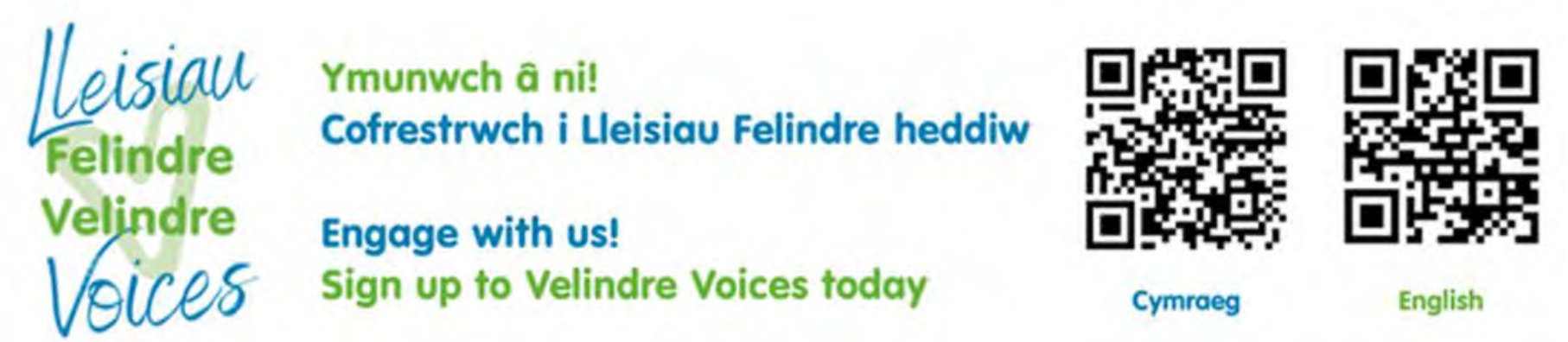
Within the organisation, collaborative discussions between Velindre Cancer Centre, Welsh Blood Service (WBS) and Velindre Cancer Charity identified opportunities to define clear pathways to enable long-term engagement with donors and patients. The result is the development of the Umbrella of Giving shown below. The Umbrella of Giving identifies clear pathways that an individual can choose to navigate depending on how they wish to engage with any or all the areas within the Trust. It allows flexibility and variety for the individual, whilst also bringing the main service areas within the Trust together to offer opportunities, with the main hope that no-one should feel unable to engage with us in whatever way suits them.

2. 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. We have recruited over 200 people to the forum.



During 2023/24, 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

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3. Giving voice to patient views

Below are two examples of how we have delivered workshops to support our colleagues with their ambition to give voice and influence to patients' views.

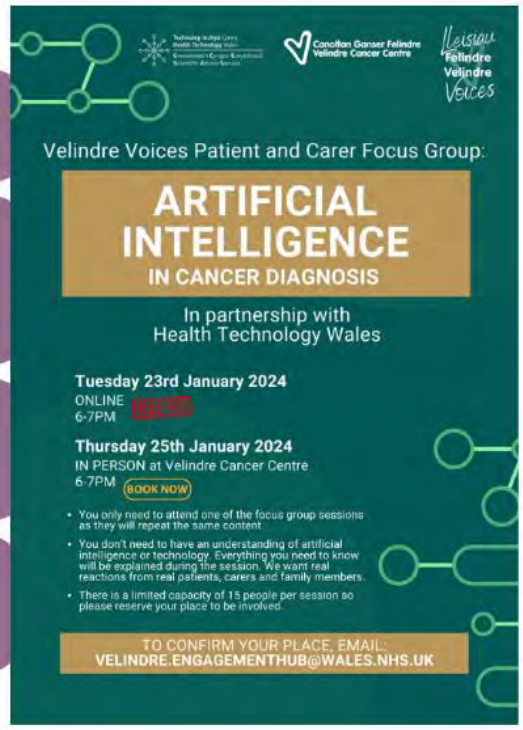
Next: Health Technology Wales Focus Group exploring the use of AI in a cancer diagnosis

Brief: To capture the honest reactions of patients, family members and carers in response to two proposed uses of Artificial Intelligence in a cancer diagnosis

Target Audience:
1. Service users of Velindre Cancer Centre (past and present)
2. Family members of VCC service users (past and present)
3. Carers of VCC service users (past and present)

Delivery:
Two focus groups have been organised, one online and one in person with approx. 30 participants.

Output:
The findings will be included in Health Technology Wales' final proposal to Welsh Government about the potential use of AI in cancer care.



4. Reviewing and revitalising the Patient and Carer Partnership Board

One of the key priorities in the Trust's Patient Engagement Strategy was strengthening the provision for patients and carers' voices to influence the Trust's work, building on the work of the Patient Liaison Group (PLG) established in 2004.

During the latter half of 2023, co-productive conversations took place with the members to redefine the name, purpose, role and recruitment process for the group.

This led to the development of a new Patient and Carer Partnership Board (PCPB), approved by Executive Board in February 2024. Recruitment for the new Board is scheduled for quarter one of 2024. The Board's work will be supported by the output of the Listening Post initiative, designed to ensure members of the Board are able to gather and represent the views from a wider group of patient and carers.

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5. Consolidating and developing our work with children and young people

The Trust is proud of the work it does to support and give voice to children and young people affected and inspired by the work that we do. During the reporting period, we continued to undertake key activities with children and young people, including:

Young Ambassadors

The Trust has a Young Ambassadors scheme that originated via those raising funds for Velindre Fundraising. The cost of living crisis meant that the ability for some Young Ambassadors, their families, communities and schools to raise funds became more difficult. It has been important to redefine the support programme for Young Ambassadors in this context, which has led to more visits to the centre, greater interaction with patients and support for school activities such as discussing specific topics with School Councils and Assemblies.

Welsh Joint Education Committee (WJEC) Victory for Velindre Skills Challenge

Since 2021 the Trust has offered an Enterprise and Employability Challenge – the Victory for Velindre Challenge available as part of the Welsh Baccalaureate.

To support a range of communities, and recognising the cost of living crisis, this challenge was expanded during 2023 to offer both fundraising and non-fundraising options. The 2023/24 challenge was to Create a Product or Service that Positively impacts Velindre Cancer Centre or the Trust Charity.

The annual challenge was hugely successful with many brilliant and innovative ideas being generated by the young people involved, including:

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Canolfan Ganser Felindre
Velindre Cancer Centre

Not for profit Model ideas:

Virtual Reality Headsets for patients who are unable to leave hospital but want to experience a change of scenery.

An app that can keep patients entertained during waiting rooms through a variety of games/activities.

A positivity wall where patients can leave quotes and words of encouragement for other patients.

A walking group or other activity that encourages patients to meet others and talk about their feelings.

Well being boxes that can be picked up by patients who are feeling low. Can contain something to boost their mood.

A product that supports young children when their loved one is receiving treatment.

A series of head scarfs or hats to boost the confidence and comfort of chemotherapy patients who experience hair loss.

Art or music activities that help patients express their feelings in a creative way.

Charity Model ideas:

An item to sell:

Branded merchandise that can be sold by Velindre charity such as water bottles, clothing or medals etc.

Cakes, ice lollies, badges, smoothies, knitted items, raffle tickets for prizes, jewellery, key rings, confectionary.

Activity stall that charges per go, eg: pie the teacher, hook a duck, tin can alley and other popular fair ground games.

A hosted event:

A charity sports match that can take place at the school.

A seasonal fair that offers crafts related to the time of year, eg: Christmas, Easter, Summer etc.

A fun run or sponsored walk that can include staff, students and families.

An end of year/term event for lower year groups such as a disco or fun day.

A sponsored challenge:

A sponsored fitness challenge which could be a walk, run, bike ride, football keep it up challenge etc.

A world record attempt.

A fundraising target focussed activity such as, Mr Evans will shave his head if we raise £500.

A group challenge like a walk-a-thon or sponsored silence.

Building on this work, a key objective for the Trust is the development of a new Youth Engagement Strategy. Initial scoping work has been undertaken to map the current relevant activities across the Trust. Our objective is to ensure that the Trust meets its obligations under the Wellbeing of Future Generations Act, and the United Nations Convention on the Rights of the Child, with clarity, consistency and creativity putting the safety and wellbeing of children and young people at the heart of everything we do.

6. Co-production and the New Velindre Cancer Centre

Over the past 12 months, we have supported many opportunities for the public to find out more and get involved with the new Velindre Cancer Centre project.

Children and Young People Workshops

In November and December 2023 the patient engagement and nVCC engagement teams undertook a number of engagement events with young people to seek their views on designs and facilities for the new Cancer Centre.

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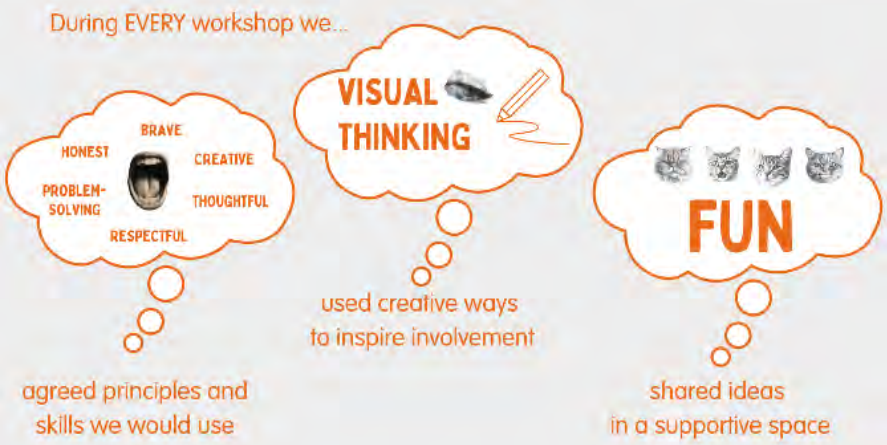
We visited a number of schools and hosted workshops to ensure the views of those with specific needs were captured. Involving experts by experience added rich and vibrant feedback, including the team at LATCH and the Teenage Cancer Trust Youth Forum.

Below are some examples of their feedback.



Inclusive Design Workshop and the New Velindre Cancer Centre

In September 2023, the patient engagement and nVCC engagement teams hosted an Inclusive Design workshop. Representatives from Wales Council for the Blind, British Deaf Association, Cardiff Learning Disability Team, Teenage Cancer Trust, Llais and Trust Ambassadors attended actively providing feedback on the current design and their requirements.

Hefyd work programme

Hefyd is the Trust's community value and benefits initiative. As a programme of work, Hefyd includes a series of activities supporting the Trust's arts, green social prescribing, sustainability agenda and community engagement. One of the key activities are regular Jamboris hosted on the site of Velindre Cancer Centre during school holidays for children and local families. These sessions not only improve relationships within the community but also enable the team to share key messaging about the new centre project and opportunities to get involved in an accessible, engaging and entertaining way. Hosted in the Velindre Roundhouse, which was built by a team of volunteers taking part in our green woodworking course, each Jambori will continue to provide free family fun in the fresh air!

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Supporting our Armed Forces

ARMED FORCES COVENANT
CYFAMOD
Y LLUOEDD ARFOG

EMPLOYER RECOGNITION SCHEME
CYNLLUN CYDNABOD CYFLOGWYR

GOLD AWARD 2023
GWOBR AUR 2023

Proudly Supporting those who serve.
Falch o gefnogi'r rhai sy'n gwasanaethu.

During the reporting period, the Trust was successful in achieving the prestigious Gold Defence Employer Award which recognises its support and advocacy for the Armed Forces and its members.

The Trust continued to foster its relationship with 203 (Welsh) Field Hospitals through the development of a formal Memorandum of Understanding (MoU) which describes the wider collaborative opportunities between us, including employment opportunities, training, education and research opportunities. Velindre Cancer Centre also provided a clinical space for blood tests to be taken pre-deployment.

Recognising the importance of attracting future employees, the Trust introduced the Royal College of Nursing (RCN) Prince of Wales Cadet Scheme which provides nursing cadets structured placements at VCC and the Welsh Blood Service (WBS). This scheme is run in conjunction with all cadet forces. The scheme aims to develop and prepare young people (16-25) for life and to support them towards employment in nursing.

To further progress its commitment to providing employment opportunities the Trust has joined the Career Transition Partnership and are committed to implementing a guaranteed interview process for those that meet essential skills criteria.

In June 2023, Armed Forces Week and Day were actively celebrated across the Trust with a range of events highlighting the work of the Armed Forces, providing leadership exercises for staff and actively promoting stories of its staff who have served in the Armed Forces and Reservists. Armistice Day was observed and supported across the Trust again this year.

Useful links

Destination 2033

Digital and Data Strategy

Estates Strategy

People Strategy

Sustainability Strategy

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

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Velindre University NHS Trust

Communications and Engagement Annual Report 2023-24

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Wales Infected Blood Support Scheme Annual Report 2023 - 2024

DATE OF MEETING	12/09/24

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	NOT APPLICABLE - PUBLIC REPORT

REPORT PURPOSE	INFORMATION / NOTING

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Mary Swiffen-Walker, Service Manager, Wales Infected Blood Support Service
PRESENTED BY	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Interim Chief Executive Officer

EXECUTIVE SUMMARY	Attached is the Wales Infected Blood Support Scheme Annual Report. This was approved at Shared Services Committee. It is shared with the Trust Board for noting on an annual basis given the governance arrangements of the work include the governance group being chaired by the Trust Director Corporate Governance & Chief of Staff, currently Interim Executive Director of Strategic Transformation, Planning and Digital. It was approved by the WIBSS Governance Group on

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	6th June 2024. The report will go to Shared Services Committee on 19th September 2024.

RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the Annual Report.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
WIBSS Governance Group meeting	6th June024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS *Approved by WIBSS GG*	

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**

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Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Wales Infected Blood Support Scheme

Annual Report 2023-24

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Wales Infected Blood Support Scheme (WIBSS)

VELINDRE UNIVERSITY NHS TRUST

THROUGH

NHS WALES SHARED SERVICES PARTNERSHIP (NWSSP)

AND

VELINDRE CANCER CENTRE (VCC)

ANNUAL REPORT 2023/2024

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

GIG CYMRU NHS WALES | Partneriaeth Cydwasanaethau | Shared Services Partnership

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Canolfan Ganser Felindre
Velindre Cancer Centre

Cynllun Cymorth Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

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Welcome
11/09/2024 10:57:49

Introduction

Established in October 2017, the Wales Infected Blood Support Scheme (WIBSS) aims to provide support to people who have been infected with Hepatitis C and/or HIV following treatment with NHS blood, blood products or tissue.

Taking over from the existing UK schemes (Eileen Trust, Macfarlane Trust, MFET Ltd, Skipton Fund and Caxton Foundation), now referred to as the Alliance House Organisations (AHOs), WIBSS aims to provide both a streamlined financial payment service and personalised support for Welsh beneficiaries. WIBSS also offers a dedicated Welfare Rights Service and a Psychology and Well-being Service.

As at 31 March 2024, WIBSS supports 225 beneficiaries, including bereaved spouses and partners. However, the welfare and psychological support is also provided to wider family members of our beneficiaries.

The Purpose of the Report

To provide an update on the finance and support services during 2023-24 as part of the Wales Infected Blood Support Scheme.

To detail the proactive work carried out by WIBSS during 2023-24; and

To look ahead to WIBSS priorities relating to 2024-25.

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Key matters arising during 2023-24

The way in which WIBSS services are provided returned to normal during 2023-24 following some required adjustments, resulting from the COVID-19 pandemic. Home visits and face-to-face appointments were reinstated. There were no major changes to the service and no action required as a result of any announcements from the Infected Blood Inquiry, therefore, it was business as usual during this year.

Public Inquiry - The Infected Blood Inquiry

This is an independent public statutory inquiry established to examine the circumstances in which men, women and children treated by the National Health Service in the United Kingdom were given infected blood and infected blood products, since 1970. The Inquiry is Chaired by Sir Brian Langstaff.

In 2023-2024 we responded to two Rule 9 requests from the Infected Blood Inquiry.

- The first request sought information regarding number of beneficiaries registered with the scheme, and what category they were in; the number of infected persons who had deceased; and the number of interim compensation payments that were made to infected and bereaved partners. .

- The second request concentrated on how many interim compensation payments had been paid to infected and bereaved persons since July 2022. It also queried what proportion of the total number of people infected and bereaved to whom payment was made in the first year of operation to 28 October 2023, have registered since 29 July 2022.

WIBSS co-operated fully with the inquiry and responded to all Rule 9 requests within the required timeframe.

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On 5 April 2023 the Chair published an interim report on compensation. The UK Government and devolved administrations stated that they would consider the recommendations in this report, alongside the recommendations made in the final report.

Second Interim Report | Infected Blood Inquiry

On 3 February 2023, the Inquiry Chair closed the Inquiry's public hearings, explaining that he would now be focused on writing his report. Some additional hearings were held in July 2023.

The Inquiry's final report was due to be published in the Autumn of 2023.

However, due to the additional hearings in July, together with Rule 13, which says that the Inquiry must inform anyone criticised in the report, of the nature of the criticism and the facts this is based on, it was not possible to publish the final report in the Autumn.

The Rule 13 warning letters issued about the final report are complex documents with detailed references to evidence. The person criticised is not obliged to respond, but the Inquiry must give them reasonable time to do that if they choose to.

The final report was published on 20 May 2024. The Inquiry Report | Infected Blood Inquiry

This WIBSS Annual Report will not go into any detail of the findings in the Final Report as it captures information relevant to 2023-2024 only.

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11/09/2024 10:57:44

Governance Group

The Governance Group monitors the operational management of WIBSS and provides governance, leadership and accountability for the scheme, on behalf of Welsh Government (WG), through Velindre University NHS Trust.

The WIBSS Governance Group (VCC and NWSSP) is authorised to:

Investigate or have investigated any activity within its Terms of Reference, and in performing these duties, shall have the right, at all reasonable times, to inspect any books, records or documents of the Trust, relevant to the Governance teams' remit, subject to any restrictions imposed by General Data Protection Regulations (GDPR).

It can seek any relevant information it requires from any employee, and all employees are directed to co-operate with any reasonable request made by the Board.

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27/09/2024 10:57:44

It is empowered with the responsibility for:

Reviewing and advising on the management of the WIBSS budgets, including running costs, the annual beneficiaries' budgets and provisions.

Advising Welsh Government on rate changes and the potential financial and service implications of policy changes, both within Wales and other areas within the UK.

Implementation of Welsh Government policy.

Ongoing negotiation and partnership with Welsh Government to ensure the smooth running of the service.

The membership of the WIBSS Governance Group is as follows:

- Director of Corporate Governance
  Velindre University NHS Trust (Chair)
- Welsh Government Finance Representative
- Head of Nursing, Quality, Patient Experience and Integrated Care
  Velindre Cancer Centre
- Welsh Government Policy Representative
- Director of Planning, Performance and Informatics
  NWSSP
- Senior Welfare Rights Manager
- WIBSS Service Manager
- Consultant Psychologist

During 2023-24 the Governance Group met three times on 16 June 2023, 19 September 2023 and 24 January 2024.

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Financial Support

The scheme recognises that individuals living with hepatitis C and/or HIV face extra costs for things like insurance, travel insurance, care costs and travel costs to attend hospital appointments etc. Financial support is available for:

- New Applicants to the scheme.
- Members of previous legacy schemes.

There are varying levels of financial support available to beneficiaries of the scheme.

These are set out in the Finance Section of this report and are also published on our website.

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Appeals Process

If an application to join the scheme is unsuccessful, an applicant can appeal if they disagree with the outcome of their application. Appeals are heard by a panel of independent medical experts with relevant clinical or similar experience in the field.

An appeal will not be considered in cases where it is acknowledged that the applicant is not eligible under the current eligibility criteria, but the applicant disagrees with those criteria (in such cases, the application could only be reconsidered if the Welsh Government agreed to amend the eligibility criteria).

During 2023-24, two appeals were submitted, and an appeals panel was convened on 9 June 2023. The panel considered all the documentation received by WIBSS from the applicants and scrutinised the decision-making process of WIBSS. The panel then considered all the evidence. In the first case the panel determined that although the evidence was not clear, leading to WIBSS rejecting the application, they felt that the application could be approved based on a “balance of probability”.

In the second case, the panel upheld the original decision made by WIBSS to reject the application but stated that if evidence of the injury which resulted in the blood transfusion was submitted, this appeal could also be approved on a “balance of probability” basis. The appellant was notified of the panel’s decision.

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Beneficiaries' activity 2023-24

There are 225 beneficiaries & bereaved partners registered for support through the scheme. This is broken down into the following groups. (Valid as at 31 March 2024).

Beneficiary Group	Number of registered Beneficiaries
Hepatitis C Stage 1	31
Hepatitis C Enhanced Stage 1+	91
Hepatitis C Stage 2	38
HIV	2
HIV & Hep C Stage 1 (Co-infected)	1
HIV & Enhanced Stage 1+ (Co-infected)	13
HIV & Hep C Stage 2	2
Bereaved Spouse/Partner	47*
Child Payments	17

*2 beneficiaries are classified as both existing beneficiaries and as bereaved spouse/ partners.

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Payment Rates

The levels of payments available to beneficiaries in 2023/24 are set out in the table below.

Beneficiary Group	Annual Payments
Hepatitis C Stage 1	**£21,467**
Hepatitis C Enhanced Stage 1+	**£32,555**
Hepatitis C Stage 2	**£32,555**
HIV	**£32,555**
HIV & Hep C Stage 1 (Co-infected)	**£44,189**
HIV & Enhanced Stage 1+ (Co-infected)	**£51,162**
HIV & Hep C Stage 2 (Co-infected)	**£51,162**
Child Payment; 1st Child	**£3,000**
Child Payment; 2nd & Subsequent Children	**£1,200**

WIBSS pay annual payments monthly or quarterly, depending on beneficiary preference. Payments are made on the 20th of the month. Where the 20th falls on a bank holiday or weekend, payment will be the nearest working day prior to the 20th.

One-off non-discretionary lump sum payments are also paid to successful new applicants to the scheme. Under Parity, a new applicant who is Hep C Stage 1 would be entitled to a £50,000 lump sum payment.

A beneficiary who moves from Hep C Stage1 to Hep C Stage 2 would receive an additional £20,000 lump sum payment. A new applicant who has already progressed to Hepatitis C Stage 2 would receive a £70,000 lump sum payment.

A new applicant who has HIV would be entitled to a lump sum payment of £80,500. If they were co-infected HIV and Hep C Stage 1, the lump sum would be £80,500 + £50,000 = £130,500 and Stage 2 would be £80,500 + £70,000 = £150,500.

A one-off non-discretionary lump sum payment of £10,000 is also paid to the bereaved spouse/partner/dependant relative or estate of a deceased infected beneficiary to assist with funeral costs.

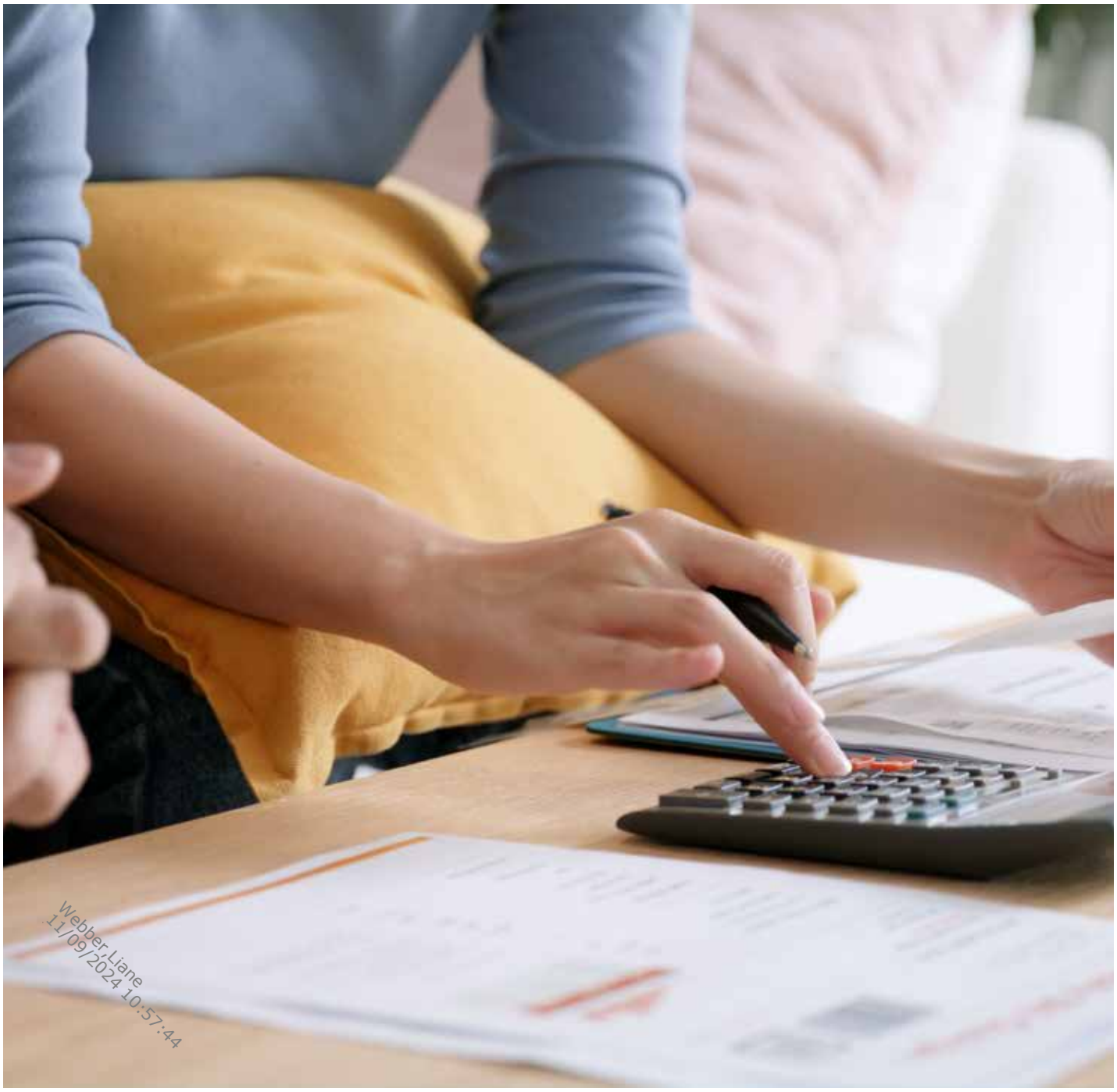
WIBSS also make regular payments to bereaved spouses/partners/dependant relatives, of an infected beneficiary who has passed away. These payments are equal to 100% of the rate the deceased beneficiary was on at time of death for one year and 75% of the rate thereafter.

Child Payments 2023-24

Child payments were introduced to WIBSS with effect from 1 January 2023.
The payment is intended for the care and support of a child/children, up to the age of 18 or 21, if in full-time education, who are either the biological child or form part of the household of an infected beneficiary.

WIBSS child payments are £3,000 for the first child, and £1,200 for the second and subsequent children.

As at 31 March 2024, the total cost of child payments is £65,400. This relates to 29 children paid to 17 beneficiaries. Payments are being paid monthly or quarterly.



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WIBSS Structure

Cynllun Cynorthwyo Gwaed Heintiedig Cymru
Wales Infected Blood Support Scheme

Alison Ramsey
Director of Planning, Performance and Informatics
NWSSP

Viv Cooper
Head of Nursing, Quality, Patient Experience and Integrated Care
Velindre Cancer Centre

Mary Swiffen-Walker
WIBSS Manager

Psychology and Well-being

Caroline Coffey
Clinical Psychologist

Julie Armytage
Counsellor

Finance

Stefan Dakovic
Finance Officer

Admin Support

Daniel Murphy
Support Officer

Welfare Rights

Hayley Price
Welfare Rights Manager

Rebecca O'Callaghan
Welfare Rights Advisor

Ryan Clappe
Welfare Rights Advisor

Shelly Robson
Welfare Rights Advisor (Maternity cover)

Webber,Liane
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Financial Report

The table below summarises the claims expenditure for 2023-24, the comparative 2022-23 figures include the Interim Compensation payments announced in July 2022 and processed in October 2022.

The announcement confirmed that an interim compensation payment of £100,000 would be paid to registered infected and bereaved partner beneficiaries of the UK Infected Blood Support Schemes.

These costs include widows and small grants payments.

WIBSS Claims Expenditure	2023 -24	2022-23 Comparative
No. of Beneficiaries	225	223
Regular Payments	£7,789,344	£7,484,327
Interim Compensation Payments	£700,000	£22,200,000
Total Payments to Beneficiaries	**£8,489,334**	**£29,684,327**

Please note the figures above have been subject to in year movements i.e., new applications, deaths in year, moves from one stage to another, ad hoc requests etc.

NWSSP provide the Health and Social Services Finance Team within Welsh Government with regular updates on forecasts throughout the year. The administration of the scheme i.e., claims expenditure, is cost neutral to both NWSSP and Velindre Cancer Centre, with Welsh Government funding the scheme in full.

Running Costs for 2023-24

A summary of the running costs for 2023-24 is set out below with a 2022-23 comparative:

WIBSS Running Costs	2023 -24	2022-23 Comparative
Pay	£223,918*	£244,417*
Expenditure	£13,880	£11,160
Total	**£237,799**	**£255,577**

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*The decrease in pay costs is due savings from vacant posts and maternity leave in 2023-24.

Performance Report

WIBSS performance against Key Performance Indicators is set out below.

Descriptor of Key Performance Indicator	2023-24 Target	Status
Responding to Welsh Government & General correspondence within set time limits	Within 4 working days	100%
Responding to Freedom of Information Requests within required deadlines	In-line with Trust Policy	100%
Dealing with applications within required timescales	Within 28 days from receipt of complete information	100%
Dealing with appeals within set time limits	1 appeal was lodged. The appeal was heard within the required timescale.	100%
Payments made on a timely basis	100% of payments to be made 0-2 days before the due date.	100%

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Description of Key Welfare Rights Incidents	Status
Total Welfare Rights Cases opened in previous 12 monts	» 62
Income generated for beneficiaries (1 April 2023 - 31 March 2024)	» £39,175.29
Outstanding outcomes March 2024	» 2 Personal Independence Payment (PIP) Renewals » 1 Attendance Allowance » 1 WIBSS Grant Application » 1 Pension Credit application
Onward Referrals	» 1 Occupational Therapy » 3 External Grants » 7 Internal Grants
Appeals and Reconsiderations	» 1 Successful Attendance Allowance Mandatory reconsideration » 9 Referrals to WIBSS Wellbeing Service » 7 Mortgage Support letters » 3 WIBSS Grants » Cardiff Social Services

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New Applications for Financial Support

WIBSS received 23 applications in 2023-24.

Application Type	Applications Received	Outcome
Hepatitis C Stage 1	2	1 Accepted, 1 Awaiting additional information
Hepatitis C Stage 2	0	N/A
HIV	1	1 Declined
Bereaved Partner	0	N/A
Hep C Stage 1+	19	19 Accepted
Move from Stage 1 to Stage 2	1	1 Accepted
Total	**23**	**21 Accepted, 1 Awaiting Confirmation, 1 Declined**

Where an application is declined, it will be because it does not meet the criteria set in Wales Infected Blood Support Scheme Directions, or insufficient evidence has been provided to support the application.

To access the Directions, please visit the WIBSS Website.

The announcement regarding the interim compensation payments and the media coverage surrounding it, led to an increase in the number of queries about the service and new beneficiaries, who had been registered with one of the legacy schemes, but had not transferred to WIBSS in 2017 when the scheme was established.

Support and Assistance Grants Scheme

In 2023-24 we received 6 applications for support compared to 5 applications in 2022-23.

The level of small grant applications has remained consistent across both years. However, this is a decrease compared to the 12 applications received in 2021-22. We believe this decrease may be partly due to the Interim Compensation payments that were paid in October 2022.

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Welfare Rights Service

There have been some changes in terms of the staff within the welfare rights team during 2023-2024. Despite a reduced number of staff in the team, for a short period of time, the service continued to offer exceptional support and assistance to our beneficiaries. Training and support were provided to new members joining the team in year.

The team work closely with both the finance team and the wellbeing service. The welfare team is often the first point of contact for those making enquires to the scheme. The team provide holistic support, offering a full service to our beneficiaries. We will continue to promote the exceptional service that is provided to our beneficiaries and ensure that all are aware of the available services we offer.

The WIBSS welfare rights service is Advice Quality Standard (AQS) accredited and bespoke to the needs of the individual and their family. In September 2023 a two-yearly monitoring assessment was carried out by the AQS. The WIBSS welfare rights service maintained its accreditation, with many areas of good practice highlighted.

Although not exhaustive, below is a list of services we may be able to assist with:

- Consulting with social services to ensure complex beneficiary needs are met, such as support from a social worker/occupational therapist/ Community Psychiatric Nurse (CPN). This may include help with adaptions to home to ensure our beneficiaries safety or mental health support.
- Signposting free NHS dental care and prescription services for those eligible due to the new benefit entitlement.
- Assisting with applying to join WIBSS including completing paperwork, requesting or chasing medical professionals seeking evidence to support applications.
- Completing benefit and welfare checks, applying for benefits, debt signposting, budgeting advice, navigating financial products etc.
- Applying for a parking badge (Blue Badge), free bus travel and concessions.
- Accessing health services, such as additional care requirements and health care transportation.
- Advice around external schemes- such as NEST part of Welsh Government's Warm Home Scheme. NEST offers financial support for insulating homes or new boilers to reduce bills and increase energy efficiency. (A new scheme is due to be introduced soon).
- SureWater schemes to reduce water bills for those using higher amount of water for medical reasons.

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Our welfare rights advisors can also consider the circumstances of family and carers to check their entitlement to benefits. Caring for someone can impact emotionally and financially. We can apply for benefits to support carers if eligible.

Additional support we can provide, as a result of being an in-house service may include things such as:

- Liaising with beneficiaries and wider family members to establish a trusting relationship and provide emotional support, outside of formal psychology and wellbeing referrals.
- Providing regular outbound check-ins with beneficiaries considered as vulnerable.
- Completion of paperwork and help to sort affairs for those unable to do so themselves.
- Completion of personalised letters confirming WIBSS payments to support with mortgage applications/ renewals.

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Energy Campaign – April 2023

As a result of the significant increase of UK-wide home energy costs during 2022-23, the welfare team produced an outbound energy campaign, which was rolled out to all our beneficiaries and was specific to the area in which they lived. The campaign provided personalised advice on available energy efficiency grants, water supplier discounted tariffs and comprehensive assistance to apply to such schemes.

Expected improvements, for eligible beneficiaries, included free boilers, improved home insulation and central heating systems. Water schemes include discount on water tariffs for those using high volumes of water due to medical need. We promoted the campaign via the WIBSS newsletter.

Possible group forums

The welfare team has canvassed opinion on whether there is any interest in holding a group style meet up sessions for WIBSS beneficiaries. The group sessions would be offered either in person or online, or a hybrid of both, depending on preference. They would provide beneficiaries with the opportunity to discuss any issues with members of WIBSS staff and amongst each other. The wellbeing team are looking to offer a similar forum, and it might be that these are combined our held at the same time.

Newsletters

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Newsletters are sent out quarterly to all beneficiaries unless they have opted not to receive them. These are sent out electronically or by post, depending on preference.

They are also available on the WIBSS website.

Newsletters this year provided information on the following:

- Infected Blood Inquiry (IBI) updates
- Reminder of the WIBSS Services
- Benefit updates and reminders (Highlighted unclaimed benefits) well-being service
- Promotion of group sessions
- Energy Campaign
- Update of WIBSS Staff
- WIBSS Payment rate notifications
- 2nd Interim Report – IBI
- Proof of WIBSS Income

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Case Study A

Beneficiary A contacted WIBSS about applying for Attendance Allowance and queried Tax payment

We supported the client to complete the Attendance Allowance application form.

Beneficiary A's application was turned down by the Department for Work and Pensions (DWP) and they were not awarded any rate of Attendance Allowance. The welfare team submitted a mandatory reconsideration form with a supporting letter to the DWP to allow them to reconsider the decision.

As a result, the application was awarded at the higher rate.

The beneficiary was also supported to complete a P50Z tax repayment form to claim back overpaid tax on a private pension flexible payment.

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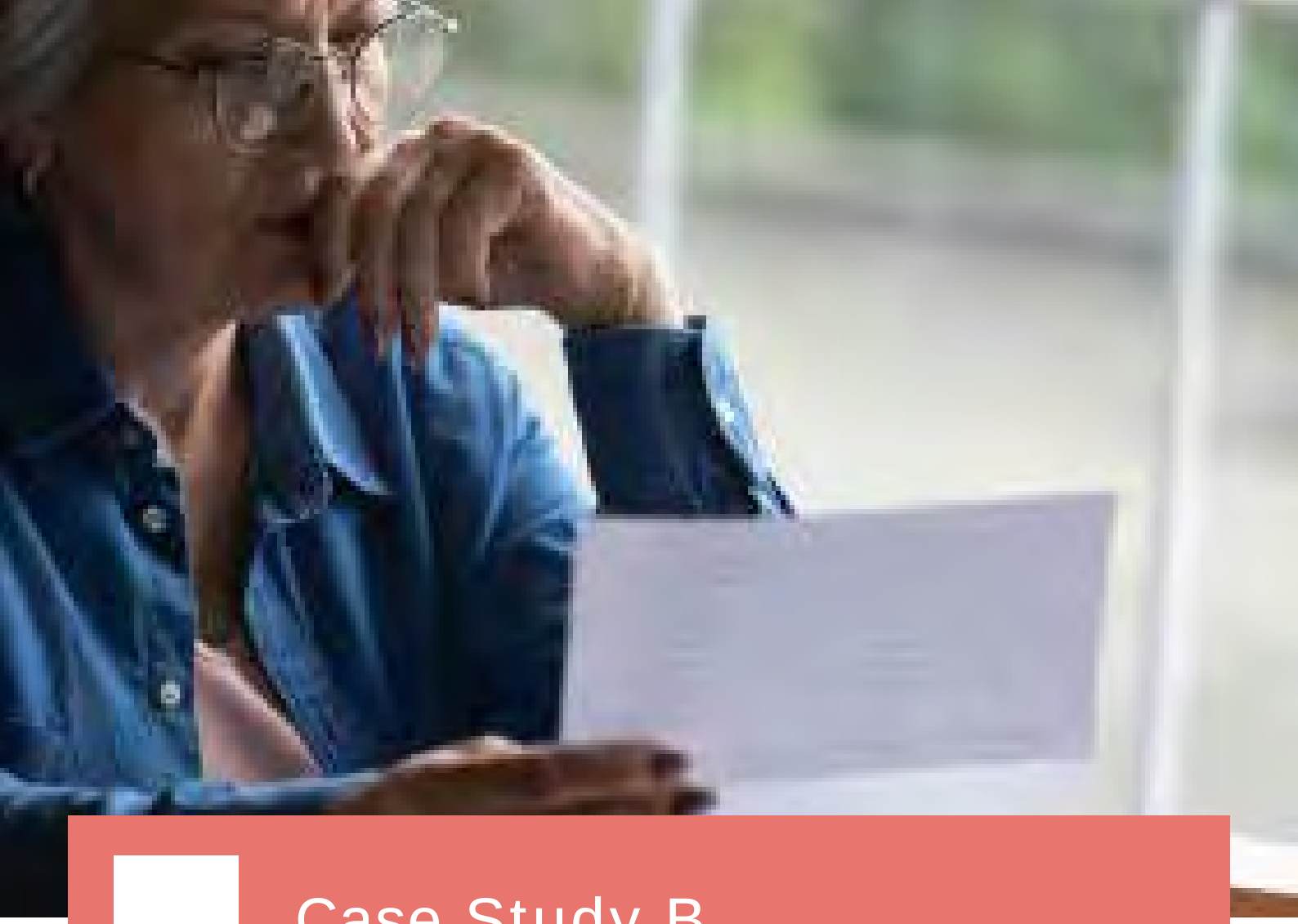

Case Study B

Beneficiary B contacted WIBSS to seek financial help towards private dental costs

We attended Beneficiary B's home to assist with completing the grant application for help towards private dental costs. Beneficiary B explained the dental treatment was needed due to not being seen by an NHS dental practice for many years, due initially to stigma around his diagnosis.

We also assisted with another grant form for a respite break, following recent surgery. A supporting letter was provided by his GP stating a respite break would benefit recovery.

Both grants were approved, and the maximum grant was awarded for the specific criteria.

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Psychology and Emotional Well-being Service

The team consists of a consultant clinical psychologist and a specialist counsellor who are highly experienced at working with those infected and affected by contaminated blood products.

Since the scheme was established, they have worked hard to engage with as many beneficiaries as possible of WIBSS, and those close to them, to access the psychology and counselling options that the service provides.

The team continue to receive self-referrals for emotional help and enquiries from external services and health care providers, regarding referral criteria and to discuss collaborative working. We have easy to access referral routes and respond in a timely way. Post referral, beneficiaries and those close to them, are offered an initial appointment to assess current emotional need and appropriateness for the service. We currently offer open ended intervention which is offered in a collaborative way, either in person, by telephone or video call.

During this year, the specialist counsellor resigned and left post in June. As the specialist counsellor delivers the bulk of the clinical time, this inevitably affected service delivery.

The recruitment process for the post was challenging due to the level of specialist, clinical experience needed for the post and the importance of the style of practitioner. The client group, understandably, can be difficult to engage with due to issues of trust and feelings of vulnerability within an NHS context. The ethos of the team has focused on attempting to heal such issues and build a strong rapport with clients (beneficiaries).

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Despite the reduction in available clinical time due to the vacant post, the well-being service continued to receive referrals. The consultant clinical psychologist (0.2WTE) for WIBSS screened and prioritised referrals at this time and remained in contact with beneficiaries as much as possible and offered ongoing appointments to those with higher levels of emotional need. Regular check in calls were also made to those who were able to wait until recruitment was successful.

The clinical priority during this year has been to support clients emotionally and psychologically through the conclusion of the Infected Blood Inquiry, and also, to highlight what the service can offer clients, on a wider scale, and on an individual, group and community level if required. WIBSS recognises that the peer support that the process of the Inquiry has provided for some has been highly valued.

We are currently considering how we can best capture ideas and thoughts from those infected and affected about the next steps regarding their emotional needs, taking into account the proposed recommendations from the Infected Blood Inquiry, plans for compensation and the establishment of the Infected Blood Compensation Authority (IBCA).

Things we will do in 2024-25

The workplan for 2024-2025 will include the following:

- Continue to deliver a responsive WIBSS service to existing beneficiaries and those seeking to apply.
- Keep beneficiaries informed of any decisions arising from the Inquiry recommendations that may impact on them.
- Consider how we can best capture ideas and thoughts from those infected and affected about the next steps regarding their emotional needs, considering the proposed recommendations from the Infected Blood Inquiry, plans for compensation and the establishment of the Infected Blood Compensation Authority (IBCA).
- Work with the Welsh Government to respond promptly to any future decisions arising from the final report of the Infected Blood Inquiry and the setting up of the Infected Blood Compensation Authority (IBCA). This may include making further interim payments.

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Cynllun Cymorth Gwaed Heintiedig Cymru

Wales Infected Blood Support Scheme

Thank you for reading our Annual Report. If you would like to find out more, please visit our website, our social media channels, or use the contact details provide below:

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This document was designed by the NWSSP Communications Team.
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GIG CYMRU NHS WALES | Ymddiriedolaeth GIG Prifysgol Felindre | Velindre University NHS Trust

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Infection Prevention & Control Policies: National Model Policy Aseptic Non-Touch Technique (ANTT) – IPC 03 & Control & Management of Multi Drug Resistant Bacteria Policy – IPC 15

DATE OF MEETING	12th September 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	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	One Infection Prevention and Control policies have been reviewed in line with the planned review process and the latest national guidance and evidence base to be ENDORSED for APPROVAL.

RECOMMENDATION / ACTIONS	Executive Management Board is asked to: • ***ENDORSE*** the National Model Policy Aseptic Non-Touch Technique (ANTT) – IPC 03 for adoption across the Trust for onward approval. • ***ENDORSE*** the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December 2024 for the national policy review and consultation to be completed.

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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 (IPCMG)	17th July 2024
Executive Management Board	5th August 2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS • ENDORSED the Infection Prevention & Control Policies: National Model Policy Aseptic Non-Touch Technique (ANTT) for onward approval. • ENDORSED the proposal for the current national Control & Management of Multi Drug Resistant Bacteria policy to remain extant until December 2024 for the national policy review and consultation to be completed.	

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 for policies

APPENDICES	
1.	IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)
2.	IPC 03 – EQIA produced by PHW for ANTT Policy

1. BACKGROUND

Both the model policy Aseptic Non-Touch Technique and Control and Management of Multi-Drug Resistant Bacteria are national (NHS Wales) model Policies. As they are predicated on best practice standards adoption across NHS Wales Organisations is expected.

2. ASSESSMENT

2.1 ***IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)***

The Trust Infection Control Team were part of the original steering group to develop this national policy.

No amendments were made to the clinical practices during this revision. The main change was to include the path to accreditation.

2.2 ***IPC Policy 15 – Control & Management of Multi Drug Resistant Bacteria***

This national policy expired in June 2024 and is currently undergoing a review and incorporation of new guidance from Public Health Wales. When completed the revised policy will provide additional guidance on the management of Clinically Significant Antimicrobial Resistant Organisms (CSARO), however there is no impact to current practices.

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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 ☒
	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). Trust IPCMG covers all aspects of Quality and Safety from an IPC perspective.
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

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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.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	This is a report following the Trust Infection Prevention and Control Management Group meeting.
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

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Appendix 1: IPC 03 – Model Policy Aseptic Non-Touch Technique (ANTT)

ASAP The Association for Safe Aseptic Practice

ANTT® Aseptic Non Touch Technique

NHS WALES GIG CYMRU

Model Policy
Aseptic Non-Touch Technique (ANTT®):
A national, standardised approach to aseptic technique

Date to be reviewed:	April 2026	**No of pages:**	30
Original Author job title(s):	Healthcare Associated Infection & Antimicrobial Resistance & Prescribing Programme (HARP), Public Health Wales (PHW) In Consultation with: • All Wales ANTT Steering Group • Higher Education Institute (HEI) sub-group • The Association for Safe Aseptic Practice • HCAI Delivery Board		
Responsible dept. / director:	HARP IP&C Team, Public Health Wales		
Approved by:	The all-Wales ANTT Steering Group & HEI sub-group The Association of Safe Practice (ASAP) HARP, Public Health Wales HCAI Delivery Board, Public Health Wales		
Original Date approved:	07 June 2019		
Original Effective Date (live):	04 July 2019		
Version:	FINAL Version 1 - 04 July 2019 FINAL Version 2 - July 2019 FINAL Version 3 – March 2023		
Date of Review	December 2022		
Date Verification form (1) completed:	24th March 2023		

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Documents to be read alongside this model policy:	ANTT® Principles[1] NHS Scotland's National Infection Prevention and Control Model Policies NIPCM -on-line[2] Welsh Health Circular 2022/014 Amr-hcai-improvement-goals-for-2021-2023.(Welsh Government 01 March 2022)[3] Welsh Code of practice for the Prevention of Infection (Welsh Government, May 2014) Code-of-Practice [18] WHC 2015-26 ANTT Implementation (Welsh Government, 5thJune 2015)[19] WHC 2015-47 ANTT Follow up (Welsh Government, 9th Oct. 2015)[20] epic 3: National Evidence-Based Guidelines for the Prevention of Healthcare-Associated Infections in Hospitals in NHS Hospitals in England (Loveday et al, 2014)[9] The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10th Edition (2020)[7] Procedures - Royal Marsden Manual (rmmonline.co.uk) National Institute of Clinical Excellence (NICE) Infection prevention and control of healthcare-associated infections in primary and community care (2017)[11] Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Executive Summary:
This model policy outlines the current national standardised approach for raising clinical standards of aseptic technique and achieving asepsis in non-invasive and invasive clinical procedures. The aim is to provide a standardised approach termed Aseptic Non-Touch Technique (ANTT®) and to reduce variation in aseptic technique and practice across Wales in the prevention of healthcare associated infections (HCAI). As agreed previously by Executive Nurse Directors, the intention is that this model policy is adopted as national policy by Health Boards and Trusts, including primary care and other health care organisation i.e., Care homes and independent hospitals within Wales. This policy requires relevant managers and leaders to organise and support its implementation and ongoing evaluation. This will ensure relevant clinical staff are appropriately trained and competency assessed in ANTT® so that it is embedded into everyday asepsis practice.
This ANTT Model policy was first published in July 2017, Emergency ANTT added in July 2019, version 3 /2023 all links refreshed, circulated for comment minor amendments and comments updating of appendices including ANTT Accreditation, terminology and updated framework information added into the appendix

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1. Introduction

Asepsis is generally considered to mean 'Freedom from pathogenic material in sufficient quantity to cause infection'.[14] During clinical procedures, the goal of asepsis is to prevent patient contamination by creating an environment that is low in microbe volume by using only sterile devices, materials and maintaining aseptic technique.

Aseptic technique is a core nursing and medical skill but is also used by other allied healthcare professionals (AHP) and healthcare support workers. The standard of aseptic technique practice can be inconsistent, and if not undertaken correctly may be instrumental in causing a healthcare-associated infection (HCAI) within primary, community, secondary and out of hospital care.

Historically, aseptic technique has been seen to be confusing and ambiguous with practice terms and principles having different meanings for different users. This has led to inconsistency and some substandard practices.

In the challenge to reduce HCAI, 'Aseptic Non-Touch Technique' (ANTT®) is used internationally as a safe and effective practice framework for aseptic technique for all aseptic clinical procedures.[19,20]

The Association of Safe Aseptic Practice (ASAP), in collaboration with Public Health Wales and supported by Welsh Government, have been providing ANTT® Resources practice and implementation support to all healthcare workers across Wales since June 2015.

Standardising aseptic technique with ANTT® across Wales will reduce variability in practice and further raise standards for the greater benefit of patients.

Welsh Government has directed all healthcare organisations to 'roll-out' ANTT® competency training to all relevant staff within their organisation.(WHC/2015/026) [19] The principles of ANTT® align with the principles of prudent healthcare[26] and a 'One Wales' agenda, Once For Wales approach. The need for asepsis, especially in the use of invasive procedures and wound management, is evidenced in the epic3 Guidelines.[9]

What is ANTT®?

The ANTT® Approach is an International Campaign designed to promote a clear understanding of asepsis and the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients/service users, healthcare professionals and healthcare organisations, to actively promote the essential '6 Actions for Safe Aseptic Technique' (Appendix 4).

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The ANTT® Practice Framework was originated by Stephen Rowley (2001),[15] and is defined as, *'A specific type of aseptic technique with a unique theoretical and clinical practice framework'*.[15]

The framework is applicable to all non-invasive and invasive clinical procedures including major surgery, the insertion and maintenance of indwelling medical devices, wound management and all primary, community and out of hospital-based care that requires aseptic practice.

ANTT® Practice Framework developments and dissemination are overseen by The Association for Safe Aseptic Practice (ASAP), a non-profit non-governmental organisation (NGO). The ASAP is working in partnership with NHS Wales and Public Health Wales to standardise aseptic technique across as a national standard and provides Welsh healthcare staff with updates to all ANTT® resources as they are reviewed and developed. The current resources and full ANTT® can be found following this link ANTT - Public Health Wales A summarised version is given in Rowley et al (2010).[16]

ASAP can be contacted for on-going support on practice and implementation issues via www.antt.org.

2. Purpose

The purpose of this national model policy is to support the implementation of the ANTT® practice framework to enable standardisation of technique and 'practice language' for all aseptic procedures. ANTT® must be embedded into every day clinical procedures as part of a robust commitment to reducing the risks of HCAI and need for antimicrobial prescribing to improve patient safety. Welsh Government set HCAI annual reduction expectations for *Clostridioides difficile*, *Staphylococcus aureus* bacteraemia and Gram-negative bacteraemia as well as expectations for antimicrobial prescribing. These expectations align to the ambitions outlined in the addendum to the 5 year UK National Action Plan (NAP) and the 20 year vision to achieve future reductions that include positively impacting on MRSA, MSSA Blood Stream Infections (BSI), Urinary Tract and Surgical Site Infection (SSI) rates. Compliance with ANTT® supports Health Boards/Trusts in reducing these and other HCAI's whilst improving patient experience and outcomes.

3. Aims and Objectives

This model policy provides a widely adopted evidence-based framework for establishing ANTT® as the safe and effective technique for all aseptic procedures in healthcare organisations across Wales.

Objectives are:

- To identify the role of ANTT® in the reduction of HCAI
- To identify key roles and responsibilities in ANTT® implementation

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- To describe the implementation and uses of ANTT®
- To identify the principles of ANTT® and its application to practice
- To outline the requirements for learning and competency assessment for staff undertaking clinical aseptic procedures
- Provide resources and toolkit to support ANTT® in practice
- To be relevant in acute, community and primary care settings, including emergency out of hospital care

4. Scope of the Policy

This model policy is applicable in all settings that provide healthcare to patients and/or service users and to all healthcare workers (HCW) who perform a clinical procedure that requires an aseptic technique.

5. Roles and Responsibilities within Organisations

The Board and Chief Executive Officer (CEO) has ultimate responsibility for Infection Prevention and Control within Health Boards and NHS Trusts. This responsibility, together with responsibility for ANTT® is delegated to the Executive Team under the leadership of the Executive Director of Nursing.

5.1 The Executive Director of Nursing

- Has overall responsibility to ensure that ANTT® is fully implemented and effectively sustained within their organisation[19,20]
- Will ensure that this and local ANTT® policy/procedures are adhered to
- Will nominate an organisational lead for ANTT®
- Will review progress and report to the Board on ANTT® implementation and maintaining compliance in all groups of HCW's
- Will ensure there are adequate financial resource

The operational and professional responsibility lies with the individual performing the procedure.

5.2 Senior Clinical Leads, Departmental and Nurse Managers will

- Be responsible for the effective implementation and monitoring of compliance with ANTT®, ensuring appropriate action is taken when staff fail to comply with policy and required training
- Identify an ANTT® lead and key trainers and assessors for their area of responsibility
- Ensure additional resources and/or equipment is available to facilitate the HCW undertaking the theory and practice of ANTT®
- Facilitate completion of the All-Wales e-learning programme for ANTT® by all HCWs involved in aseptic procedures e.g., protected work time and access to a computer
- Facilitate completion of competency assessment for all HCWs undertaking any type of aseptic procedure
- Monitor and report on competency level of the team and report to the appropriate risk committee

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- Support HCWs in achieving compliance with all statutory and mandatory training, including Standard Infection Prevention and Control Precaution (SICP) mandatory training
- Bring this model policy to the attention of all health professionals or workers involved in ANTT® including educational and specialist roles
- Embed ANTT® into routine aseptic practice and all teaching of clinical procedures that require asepsis

5.3 Healthcare Workers (HCWs) will

- Have a responsibility to be familiar with NIPCM policies[2] and adhere to this model policy and other relevant local IPC policies to reduce the risk of transmission of infection
- Always act in the patients' best interest
- Perform invasive and other procedures in accordance with the principles and process of ANTT® (appendices 2-5) and this policy.
- Take personal responsibility for attendance at mandatory training or completion of relevant e-learning and act in accordance with the Welsh Code of Practice for the Prevention and Control of Healthcare Associated Infections[18] in Wales
- Be accountable for their practice in accordance with their job description and professional codes of conduct, for example, NMC The Code - The Nursing and Midwifery Council[12] and GMC Good Medical Practice[8]
- Undertake the required ANTT® training and competency assessment if performing any aseptic clinical procedures
- Embed ANTT® into all aseptic practice

5.4 Primary and Community Care Healthcare Staff, including Welsh Ambulance NHS Trust (WAST)

In any out of hospital care settings (e.g., Community Nursing, Primary Care, Long Term Care Facilities, Welsh Ambulance Service) there may be challenges in the application of ANTT® principles relating to equipment and the environment. A local risk assessment (Appendix 7) should be undertaken to assess how the principles can be adopted and any adaption (if necessary) should be documented, minimising patient risk. Resources to assist with this risk assessment are available within the ANTT Framework on Public Health Wales website ANTT Framework.

Whilst recognising the application of ANTT® in challenging situations, it is still possible to aim to minimise patient risk by applying ANTT® '4 Actions for Safe Aseptic Technique' (Appendix 3). Tools and resources specific to community settings and ambulance staff can be accessed via this link Appendix 6 provides an example template for 'Ambulance Peripheral Cannulation Guideline'.
See also 8.6 – Emergency ANTT®

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ANTT® principles will be applied and adapted to the management of chronic wounds. While it is recognised some chronic wound procedures e.g., leg

ulcer cleansing and dressing in a patients' own home, can be simplified, the aim is always asepsis, with the aim being not to introduce any further microorganisms into the wound. Guidance should be sought from the Tissue Viability Nurse on aspects that do require ANTT®.

5.5 Consultant Medical Staff will

- Undertake the required ANTT® training and competency assessment
- Be competent and keep your professional knowledge and skills up to date
- Comply with the Good Medical Practice Framework.[8] GMC Good medical practice
- Be responsible for ensuring their junior doctors and teams adhere to and embed the principles of ANTT® and undertake the required training and competency assessment

5.6 Infection Prevention and Control Team (IPCT), Tissue Viability Nurse (TVN), Continence Teams and Intravenous Access Teams

These specialist teams will participate in the National ANTT® Steering Group supporting ANTT® rollout across Wales. They have a pivotal role in assisting relevant organisational teams to coordinate ANTT® implementation, ensure training in their specialist fields conforms to ANTT principles as well as risk-management and evaluating effectiveness of its use.

The IPCT will:

- Provide expert advice in accordance with this policy
- Support managers and staff with the implementation of ANTT®
- Provide information, advice, and training to enable managers and users to undertake necessary risk assessment
- Support investigations in areas with specific risk to advise on safe practice
- Ensure local or adapted procedures/policy remains consistent with the evidence-base for safe practice and review/update local policy and procedures at least every 3 years
- Identify areas for improvement and report to Infection Prevention and Control Managers, local Infection Prevention and Control Committee, and local Clinical Risk or Patient Safety, Health and Safety and national groups
- Support education and training programme for ANTT® across primary and secondary care
- Report any impact of compliance identified during investigations related to an HCAI, in line with Duty of Quality and Duty of Candour. [29, 30] Assurance around shared learning from such investigation will be reported to the relevant governance, quality, and safety groups.

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5.7 Nominated ANTT® Lead will

- Provide local leadership for the roll-out of ANTT®

- Participate in PHW-led all-Wales ANTT® Steering Group to enable sharing of best practice from and within their organisation
- Provide guidance to their organisation on future developments, e.g., primary care roll out, updated resources, standardised packs
- Ensure that all local training, policies, procedures, and guidelines are ANTT® compliant

5.8 Nominated Key-Trainers/Facilitators from each clinical area or professional group will:

- Facilitate completion of All Wales ANTT® e-learning training by all HCWs involved in aseptic processes
- Provide supplementary electronic/paper ANTT® training and competency assessment to relevant staff within their department
- Keep accurate records of staff trained
- Instil a culture for asepsis and of ANTT® practice across their clinical area/professional group
- Ensure compliance with ANTT® practice is achieved, challenging unsafe practice appropriately
- Maintain own compliance with ANTT® competence and practice
- Identify and support additional resources needed for compliance with ANTT® key principles
- Identify and address challenges and share areas of good practice via the Quality, Safety and Experience structures

5.9 Procurement Leads

Prior to purchase of any re-usable patient equipment, discussion must take place with manufacturers, local infection prevention and control leads, and local decontamination leads, where applicable, to ensure that such items can be safely decontaminated within the organisation. Equipment in use is required to facilitate ANTT® e.g., insertion packs, trays, trolleys. These should be made readily available and accessible across the organisation. There should be rationalisation and standardisation of equipment choices across Wales to help reduce practice variation in aseptic technique.

5.10 Higher Education Institutes (HEI):

Universities across Wales will work to standardise their curriculum regarding teaching and learning competencies in ANTT® for all healthcare professional students e.g., nursing, medical, podiatry, paramedics, and allied health in respect of ANTT®, at the point of registration.

6. Implementation of ANTT®

The implementation of ANTT® will require:

- Executive level commitment
- A robust ANTT® training and assessment programme
- Equipment and appropriate resources
- Raising ANTT® awareness across the whole organisation
- A locally agreed ANTT® audit programme

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- External audit programme, as agreed with ASAP and HARP, PHW
- Robust monitoring and recording processes for compliance
- Key reporting mechanisms on impact or harm

6.1 ANTT® Accreditation for Healthcare Providers:

ANTT Accreditation Guide 2023 (PHW NHS. Wales) overseen freely by ASAP, provides healthcare organisations with a mechanism to demonstrate effective clinical governance for aseptic technique, and commitment to infection prevention and patient safety. This can be useful to demonstrate an organisations hard work in infection prevention to external regulators, patients/service users, and the public.

There are three levels of accreditation: Bronze, Silver, and Gold.

- ANTT Bronze Accreditation Workbook
- ANTT Silver Accreditation Workbook
- ANTT Gold Accreditation Workbook

Accreditation criteria is based upon the following pre-requisites for safe and best practice:

- ANTT® Policy
- ANTT® Education
- ANTT® Assessment
- ANTT® Monitoring

For support with ANTT® Accreditation please contact enquiries@antt.org

7. Training:

Wales commenced ANTT® programme roll out in June 2015(WHC/2015/026) [19] Substantial progress has been made across Wales despite limited resources to support this; however, all organisations are required to continue to aim for 100% compliance for those who will be performing procedures (regardless of job title) requiring the principles of aseptic technique.

As new employees join the organisation, compliance with ANTT® should be mandated as part of their induction programme.

Priority for training should be given to staff working within augmented care units, staff carrying out invasive procedures, and all new employees.

Professional registrants must recognise their accountability in accordance with their own code of conduct,[8,12] e.g. The Code (Nursing and Midwifery Council 2015)[12] states that nurses must have a good knowledge base before performing any clinical procedure, should be trained appropriately, and have achieved competency within their clinical area. The General Medical Council (Good medical practice-English 2014 (gmc-uk.org))[8] states that doctors must recognise and work within the limits of their competence, provide good standards of practice of care and keep professional knowledge and skills up to date.

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- All HCWs across Wales who are involved in aseptic procedures will complete the nationally agreed ANTT® training in the principles and theory for ANTT® prior to competency assessment i.e., current e-learning module at learning@ NHS Wales: https://learning.wales.nhs.uk/
- ANTT® will also be taught locally within departments by means of trained key-trainers/facilitators/assessors, using ANTT® resources: ANTT resources (antt.org) within an implementation framework set out by the local organisation
- All taught procedures involving asepsis will be undertaken using ANTT®
- All HCWs performing ANTT® must be assessed as competent in the application of ANTT® utilising either the Standard ANTT® Competency Assessment tool (CAT) Standard CAT v1.5 or the Surgical Assessment tool Surgical CAT v2
- It is recommended that ANTT® competency assessment should be undertaken within 3 months of completing the ANTT® e-learning programme
- HCW's performing aseptic procedures must maintain their ANTT® competency with at least three-yearly practical competency assessment, monitored via local annual appraisal process and entered to ESR
- HCW's have an individual responsibility to ensure their competencies are maintained and must inform their line manager of any obstacles preventing them to achieve this, or lapse in competency
- Should a HCW change specialties or commence a new post within the HB/Trust requiring competence in different skill sets, the need for further ANTT® training/assessment must be risk assessed and agreed with their line manager. Advice can be sought from the local ANTT® Lead

For staff who are unable to access ANTT® eLearning programmes through either ESR or Learning@Wales, arrangements need to be made for electronic/paper educational resources, which must include the main principles of ANTT®.

It is acknowledged there remains a period of time when not all staff performing aseptic technique will have undergone the appropriate training and assessment in ANTT®. Therefore, existing aseptic practice skills, may be used to ensure service delivery is not affected, following individual local risk assessment with intention of becoming compliant as soon as practically possible.

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8. Important basic infection prevention practice for aseptic technique:

This resource is not intended as a comprehensive educational tool, however, as well as providing an outline of the ANTT® Framework (see

appendix 9), some important general aspects of aseptic technique are outlined below.

8.1. Use of Standard Infection Prevention and Control Precautions (SIPCP) such as hand hygiene:

A pre-requisite to safe ANTT® is compliance with standard infection control precautions (SICP's):

SICPs should be performed in line with epic3 Guidelines[9] and the Scottish National Infection Prevention and Control Manual (NIPCM)[2] which is the resource adopted for use for healthcare in Wales. The 10 elements of SICP are:

- Patient Placement
- Hand Hygiene
- Respiratory cough and Hygiene
- Personal Protective Equipment
- Safe management of care equipment
- Safe management of care environment
- Safe management of linen
- Safe management of blood and body fluid spillages
- Safe disposal of waste
- Occupational safety: Prevention and Exposure management (e.g., sharps)

Key elements related to ANTT practice are hand hygiene, safe care of equipment and the environment, appropriate safe use of PPE and waste disposal.

8.2. Hand Hygiene

Hand hygiene is the single most effective way of preventing HCAI and cross infection from direct and indirect contact.[2,9,21] It is essential that hands are effectively decontaminated in accordance with the World Health Organisation (WHO) "MY five Moments of Hand Hygiene"[21] WHO SAVE LIVES Clean **YOUR** Hands. Technical Reference Manuel 2009 prior to, during (as required) and after all aseptic procedures are performed.

8.3. Use of personal protective equipment (PPE)

Gloves and other PPE provide a barrier between microorganisms on hands, clothing, and the susceptible sites but must be used in conjunction with good hand hygiene and donning and doffing technique.

Gloves use for ANTT:

- Must be donned and used as intended, changed at appropriate frequency and between procedures, and removed with care to prevent shedding or spreading of microorganisms
- Are **non-sterile** gloves for Standard-ANTT® procedures e.g., preparing and delivering intravenous medication, attaching

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parenteral nutrition, venepuncture, and cannulation, as per local policies
- Are **Sterile** gloves for Surgical ANTT® procedures such as surgery, urinary catheterisation, or central venous catheter insertion

Aprons and Other PPE (aprons, gowns, masks, face protection) should be worn according to NIPCM and associated infection.

8.4. Environmental / Air contamination

Airborne particles in the clinical space will contain a range of microorganisms including those from the patient/service user, staff, and other sources. These have increasingly been shown to present a risk of transmission of a range of infections. Sensible precautions can be taken to reduce the risk of particle contamination of the aseptic site during ANTT procedures including:

- Preparation of drugs to be undertaken in an appropriate designated area away from the bedside and sink
- Where available, ANTT procedures i.e., changing of wound dressings, insertion of medical devices should be undertaken in a dedicated fit for purpose treatment/dressing/examination room away from the patients' bed area
- Do not undertake ANTT® when air particle movement levels are likely to be at their highest e.g., ward/department cleaning, adjacent to portable electric fans or close to open windows or building refurbishment
- Do not undertake ANTT® following recent bed making or patient undressing/dressing
- Advise patient of cough/sneeze etiquette e.g., use of tissues

8.5. Pre-requisite support of effective aseptic technique

The risk of microbiological contamination during ANTT® procedures can be reduced by important pre-requisite measures including:
- Effective environmental cleaning
- Safe storage of procedure equipment
- Compliance with decontamination procedures and policies
- Ergonomically designed clinical preparation areas
- Rationalisation and standardisation of procedure and equipment choices e.g., procedure packs, trays

8.6. Emergency ANTT

For WAST frontline emergency staff, including advanced paramedic practitioners, paramedics, advanced technicians, technicians, urgent care services staff, sub-contracted emergency staff, non-NHS organisations, Bank, and agency frontline staff.

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The use of ANTT® is widespread within acute hospitals, yet ANTT's simple but robust practice principles are equally effective in the most challenging

and emergency situations and environments. Emergency life-saving time-critical procedures undertaken in the out of hospital environment justify reason for reduced compliance with all the principles of ANTT® and therefore Emergency ANTT® is the pragmatic approach to ANTT®, focusing specifically on:

- What is possible to deliver at that moment
- Prioritise the points at which 'Key-Parts' and 'Key-Sites' interact (the moments microbes can transfer)
- Dynamic risk assessment to determine preparation steps, and if they cannot be delivered, the most essential components of aseptic technique are prioritised first
- Recording the ANTT applied during the procedure e.g., Standard, emergency, surgical

The intention is not to dilute ANTT® or reduce standards, but to focus the practitioners' attention to the most important elements of safe practice first, in relation to time, setting and equipment permitting.

Emergency ANTT® should only be selected following risk assessment of the situation, for example: 'Do I have the time, the equipment, and the environment to apply Standard or Surgical ANTT?'
If the answer is 'yes' – use Standard or Surgical ANTT
If the answer is 'no' – use Emergency ANTT

It is important for the practitioner to document and handover when emergency ANTT is used and clarify if asepsis was maintained or compromised due to the 'emergency' situation. WAST have introduced the ANTT coded colour labels, which will be applied to any invasive procedures performed to alert receiving staff of ANTT procedures used (see Appendix 7).

9. ANTT Resources

9.1. ANTT® Procedure Guidelines

These simple picture-based procedure guidelines are a highly effective way for the organisation to make practice expectancy explicit, setting out procedure sequence and equipment. They should be displayed prominently in relevant clinical areas.

9.2. ANTT Approach Educational PowerPoint

'The ANTT-Approach' is an International Campaign designed to promote the essential elements of aseptic technique. This approach is a three-way 'partnership' between patients, HCWs and healthcare organisations to actively promote the essential '6 Actions for Safe Aseptic Technique' to be used every time.

Three posters simplify this framework:

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- Patient poster – Appendix 3
- Clinical Staff Poster – Appendix 4
- ANTT® Clinical Practice Framework poster – *Appendix 5*

9.3. Steps for ANTT® procedure – see Appendix 2

10. Dissemination and Implementation

This revised and updated policy will be implemented via the following routes:

- Circulation to all Health Board/Trust Executive leads, IPCT leads, WAST leads, Primary & Community Care leads, HCAI DB
- Available via local Health Board/Trust Document library
- Available via PHW/HARP website
- Available to all HCWs via local Health Board/Trust intranet

Each Health Board/Trust is responsible for the full implementation of this revised policy and must ensure all relevant staff have access to the policy.

11. Audit and Monitoring of ANTT® Implementation

Monitoring will be undertaken through:

- The percentage of staff that have completed ANTT® theory and ANTT® Competency Assessments through ensuring records are updated centrally on ESR
- Audit observation of clinical practice and aseptic procedures
- Targeted patient feedback
- Documentation/policy review
- As part of the Improvement Cymru initiatives (Previously known as 1000 plus lives) e.g., bundle use and catheter-associated urinary tract infection (CAUTI) prevention, peripheral venous catheter (PVC) and central venous catheter (CVC) care, prevention of surgical site infection (SSI)
- Identifying impact and compliance levels of ANTT® on investigating HCAI, e.g., *Staphylococcus aureus* bacteraemia or surgical site infection (SSI), CAUTI through root cause analysis (RCA) and post-incident review (PIR)
- Annual IPC rolling programme of audit, including external audit by ASAP or ad hock audits by HARP team
- Target audit programmes, where deemed necessary following incident or outbreak
- Required changes in practice identified and actioned
- ANTT® accreditation

Any 'lessons learnt' should be shared locally and nationally across Wales to support and promote best practice.

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12. Policy Conformance / Non-Compliance

If any Health Board employee fails to comply with this policy, the matter may be dealt with in accordance with their workforce and OD polices. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances, failure to follow this policy could be considered gross misconduct.

13. Distribution

The all-Wales policy will be available on the PHW/HARP internet site and via local Health Board/Trust Intranet site. Where staff do not have access to the intranet, their line manager must ensure that they have access to a current paper copy of this policy.

14. Review

This policy will be reviewed every 2 years or if guidance changes.

15. Legislation

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended), Health and Safety Executive, L5 (6th edition) 2013. Welsh Government Health and Care Standards 201529. The 2023 Health and Social Care (Quality and Engagement) (Wales) Act 2020.[30]

16. Equality

An Equality Impact Assessment has been undertaken at an all-Wales level on completion of version 1 (July 2017), Version 2 review (June 2019) and version 3 review (December 2022) with no change required.

A Verification report has been completed for HARP, Public Health Wales to support version 3 (December 2022).

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17. References and Bibliography

1. ANTT principles: www.antt.org

2. NHS Scotland's and Wales National Infection Prevention and Control Model Policies (NIPCM) on-line: NIPCM

3. Welsh Government: Welsh Health Circular (WHC/2022/14) Issue date:01/03/22: AMR improvement goals and HCAI reduction expectations by March 2023: Primary and secondary Care Antimicrobial Prescribing Goals; *C-difficile*, *S.Aureus*, Bacteraemia and Gram Negative Bacteraemia.

4. Implementing the Aseptic Non-Touch Technique (ANTT®) clinical practice framework for aseptic technique: a pragmatic evaluation using a mixed methods approach in two London hospitals. Volume 9, Issue 1. January 2018. Journal of Infection Prevention, SAGE Journals. https://journals.sagepub.com/doi/full/10.1177/1757177417720996

5. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended). Health and safety Executive, L5 (6th edition) 2013: http://www.hse.gov.uk/pUbns/priced/l5.pdf

6. Department of Health (2009), the Health and Social Care Act (2008). Code of Practice for health and adult social care on the prevention and control of infections and related guidance. London.

7. Dougherty L. Lister S (2015) Aseptic Technique In: L Dougherty & S Lister (eds) The Royal Marsden Hospital Manual of Clinical Nursing Procedures 10. UK. Wiley-Blackwell 24th April 2020. Procedures - Royal Marsden Manual

8. General Medical Council (GMC) Good Medical Practice, Good medical practice - ethical guidance - GMC (gmc-uk.org) Good medical practice-English (gmc-uk.org)

9. Loveday H.P., Wilson J.A., Pratt R.J., Golsorkhi M., Tingle M., Bak A., Browne J., Prieto J., Wilcox M. (2014) epic 3: National Evidence - Based Guidance for Preventing Healthcare Associated Infections in NHS Hospitals in England. Journal of Hospital Infection. S1.

10. Overview | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE , last update 11 April 2019.

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11. NICE Infection prevention and control of healthcare-associated infections in primary and community care: Clinical guideline (CG139). Accessed October 2022.

12. NMC (2015) Code of Professional Practice. London. NMC. Last update: October 2022: The NMC Code:

13. Rowley, S. (2009) Improving standards of aseptic technique practice through an ANTT trust-wide implementation process: a matter of prioritisation and care. Journal of Infection Prevention, 10(1) JIP-2009 Improving standards

14. Rowley, S and Clare S (2011) ANTT: a standard approach to aseptic technique. Nursing Times; 107 :(36) Rowley, J. ANTT: 2011 a standard approach to aseptic technique | Nursing Times

15. Rowley, S (2001) Aseptic Non-Touch Technique Nursing Times. Infection Control Supplement Feb 15 97(7) p V1-V111. Aseptic non-touch technique |2001 Nursing Times

16. Rowley S, Clare S, Macqueen S, Molyneux, R (2010) ANTT v2: An updated practice framework for aseptic technique. British Journal of Nursing 2010: 19(5); S5-S11. ANTT v2: An updated practice framework for aseptic technique

17. Wales Governance e-Manual Standard 2.4 Infection Prevention and Control (IPC) and Decontamination - NHS Wales Shared Services Partnership

18. Welsh Government (May 2014). Code of Practice for the Prevention and Control of Healthcare Associated Infections Wales 2014 Code of Practice (Currently under review)

19. Code of practice for the prevention and control of healthcare associated infections (gov.wales)

20. Welsh Government: Welsh Health Circular (WHC/2015/026) 5 June 2015: Aseptic Non-Touch Technique (ANTT): Implementation of a National Standardised Approach (Welsh Government, June 2015).

21. Welsh Government: Welsh Health Circular (WHC/2015/047) 9 October 2015: Aseptic Non Touch Technique (ANTT): Implementation of a National Standardised approach- Follow-up (Welsh Government, October 2015).

22. World Health Organisation Save lives clean your hands "My Five moments" Technical reference manual ' WHO My Five moments

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23. Welsh Government: WHC/2018/020: AMR Improvement Goals & HCAI Reduction Expectations by March 2019: Primary & Secondary Care Antimicrobial Prescribing Goals; *C.difficile*, *S.aureus* bacteraemia's and Gram-negative bacteraemia. Issue date: 04/05/2018.

24. Khurana, S., Saini, S.S., Sundaram, V., Dutta, S. and Kumar, P., 2018. Reducing Healthcare-associated Infections in Neonates by Standardizing and Improving Compliance to Aseptic Non-touch Techniques: A Quality Improvement Approach. *Indian paediatrics*, *55*(9), pp.748-752. Reducing Healthcare associated Infections in Neonates

25. Aziz, A.M., 2018. Winter and the key infection prevention and control practices. *British journal of community nursing*, *23*(11), pp.530-533. Winter and the key infection prevention and control practices - PubMed (nih.gov)

26. Haesler, E., Thomas, L., Morey, P. and Barker, J., 2016. A systematic review of the literature addressing asepsis in wound management. *Wound Practice & Research: Journal of the Australian Wound Management Association*, *24*(4), p.208. Systematic Review

27. Welsh Government/Prudent health care 2019: securing health and well being for future generations

28. UK Government Tackling antimicrobial resistance 2019 to 2024: the UK's 5-year National Action Plan. Tackling antimicrobial resistance 2019 to 2024: addendum to the UK's 5-year national action plan - GOV.UK (www.gov.uk)

29. UK Government How the UK will contribute to containing and controlling antimicrobial resistance (AMR) by 2040 UK 20-year vision for antimicrobial resistance - GOV.UK (www.gov.uk)

30. Welsh Government Heath Care standards 2015 Health standards framework English (gov.wales)

31. The Health and Social Care (Quality and Engagement) (Wales) Act 2020, The Duty of Quality Statutory Guidance 2023 and The consultation document on the duty of quality | GOV.WALES

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18. APPENDICES

Appendix 1: Definitions / Glossary

Asepsis
Freedom from pathogenic material in sufficient dose to cause infection.

Aseptic field
A working area that has been rendered aseptic to reduce the risk of contamination of procedure equipment.

Aseptic Technique
A generic term and variable process for describing the precautions taken to reduce the risk of infection during invasive clinical procedures.

Aseptic Non-Touch Technique (ANTT®)
A specific type of aseptic technique with a unique theoretical and clinical practice framework (NICE 2012).

Decontamination
Removing, or killing pathogens on an item or surface to make it safe for handling, re-use or disposal by cleaning, disinfection and/or sterilisation.

Direct contact transmission
Spread of infectious agents from one person to another by direct skin-to-skin contact.

Disinfectant
A cleaning chemical used to remove infectious agents from objects and surfaces.

Disinfection
A process, for example using a chemical disinfectant, to reduce the number of infectious agents from an object or surface to a level that means they are not harmful to your health.

Hand Hygiene (HH)
HH is the single most important procedure for preventing the spread of HCAI. Effective HH is essential to ANTT® and must take place prior to and after all invasive techniques. HH applies to hand washing, antiseptic hand wash, antiseptic hand rub or surgical hand antisepsis.

Healthcare-associated Infection (HCAI)
Any infection acquired by a person as a consequence of healthcare interventions regardless of where care is delivered.

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Indirect contact transmission – The spread of infectious agents from one person to another via a contaminated object.

Invasive device – A device which penetrates the body, either through a body cavity or through the surface of the body. Central Venous Catheters (central line), Peripheral/ Arterial Lines and Urinary Catheters are examples of invasive devices.

Invasive Procedures
A medical/nursing procedure that invades (enters) the body, usually by cutting or puncturing the skin or by inserting instruments into the body cavity.

Microorganism (microbe) – Any living thing (organism) that is too small to be seen by the naked eye. Bacteria, viruses, and some parasites are microorganisms.

Mode of transmission – The way that microorganisms spread from one person to another. The main modes or routes of transmission are airborne (aerosol) transmission, droplet transmission and contact transmission.

MRSA – Strains of the infectious agent (bacterium) *Staphylococcus aureus* that are resistant to many of the antibiotics commonly used to treat infections.

Personal Protective Equipment (PPE)
Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infections e.g., disposable gloves and disposable aprons.

Spore
A form that some types of bacteria take under certain environmental conditions. Spores can survive for long periods of time and are very resistant to heat, drying and chemicals.

Sterile
Free from all live bacteria or other microorganisms.

Sterilisation
The procedure of making some object free of all germs, live bacteria, or other microorganisms (usually by heat or chemical means).

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Appendix 2: Steps to an ANTT® procedure

Step 1.	ANTT® risk assessment: Does this procedure need the ANTT® principles applied? Is a Standard or Surgical-ANTT® required? Gain patient's consent and explain procedure Draw curtains around patient or take to appropriate room
Step 2	Decontaminate hands
Step 3	Clean trolley/tray with appropriate detergent wipe Gather equipment including alcohol hand rub
Step 4	Create suitable working environment. If procedure is performed at the bedside, ensure no cleaning or bed making are ongoing within the area for at least 30 minutes. Ensure windows are closed and no fans are on
Step 5	Decontaminate hands
Step 6	Apply single use disposable apron
Step 7	If required open dressing pack/sterile drape
Step 8	Open and prepare all equipment on the tray/trolley. Keep all equipment within their packaging. Identify Key-Parts
Step 9	Decontaminate hands
Step 10	Apply gloves if required
Step 11	Perform procedure using ANTT®
Step 12	Remove gloves and aprons and other PPE
Step 13	Dispose of waste
Step 14	Decontaminate hands
Step 15	Take patient back to the bedside if required and ensure patient is comfortable
Step 16	Clean trolley/tray/environment
Step 17	Decontaminate hands

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Appendix 3: ANTT® Patient Poster

Protecting YOU Every Time with...
4 Actions for Safe Aseptic Technique

The ANTT-Approach

***Aseptic Technique** describes the measures we take to protect you from infection during invasive clinical procedures, such as surgery, insertion of medical devices and administration of intravenous medications. ANTT is a unique type of aseptic technique (NICE 2012).*

1 Hand Cleaning

We clean our hands immediately prior to commencing your procedure, and use protective equipment like gloves

2 Using Aseptic Fields

We protect procedure equipment from microorganisms by using a cleaned procedure tray and individual equipment covers or, for more complex procedures, use a sterilized drape

3 Using Non-Touch Technique

We avoid touching the 'Key-Parts' of procedure equipment & any open wound or procedure skin site. If we must touch them we wear sterilized gloves

4 Preventing Cross Infection

We remove our gloves and wash our hands immediately after we have tidied up your procedure

If you have questions or concerns about aseptic technique please ask the nurse in charge

www.antt.org

ASAP The Association for Safe Aseptic Practice

ANTT Aseptic Non Touch Technique

MRSA Action UK

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Appendix 4: ANTT® Clinical Staff Poster

ASAP The Association for Safe Aseptic Practice

ANTT Aseptic Non-Touch Technique

MRSA Action UK

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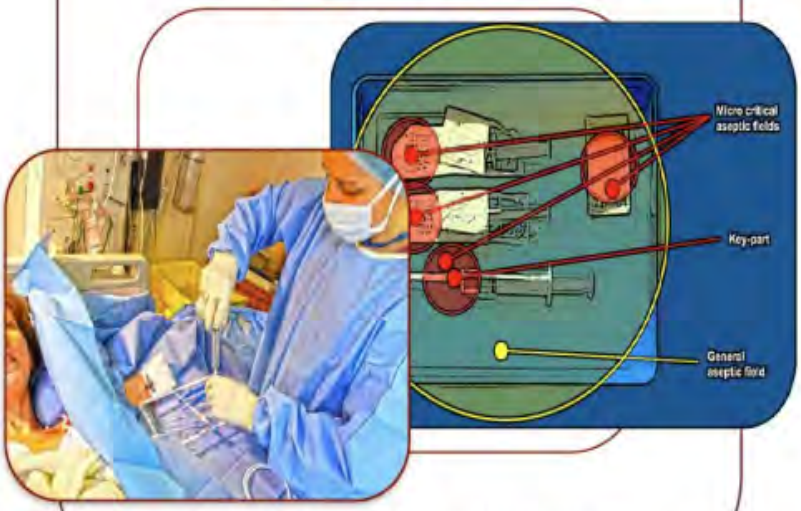
Appendix 5: ANTT® Clinical Practice Framework Poster:

ANTT®
Aseptic Non Touch Technique

www.antt.org

Aseptic Non Touch Technique
The ANTT Clinical Practice Framework
...for all invasive Clinical Procedures from Surgery to Community Care



Essential Theory Applied to Practice

First, do no harm

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Appendix 6: Example template for Ambulance Staff: Peripheral Cannulation Guideline (2017)

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Appendix 7: Emergency ANTT Risk Assessment

Emergency-ANTT® Risk Assessment

It is important that emergency ANTT® is only selected when necessary

Decided by risk assessment ...

"Do I have the time, the equipment and the environment to apply Standard or Surgical-ANTT?"

If yes – use Standard or Surgical-ANTT

If no – use **Emergency-ANTT ®**

Document and handover whether you used Emergency-ANTT® and maintained asepsis, or had to use Emergency-ANTT and may have compromised asepsis

ANTT

ANTT® ©2016 www.antt.org enquiries@antt.org

Use of colour coded labels to alert receiving healthcare staff of ANTT procedure used:

Red Label applied to the procedure site. **ANTT not performed in optimal conditions. Date.**

ANTT not performed in optimal conditions ..../..../....

Green Label applied to the procedure site. **ANTT performed in optimal conditions. Date.**

ANTT performed in optimal conditions ..../..../....

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Appendix 8: Standard Terminology

Aseptic technique is historically confused with ambiguous terms used interchangeably. The ANTT® Practice Framework defines aseptic practice explicitly:

- ***Sterile Technique***

ANTT® does not use the word "sterile" for describing technique; due to the natural multitude of organisms in the atmosphere, it is not possible to achieve a true sterile technique in any setting. The term sterilized is used to identify products and equipment that have been sterilized. However, once opened to air equipment and products are said to be aseptic.

- ***Asepsis / Aseptic technique***

The term 'asepsis' means, '*Freedom from pathogenic material in sufficient quantity to cause infection*'. It is possible to achieve asepsis in health care delivery by taking steps to reduce patient contamination. Aseptic technique is a generic term for aseptic practice and has no explicitly defined practice framework.

- ***Aseptic Non-Touch Technique (ANTT®)***

ANTT® is a specific type of aseptic technique with a unique theoretical and clinical practice framework.[10,11,12] The ANTT® Practice Framework includes a set of Principles and Safeguards that, if followed, will ensure asepsis for all types of invasive procedures 'from the operating theatre to the community setting'. It is based on a novel concept termed 'Key-Part and Key-Site Protection'.

The 'ANTT-Approach' involves a combination of methods aimed at achieving and supporting best practice aseptic technique; including the ANTT® Practice Framework, a set of ANTT® Guidelines for the most common invasive procedures and a standard implementation process.

- ***Non-Touch Technique***

Non-touch technique is not a technique in itself. It is however an important component of ANTT®.

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Appendix 9: ANTT® Practice Framework outline

This model policy is not intended as an educational tool for ANTT®. It is important that Practice Leads refer to the full ANTT® Practice Framework available on the www.antt.org or Public Health Wales on ANTT Framework
A snapshot of the framework is outlined below:

- The aim of ANTT® is always asepsis (see appendix 8)
- **Key-Parts** are the critical parts of any equipment that come into contact with Key-Sites; any liquid infusion; or with any other active Key-Parts connected to the patient via a medical device. If contaminated during a procedure, Key-Parts provide a route for the transmission of pathogens onto or into the patient and present a significant infection risk.
- **Key-Sites**: open wounds, including insertion and puncture sites for invasive medical devices.
- **There are two types of ANTT® (Surgical and Standard) determined by a simple ANTT® Risk Assessment:**
- **Standard-ANTT®** is used for procedures that are technically simple to achieve asepsis. Typically, such a procedure will be of short duration and involve few small Key-Parts and Key-Sites. In Standard-ANTT, primarily non-touch technique and individual Micro Critical Aseptic Fields protect Key-Parts.
- **Surgical-ANTT®** is required for procedures that are technically complex to achieve asepsis, are of longer duration, involve large open-sites and large or numerous Key-Parts. In contrast to Standard-ANTT, in Surgical-ANTT, Key-Parts are managed on one main Critical Aseptic Field (sterile drape) and sterile gloves are essential.
- **Aseptic Fields in ANTT®**: the type of aseptic field and how it is managed is dependent upon the type of ANTT® being utilized.

ANTT® uses three types of aseptic field:

✓ **Critical Aseptic Field:** a large sterile drape that is managed 'critically'
✓ **Micro Critical Aseptic field:** sterilized caps and covers etc. including the inside of some equipment packaging
✓ **General Aseptic Field**: A disinfected plastic tray, suitable sized single-use cardboard tray. NB: General Aseptic Fields are not relied upon to maintain asepsis. They are used to promote asepsis whilst Key-Parts within them are protected by Micro Critical Aseptic Fields. (See above).

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A pre-requisite to safe ANTT® is compliance with standard infection prevention and control precautions:

Appendix 2 – ANTT Model Policy EQIA – PHW

Equality & Health Impact Assessment for

Aseptic non touch technique (ANTT) all-Wales model Policy
1st Review – June 2019 – no amendments required.

Review July 2019 - no change required

Please note:

- The completed Equality & Health Impact Assessment (EHIA) must be
  - Included as an appendix with the cover report when the strategy, policy, plan, procedure and/or service change is submitted for approval
  - Published on the UHB intranet and internet pages as part of the consultation (if applicable) and once agreed.
- Formal consultation must be undertaken, as required
- Appendices 1-3 must be deleted prior to submission for approval

Please answer all questions:-

1.	For service change, provide the title of the Project Outline Document or Business Case and Reference Number	Not applicable – All Wales Policy document
2.	Name of Clinical Board / Corporate Directorate and title of lead member of staff, including contact details	Executive Director of Public Services (Dr Quentin Sandifer) and Executive Director of Quality Nursing & Allied Health Professionals (Rhiannon Beaumont-Wood)
3.	Objectives of policy	Objective is to provide a standardised approach to the roll out of ANTT across Wales & to provide clarity of individual and Health Board/Trust roles & responsibilities in implementing & sustaining ANTT principles to all staff who perform asepsis within their healthcare setting.

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4.	Evidence and background information considered. For example • population data • staff and service users data, as applicable • needs assessment • engagement and involvement findings • research • good practice guidelines • participant knowledge • list of stakeholders and how stakeholders have engaged in the development stages • comments from those involved in the designing and development stages Population pyramids are available from Public Health Wales Observatory and the 'Shaping Our Future Wellbeing' Strategy provides an overview of health need.	Draft policy shared with all Infection Prevention Teams and nominated ANTT leads across Wales, all members of ANTT steering group & sub group members (Primary & Community Care sub group & HEI sub group), all members of the Healthcare associated infection (HCAI) programme, PHW and Health Protection Team, PHW, during policy development from August 2016 to December 2016, all comments, where applicable & appropriate, incorporated into final draft. Draft policy shared with Stephen Rowley, Clinical Director for Association for Safe Aseptic Practice, between September 2016 & December 2016, comments received incorporated into the policy. Literature review undertaken & ANTT document review undertaken (ANTT principles provided by Stephen Rowley already available on PHW intranet site for all staff to access)
5.	Who will be affected by the policy	Public Health Wales provides this policy for use by all healthcare organizations including PHW. The policy predominantly impacts on any healthcare worker performing or being involved in any procedure that requires asepsis. In PHW this predominantly relates to Screening Services but is also applicable in other areas of the organization. The expected positive impact on patients/service user is reducing the risks of healthcare-associated infections. All healthcare staff within Wales undertaking principles of ANTT should have access to this policy, which will supplement their own local policy. This policy provides guidelines to all those involved in care provision and should be adopted, with local variations agreed, for infection prevention & control procedures. This policy is a reference for

Review July 2019 - no changes required
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		healthcare professionals across Wales and within PHW and will be applicable to those healthcare workers performing or being involved in any procedure that requires asepsis – standard or surgical. ANTT is already being rolled out across Wales, staff already have had access to ANTT principles via the Intranet since early 2016, this model policy will clarify roles & responsibilities within PHW, Welsh Health Boards/Trusts. Where PHW's services are embedded within and working in partnership with Health Boards, staff will need to comply with local policies and procedures.

Review July 2019 - no chnage to policy

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6. EQIA / How will the strategy, policy, plan, procedure and/or service impact on people?

Questions in this section relate to the impact on people on the basis of their 'protected characteristics'. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
6.1 Age For most purposes, the main categories are: • under 18; • between 18 and 65; and • over 65	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Potential positive impact is reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.2 Persons with a disability as defined in the Equality Act 2010 Those with physical impairments, learning disability, sensory loss or	The policy should not have an impact on disability. Consent should be sought from the service user or the authorised guardian after full explanation	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
impairment, mental health conditions, long-term medical conditions such as diabetes	of the need/procedure. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Potential positive impact is reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.3 People of different genders: Consider men, women, people undergoing gender reassignment **NB** Gender-reassignment is anyone who proposes to, starts, is going through or who has completed a process to change his or her gender with or without going through any medical	Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups and all genders receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
procedures. Sometimes referred to as Trans or Transgender			
6.4 People who are married or who have a civil partner.	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.5 Women who are expecting a baby, who are on a break from work after having a baby, or who are breastfeeding.	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive	All healthcare staff to have completed ANTT e learning & practical assessment & be	

Webber, Jane
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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
They are protected for 26 weeks after having a baby whether or not they are on maternity leave.	procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.6 People of a different race, nationality, colour, culture or ethnic origin including non-English speakers, gypsies/travellers, migrant workers	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	

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Review May 2019 - no change

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	associated infection for all age groups receiving care requiring asepsis		
6.7 People with a religion or belief or with no religion or belief. The term 'religion' includes a religious or philosophical belief	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.8 People who are attracted to other people of: • the opposite sex (heterosexual);	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
• the same sex (lesbian or gay); • both sexes (bisexual)	higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.9 People who communicate using the Welsh language in terms of correspondence, information leaflets, or service plans and design Well-being Goal – A Wales of vibrant culture and thriving Welsh language	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
	groups receiving care requiring asepsis		
6.10 People according to their income related group: Consider people on low income, economically inactive, unemployed/workless, people who are unable to work due to ill-health	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	
6.11 People according to where they live: Consider people living in areas known to exhibit poor economic and/or health indicators, people unable to access	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate. Make reference to where the mitigation is included in the document, as appropriate
services and facilities	asepsis is poor or inadequate.		
6.12 Consider any other groups and risk factors relevant to this strategy, policy, plan, procedure and/or service	The policy should impact equally on all. There is a risk of infection to anyone who is undergoing any invasive procedure, the risk being higher for those where asepsis is poor or inadequate. Expected positive impact is improvement in healthcare worker skills in performing aseptic procedures with reduced risk of healthcare-associated infection for all age groups receiving care requiring asepsis	All healthcare staff to have completed ANTT e learning & practical assessment & be competent in performing ANTT. Individual Health Boards/Trusts & PHW team to ensure adequate training & support tools available to achieve this.	

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7. HIA / How will the policy impact on the health and well-being of our population and help address inequalities in health?

Questions in this section relate to the impact on the overall health of individual people and on the impact on our population. Specific alignment with the 7 goals of the Well-being of Future Generations (Wales) Act 2015 is included against the relevant sections.

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
7.1 People being able to access the service offered: Consider access for those living in areas of deprivation and/or those experiencing health inequalities Well-being Goal - A more equal Wales	Policy is for healthcare workers to access & will be widely available on PHW intranet & local organisations' website.	Paper copies should be provided to any healthcare organisations or staff groups within Wales who do not have access to the intranet.	
7.2 People being able to improve /maintain healthy lifestyles: Consider the impact on healthy lifestyles, including healthy eating, being active, no smoking /smoking cessation, reducing the	Compliance with ANTT principles is considered to have a direct influence the risk of and reduction of healthcare-associated infections and therefore will reduce the spread of infection and reduce the risk		

Webber, Jayne
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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
harm caused by alcohol and /or non-prescribed drugs plus access to services that support disease prevention (eg immunisation and vaccination, falls prevention). Also consider impact on access to supportive services including smoking cessation services, weight management services etc Well-being Goal – A healthier Wales	of potential patient harm.		
7.3 People in terms of their income and employment status: Consider the impact on the availability and accessibility of work, paid/ unpaid employment, wage levels, job security, working	Healthcare-associated infections can potentially mean patients/clients have to take time off work due to their extended illness and/or treatment regime, which can potentially impact on their income.		

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
conditions Well-being Goal – A prosperous Wales			
7.4 People in terms of their use of the physical environment: Consider the impact on the availability and accessibility of transport, healthy food, leisure activities, green spaces; of the design of the built environment on the physical and mental health of patients, staff and visitors; on air quality, exposure to pollutants; safety of neighbourhoods, exposure to crime; road safety and preventing injuries/accidents; quality and safety of play areas and open spaces Well-being Goal – A resilient	Principles of ANTT can be performed by the healthcare worker appropriately within any healthcare setting/environment with local adaptations. In emergency situations and patients own home environment it may not ba possible to achieve the same quality of asepsis as would be expected in a healthcare setting, however, the principles of ANTT will be applied	Local risk assessment, where applicable, to ensure best practice is delivered within constraints of the environment	

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How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
Wales			
7.5 People in terms of social and community influences on their health: Consider the impact on family organisation and roles; social support and social networks; neighbourliness and sense of belonging; social isolation; peer pressure; community identity; cultural and spiritual ethos Well-being Goal – A Wales of cohesive communities	When people are unwell and diagnosed with an infection this can potentially lead to patient isolation when within a healthcare setting, which for some patients can make them feel isolated from the rest of the ward. This may also impact on people within their community if they are perceived to have a transmissible infection, for example, MRSA.		
7.6 People in terms of macro-economic, environmental and sustainability factors: Consider the impact of government policies; gross domestic product; economic development; biological	ANTT roll out is a Welsh Government directive. Supports the Future Generations Act ie being responsible and looking after future generations		

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Review July 2019 - no chnage rec

How will the strategy, policy, plan, procedure and/or service impact on:-	Potential positive and/or negative impacts and any particular groups affected	Recommendations for improvement/ mitigation	Action taken by Clinical Board / Corporate Directorate Make reference to where the mitigation is included in the document, as appropriate
diversity; climate Well-being Goal – A globally responsible Wales			

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Please answer question 8.1 following the completion of the EHIA and complete the action plan

8.1 Please summarise the potential positive and/or negative impacts of the strategy, policy, plan or service	Positive impact is improved compliance with principles of asepsis and delivery of ANTT which will reduce the risk of healthcare-associated infections. No negative impact on individuals or population. The impact will be for Health Boards and Trusts in relation to the time required to release staff to be trained.

Action Plan for Mitigation / Improvement and Implementation

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.2 What are the key actions identified as a result of completing the EHIA?	Training to be rolled out across Wales. Each organisation responsible for the trinaing of its own staff. Within Public Health Wales the training will be undertaken by identified key trainers, supported by designated ANTT lead within each Health Board/Trust and Infection Prevention Team	Health Board/Trust designated ANTT lead and Infection Prevention Team lead	Each Health Board/Trust to set timescale locally via individually-agreed ANTT roll-out programme.	Endorsed by Executive Team and ultimately the Board as an all Wales policy

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Review on 2024 - Change required

	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate
8.3 Is a more comprehensive Equalities Impact Assessment or Health Impact Assessment required? This means thinking about relevance and proportionality to the Equality Act and asking: is the impact significant enough that a more formal and full consultation is required?	No			

Review July 2019 - no chnage requir

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	Action	Lead	Timescale	Action taken by Clinical Board / Corporate Directorate

8.4 What are the next steps?
 	
Some suggestions:-
• Decide whether the strate policy, plan, procedure and/or service proposal:
  ○ continues unchanged as there are no significant negative impacts
  ○ adjusts to account for the negative impacts
  ○ continues despite potential for adverse impact or missed opportunities to advance equality (set out the justifications for doing so)
  ○ stops.
• Have your strategy, policy, plan, procedure and/or service proposal approved
• Publish your report of this impact assessment
• Monitor and review
	Policy continues unchanged to the Executive Team via a formal consultation process.	Chris Jeffrey	March 2017	

Review July 2019 - no chnage requ

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Appendix 1

Equality & Health Impact Assessment

Developing strategies, policies, plans and services that reflect our Vision to 'create a healthier, happier and fairer Wales'

Guidance

The Public Health Wales strategy (Integrated Medium Term Plan) 'Creating a healthier, happier and fairer Wales for everyone' (2016-2019) outlines how we exist to protect and improve health and wellbeing and reduce health inequalities for people in Wales. Our population has varied and diverse needs with some of our communities and population groups requiring additional consideration and support. With this in mind, when developing or reviewing any strategies, policies, plans, procedures or services it will be required that the following issues are explicitly included and addressed from the outset:-

- Equitable access to services
- Service delivery that addresses health inequalities
- Sustainability and how the UHB is meeting the requirements of the Well-being of Future Generations (Wales) Act (2015)[1]

This explicit consideration of the above will apply to strategies, policies, plans, procedures and services /activity.

Considering and completing the Equality & Health Impact Assessment (EHIA) in parallel with development stages will ensure that all organisational strategies, policies, plans, procedures or services comply with relevant statutory obligations and responsibilities and at the same time takes forward the organisation's Vision, plan and its strategic priorities. This process should be proportionate but still provide helpful and robust information to support decision making. Where a more detailed consideration of an issue is required, the Integrated Screening Tool will identify if there is a need for a full impact assessment.

[1] http://thewaleswewant.co.uk/about/well-being-future-generations-wales-act-2015

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Review July 2019 - no amend required

Some key statutory/mandatory requirements that strategies, policies, plans, procedures and services must reflect include:

- All Wales Standards for Communication and Information for People with Sensory Loss (2014)[2]
- Equality Act 2010[3]
- Well-being of Future Generations (Wales) Act 2015[4]
- Social Services and Well-being (Wales) Act 2015[5]
- Health Impact Assessment (non statutory but good practice)[6]
- The Human Rights Act 1998[7]
- United Nations Convention on the Rights of the Child 1989[8]
- United Nations Convention on Rights of Persons with Disabilities 2009[9]
- United Nations Principles for Older Persons 1991[10]
- Welsh Health Circular (2015) NHS Wales Infrastructure Investment Guidance[11]
- Welsh Government Health & Care Standards 2015[12]
- Welsh Language (Wales) Measure 2011[13]

This EHIA allows us to meet the requirements of the above as part of an integrated impact assessment method that brings together Equality Impact Assessment (EQIA) and Health Impact Assessment (HIA). A number of statutory /mandatory requirements will need to be included and failure to comply with these requirements, or demonstrate due regard, can expose the organisation to legal challenge or other forms of reproach. This means showing due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation;
- advance equality of opportunity between different groups; and
- foster good relations between different groups.

[2] http://gov.wales/topics/health/publications/health/guidance/standards/?lang=en
[3] https://www.gov.uk/guidance/equality-act-2010-guidance
[4] http://gov.wales/topics/people-and-communities/people/future-generations-act/?lang=en
[5] http://gov.wales/topics/health/socialcare/act/?lang=en
[6] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782
[7] https://www.equalityhumanrights.com/en/human-rights/human-rights-act
[8] http://www.unicef.org.uk/UNICEFs-Work/UN-Convention
[9] http://www.un.org/disabilities/convention/conventionfull.shtml
[10] http://www.ohchr.org/EN/ProfessionalInterest/Pages/OlderPersons.aspx
[11] http://www.wales.nhs.uk/sites3/Documents/254/WHC-2015-012%20-%20English%20Version.pdf
[12] http://gov.wales/topics/health/publications/health/guidance/care-standards/?lang=en
[13] http://www.legislation.gov.uk/mwa/2011/1/contents/enacted

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EQIAs assess whether a proposed policy, procedure, service change or plan will affect people differently on the basis of their 'protected characteristics' (ie their age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion, sex or sexual orientation) and if it will affect their human rights. It also takes account of caring responsibilities and Welsh Language issues.
They provide a systematic way of ensuring that legal obligations are met and are a practical means of examining new and existing policies and practices to determine what impact they may have on equality for those affected by the outcomes.

HIAs assess the potential impact of any change or amendment to a policy, service, plan, procedure or programme on the health of the population and on the distribution of those effects within the population, particularly within vulnerable groups. HIAs help identify how people may be affected differently on the basis of where they live and potential impacts on health inequalities and health equity. HIA increases understanding of potential health impacts on those living in the most deprived communities, improves service delivery to ensure that those with the greatest health needs receive a larger proportion of attention and highlights gaps and barriers in services.

The **EHIA** brings together both impact assessments in to a single tool and helps to assess the impact of the strategy, policy, plan, procedure and/or service. Using the EHIA from the outset and during development stages will help identify those most affected by the proposed revisions or changes and inform plans for engagement and co-production. Engaging with those most affected and co-producing any changes or revisions will result in a set of recommendations to mitigate negative, and enhance positive impacts. Throughout the assessment, 'health' is not restricted to medical conditions but includes the wide range of influences on people's well-being including, but not limited to, experience of discrimination, access to transport, education, housing quality and employment.

Throughout the development of the strategy, policy, plan, procedure or service, in addition to the questions in the EHIA, you are required to remember our values of *care, trust, respect, personal responsibility, integrity and kindness* and to take the Human Rights Act 1998 into account. All NHS organisations have a duty to act compatibly with and to

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respect, protect and fulfil the rights set out in the Human Rights Act. Further detail on the Act is available in Appendix 2.

Completion of the EHIA should be an iterative process and commenced as soon as you begin to develop a strategy, policy, plan, procedure and/or service proposal and used again as the work progresses to keep informing you of those most affected and to inform mitigating actions. It should be led by the individual responsible for the strategy, policy, plan, procedure and/or service and be completed with relevant others or as part of a facilitated session. Some useful tips are included in Appendix 3.

For further information please contact Andrew Richardson, Corporate Governance Manager (andrew.richardson2@wales.nhs.uk) or Heather Ramessur-Marsden, Interim Equality Lead (heather.ramessur-marsden@wales.nhs.uk).

Based on

- Cardiff Council (2013) Statutory Screening Tool Guidance
- NHS Scotland (2011) Health Inequalities Impact Assessment: An approach to fair and effective policy making. Guidance, tools and templates[14]
- Wales Health Impact Assessment Support Unit (2012) Health Impact Assessment: A Practical Guide[15]

[14] http://www.healthscotland.com/uploads/documents/5563-HIIA%20-%20An%20approach%20to%20fair%20and%20effective%20policy%20making.pdf (accessed 4 January 2016)
[15] http://www.wales.nhs.uk/sites3/page.cfm?orgid=522&pid=63782 (accessed on 4 January 2016)

Review July 2019 no chnage required

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Appendix 2 – The Human Rights Act 1998[16]

The Act sets out our human rights in a series of 'Articles'. Each Article deals with a different right. These are all taken from the European Convention on Human Rights and are commonly known as 'the Convention Rights':

1. Article 2 Right to life. NHS examples: the protection and promotion of the safety and welfare of patients and staff
2. Article 3 Freedom from torture and inhuman or degrading treatment. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, issues of patient restraint and control
3. Article 4 Freedom from slavery and forced labour
4. Article 5 Right to liberty and security. NHS examples: issues of patient choice, control, empowerment and independence, issues of patient restraint and control
5. Article 6 Right to a fair trial
6. Article 7 No punishment without law
7. Article 8 Respect for your private and family life, home and correspondence. NHS examples: issues of dignity and privacy, the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers, the right of a patient or employee to enjoy their family and/or private life
8. Article 9 Freedom of thought, belief and religion. NHS examples: the protection and promotion of the safety and welfare of patients and staff, the treatment of vulnerable groups or groups that may experience social exclusion, for example, gypsies and travelers
9. Article 10 Freedom of expression. NHS examples: the right to hold and express opinions and to receive and impart information and ideas to others, procedures around whistle-blowing when informing on improper practices of employers where it is a protected disclosure
10. Article 11 Freedom of assembly and association
11. Article 12 Right to marry and start a family
12. Article 14 Protection from discrimination in respect of these rights and freedoms. NHS examples: refusal of medical treatment to an older person solely because of their age, patients presented with health options without the use of an interpreter to meet need, discrimination against UHB staff on the basis of their caring responsibilities at home
13. Protocol 1, Article 1 Right to peaceful enjoyment of your property

[16] https://www.equalityhumanrights.com/en/human-rights/human-rights-act

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14. Protocol 1, Article 2 Right to education
15. Protocol 1, Article 3 Right to participate in free elections
16. Protocol 13, Article 1 Abolition of the death penalty

Review July 2019 - no chnage required

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Appendix 3

Tips

- Be clear about the policy or decision's rationale, objectives, delivery method and stakeholders.
- Work through the Toolkit early in the design and development stages and make use of it as the work progresses to inform you of those most affected and inform mitigating actions
- Allow adequate time to complete the Equality Health Impact Assessment
- Identify what data you already have and what are the gaps.
- Engage with stakeholders and those most affected early. View them as active partners rather than passive recipients of your services.
- Remember to consider the impact of your decisions on your staff as well as the public.
- Record which organisations and protected characteristic groups you engaged with, when you engaged with them and how you did so (for example, workshop, public meeting, written submission).
- Produce a summary table describing the issues affecting each protected group and what the potential mitigations are.
- Report on positive impacts as well as negative ones.
- Remember what the Equality Act says – how can this policy or decision help foster good relations between different groups?
- Do it with other people! Talk to colleagues, bounce ideas, seek views and opinions.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

MANAGEMENT OF SAFETY ALERTS AND IMPORTANT NOTIFICATION POLICY (Reference QS02)

DATE OF MEETING	12th September 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	Jade Coleman, Quality Safety & Assurance Manager and Tina Jenkins, Head of Quality, Safety & Assurance
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	The Trust Management of Safety Alerts and Important Notification Policy has been reviewed to reflect the revised national responsibilities in respect of the management and oversight of safety alerts.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to ***APPROVE*** the revised Trust Management of Safety Alerts and Important Notification Policy.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Integrated Quality & Safety Group	21/11/23
Executive Management Board	29/08/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	

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Endorsed for approval

7 LEVELS OF ASSURANCE
N/A for a policy revision

APPENDICES	
1	Management of Safety Alerts and Important Notifications Policy

1. BACKGROUND

The Management of Safety Alerts and Important Notifications policy is in place to ensure the robust management of Patient Safety Solutions and that the Trust is meeting its legislative and national requirements and is a long-standing Trust policy.

The purpose of this policy is to ensure that Velindre University NHS Trust fulfils the requirements for the robust management of Safety Alerts and Important Notifications and to set out and ensure an effective internal management system within Velindre University NHS Trust for the distribution, monitoring and compliance of all Safety Alerts and Important Notifications received throughout the Trust. The Trust must be able to demonstrate that it has responded appropriately to alert information that is received, and evidence that robust audit trails are in place which confirm that appropriate actions have been taken within a reasonable time period.

2. ASSESSMENT & SUMMARY OF MATTERS FOR CONSIDERATION

The Safety Alerts Policy was due for review in January 2024.
The Corporate Quality and Safety Team continue to attend the All-Wales Patient Safety Network and Patient Safety workstreams to provide input into the development of the Datix Cymru module. Whilst this is ongoing the Corporate Quality and Safety Team will continue to record, monitor, and manage all Safety alerts through the Datix v14 system. Safety Alerts are monitored through the Integrated Quality and Safety Group.

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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:	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	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
	As this policy is only a revision to an existing policy, therefore a new EQIA is not required.

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	The Trust has a legal duty to ensure the robust management and timely review of each Safety Alert and Important Notification that is received. In addition, the Trust is responsible for addressing and ensuring compliance when Safety Alerts are received placing an onus on the Trust to ensure that safety alerts are properly reviewed and appropriate actions taken to ensure the Trust comply with the recommendations within the alerts and reporting back to Welsh Government.
	Potential financial implications arise when it is identified that errors have occurred, omissions to act or there have been system failures

4. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No current related risks

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Velindre Cancer Centre

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

Welsh Blood Service
Gwasanaeth Gwaed Cymru

QS02
Management of Safety Alerts and Important Notifications Policy

Executive Sponsor & Function:	Executive Director Nursing, Allied Health Professionals and Health Science
Document Author:	Quality, Safety and Assurance Manager
Approved by:	Quality, Safety & Performance Committee
Approval Date:	*TBC*
Date of Equality Impact Assessment:	NA
Equality Impact Assessment Outcome:	NA
Review Date:	*January 2024*
Version:	1

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6. Audit and Review 5

7. APPENDICES

Appendix 1 Nominated Assigned Leads 6

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1. Policy Statement

Safety Alerts and Important Notifications are developed and distributed to Velindre University NHS Trust, to support and direct solutions required to improve patient safety. The NHS Executive has been given the authority by Welsh Government to lead on the vital role of adapting existing Patient Safety Solutions, so that they are applicable for Wales. Key safety risks, concerns and solutions are identified and developed at a national level, and where appropriate are adopted in Wales through a collaborative approach. The Delivery Unit is responsible for distributing Patient Safety Solutions at an all-Wales level to help manage risks identified and monitor compliance with NHS Wales's organisations.

The purpose of this procedure is to set out and ensure an effective internal management system within Velindre University NHS Trust for the distribution, monitoring and compliance of all Safety Alerts and Important Notifications received throughout the Trust. The Trust must be able to demonstrate that it has responded appropriately to alert information that is received, and evidence that robust audit trails are in place which confirm that appropriate actions have been taken within a reasonable time period.

It does not replace the duty and professional accountability of staff to report any adverse incidents with a medical device, hazardous product or unsafe procedure.

Working to a defined standard will reduce variations, so that solutions are relevant and useful to Velindre University NHS Trust and should avoid unnecessary overload of solutions work.

2. Responsibilities

The Chief Executive has overall responsibility for the management and oversight of all alerts and notifications management process, alert compliance, implementation and sign off within the Trust. For the practical operation of the system the Chief Executive has delegated this responsibility to the Corporate Quality and Safety Department (Quality, Safety and Assurance Manager's) who have a central role in ensuring that key personnel receive the solutions for actions, as considered appropriate by Velindre University NHS Trust. The role requires responsibility for acknowledging, disseminating, closing off safety alerts and providing feedback to relevant service divisions within designated timescales. The Divisional Directors have responsibilities to ensure arrangements are in place locally for the dissemination, action, and review of alerts within their area(s) of activity and responsibilities. This includes the nomination of an assigned nominated lead for the alerts and notification process and is set out in **APPENDIX 1** within this policy.

If, following the implementation of alert, information needs to be shared to identified staff, this will be done so via the most appropriate method of communication. All staff who receive information are responsible for ensuring they understand and apply to their practice.

2.1 The nominated Trust lead/deputy is responsible for:

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- The onward distribution within the Trust to the Velindre Cancer Service and Welsh Blood Service Divisional leads.
- Consulting with the Divisional leads nominated to review the alert.

- Monitoring progression of solutions against set deadlines.
- Liaising with the Delivery Unit, updating the Datix Alerts Module, to ensure up to date and robust compliance recording.
- Confirming to the Delivery Unit the Trust compliance status by the deadline set out within the alert.
- Attending the All-Wales Patient Safety Solutions Reference Group contributing to the development and oversight of solutions compliance.

2.2 The service leads are responsible for:

- Receiving alerts via the Corporate Quality & Safety Department on behalf of their division and speciality area.
- Acknowledging all alerts and to confirm if the alert is applicable within 48 hours of receipt.
- Ensuring the review of alerts and identifying appropriateness for the service.
- Undertaking a baseline assessment against Divisional compliance, risk assessing the issues involved and adding to the Risk Register if appropriate.
- Ensuring actions are identified and implemented within the area of responsibility to enable compliance with the alert.
- Leading on completing the actions held within the action plans and return compliance status to the Corporate Quality and Safety Department.

3. The various types of Safety Alerts and Important Notifications include:

- Patient Safety Alerts
- Patient Safety Notices
- Ministerial Letters
- Pharmaceutical Alerts
- Product Recalls and Manufacturer/Field Safety Notices
- Estates and Facilities Alerts
- Medical Device Alerts
- Security Alerts
- Welsh Health Circulars
- Healthcare Inspectorate Wales Reports
- Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority
- Accreditation visit reports
- Internal Safety Notices (Health and Safety)
- Internal Safety Notices (Patient Safety)
- Professional Regulatory Alerts

This list is not exhaustive and from time-to-time other important notifications may be received which require an equivalent response by the Trust. NHS organisations are required to submit responses on the action they have taken and are monitored on their compliance with completing such alerts within agreed deadlines when required.

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4. Velindre University NHS Trust Integrated Quality and Safety Group

The Trust Integrated Quality and Safety Group meet on a monthly basis and are responsible for overseeing the alerts and notification process, ensuring actions are implemented as per the appropriate action plans. Areas of non-compliance are reviewed and referred to an appropriate management group for further review and to determine mitigation actions. The Group, through its chair, will seek assurance that all alerts are appropriately managed in an effective and timely manner.

As well as managing externally created alerts, the Trust has developed its own system for sharing internal safety alerts to make staff aware of particular issues arising from concern and incidents learning outcomes.

5. Record Keeping

The Corporate Quality and Safety department is responsible for maintaining a register of all publications received and monitoring follow-up action status for reporting to the Trust Quality, Safety and Performance Committee.

To ensure the Trust is operating a robust system for managing alerts regular monitoring will be carried out. Quarterly reports outlining performance will be reported to the Trust Quality, Safety and Performance Committee.

6. Audit and Review

An annual audit will be undertaken by the Trust Corporate Quality and Safety Department to assess ongoing compliance with actions and timeframes and will include a review against compliance of twenty percent of Safety Alerts and Important Notifications received within each financial year.

The audit outcome will be reported to the March Trust Quality, Safety and Performance Committee.

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Appendix 1

Nominated assigned leads:

Type of safety alert / notification	Divisional nominated leads	Department	Responsible group / committee
Patient safety alerts	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Patient safety notices	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Ministerial Letters	Board Secretary	Governance Department	Executive Board & Quality, Safety and Performance Committee
Pharmaceutical Alerts	**Velindre Cancer Service** Head of Pharmacy / Responsible Pharmacy technicians **Welsh Blood Service** Health, Safety and Environmental Compliance Manager / Head of Nursing	Pharmacy Department	Trust Integrated Quality and Safety Group / Medicine Management Group
Product Recalls and Manufacturer/Field Safety Notices	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety & Environment Manager	Estates Department / Health and Safety	Planning & Performance Committee/Trust Health & Safety Management Group/Integrated Quality and Safety Group
Estates and Facilities Alerts	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety & Environment Manager	Estates Department /Health and Safety	Planning & Performance Committee/Trust Health & Safety Management Group/Integrated Quality and Safety Group

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Medical Device Alerts	**Velindre Cancer Service** Medical Physics lead **Welsh Blood Service** Health, Safety & Environment Manager	Medical physics	Integrated Quality and Safety Group / Infection Prevention and Control Management Group/Trust Health and Safety Management Group
Welsh Health Circulars	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager **Welsh Blood Service** Health, Safety & Environment Manager	Quality and Safety Department	Trust Integrated Quality and Safety Group/Quality, Safety and Performance Committee
Security Alerts	**Velindre Cancer Service** Head of Estates **Welsh Blood Service** Health, Safety and Environment Manager	Estates Department	Planning & Performance Committee/Trust Health & Safety Management Group
Healthcare Inspectorate Wales Reports	Head of Quality and Safety Department	Quality and Safety Department	Integrated Quality and Safety Group / Quality, Safety and Performance Committee
Regulatory agency reports e.g., Health and Safety Executive, Fire authority, Human Tissue authority	Head of Quality and Safety Department	Quality and Safety Department	Integrated Quality and Safety Group / Quality, Safety and Performance Committee
Accreditation visit reports	Head of Corporate Governance	Corporate Governance Department	Quality, Safety and Performance Committee
Internal Safety Notices (Health and Safety)	**Velindre Cancer Service** Head of Nursing Quality and Safety Manager / VCS Quality and Safety Manager **Welsh Blood Service** Health, Safety & Environment Manager	Health and Safety Department	Trust Health & Safety Management Group/Local Groups

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Internal Safety Notices (Patient Safety)	**Velindre Cancer Service:** Head of Nursing Quality and Safety Manager **Welsh Blood Service** Health, Safety and Environment Manager	Quality and Safety Department	Quality, Safety and Performance Committee
Professional Regulatory Alerts	HR Officers Medical/Clinical Directors	Velindre Cancer Service/Welsh Blood Service/Divisions/Hosted Organisations	Workforce & Organisational Development Committee

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

VUNHST Security Policy PP02

DATE OF MEETING	12/09/2024

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	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital
APPROVED BY	Carl James, Executive Director of Strategic Transformation, Planning and Digital

EXECUTIVE SUMMARY	Velindre University NHS Trust Board acknowledges its dual role as both an employer and a service provider. The Velindre NHS University Trust (the 'Trust') is dedicated to establishing, to the fullest extent possible a safe and secure environment for patients, donors, staff and visitors. Additionally, the Trust is committed to safeguarding people, property, equipment, and assets from the risk of injury, loss, or damage while on Trust premises.

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RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is requested to approve the final version of the Security policy [PP02].

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Velindre Cancer Centre Cynefin Group Members	**21/03/2024**
Welsh Blood Service Cynefin Group Members	**21/03/2024**
Executive Management Board – Run	**25/06/2024**

SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS

Feedback received from VCC & WBS Cynefin Groups to add additional information listed below:

- **Velindre Fundraising** - Volunteers 3.0 scope
- **Estates** - Departmental Managers 5.4
- **Radiotherapy** – 6.1.4 Additional information added for Natural Resources Wales (NRW)
  6.2.1 Added information regarding staff lockers.
- **Digital** – 6.3 additional information added for IT equipment left in vehicles unattended.
- **Estates** - 6.9 Identification badges section amended to reflect safe keeping and contractors attending site must undertake a site induction.
- **Estates** – section 18 Acknowledgements has been removed.

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**

APPENDICES	
Appendix 1	EQIA Form

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1. SITUATION

1.1 To ensure a safe and secure environment is provided for Trust service users, patients, donors, visitors and staff whilst on Trust premises or working on behalf of the Trust.

2. BACKGROUND

2.1 The purpose of this policy is to ensure that the Trust and continue to comply with their statutory and mandatory duties with regarding security.

2.2 This policy applies to all staff employed by or contracted to the Trust.

3. ASSESSMENT

3.1 As there has been no significant changes to legislation, guidance or best practice since the last review of the policy.

3.2 Information have been added into the policy detailed below:

- Velindre Fundraising - Volunteers 3.0 scope
- Estates - Departmental Managers 5.4
- Radiotherapy – 6.1.4 Additional information added for Natural Resources Wales (NRW)
  6.2.1 Added information regarding staff lockers.
- Digital – 6.3 additional information added for IT equipment left in vehicles unattended.
- Estates - 6.9 Identification badges section amended to reflect safe keeping and contractors attending site must undertake a site induction.
- Estates – section 18 Acknowledgements has been removed.

4. SUMMARY OF MATTERS FOR CONSIDERATION

No immediate matters for consideration / action.
The report is presented to the Quality, Safety and Performance Committee for approval.

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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 ☒
	Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	
	Not required

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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: n/a
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
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
	Departmental managers within the Trust will ensure employees within their team will be aware of the Trust Security policy and any Divisional security procedures. EQIA attached in appendices
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

6. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	All Security risks will be logged on the Trust Datix system.
WHAT IS THE CURRENT RISK SCORE	n/a
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	n/a

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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	

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

Ref: PP 02

SECURITY POLICY

Executive Sponsor & Function:	Director of Strategic Transformation, Planning, Performance and Estates
Document Author:	Interim Assistant Director of Estates, Environment and Capital
Approved by:	Planning and Performance Committee
Approval Date:	
Date of Equality Impact Assessment:	17/05/2024
Equality Impact Assessment Outcome:	Approved
Review Date:	
Version:	2

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Introduction

1. Policy Statement

1.1 The Velindre University NHS Trust Board recognises its exemplar role both as an employer and as a service provider. Velindre NHS University Trust (the 'Trust') is committed to creating, as far as reasonably practicable, a safe and secure environment for patients, donors, staff and visitors and also to protect people, property, equipment and assets against risk of injury, loss or damage whilst on Trust premises.

1.2 So far as is reasonably practicable, the Trust will ensure that security does not compromise safe means of escape in the event of fire or other emergency through assessment of risk.

1.3 The Trust is committed to working in partnership with staff, trade unions and outside agencies, such as the police, to achieve the aims of this policy.

2. Purpose

2.1 To ensure a safe and secure environment is provided for Trust service users, patients, donors, visitors and staff whilst on Trust premises or working on behalf of the Trust.

2.2 To provide a secure environment for property, equipment and assets of the Trust.

3. Scope

3.1 The Security Policy covers all areas within the Trust;

- patients, donors and visitors
- employees
- contractors
- property and equipment of the Trust
- personal property on Trust premises ("Trust premises" defined as "any premises either owned or leased by Velindre University NHS Trust, Divisions or Hosted bodies")
- volunteers

4. Aims and Objectives

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4.1 The aim is to provide a safe and secure environment for patients, donors, staff and visitors within Trust premises and to provide a secure environment for property, equipment and assets of the Trust.

4.2 This Policy aims to be an overarching policy all Divisions and hosted organisations will implement procedures to support this policy. The policy is deemed to set the minimum requirements.

4.3 Objectives; to prevent/minimise the number of incidents relating to;
- Violence and Aggression (physical or verbal)
- Criminal Damage
- Theft (from Trust premises or of Trust property)
- Arson

4.4 To provide safe and secure working environments, taking into account the need for safe means of escape in the event of fire or other emergency.

4.5 To fulfil the Board's legal duty of care to all its employees, patients, donors and others to provide a safe working environment.

5. Roles and Responsibilities

5.1 Executive Lead

The Chief Executive has overall responsibility and is accountable to the Trust Board for the management of Security within the organisation.

The responsibility for policy implementation rests with the Director of Planning, Performance and Estates.

The Director of Strategic Transformation, Planning, Performance and Estates, through delegated powers, shall ensure that all employees, patients, donors and others are aware of the policy and of their role in its implementation and monitoring.

5.2 Trust Policy Review

The Assistant Director of Estates, Environment and Capital Development is the Trust lead for the review of this document.

5.3 Divisional Directors / Hosted Bodies

The Divisional Directors and Directors of Hosted bodies within the Trust are responsible for ensuring:
- policy is implemented within their Divisions.
- a responsible person is identified to manage security on a day to day basis and appropriate training given where necessary.

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5.4 **Departmental Managers**

Departmental managers within the Trust will ensure:

- employees within their team will be aware of the Trust Security policy and any Divisional security procedures.
- assessments of security risks present within their areas of responsibility.
- relevant training responsibilities of staff are fulfilled.
- engage with the operational Teams and instigate (6 monthly) security audits and implement action plans derived from said audits.
- reasonable precautions, through risk assessment and taking appropriate action, to protect the Trust's staff, service users, patients, donors, visitors, contractors, property, equipment and assets.
- empower employees to raise any issues of security concerns or breaches of current security systems.

5.5 **All Staff**

- responsibility of all employees to adhere to this policy and the divisional operational procedures to which they refer to.
- responsibility to ensure security of the areas within which they work by closing windows and locking doors as necessary when the area is not in use.
- must take reasonable precautions to safeguard the Trust's staff, service users, donors, patients, visitors, contractors, property, equipment and assets.
- assist with any security investigation and engage and assist with any management security audits.
- aware of their own circumstances and report any security concerns to line managers.

6 Content for Divisional Procedures

The following areas will need to be addressed within all divisional procedures;

6.1 **Site Security**

6.1.1 Risk assessments completed to ensure that staff, patients, donors, visitors, property, equipment and assets of the Trust are not put at risk during the normal operational activities of the Trust's services.

6.1.2 Risk assessments completed to ensure that staff, patients, donors, visitors, property, equipment and assets of the Trust are not put at risk

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during exceptional circumstances of operational activities of the Trust's services.

6.1.3 All areas of the Trust should be risk assessed by a competent person/s in order to identify any security related risks. It is the responsibility of the service divisions to ensure security risks are assessed and review the appropriate and effectiveness of security in relation to security procedures.

6.1.4 When completing a risk assessment, the following risks should be considered. *(This is not an exhaustive list)*

- Points of ingress and egress
- Keypads /Key Locked / Access controlled doors
- Identification and visitor badges
- Security procedure and protocol for incidents / breaches
- Intruder alarms
- Intercom
- Security lighting
- Closed circuit television (CCTV)
- Sound maintenance practices
- Maintaining security during normal operational hours
- Securing the site/departments safely after operational department requirements have been completed.
- Security requirements specified by regulatory authorities e.g. NRW

6.1.5 Notices to deter criminal activity and dissuade persons from intimidating, threatening or violent behaviour are recommended. Signs concerning security measures must be prominently displayed in buildings and grounds, in particular reference to when CCTV is in operation, all signage produced should be bi-lingual.

6.1.6 No staff, unless trained to do so, should confront unauthorised persons on any premises. Personal safety is paramount.

If it is suspected that an intruder is on the premises or that a theft is being committed, staff should seek assistance or remove themselves to a safe area and inform the police immediately, contacting their manager where appropriate. Advice on any other or further action to be taken will be provided by the police.

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6.1.7 Security of Unoccupied Offices/Departments - areas that are in use for only part of the day must have a visual check made that the building is secure before it is vacated and intruder systems correctly armed. The use of blinds and similar equipment will keep property out of obvious view to a prospective thief. Managers must encourage members of staff to use drawers and cupboards to place items out of site and temptation.

6.2 Security of possessions

6.2.1 Staff

The Trust cannot accept responsibility for the security of personal belongings on the premises. Staff are advised that personal belongings of a valuable nature should not be brought onto the trust premises.

All offices should be locked when not in use and all personal items should be removed from surfaces.

In some areas secure (locked) lockers will be available to staff to use and these will be managed locally by individual departments.

6.2.2 Patients / Donors

Patients (Velindre Cancer Centre), whose admission is planned must be told not to bring items of value into the hospital. If on arrival, patients are in possession of items of value they must be requested to ask a relative to take them home.

In the event that a patient / donor wish to deposit items of value with the Trust, a detailed record of the items must be completed and the items must be taken to a secure area as soon as possible. The Trust then accepts responsibility for this property unless the patient / donor are made aware otherwise.

6.3 Security of Equipment off Trust Premises

The Trust's property and equipment must only be removed from site for legitimate purposes e.g. for repair, transfer to another Trust premises or to facilitate fulfilment of the Trust's business.

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Managers must ensure that any property or equipment removed from Trust facilities or being used on other sites, must be handled and transported with reasonable care and must be kept and stored in a secure environment. All members of staff must take reasonable security measures to prevent theft and or damage to Trust property, accidental or otherwise.

Departmental Managers should ensure staff understand the importance of securely transporting and storing Trust equipment while working remotely and always adhere to the Trust guidelines. To avoid thefts of IT Equipment and misuse staff must not leave equipment in unattended vehicles or in public spaces.

6.4 Storage

Division or departments that hold stores / stock must have procedures that effectively and actively manage the prevention of theft, damage or sabotage.

There must be regular stock audits, as defined by the manager responsible for the area or as dictated to by current departmental procedures, of stock, for high value or high-risk items.

6.5 Possession of Illegal substances

The Trust has a duty under the Misuse of Drugs Act 1977 (and subsequent Amendments) to ensure that its premises are not used for the illegal supply, use or possession of any controlled or illicit substance.

In relation to employees of the Trust please refer to the Trusts policy on Substance Misuse at Work.

6.6 Weapon Possession

There is no justification for any person on the Trust's premises to be in possession of a weapon. Safety is the first concern and no member of staff, unless trained to do so, should challenge or confront a person who is suspected of possessing a weapon.

Members of staff must remove themselves to a safe area and contact the police immediately.

6.7 Key Handling / Access Systems

Managers are to ensure robust, recorded and auditable systems are in place in relation to the management of existing and the provision of new key / access swipe cards.

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Where digital or coded keypad door locks are fitted managers must ensure that the code entry is changed at regular risk assessed intervals.

6.8 **Future Security Design**

All new significant schemes shall be designed to comply with current Health Building Notes (HBN's) for Velindre Cancer Centre, and the principals of "*Secure by Design" and NRW requirements,* for non-hospital facilities.

6.9 **Identity Badges**

The policy requires that;

- identity badges must at a minimum contain a photograph of the member of staff, their name and be integrated into a managed computer data base system.
- badges are to be worn at all times and be clearly visible.
- refusal or consistent failure to display identification badges whilst in the work place may result in the instigation of the Trust's disciplinary code.
- lost badges must be reported immediately to the manager.
- when not being worn, identity badges must be stored securely and taken home after the end of the work shift
- all personnel are provided with a badge and that all new starters are immediately issued with an identity badge.
- It is crucial to implement the correct badge identification policy across Trust premises while always respecting the patient experience.
- Managers will ensure that staff leaving the Trust/Division will have their identity badge, swipe cards and keys returned.
- the use of visitor's books or temporary visitors' identification badges should be used where appropriate.
- contractors employed to work on Trust premises must undertake a full contractor's induction and wear appropriate identification badges in line with local procedures and returned upon completion of works (daily or otherwise stated).

6.10 **Arson –** *Further guidance provided in Fire Prevention and Arson Prevention protocol*

All cases of suspected arson must be reported immediately to;

- The Police and Fire Service who will investigate
- Divisional Director
- The Fire Safety Manager

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6.11 **Assault**

Acts of physical or verbal assault on members of staff, patients, donors, visitors and any other persons on Trust premises will not be tolerated (Trust's Violence and Aggression Policy and the Domestic Abuse Policy). The Trust fully supports and endorses the involvement of the police.

Employees accused of the above will be subject to investigation under the Trusts Disciplinary code along with potential criminal investigations.

6.12 **Criminal Damage**

The Trust maintains the right to actively pursue those individuals that inflict criminal damage to their property or equipment where the offender can be identified.

6.13 **Out of Hours**

The Trust requires all sites to have out of hour's procedures in place, to deal with incidents relating to Trust premises, staff, equipment and key holding functionality to buildings.

7 Equality

7.1 The Trust is committed to ensuring that, as far as is reasonably practicable, the way it provides services to the public and the way it treats its employees reflects their individual needs and does not discriminate against individuals or groups.

7.2 The Trust has undertaken an Equality Impact Assessment and received feedback on this policy and the way it operates. The Trust wanted to know of any possible or actual impact that this procedure may have on any groups in respect of gender (including maternity and pregnancy as well as marriage or civil partnership issues) race, disability, sexual orientation, Welsh language, religion or belief, transgender, age or other protected characteristics.

7.3 The assessment found that there was no impact to the equality groups mentioned. Where appropriate the Trust will make plans for the necessary actions required to minimise any stated impact to ensure that it meets its responsibilities under the equalities and human rights legislation.

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8 Training

8.1 Whilst there are no formal training programmes in place to ensure implementation of this policy, each Executive Director, Divisional Director, Clinical Director, Divisional General Manager, Divisional Nurse, Departmental Manager, Head of Nursing and Head of Departments must ensure that managers and all staff, clinical and non-clinical, are made aware of the policy provisions and that they are adhered to at all times.

8.2 Training must include equality and diversity training for managers, to highlight the risk of stereotyping in the workplace and service provision.

9 Resources

9.1 The implementation and management arrangements associated with this policy do not present any significant resource implications to the Trust.

10 Implementation

10.1 This policy will be maintained by the Planning, Performance and Estates Department.

10.2 Please refer to the responsibilities section for further information in relation to the responsibilities in connection with this policy.

11 Audit and Monitoring

11.1 The Planning, Performance and Estates Department will review the operation of the policy as necessary and at least every 3 years.

12 Policy Conformance / Non-Compliance

12.1 If any Trust employee fails to comply with this policy, the matter may be dealt with in accordance with the Trusts Disciplinary Policy. The action taken will depend on the individual circumstances and will be in accordance with the appropriate disciplinary procedures. Under some circumstances failure to follow this policy could be considered to be gross misconduct.

13 Distribution

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13.1 The policy will be available via the Trust Intranet Site. Where staff do not have access to the intranet their line manager must ensure that they have access to a copy of this policy.

14 Review

14.1 The Assistant Director of Estates, Environment and Capital Development will review the operation of the policy as necessary and at least every 3 years.

15 Legislation

15.1 The major piece of legislation in terms of security is the Health & Safety at Work Act 1974.

The employer is criminally liable if they fail to protect employees whilst at work. As such the Division is required to provide 'reasonable' security arrangements for all staff.

16 Further Information

16.1 This policy is supported by the following Trust Policies / protocols;

- Violence and Aggression Policy
- Health, Safety and Welfare Policy
- Business Continuity and Emergency Planning Policy
- Fire Safety Policy
- Reporting Incidents and Investigation Policy
- Data Protection and Confidentiality Policy
- Lone Working Policy
- Information Governance Policy
- Substance Misuse at work Policy and Procedure
- Domestic Abuse Policy
- Bomb Threats and Suspicious Packages protocol
- Fire Prevention and Arson Prevention protocol

16.2 Further information and support is available from the Assistant Director of Estates, Environment and Capital Development on 02920 316272**.**

17 References

17.1 HBN's – *Health Building Notes*

17.2 "*Secure by Design"* - Secured by Design has been cited as a key model in the Office of Deputy Prime Minister's guide *'Safer Places - The Planning System & Crime Prevention'* and in the Home Office's *'Crime Reduction Strategy 2008-11'*.

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EQIA Template & Action Plan

All policies and decisions that affect people are assessed to identify ways to reduce discrimination and to make Wales fairer. I confirm that an assessment has been undertaken and the relevant actions are highlighted below.

Name of Policy	PP 02 Security Policy		
Manager	Interim Assistant Director of Estates, Environment and Capital Development		
Date of meeting with OD Manager – ED&I	**17-05-2024**		
Date of submission	May 2024		
Date of next review	May 2027		
These changes will affect:	Staff: ☐	Patients: ☐	Both: ☒

1.1	What is the policy or decision that you are conducting an EQIA for?	PP02 Security Policy
1.2	Who owns it?	Director of Strategic Transformation, Planning & Digital
1.3	What is the aim of the change(s)?	To ensure a safe and secure environment for patients, donors, staff and visitors within Trust premises and to provide a secure environment for property, equipment and assets of the Trust.
1.4	Who is affected most by the change?	Staff, patients, donors, contractors, employees.
1.5	How does this topic fit into the wider context of the organisation?	This Policy aims to be an overarching policy and all Divisions and hosted organisations will implement procedures to support this policy.
1.6	Who is undertaking the EQIA	Assistant Director of Estates, Environment and Capital Development.
1.7	When will you start and end the EQIA?	After meeting with EQIA lead and any actions are amended estimated 24th May 2024
2.1	What data is available to help inform the EQIA?	This policy is supported by the following Trust Policies / protocols; • Violence and Aggression Policy • Health, Safety and Welfare Policy • Business Continuity and Emergency Planning Policy • Fire Safety Policy • Reporting Incidents and Investigation Policy

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		•Data Protection and Confidentiality Policy •Lone Working Policy •Information Governance Policy •Substance Misuse at work Policy and Procedure •Domestic Abuse Policy •Bomb Threats and Suspicious Packages protocol •Fire Prevention and Arson Prevention protocol Data can be assessed in the number of incidents related to security to
2.2	What information is still needed?	No data is needed.
2.3	How will missing data be collected?	No data is missing.
2.4	What is considered relevant information and data?	Data relating to Security incidents within the Trust.

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3 - Equality Impact Assessment Template

Questions for you to think about for each of the protected characteristic groups:

- What are the possible impact outcomes?
- What type of impact does the change create?

Protected Characteristic	Potential Impact [Please tick column(s)]			Details	Recommendations
	Positive	Negative	None		
Age *Younger people* *Middle age people* *Older people* *Other…*			x		
Disability *Physical* *Learning needs* *Neurodiversity* *Sensory Loss* *Mental Health issue* *Other…*			x		
Gender re-assignment *Would this affect those in/post-transition differently?*			x		
Marriage or civil partnership			x		

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Are single people affected differently? *Are married people or civil partners treated differently?*					
Pregnancy or Maternity *Whilst pregnant* *On maternity leave* *Returning to work* *Other…*			**x**		
Race *Colour* *Nationality* *Ethnic group* *National origins* *Other…*			**x**		
Religion *Affects one religious group more?* *Clashes with religious holidays?* *What about groups with no religion?*			**x**		
Sex/Gender *Does it only apply to men / women?* *Could this affect one*			**x**		

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group more than the other?					
Sexual Orientation *Would this affect any group from LGBTQ+ communities differently?*			**x**		
Socio Economic Duty *Low income / no income groups?* *Rural locations affected differently?* *Those with caring responsibilities?*			x		
Welsh Language *Will everything be available bilingually?* *How many staff might need to know Welsh?* *1. Does the subject treat the Welsh language less favourably than the English language?*	**x**			All Policies are translated into Welsh. The initiatives are bilingual, and promotion will always have a Welsh version.	

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2. Have you considered the Cultural opportunities / Promotion of the project? E.g. literature / Visual art representing Welsh artists *3. Are you assured that all aspects of this project / policy etc has considered the needs of Welsh speakers?* *If yes, identify the specifics If no, state what should be included.*					

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4.1	You will need to evidence and recommend one of four policy implementation options: 1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	No major change standard items have been included in the policy review after consultation with departments.
4.2	If the change will be implemented regardless of the presence of a negative impact, you must be able to evidence: The implementation was necessary to carry out specific functions, there is no way of achieving the aims of the policy that has less negative impact and the means employed to achieve the aims of the policy are necessary and appropriate	No negative impact
4.3	Could be policy be implemented in a different way to avoid negative impact?	No the policy has no negative impact.
4.4	How will this change promote equality of access and equality of opportunity?	This change will not have any negative impact of equality of access or opportunity and therefore can be promoted locally through various operational requirements.
4.5	Is it possible to implement a different policy which achieves practice aims but avoids adverse impact?	This can be considered in developing local procedures to avoid adverse impact.
5.1	What do you have so far?	Draft Policy and EQIA documents
5.2	Have any themes emerged?	No themes have emerged.

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5.3	What do people have to say about our work?	There has been no comments received on our topic of work.
5.4	How will you consult widely on your topic?	Through local forums in both divisions vcc & wbs
5.5	Who will you consult with?	All departments in both divisions
5.6	How long will the consultation stage last?	4 weeks in total
6.1	The action plan must appropriately evidence the decision for one of the following policy options:1. No major change 2. Adjust the policy 3. Continue the policy 4. Stop and remove the policy	No action plan required after consultation process with relevant groups at each division
6.2	What will you do with the comments or information you have gathered from your consultations?	Make changes to policies after EMB – QSP sign off
6.3	How did the consultation help guide new policy?	It was good with some updated information added to policy to include key areas that were missing.
6.4	Will you make any changes to the draft report you produced?	No final document has been agreed and awaiting comments back from EMB-QSP.
7.1	Confirm actions	Implement policy

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8.1	Establish timetable for reviewing actions and refreshing the assessment	Completed

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Equality Impact Assessment – Action Plan

Action Plan

These actions will reduce discrimination and make Wales fairer:

	Action	Criterion	By When	Resource implications
1	Departmental managers within the Trust will ensure employees within their team will be aware of the Trust Security policy and any Divisional security procedures.	Make policy available via the Trust intranet page.	Following implementation.	To be decided by departments
2				
3				

Strategic Alignment

	Future Generations Act Wellbeing Objectives	Links to Objective
1	A prosperous Wales	☒
2	A resilient Wales	☒
3	A healthier Wales	☒
4	A more equal Wales	☒
5	A Wales of more cohesive communities	☒
6	A Wales of vibrant culture and thriving Welsh language	☒
7	A globally responsible Wales	☒

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Attachments

1. The policy concerned
2. Data used in completing the assessment
3. Details of consultation undertaken
4. Final version of the assessment template

Return to OD Manager – Equality, Diversity and Inclusion:
VUNHST.Equality&Diversity@wales.nhs.uk

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Last updated: 8th January 2024

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

AMENDMENT TO STANDING ORDERS – SCHEDULE 3 QUALITY, SAFETY AND PERFORMANCE COMMITTEE – TERMS OF REFERENCE REVIEW

DATE OF MEETING	12/09/2024

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	Liane Webber, Business Support Officer
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance

EXECUTIVE SUMMARY	In accordance with the Quality, Safety and Performance Committee Cycle of Business, the proposed changes to the Committee Terms of Reference which are part of Schedule 3 of the Trust Standing Orders are for review and consideration.

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RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **ENDORSE** the amendments to the Committee's Terms of Reference at **Appendix 2**.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	March 2024
Quality, Safety & Performance Committee	14/03/Y2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Endorsed for approval	

7 LEVELS OF ASSURANCE
N/A

APPENDICES	
Appendix 1	Quality, Safety and Performance Committee Terms of Reference approved by the Trust Board in January 2023
Appendix 2	Revised Quality, Safety and Performance Committee Terms of Reference

1. SITUATION

The Velindre University NHS Trust Standing Orders form the basis upon which the Trust's governance and accountability framework is developed and, together with the adoption of the Trust's Standards of Behaviour Framework Policy, is designed to ensure the achievement of the standards of good governance set for the NHS in Wales.

2. BACKGROUND

The Trust Board approved the current Quality, Safety and Performance Committee Terms of Reference ***(Appendix 1)*** in January 2023 and, at that time, the Committee agreed that the annual review cycle for the Terms of Reference will be in March each year, in line with the full annual reporting cycle.

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In accordance with the Quality, Safety and Performance Committee Cycle of Business, the revisions to the Committee Terms of Reference were presented in

March 2024 however, following due consideration the Committee felt that it could not endorse the Terms of Reference until the following points have been addressed:

- As there was no clear link between the Integrated Quality & Safety Group (IQSG), the Committee requested that this be amended to clearly reflect the link from the IQSG to this Committee.
- In terms of quoracy, the Committee Chair highlighted that under the current Terms of Reference no Executive Directors are required to be present. It was agreed that this required review and would be discussed at the forthcoming Independent Members Group meeting.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

The amendments detailed in this report have been agreed via the Executive Lead and Chair of the Quality, Safety and Performance Committee and are set out in ***Appendix 2.***

The proposed amendments include the following changes:

Terms of Reference & Operating Arrangements	Summary of Amendments
Quality Safety and Performance Committee	**2. Purpose** ***2.1:*** • Inclusion of compliance with the Duty of Quality and Duty of Candour legislation • Inclusion of the integrated and triangulated quality and safety outcomes • Inclusion of: o Infection prevention and control o Putting Things Right regulations o Quality and Safety Framework compliance o Mortality o Information governance o Divisional quality oversight o Trust Assurance Framework • Updated Health & Care Quality Standards to 2023

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Quality Safety and Performance Committee	**3. Delegated Powers and Authority** ***3.1:*** • Inclusion of Duties of Quality and Candour • Amendment to bullet regarding risks: o Ensure there are robust risk identification reporting and escalation processes risks are actively identified and robustly managed at all levels of the Trust; • Update to Health and Care Standards bullet to reference change in legislation and compliance • Added 3.2 - Inclusion of reference to the Integrated Quality and Safety Group and its function • ***Authority*** - renumbered bullets 3.3 and 3.4 • ***Access*** - renumbered bullet 3.5 • ***Sub Committees*** - renumbered bullet to 3.6 ***3.2:*** • Inclusion of the reference to the Integrated Quality and Safety Group as follows: **Integrated Quality & Safety Group** 3.2 The monthly Integrated Quality & Safety Group will consider all matters relating to the Integrated Quality & Safety agenda and will produce a quarterly report to the Committee synthesising and analysing the outcomes to provide assurance and exception reporting to the Committee.

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Quality Safety and Performance Committee	**4. Membership** ***4.2 Attendees*** • Addition of Deputy Director of Organisational Development and Workforce • Amendment to title of Quality and Safety Manager to Head of Quality and Safety Inclusion of an additional sentences "**As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:** • **Executive Director of Nursing, Allied Health Professionals and Health Science;** • **Executive Medical Director;** • **Executive Director of Finance;** • **Executive Director of Organisational Development & Workforce.** **Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.** ***4.3 By Invitation*** • Amendment to reflect change from Community Health Council to Llais.
Quality, Safety and Performance Committee	**Quorum** Inclusion of an additional sentences **"5.2 As a minimum there must be at least 2 Executive/Board Directors in attendance from the following:** • **Executive Director of Nursing, Allied Health Professionals and Health Science;** • **Executive Medical Director;**

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	• **Executive Director of Finance;** • **Executive Director of Organisational Development & Workforce.** **Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.** Remainder of section to be renumbered following inclusion of the additional sentence above.
Quality Safety and Performance Committee	**7. Reporting and Assurance** 7.1 "***presentation*** of an annual Quality, Safety & Performance Committee report" replaced with "***submission*** of…"

4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report directly support the achievement of the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☐ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☐	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance

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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 ☒
	Evidence suggests there is correlation between governance behaviours in an organisation and the level of performance achieved at that same organisation. Therefore, enduing good governance within the Trust can support quality care.
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required - please outline why this is not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	*There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.*
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

The Trust's governance structure aims to identify issues early to prevent escalations and the Committee integrates into the overall Board arrangements.

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

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Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	November 2022
Approved:	
Next Review Due:	March 2023

Webber,Liane
11/09/2024 10:57:44

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 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;
  - safeguarding and public protection;
  - patient, donor and staff experience;
  - all aspects of workforce;
  - digital delivery and information governance;
  - relevant statutory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020, Well-being of Future Generations (Wales) Act 2015;
  - Health and Care Standards (2015);
  - financial performance;
  - regulatory compliance; and,
  - organisational and clinical risk.

3. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021);

Webber,Liane
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- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of

its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

  Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.
- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide

Webber,Liane
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the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure risks are actively identified and robustly managed at all levels of the Trust;

- Ensure the Health and Care Standards (2015) are used to monitor and improve standards across the Trust;

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:

  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Authority

3.2 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit, ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

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

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

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- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.3 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

3.4 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

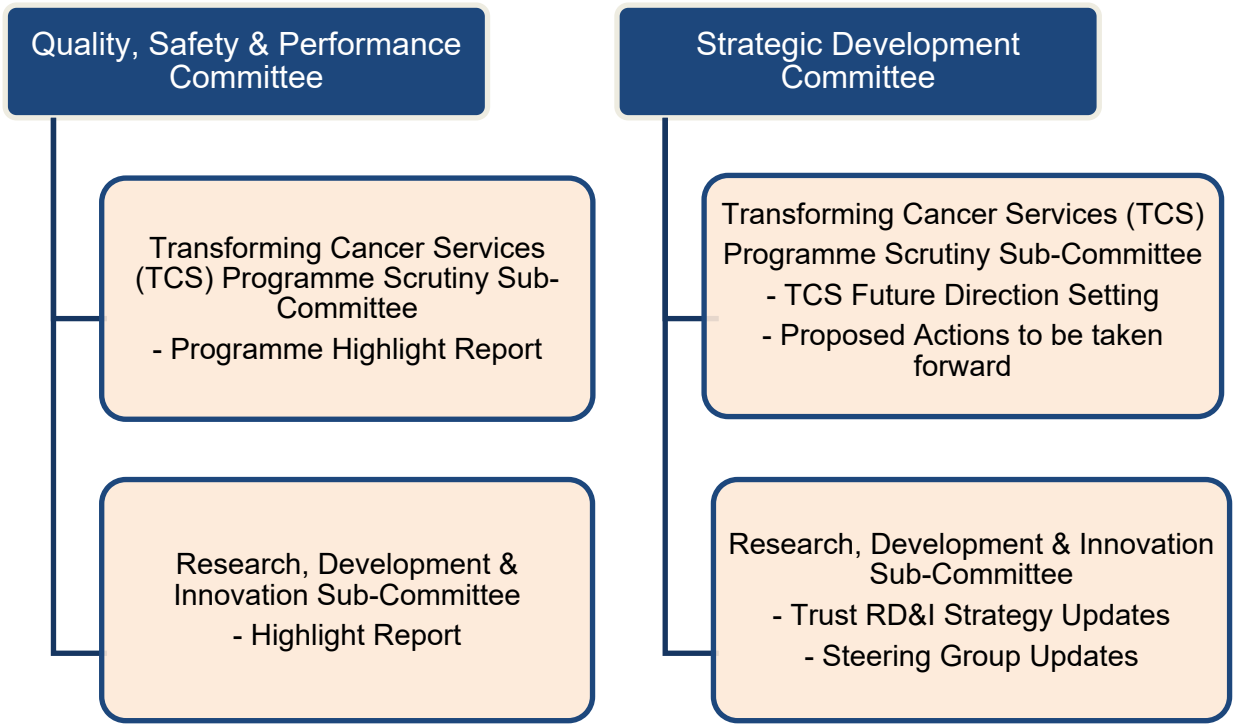
Sub Committees

3.5 The Committee has, with approval of the Trust Board, established the:

- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

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4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:

Chair Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

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

4.2 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Centre Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Chief Digital Officer (*also cyber/data outtages/performance)*
- Quality & Safety Manager
- Head of Corporate Governance

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Community Health Council

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Webber, Jane
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Member Appointments

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

4.6 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
-
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Chair is not present an agreement as to who will chair from the independent members in their absence.

Frequency of Meetings

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

Withdrawal of individuals in attendance

5.3 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

Webber,Liane
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6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and

assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the presentation of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

Webber, Lynne
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9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

Webber,Liane
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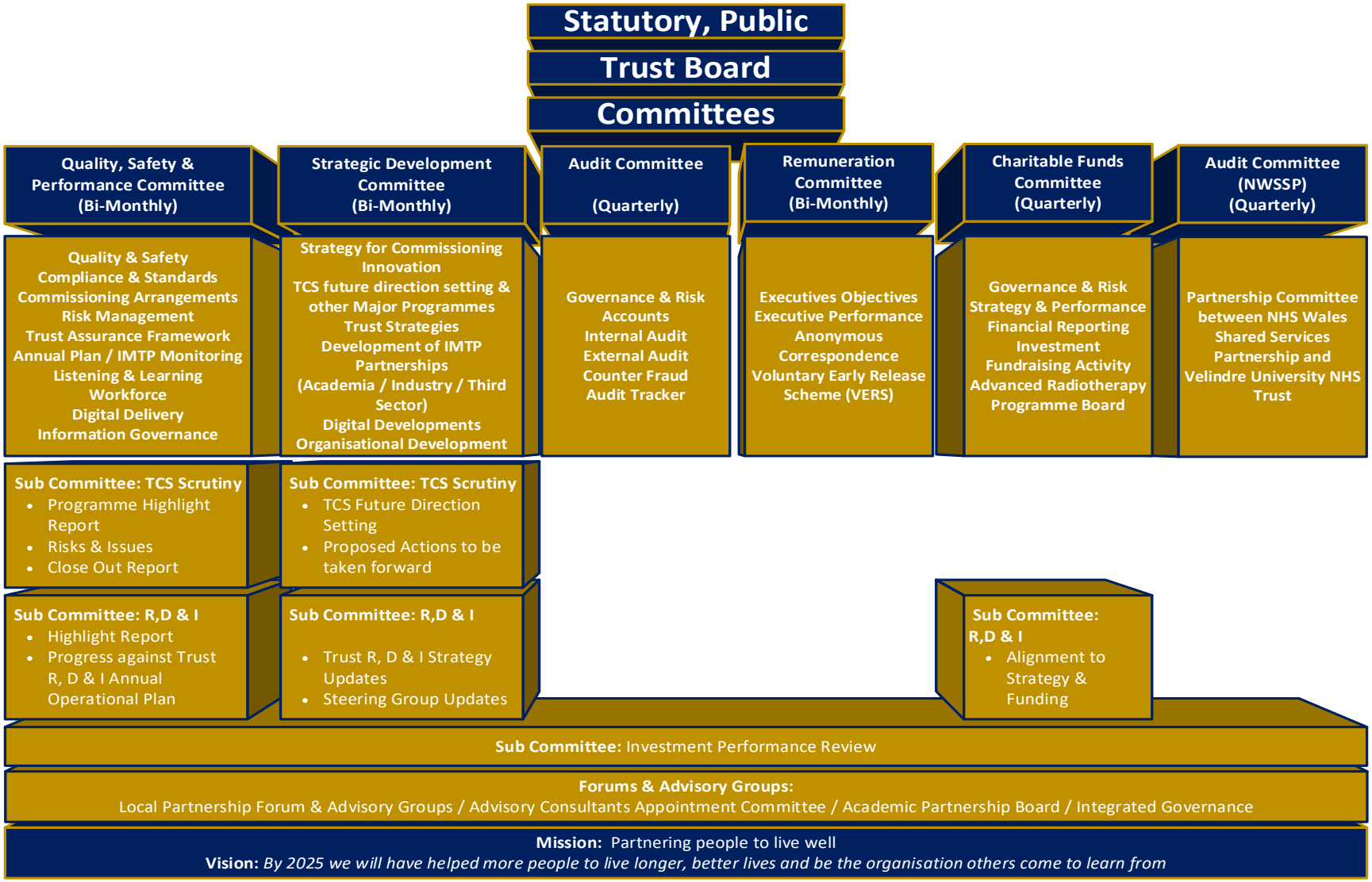
ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



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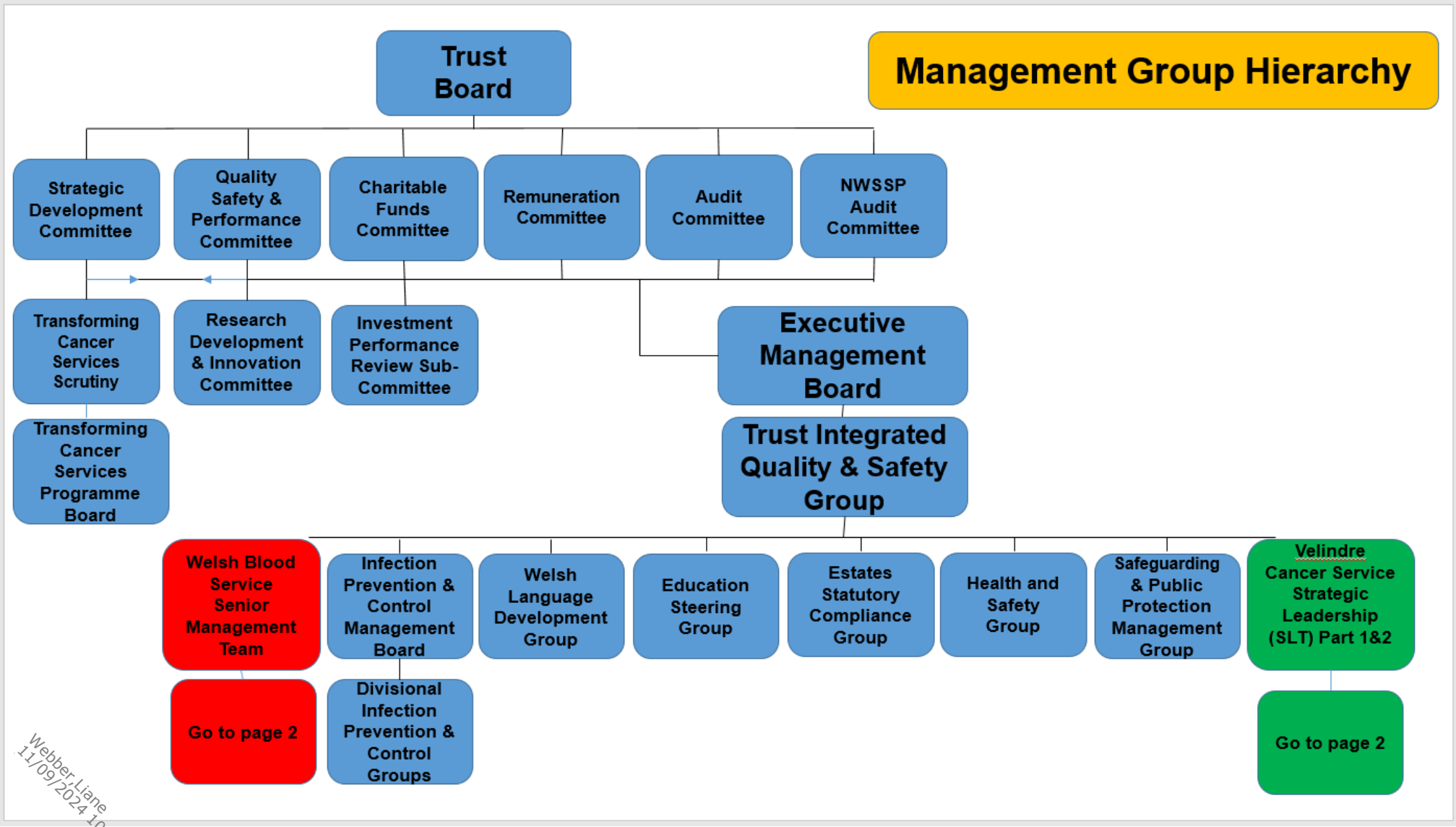
ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK



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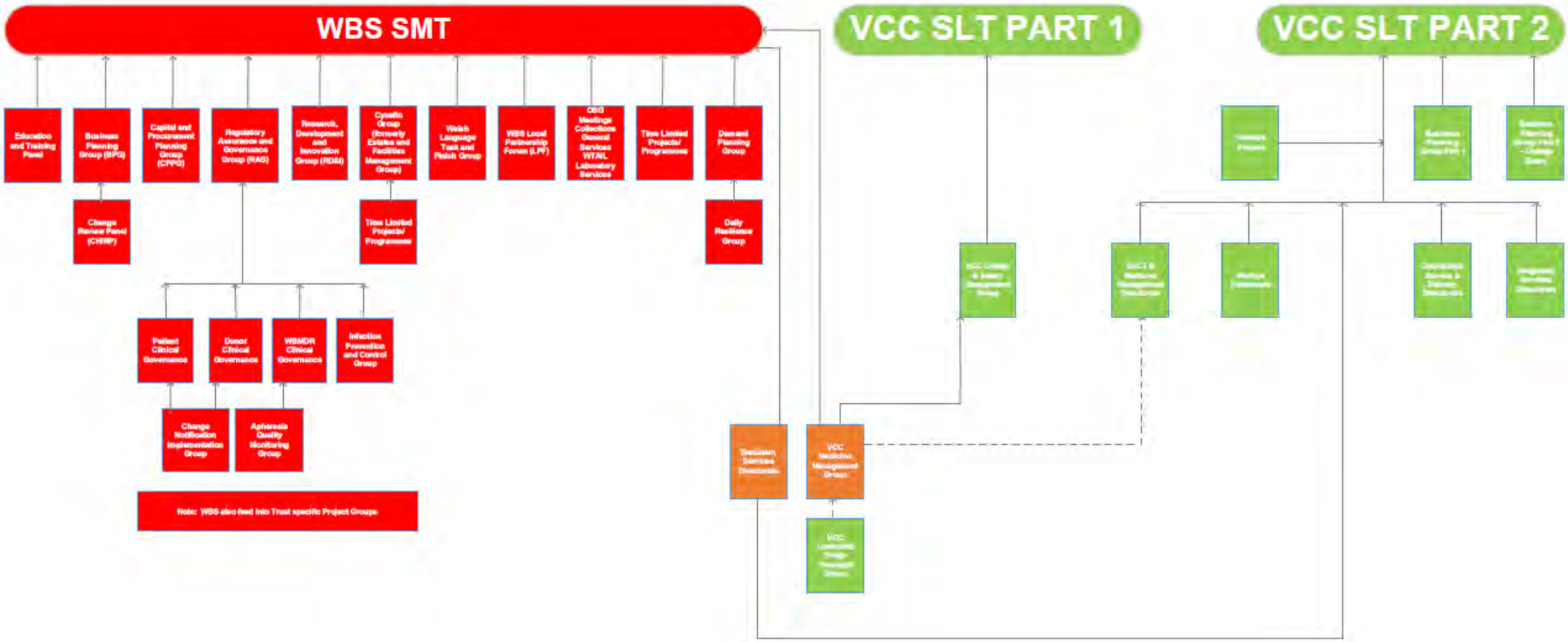

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Quality, Safety and Performance Committee

Terms of Reference & Operating Arrangements

Reviewed:	March 2024
Approved:	
Next Review Due:	

Webber,Liane
11/09/2024 10:57:44

1. INTRODUCTION

1.1 The Trust's standing orders provide that "The Board may and, where directed by the Assembly Government must, appoint Committees of the Trust either to undertake specific functions on the Board's behalf or to provide advice and assurance to the Board in the exercise of its functions. The Board's commitment to openness and transparency in the conduct of all its business extends equally to the work carried out on its behalf by Committees".

1.2 In line with standing orders and the Trust's scheme of delegation, the Board shall nominate annually a Committee to be known as the **Quality, Safety and Performance Committee.** The detailed Terms of Reference and operating arrangements set by the Board in respect of this Committee are set out below.

2. PURPOSE

2.1 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. DELEGATED POWERS AND AUTHORITY

3.1 The Committee will, in respect of its provision of **advice** and **assurance** to the Board use where possible a triangulated approach to:

Webber,Liane
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- Seek assurance that governance arrangements are appropriately designed and operating effectively to ensure the provision of high quality, safe healthcare and services across the whole of the Trust's activities;

- Ensure the Trust has in place a robust Quality Management System and is working towards meeting the requirements outlined in the Wales Quality Framework: Learning & Improving (2021) and the Duties of Quality and Candour;

- Consider the implications for quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arising from the development of the Trust's corporate strategies and plans or those of its stakeholders and partners, including those arising from any Joint (Sub) Committees of the Board;

- Consider the implications for the Trust's quality, safety, patient / donor experience / outcomes, planning and performance, workforce, finance, digital and information governance arrangements from review/investigation reports and actions arising from the work of external regulators;

- Monitor progress against the Trust's Integrated Medium-Term Plan (IMTP) ensuring that areas of weakness or risk and areas of best practice are reported to the Board;

- Align service, workforce and financial performance matters into an integrated approach in keeping with the Trust's commitment to the Sustainable Development Principle defined by the Well-being of Future Generations (Wales) Act 2015.

- Monitor the Trust's sustainability activities and responsibilities;

- Monitor progress against cost improvement programmes;

- Monitor and review performance against the Trust's Assurance Framework.

- Ensure there are robust risk identification reporting and escalation processes ensuring risks are actively identified and robustly managed at all levels of the Trust;

- Ensure areas of significant patient / donor / service / performance improvement are highlighted to the Board and other relevant Board Committees as necessary to ensure best practice is shared across the organisation;

- Monitor outcomes/outputs from patient / donor / service improvement programmes to provide assurance on sustainable improvements in the quality and efficiency of service delivery;

- Assess implications of any relevant existing, new or amended statutory and regulatory requirements e.g. the Health and Social Care (Quality and Engagement) (Wales) Act 2020 and oversee the Trust's implementation;

- Ensure the Trust Policies, Procedures and Strategies are consistent with internal and external legislative and regulatory requirements and are implemented effectively.

- Ensure the Trust, at all levels (divisional/team) has a citizen centred approach, putting patients, patient / donor experience, safety and safeguarding above all other considerations;

- Ensure that care and services are planned and delivered in line with relevant national / statutory / regulatory and best practice standards;

Webber,Liane
11/09/2024 10:50:44

- Ensure the Trust has the right systems and processes in place to deliver patient /donor focused, efficient, effective, timely and safe services;

- Ensure the workforce is appropriately selected, trained, supported and responsive to the needs of the Trust, ensuring recruitment practices safeguard adults and children at risk, that professional standards and registration/revalidation requirements are maintained, and there is compliance with the requirements of the Nurse Staffing Levels (Wales) Act 2016;

- Ensure there is effective collaboration with partner organisations and other stakeholders in relation to the sharing of information in a controlled manner, to provide the best possible outcomes for its citizens (in accordance with the Wales Accord for the Sharing of Personal Information and Caldicott requirements);

- Ensure the integrity of data and information is protected, valid, accurate, complete and timely data and information is available to support decision making across the Trust;

- Ensure there is an ethos of learning and continual quality improvement and a safety culture that supports safe high-quality care;

- Ensure there is good team working, collaboration and partnership working to provide the best possible outcomes for our citizens;

- Ensure compliance with the Health and Care Quality Standards (2023);

- Ensure all reasonable steps are taken to prevent, detect and rectify irregularities or deficiencies in the quality, safety and performance of care provided, and in particular that:
  - sources of internal assurance are reliable
  - recommendations made by internal and external reviewers are considered and acted upon on a timely basis; and
  - lessons are learned from concerns, incidents, complaints and claims.

- Ensure there is an effective clinical audit and quality improvement function that meets the standards set for the NHS in Wales and provides appropriate assurance to the Board; and,

- Advise the Board about key indicators of quality, safety and performance, which will be reflected in the Trust's performance framework, against which performance will be regularly assessed and reported on through Annual Reports.

Integrated Quality & Safety Group

3.2 The monthly Integrated Quality & Safety Group will consider all matters relating to the Integrated Quality & Safety agenda and will produce a quarterly report to the Committee synthesising and analysing the outcomes to provide assurance and exception reporting to the Committee.

Webber, Jane
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Authority

3.3 The Committee is authorised by the Board to investigate or commission investigation of any activity within its terms of reference. In doing so, the Committee shall have the right to inspect any books, records or documents of the Trust relevant to the Committee's remit,

ensuring patient, and donor and staff confidentiality, as appropriate. The Committee may seek relevant information from:

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

- Obtain legal / other providers of independent professional advice, and to secure the attendance of individuals external to the Trust who have relevant experience and expertise if necessary, and in accordance with the Board's procurement, budgetary and other requirements.

- By giving reasonable notice, require the attendance of any of the officers or employees and auditors of the Trust at any meeting of the Committee.

3.4 Approve policies relevant to the business of the Committee as delegated by the Board.

Access

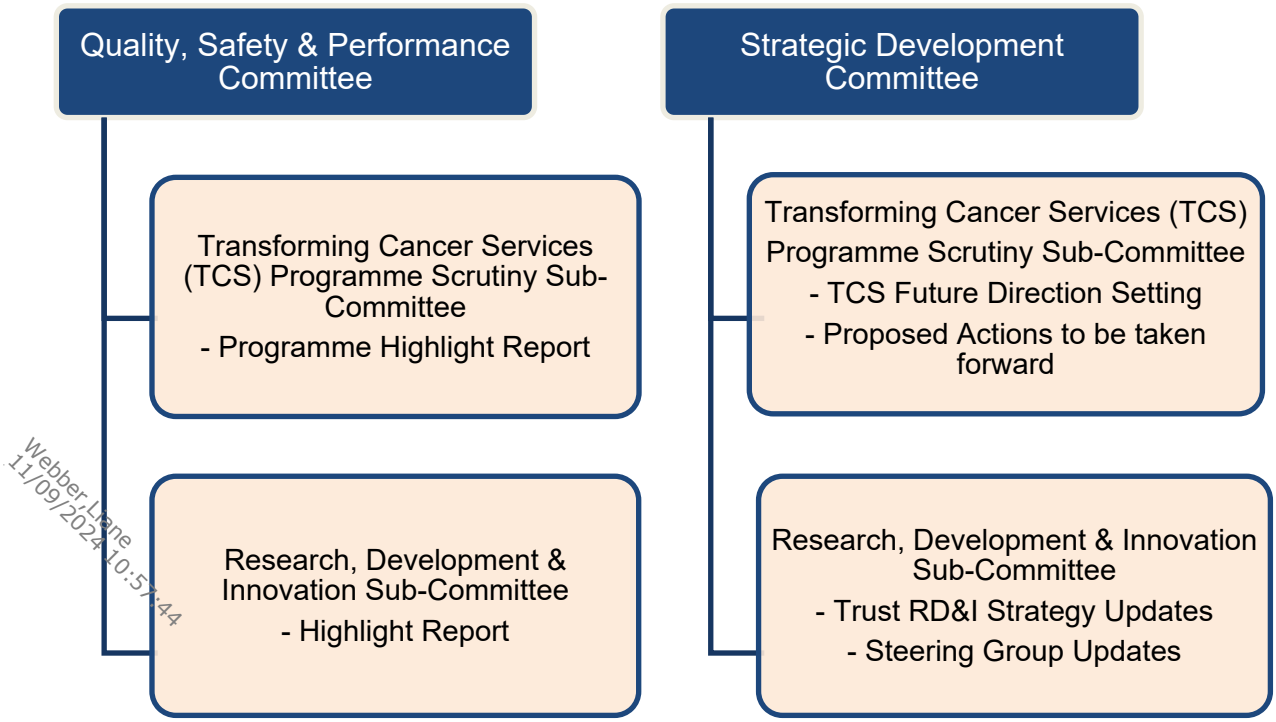
3.5 The Chair of the Quality, Safety & Performance Committee shall have reasonable access to Executive Directors and other relevant senior staff.

Sub Committees

3.6 The Committee has, with approval of the Trust Board, established the:
- Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee; and the
- Research, Development & Innovation Sub-Committee.

Note: an overarching summary of the Trust's Governance & Accountability Framework is provided at Annex 1. In addition, the wider governance and accountability reporting arrangements in place at a local divisional level that feed upwards into the Quality, Safety & Performance Committee structure are also summarised at ***Annex 2***.

The two sub-committees will have a dual reporting line to both the Quality, Safety and Performance Committee and the Strategic Development Committee as illustrated below:



Webber, Lynne
11/09/2024 10:57:44

Although the Transforming Cancer Services (TCS) Programme Scrutiny Sub-Committee and Research, Development & Innovation Sub-Committee, are sub-committees with dual reporting lines, they will both retain the delegated authority for decision making granted by the Trust Board. Further details regarding delegated powers and authority are set out in each of the Sub-Committee Terms of Reference. The Research, Development & Innovation Sub-Committee will also feed into the Trust Charitable Funds Committee for alignment with strategy and funding. Further details are set out in each of the respective Terms of Reference.

4. MEMBERSHIP

Members

4.1 A minimum of two (2) members, comprising:

Chair Independent member of the Board (Non-Executive Director)
One independent member of the Board (Non-Executive Directors)

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

4.2 **Attendees:**

- Chief Executive Officer
- Executive Director of Nursing, Allied Health Professionals and Health Science (Committee Lead Executive Officer)
- Executive Medical Director *(also Caldicott Guardian)*
- Chief Operating Officer
- Welsh Blood Service and Velindre Cancer Service Divisional Directors
- Directors of Hosted Organisations or representatives
- Director of Corporate Governance and Chief of Staff
- Executive Director of Finance
- Executive Director of Organisational Development and Workforce
- Executive Director of Strategic Transformation, Planning & Digital
- Deputy Director of Planning and Performance
- Deputy Director of Nursing, Quality and Patient Experience
- Deputy Director of Organisational Development and Workforce
- Chief Digital Officer (*also cyber/data outages/performance)*
- Head of Quality & Safety
- Head of Corporate Governance

As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Director of Nursing, Allied Health Professionals and Health Science;
- Executive Medical Director
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Webber, Liane
11/09/2024 10:37:14

Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

4.3 **By invitation**

The Committee Chair may extend invitations to individuals from within or outside the organisation, taking account of the matters under consideration at each meeting.
The Committee welcomes attendance at Committee meetings by staff from within the Organisation, representatives of independent and partnership organisations and our regulators including:

- Healthcare Inspectorate Wales
- Audit Wales
- Trade Unions
- Llais (Citizens Voice Body)

Secretariat

4.4 Secretary - as determined by the Director of Corporate Governance and Chief of Staff

Member Appointments

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

4.6 Members shall be appointed for a maximum of 3 consecutive years before formally reviewing their role on the Committee. During this time a member may resign or be removed by the Board.

Support to Committee Members

4.7 The Director of Corporate Governance and Chief of Staff, on behalf of the Committee Chair, shall:

- Arrange the provision of advice and support to Committee members on any aspect related to the conduct of their role; and
- Ensure the provision of a programme of organisational development for Committee members as part of the Trust's overall OD programme developed by the Executive Director of Organisational Development & Workforce.

5. COMMITTEE MEETINGS

Quorum

5.1 At least two independent members must be present to ensure the quorum of the Committee. If the Committee Chair is not present an agreement as to who will chair from the independent members in their absence.

5.2 As a minimum, there must be at least 2 Executive/Board Directors in attendance from the following:

- Executive Director of Nursing, Allied Health Professionals and Health Science;
- Executive Medical Director
- Executive Director of Finance
- Executive Director of Organisational Development & Workforce

Webber, Jane
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Should any Executive/Board Director be unavailable to attend, they may nominate a Deputy with the agreement of the Chair, however these deputies will not count towards the quorum.

Frequency of Meetings

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

Withdrawal of individuals in attendance

5.4 The Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

6. RELATIONSHIPS & ACCOUNTABILITIES WITH THE BOARD AND ITS COMMITTEES / GROUPS

6.1 Although the Board has delegated authority to the Committee for the exercise of certain functions as set out within these terms of reference, it retains overall responsibility and accountability for ensuring the quality, safety and performance of healthcare for its citizens through the effective governance of the organisation.

6.2 The Committee is directly accountable to the Board for its performance in exercising the functions set out in these terms of reference.

6.3 The Committee, through its Chair and members, shall work closely with the Board's other Committees, including Joint (Sub) Committees and Groups to provide advice and assurance to the Board through the:

- joint planning and co-ordination of Board and Committee business; and
- sharing of information

in doing so, contributing to the integration of good governance across the organisation, ensuring that all sources of assurance are incorporated into the Board's overall risk and assurance framework.

6.4 The Committee will consider the assurance provided through the work of the Board's other Committees and Sub Groups to meet its responsibilities for advising the Board on the adequacy of the Trust's overall framework of assurance.

6.5 The Committee shall embed the Trust's corporate objectives, priorities and requirements, e.g., equality and human rights through the conduct of its business.

7. REPORTING AND ASSURANCE ARRANGEMENTS

7.1 The Committee Chair shall:

- Provide a formal report to the Board of the Committee's activities. This includes updates on activity and triangulated assurance outcomes through the submission of written Committee Highlight Reports and other relevant written reports, as well as the submission of an annual Quality, Safety & Performance Committee report;

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

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- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

- Bring to the Board's specific attention any significant matters under consideration by the Committee;

- Ensure appropriate escalation arrangements are in place to alert the Trust Chair, Chief Executive or Chairs of other relevant Committees of any urgent/critical matters that may compromise patient / donor care and affect the operation and/or reputation of the Trust.

7.2 The Director of Corporate Governance and Chief of Staff, on behalf of the Board, shall oversee a process of regular and rigorous self-assessment and evaluation of the Committee's performance and operation including that of any Sub Committees established.

8. APPLICABILITY OF STANDING ORDERS TO COMMITTEE BUSINESS

8.1 The requirements for the conduct of business as set out in the Trust's Standing Orders are equally applicable to the operation of the Committee, except in the following areas:

- Quorum

Cross referenced with the Trust Standing Orders.

9. REVIEW

9.1 Terms of reference and operating arrangements, and the Committees Programme of Work will be reviewed annually by the Committee, with reference to the Board.

10. CHAIR'S ACTION ON URGENT MATTERS

10.1 There may, occasionally, be circumstances where decisions normally made by the Committee need to be taken between scheduled meetings. In these circumstances, the Committee Chair, supported by the Director of Corporate Governance and Chief of Staff as appropriate, may deal with the matter on behalf of the Board, after first consulting with one other Independent Members of the Committee. The Director of Corporate Governance and Chief of Staff must ensure that any such action is formally recorded and reported to the next meeting of the Committee for consideration and ratification.

10.2 Chair's urgent action may not be taken where the Chair has a personal or business interest in the urgent matter requiring decision.

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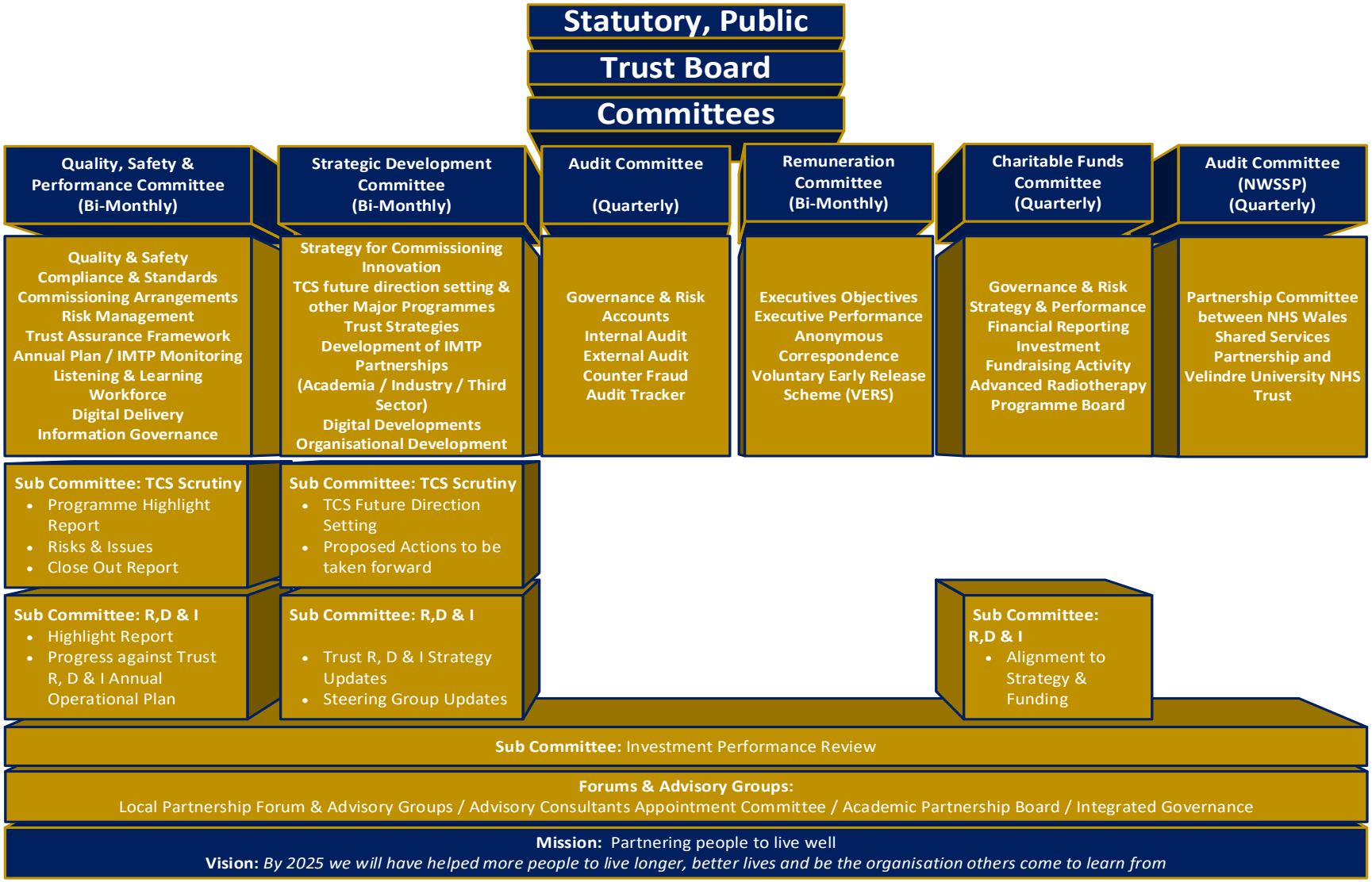
ANNEX 1 – GOVERNANCE & ACCOUNTABILITY FRAMEWORK



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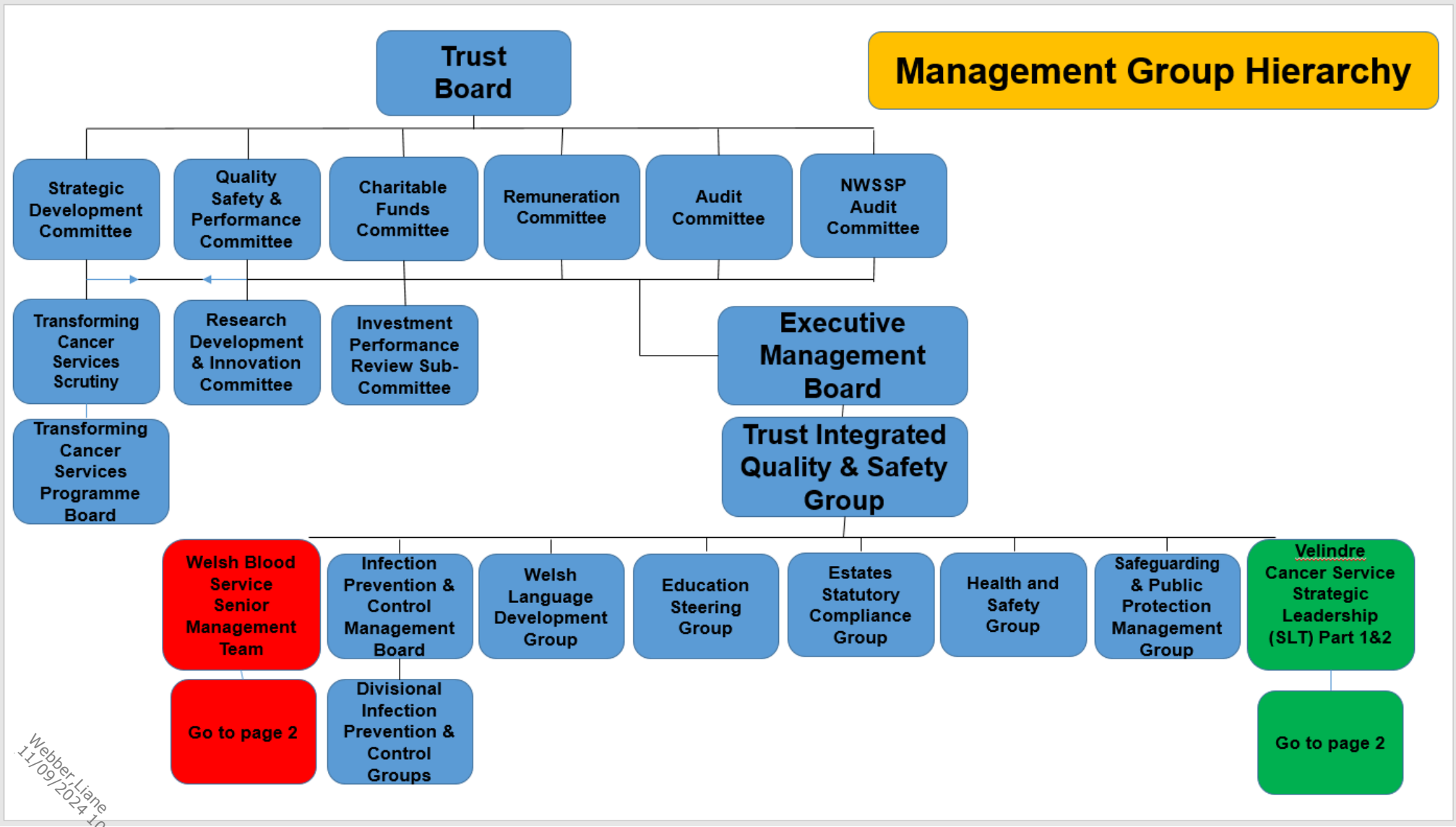
ANNEX 2 – WIDER GOVERNANCE & ACCOUNTABILITY FRAMEWORK



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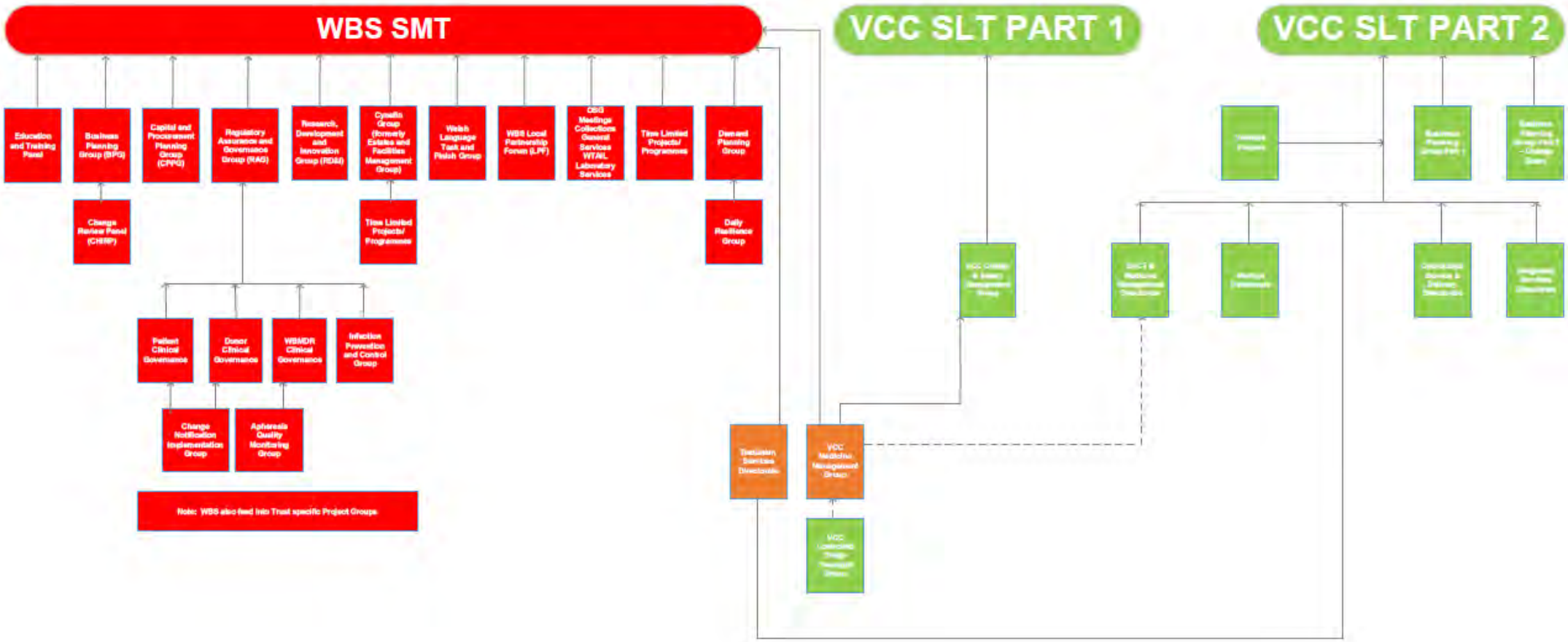

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Quality, Safety and Performance Committee

Annual and three-year Assurance Reports on Compliance with the Nurse Staffing Levels (Wales) Act 2016

DATE OF MEETING	12th September 2023
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	ASSURANCE AND ENDORSEMENT
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Rhian Wright, Nurse Staffing Programme Lead
PRESENTED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences

EXECUTIVE SUMMARY	Section 25E of the Nurse Staffing Levels (Wales) Act 2016 requires Health Boards/Trusts to report their compliance in maintaining the nurse staffing level for each adult acute medical and surgical ward and paediatric inpatient wards This paper is to provide the Quality, Safety and Performance Committee with both the annual (6th April 2023 to 5th April 2024) assurance and the three-year report covering April 2021 to April 2024. During 2023/24: • The planned roster was met and appropriate for the majority of shifts. • All reasonable steps were taken to maintain the nurse staffing level in line with the requirements of the Act. • **There have been no instances of reportable harm for pressure damage, falls or medication never events where staffing levels contributed.** • **There have been no instances where nurse**

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	staffing levels were thought to be a contributory factor to harm or complaints. • The nursing establishment was sufficiently funded and appropriate to provide the planned roster for the First Floor Ward.

RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to ***ENDORSE*** the 2023/2024 Nurse Staffing Levels Wales Annual Report, and the 2021/2024 Nurse Staffing Levels Wales 3-year report prior to submission for onward approval by the Trust Board prior to submission to the Welsh Government.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Professional Nursing Forum	01/08/24
Executive Management Board	29/08/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Endorsed for onward approval	

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

APPENDICES	
Appendix 1	2023/2024 Nurse Staffing Levels Wales Annual Report
Appendix 2	2021/2024 Nurse Staffing Levels Wales 3-year report

1. BACKGROUND

The Nurse Staffing Levels (Wales) Act 2016 requires health service bodies to make provision for safe nurse staffing levels, and to ensure that nurses are deployed in sufficient numbers. The Act is intended to:

- Enable the provision of safe nursing care to patients at all times;
- Improve working conditions for nursing and other staff; and;
- Strengthen accountability for the safety, quality and efficacy of workforce planning and management.

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The Velindre Cancer Service First Floor Ward was re-classified in April 2021 as meeting the wider definition of a 'medical ward' as it is a specialist oncology medical

ward and therefore, the ward and Trust are now required to meet the full reporting requirements of the Nurse Staffing Levels (Wales) Act 2016. Bi-annual nursing establishment reviews of both 25A and 25B areas are carried out utilizing a triangulated approach. The full detailed report will follow however part of this is considered in the assessment/summary below.

2. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 Nurse Staffing Levels Act Reporting

To facilitate the preparation of the statutory three-yearly report to Welsh Government, there is an agreed All Wales requirement that an annual assurance report be prepared to provide assurance to the Board that all statutory requirements are being met. The Nurse Staffing Levels (Wales) Act 2016 Annual Assurance Report has been completed and the report (using the national reporting template) is attached. This report highlights:

- Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 biannual nursing establishment reviews have taken place using a triangulated approach in first floor ward, 25B area.
- Although not a requirement under the Act the same process of undertaking bi-annual establishment reviews is enacted for 25A areas.
- There has been no change in the nursing establishment for first floor during the current reporting period.
- SafeCare has been utilised to record nurse staffing and acuity levels on first floor since March 2023 with a compliance rate of 93.2%.
- The planned roster was met and appropriate for the majority of shifts.
- All reasonable steps are utilised to maintain the nurse staffing level in line with the requirements of the Act.
- Historically Velindre has not had a problem recruiting into nursing vacancies, However, unprecedented national and global challenges in nurse recruitment and retention has impacted on the Trust during the reporting period. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated which has had a positive impact.
- **There have been no instances of reportable harm for pressure damage, falls or medication never events. There have been no instances where nurse staffing levels were thought to be a contributory factor to harm or complaints.**
- There was only one complaint in relation to nursing care, related to discharge planning and communication with the family concerned. The concern has been

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communicated to ward staff and appropriate learning has been embedded.

- Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor.

3.2 Establishment Reviews

Following each national benchmarked acuity review (twice yearly) an establishment review is undertaken across all areas of the Trust that employs registered nurses. The establishment reviews include all front line care/treatment delivery (both Divisions) chaired by the Executive Director of Nursing, AHP & Health Science and supported by the relevant Head of Nursing and Senior Nurses. The establishment reviews are reported on a template for agreement at each level. Each establishment review includes an overview of:

- Current funded establishments
- Vacancies and staff in post
- Datix Incidents – related to service delivery and staffing
- Complaints relevant to establishment or staffing
- Training compliance
- PADR compliance
- Review of Roster
- Patient Feedback (CIVICA)
- Audits (Tendable)
- Acuity that may be formally assessed i.e. First floor or discussion of area for understanding
- KPI review
- Quality Indicators (25B)
- Service plans or Clinic Templates as applicable (not all areas)

In summary, there were no incidents relating to the quality indicators or complaints effecting care linked to nurse staffing levels for the reporting period for the. PADR compliance overall was good (100% in some areas) First Floor PADR compliance was excellent, reported at 97% in October 2023. Training compliance was overall good.

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	☐

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• 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 Nurse Staffing Levels (Wales) Act 2016 covers all aspects of safe, timely and effective care. Rostering of staff against demand considers equitable and efficient care to deliver patient centred delivery.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
	Socio-economic disadvantage and inequality of outcome is not relevant to this paper
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	To enable us to achieve a Healthier Wales and our organisational goals we need a sufficient workforce with the right skills and in the right place to be able to provide safe, timely and effective care to our patients and donors.
FINANCIAL IMPLICATIONS / IMPACT	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
	There is no evidence to suggest that the information in this paper could benefit or disadvantage any particular group of people.

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ADDITIONAL LEGAL IMPLICATIONS / IMPACT	Yes (Include further detail below)
	Compliance with the relevant sections of the Nurse Staffing Levels (Wales) Act 2016 is a statutory obligation and will be subject to scrutiny

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No

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Appendix 1

Annual Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Board/Delegated Committee			
Health board/trust	Velindre University NHS Trust		
Date annual assurance report is presented to Board	The report is based on data from April 6th 2023 - April 5th 2024 *This annual report refers only to year 2023/ 2024* but this report forms part of the 3 yearly assurance report that will be presented to Welsh Government in October for the *reporting period from April 2021- April 2024.*		
	Adult acute medical inpatient wards	**Adult acute surgical inpatient wards**	**Paediatric inpatient wards**
During the last year the lowest and highest number of wards	**1**	NA	NA
During the last year the number of occasions (wards where section 25B applies) where the nurse staffing level has been recalculated outside the bi-annual calculation periods	0	NA	NA
The process and methodology used to calculate the nurse staffing level.	The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. The first floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave. The ward manager remains supernumerary to the planned roster. A nurse co-ordinator is also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients. The annual presentation of the nurse staffing level was presented to the Executive Board in December 2023. There have been no changes in establishment during the last 12 months reporting period. The ward has not changed its primary purpose during the reporting period and no recalculations have taken place outside of the bi-annual calculation cycle.		
Informing patients	Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period and the date that the calculation was		

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	undertaken and signed off by the designated person. The posters are amended following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQ's for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level has been maintained

As the nurse staffing level is defined under the NSLWA as comprising of both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained during the period of this annual report

Extent to which the required establishment has been maintained within adult acute medical and surgical wards. NB: First cycle: spring 2022 following January audit Second cycle: autumn 2022: following June audit		**Period Covered …2023……**		
		Number of Wards:	**RN (WTE)**	**HCSW (WTE)**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during first cycle (May)	**1**	**28.42**	**14.21**
	WTE of required establishment of adult acute medical and surgical wards funded following first (May) calculation cycle	**1**	**28.42**	**14.21**
	Required establishment (WTE) of adult acute medical and surgical wards calculated during second calculation cycle (Nov)	**1**	**28.42**	**14.21**
	WTE of required establishment of adult acute medical and surgical wards funded following second (Nov) calculation cycle	**1**	**28.42**	**14.21**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**		
	There has been no required change to the funded establishment during the current reporting period. In addition to the Ward Manager there is also a supernumerary nurse co-ordinator WTE 1.269 which is funded but excluded from the planned roster. The nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor. After undertaking a review of the current funded nursing establishment against the required establishment for First Floor Ward, the Integrated Care Directorate is			

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of the opinion that the current establishment is sufficient to manage and deliver care sensitively to patients nursed on First Floor up to the full capacity of 32 beds.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there are a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within adult acute medical and surgical wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
TOTAL	*682*	*593* *86.95 %*	26 3.81%	10 1.47%	53 7.77%	*93.2%*

There has been an overall improvement in the percentage of shifts where the planned roster was met and was appropriate. This is achievable as our beds are commonly not utilised to full capacity. Shifts where the planned roster was not met and not appropriate have significantly reduced from 20% in April 2023 to 7.77% currently. When the planned roster is not met temporary staffing is considered and often requested, however, this can be challenging if sickness has been reported close to the shifts commencement. On such occasions the nurse in charge will consider if there are any staff that are supernumerary to the planned roster that can be deployed to assist in direct patient care. Overall compliance for completing the data has improved to 93.2% from 89% last year.

Process & systems for capturing data on the extent to which the planned roster has been maintained on wards where section 25B applies.

Each health board/trust is committed to implementing Allocates Safecare system and each organisation is at different stages of implementing this system within their areas, prioritising section 25B wards. Health boards/Trusts have also been using the Health Care Monitoring system (HCMS) which has been adapted to ensure consistency in the data collection and analysis to aid reporting.

During this reporting period from April 2023 to April 2024, Velindre University NHS Trust has recorded acuity twice a day solely utilising the SafeCare system. The ward ceased using the Health Care Monitoring System in March 2023 for ease of use and to eliminate dual reporting.

Process for maintaining the Nurse staffing level

There are risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and

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	staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of the patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include: • Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care. • Utilising bank and agency.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)		Falls resulting in serious harm or death (i.e. 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	avoidable	unavoidable	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	0	1	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next year	0	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	0	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the	0	0	0	0	0

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nurse staffing level (planned roster)was considered to have been a contributing factor					

Additional narrative

There was only one complaint in relation to nursing care. There has been no change in the level of complaints as there was one reportable complaint during the previous reporting period. The complaint was in relation to discharge planning and communication with the patients family. The concern has been feedback to ward staff and appropriate learning has been embedded.

The fall that was open from last year has been reviewed by the learning panel and is now closed and does not reach the threshold for a reportable quality indicator. There has been no reportable medication never events linked to the ward. There is one pressure damage case that has been discussed at the pressure damage learning panel has been deemed as unavoidable. There have been no instances of reportable harm.

Revised national indicators / measures will come into effect at the beginning of the next reporting period i.e. from April 2024. The quality indicators for the adult medical and surgical wards will be as follows:

- *Hospital acquired pressure damage (grade 3, 4 and unstageable) (avoidable and unavoidable)*
- *Falls resulting in moderate harm, serious harm or death (i.e. level 3, 4 and 5 incidents).*
- *Medication errors resulting in moderate harm, severe harm, death & never events (i.e. level 3, 4, 5 and never events incidents).*
- *Any complaints received about nursing care (Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR))*

The data to be reported for each of the above will be:

- *Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.*
- *Total number of incidents/ complaints not closed and to be reported on/during the next year*
- *Number of incidents/ complaints occurring when the nurse staffing level (planned roster) had not been maintained*
- *Number of those incidents/complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor*
- *Number of incidents/complaints occurring when the nurse staffing level (planned roster) had been maintained*
- *Number of those incidents/complaints when the nurse staffing level was deemed to have been a contributing factor, even when planned roster had been maintained.*

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	Section 25E (2c) Actions taken if the nurse staffing level is not maintained (or maintained but not appropriate *
Actions taken if the nurse staffing level was not maintained in wards where section 25B applies	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g. the utilisation of temporary workforce, using a risk-based approach to redeploy staff. On several occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care on the ward. Staff can raise red flags on SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition:

	• All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
	Section 25A: Duty to have regard to provide sufficient nurses
Requirements of Section 25A (NB: Section 25A refers to the Health Boards/Trusts overarching responsibility to ensure appropriate nurse staffing levels in any area where nursing services are provided or commissioned, not only wards where section 25B applies)	The establishment review process for section 25A areas follows the same process as our 25B ward. During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined. There is a robust plan in place to recruit into registered nurse vacancies. Velindre University NHS Trust has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala who are currently undergoing a preceptorship programme. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.
	Conclusion & Recommendations
	There have been no instances of reportable harm for pressure damage, falls or medication never events. There have been no instances where nurse staffing levels were thought to be a contributory factor to harm or complaints.

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A summary of Nurse Staffing Levels for Wards where section 25B applies
Appendix 1: Annual Assurance Report

Health board/trust:	Velindre University NHS Trust
Period of the report	6th April 2023 - 5 April 2024
adult acute medical wards	1

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within this appendix but further information can be found within the main body of the annual assurance report

Adult Acute Medical Inpatient wards

	TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the start of this report (Spring calculation cycle) including uplift 26.9%		TOTAL (WTE) band 7 supernumerary ward sister/Charge nurse	Required Establishment at the end of the period of this report (autumn calculation cycle) including uplift 26.9%		Biannual calculation cycle reviews, and rationale for any changes made			Any reviews outside of biannual calculation, if yes provide rationale for any changes made			
Name of Ward		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)		TOTAL WTE RN (band 5,6)	TOTAL WTE HCSW (bands 2,3,4)	Completed (Yes/No)	Changed	Rationale	Completed (Yes/No)	Date	Changed	Rationale
First Floor	1	28.42	14.21	1	28.42	14.21	Y	N	Not required	N			

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Appendix 2

`	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Velindre University NHS Trust		
Reporting period	The reporting period is from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly report that go to Board in May 2024 will only include data relating to serious incidents closed by 31st January 2024 (A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024).		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	28/7/2022 P:\board papers\Annual Assurance Report May NSA 2021-2022.docx	25/5/2023 Annual Assurance Report NSL 2023 NT Final.docx	Annual assurance report EMB run Aug 23-24 ver1.docx
Number of adult acute medical inpatient wards where section 25B applies	1	1	1
Number of adult acute surgical / Paediatric inpatient wards where section 25B applies	0	0	0
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**
Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	• During the COVID pandemic in 2020 bed capacity was reduced from 32 to 20 beds (to meet required bed spacing standards given patient vulnerability). There was no change in the primary purpose of the ward during this time. Due to the fact that there is only one inpatient ward there was no specific COVID ward. Suspected COVID patients were nursed in cubicles or cohorted to help reduce any spread of infection. • The ward was reinstated to full capacity of 32 beds in September 2022. • Nurse staffing was not a significant problem on the ward during this period due to the reduction in bed capacity.		

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Informing patients	• Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period, and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQs for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. • Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 1**
		RN: 23.68
		HCSW: 23.68

		2021/2022	2022/2023	2023/2024
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards	**Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May)**	**Number of wards: 1**	**Number of wards:1**	**Number of wards:1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**
	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during second cycle (Nov)	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN:28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
		Number of wards: 1	**Number of wards: 1**	**Number of wards: 1**

Webber,Liane
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	WTE of required establishment of adult acute medical and surgical inpatients wards funded following second (Nov) calculation cycle	**RN: 23.68**	**RN: 28.42**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**	**WTE: 1**	**WTE: 1**

The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor Ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.

The first-floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave.
The ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients.

- The planned roster was reduced during the pandemic to reflect reduced bed capacity.
- There has been no change in the planned roster since 2022.
- The band 7 ward manager is supernumerary and not included in the required establishment figures. First floor has a nurse co-ordinator role that is also additional to the planned roster.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
2021/2022	*4745*	*3773* *80%*	*0*	*972* *20%*	*0*	*100%*
2022/2023	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89%*
2023/2024	*682*	*593* *86.95 %*	26 3.81%	10 1.47%	53 7.77%	*93.2%*

Hughes, Liane
4/10/2024 10:57:44

	Year 1 and 2 data was extracted from the Health Care Monitoring System (HCMS). Year three data has been extracted from SafeCare. SafeCare was fully implemented and has been utilised to record nurse staffing and acuity data since March 2023. The data highlights a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. There has also been an improvement in the number of shifts where the planned roster was not met and not appropriate reducing from 20% in Year 2 to 7.77% in Year 3.
Process for maintaining the nurse staffing level for Section 25B wards	There are established risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include: • Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills. • Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care. • Utilising bank and agency. During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined. Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, Velindre University NHS Trust has had to rethink the workforce planning strategy and has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala who are currently undergoing a preceptorship programme. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care	Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
	TOTAL	TOTAL	TOTAL	TOTAL

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Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	**Year 1**	0	0	0	5
	Year 2	0	0	0	1
	Year 3	0	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	**TOTAL**	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	**Year 1**	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	**Year 1**	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0

There has been no reportable harm in relation to the quality indicators during the last 3-year period. There have been no complaints or harm caused where nurse staffing levels were considered to be a contributing factor. There were 7 complaints about nursing care which were managed through the putting things right framework: 5 in year one, one in year 2 and one in year 3.

Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate

Actions taken when the nurse staffing level was not maintained in section 25B wards	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g., the utilisation of temporary workforce and using a risk-based approach to redeploy staff. On occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care. Staff can raise red flags in SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.

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Conclusion & Recommendations	• During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022 • Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for First Floor ward (25B) have taken place using the triangulated approach • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor • Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas • There has been no change in the planned roster since 2022. • The first floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift • HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023 • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. • There has been no reportable harm in relation to the quality indicators during the last 3-year period • There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act • Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated. • In relation to 25A areas it was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

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Appendix 2

`	Three-Yearly Assurance Report on compliance with the Nurse Staffing Levels (Wales) Act: Report for Welsh Government		
Health board	Velindre University NHS Trust		
Reporting period	The reporting period is from the 6th of April 2021 to the 5th of April 2024. However, due to the timeframe for closing serious incident reports, the three-yearly report that go to Board in May 2024 will only include data relating to serious incidents closed by 31st January 2024 (A final, updated version of the report - including all serious incident reports that occurred prior to April 5th 2024 - which should by then be closed - will be presented to the Board in September 2024 and then Welsh Government in October 2024).		
	2021/2022	**2022/2023**	**2023/2024**
Date annual assurance report of compliance with the Nurse Staffing Levels (Wales) Act presented to Board	28/7/2022 P:\board papers\Annual Assurance Report May NSA 2021-2022.docx	25/5/2023 Annual Assurance Report NSL 2023 NT Final.docx	Annual assurance report EMB run Aug 23-24 ver1.docx
Number of adult acute medical inpatient wards where section 25B applies	1	1	1
Number of adult acute surgical / Paediatric inpatient wards where section 25B applies	0	0	0
Number of occasions where the nurse staffing level recalculated in addition to the bi-annual calculation for all wards subject to Section 25B	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**	Number of wards where a re-calculation in addition to the bi-annual calculation has been undertaken in **adult acute medical inpatient wards** **0**

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Changing the purpose of section 25b wards to support the management of COVID or opening new COVID wards.	• During the COVID pandemic in 2020 bed capacity was reduced from 32 to 20 beds (to meet required bed spacing standards given patient vulnerability). There was no change in the primary purpose of the ward during this time. Due to the fact that there is only one inpatient ward there was no specific COVID ward. Suspected COVID patients were nursed in cubicles or cohorted to help reduce any spread of infection. • The ward was reinstated to full capacity of 32 beds in September 2022. • Nurse staffing was not a significant problem on the ward during this period due to the reduction in bed capacity.
Informing patients	• Bilingual All Wales 'Informing Patients Posters' are displayed at the entrance of the ward, informing patients and relatives of the nurse staffing numbers calculated for the identified period, and the date that the calculation was undertaken and signed off by the designated person. The posters are updated following each bi-annual re-calculation. Bilingual easy read FAQ's are displayed alongside the informing patients posters. In addition, bilingual copies of the All-Wales FAQs for Nurse Staffing Levels are available for patients and visitors to view on the ward. The Nurse Staffing Programme Lead regularly checks and updates the information displayed. • Patients can provide anonymous feedback through a digital feedback system called CIVICA. This helps to ensure that patients can provide real time feedback for any concerns relating to patient care.

Section 25E (2a) Extent to which the nurse staffing level is maintained

As the nurse staffing level is defined under the NSLWA as comprising both the planned roster *and* the required establishment, this section should provide assurance of the extent to which the planned roster has been maintained *and* how the required establishments for Section 25B wards have been achieved/maintained over the reporting period.

	Required establishment (WTE) of adult acute medical and surgical inpatients wards at the end of the last reporting period – (as of 5th April so data from the annual presentation of the NSL to the report in Nov 2020)	**Number of wards: 1**
		RN: 23.68
		HCSW: 23.68

		2021/2022	2022/2023	2023/2024
Extent to which the required establishment has been maintained within adult acute medical and surgical inpatients wards	**Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during first cycle (May)**	**Number of wards: 1**	**Number of wards:1**	**Number of wards:1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following first (May) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 23.68**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 23.68**	**HCSW: 14.21**

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	Required establishment (WTE) of adult acute medical and surgical inpatients wards calculated during second cycle (Nov)	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN:28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**
	WTE of required establishment of adult acute medical and surgical inpatients wards funded following second (Nov) calculation cycle	**Number of wards: 1**	**Number of wards: 1**	**Number of wards: 1**
		RN: 23.68	**RN: 28.42**	**RN: 28.42**
		HCSW: 23.68	**HCSW: 14.21**	**HCSW: 14.21**

		2021/2022	**2022/2023**	**2023/2024**
	WTE Supernumerary band 7 sister/charge nurse (funded but excluded from planned roster)	**WTE: 1**	**WTE: 1**	**WTE: 1**

The triangulated approach as documented in the Welsh Levels of Care Toolkit has been utilised to inform the calculation of the nurse staffing levels on First Floor Ward. When calculating the nurse staffing levels, quality indicators including patient falls, pressure damage, medication errors and patient complaints are taken into consideration to inform the calculation of safe nurse staffing levels. Establishment reviews are carried out bi-annually with the senior nurse management team following the bi-annual nurse staffing calculation. Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas.

The first-floor establishment includes the required 26.9% headroom to account for sickness, study leave and annual leave.
The ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift. The designated person asks each ward/unit manager during the establishment review process if they have sufficient establishment to provide sensitive care to patients.

- The planned roster was reduced during the pandemic to reflect reduced bed capacity.
- There has been no change in the planned roster since 2022.
- The band 7 ward manager is supernumerary and not included in the required establishment figures. First floor has a nurse co-ordinator role that is also additional to the planned roster.

In accordance with the requirements of the Nurse Staffing Levels (Wales) Act 2016 and its associated Statutory Guidance, the 'nurse staffing level' is the establishment of registered nurses - and other staff to whom nursing duties have been delegated by a registered nurse - required to deliver the planned roster. It is acknowledged that there is a range of additional healthcare professionals that contribute to the delivery and coordination of patient care and treatment. However, these staff are not included within the data for this report.

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Extent to which the planned roster has been maintained within adult acute medical and surgical inpatients wards

	Total number of shifts	Shifts where planned roster met and appropriate	Shifts where planned roster met but not appropriate	Shifts where planned roster not met but appropriate	Shifts where planned roster not met and not appropriate	Data completeness
2021/2022	*4745*	*3773* *80%*	*0*	*972* *20%*	*0*	*100%*
2022/2023	*652*	*414* *64%*	*36* *5%*	*72* *11%*	*130* *20%*	*89%*
2023/2024	*682*	*593* *86.95 %*	26 3.81%	10 1.47%	53 7.77%	*93.2%*

Year 1 and 2 data was extracted from the Health Care Monitoring System (HCMS). Year three data has been extracted from SafeCare. SafeCare was fully implemented and has been utilised to record nurse staffing and acuity data since March 2023.

The data highlights a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. There has also been an improvement in the number of shifts where the planned roster was not met and not appropriate reducing from 20% in Year 2 to 7.77% in Year 3.

Process for maintaining the nurse staffing level for Section 25B wards

There are established risk escalation processes in place to enable real time nurse staffing levels risk escalation. Concerns regarding nurse staffing levels in Velindre Cancer Centre are escalated to the senior nursing team via a bleep system. Operational teams are taking "all reasonable steps" to maintain the nurse staffing level required. Reasonable steps are considered and staff redeployment from other areas as well as bank and agency are utilised if staffing levels are deemed insufficient. SafeCare is utilised to help determine whether staffing levels are appropriate for the acuity of patients and staff can raise red flags to highlight any concerns. Operational steps to maintain the nurse staffing level include:

- Clearly defined mechanisms in place to ensure deployment of staff to ensure appropriate clinical and/or leadership skills.
- Deployment of staff deemed as supernumerary or non-rostered for example, ward manager, nurse coordinator and practice educator to provide direct patient care.
- Utilising bank and agency.

During the October 2023 establishment review process, it was highlighted that three 25A areas were possibly under established and that one area was carrying several nursing vacancies. These areas are 25A, however, this situation has impacted the ward (25B) area as staff have had to cover the service and it has adversely affected staff morale. A meeting was held in April 2024 to scrutinise the financial establishments verses the required roster in three 25A areas. It was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernisation required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

Webber,Liane
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	Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, Velindre University NHS Trust has had to rethink the workforce planning strategy and has joined student streamlining for the first time and has recently recruited three newly qualified nurses to a new 18-month rotation programme. The Trust has also for the first time signed up to the All-Wales International Recruitment Programme. The Trust has successfully recruited 14 nurses from Kerala who are currently undergoing a preceptorship programme. These posts will fill a large proportion of vacancies in the Cancer Centre although it will take time to embed the new staff into the organisation.

Section 25E(2b) Impact on care due to not maintaining the nurse staffing levels on adult acute medical and surgical inpatient wards (years 1 & 2)

Incidents of patient harm with reference to quality indicators and complaints about nursing care		Hospital acquired pressure damage (grade 3, 4 and unstageable)	Falls resulting in serious harm or death (i.e., 4 and 5 incidents).	Medication errors never events	Any complaints received about nursing care (NOTE: Complaints refers to those complaints managed under NHS Wales complaints regulations (Putting Things Right (PTR)
		TOTAL	TOTAL	TOTAL	TOTAL
Number of closed incidents/complaints occurring during current year & those that were carried forward from the previous year.	Year 1	0	0	0	5
	Year 2	0	0	0	1
	Year 3	0	0	0	1
Total number of incidents/ complaints not closed and to be reported on/during the next reporting period	TOTAL	0	0	0	0
Number of closed incidents/ complaints occurring when the nurse staffing level (planned roster) was not maintained	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0
Number of closed incidents/ complaints where failure to maintain the nurse staffing level (planned roster) was considered to have been a contributing factor	Year 1	0	0	0	0
	Year 2	0	0	0	0
	Year 3	0	0	0	0

Webber, Jayne 11/09/2024 10:32:14

There has been no reportable harm in relation to the quality indicators during the last 3-year period. There have been no complaints or harm caused where nurse staffing levels were considered to be a contributing factor. There were 7 complaints about nursing care which were managed through the putting things right framework: 5 in year one, one in year 2 and one in year 3.	
Section 25E (2c) Actions taken if the nurse staffing level is not maintained or not appropriate	
Actions taken when the nurse staffing level <u>was not</u> maintained in section 25B wards	When nurse staffing levels have not been maintained, there is evidence that operational teams are taking 'all reasonable steps' to maintain the nurse staffing levels e.g., the utilisation of temporary workforce and using a risk-based approach to redeploy staff. On occasions the ward manager or the ward coordinator have stepped in to assist with direct patient care. Staff can raise red flags in SafeCare to indicate concerns in relation to staffing levels and the senior nurse is contactable via a bleep system. In addition: • All incidents related to inpatient falls and pressure damage are reviewed by monthly learning panels, nurse staffing levels are considered as a possible contributing factor of the investigations conducted. • The medication safety group meets monthly to discuss all incidents relating to medication errors, to share good practice and plan any relevant learning. • Regular Trust wide complaints meetings are conducted to discuss complaints, concerns and compliance with the Putting Things Right process.
Conclusion & Recommendations	• During the COVID pandemic in 2020 the ward bed capacity was reduced to 20 beds, the ward was reinstated to full capacity of 32 beds in September 2022 • Aligning with the requirements of the Nurse Staffing Levels (Wales) Act 2016 the biannual nursing establishment reviews for First Floor ward (25B) have taken place using the triangulated approach • Currently, the nursing establishment is sufficiently funded and appropriate to provide the planned roster for First Floor. There are no financial concerns in relation to the staffing of First Floor • Although not a requirement under the Act the same process of bi-annual establishment reviews is enacted for 25A areas • There has been no change in the planned roster since 2022. • The first floor establishment includes the required 26.9% headroom, the ward manager remains supernumerary to the planned roster. A nurse co-ordinator also remains surplus to the planned roster on each day shift • HCMS was used to record and extract data in Year 1 and 2 of the reporting period. Year 3 data has been extracted from the SafeCare system which was fully implemented in March 2023 • There has been a significant improvement in the number of shifts where the planned roster was met and appropriate from 64% in Year 2 to 86.95% in Year 3. • There has been no reportable harm in relation to the quality indicators during the last 3-year period • There have been 7 complaints in total during the last 3 years relating to nursing care. There have been no complaints where nurse staffing levels were considered to be a contributing factor • All reasonable steps have been utilised to maintain the nurse staffing level in line with the requirements of the Act

Webber,Liane
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	• Historically the Trust has not encountered problems recruiting into nursing vacancies, however, due to unprecedented national and global challenges in nurse recruitment and retention this has now impacted on the Trust over the last 18 months. Due to a rising vacancy factor, international nurse recruitment and student streamlining has been initiated. • In relation to 25A areas it was deemed that there is sufficient establishment to create the required headroom within SACT and Assessment Unit. The area where headroom cannot be currently assured is the Clinical Nurse Specialist Team. Due to the workplan modernization required it will be Autumn 2024 before the quantification of any headroom deficit can be determined.

Webber,Liane
11/09/2024 10:57:44

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

Quality, Safety and Performance Committee

TRUST INTEGRATED MEDIUM TERM PLAN – PROGRESS AGAINST QUARTERLY (Q1) ACTIONS FOR 2024 / 2025

Date of meeting	12/09/24

PUBLIC OR PRIVATE REPORT	**Public**

IF PRIVATE PLEASE INDICATE REASON	**Not Applicable - Public Report**

REPORT PURPOSE	**INFORMATION / NOTING**

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	**NO**

Prepared by	**Peter Gorin, Head of Strategic Planning and Performance**
PRESENTED BY	**Phil Hodson, Deputy Director of Planning and Performance**
APPROVED BY	**Lauren Fear, Interim Executive Director of Strategic Transformation, Planning and Digital**

EXECUTIVE SUMMARY	**1. VELINDRE NHST IMTP PROGRESS 2024/25** 1.1 This report provides an update (position as of 30th June 2024) of progress against the actions (April to June 2024) which were included within the IMTP for 2024/25 as at Quarter 1. 1.2 These updates are provided in the form of the monitoring templates for WBS, VCS and Trust-wide (See Appendix 1, Appendix 2 and Appendix 3). 1.3 Good progress has been made again against IMTP actions as at Quarter 1.

Webber,Liane
11/09/2024 10:57:44

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

RECOMMENDATION / ACTIONS	The Quality Safety & Performance Committee is asked to: • NOTE the progress made in the delivery of the agreed IMTP (2024 – 2027) actions as at Quarter 1 for both the Velindre Cancer Service, the Welsh Blood Service and Trust-wide services.

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

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

APPENDICES	
1	Welsh Blood Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.
2	Velindre Cancer Service - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.
3	Trust-wide Initiatives - IMTP Quarterly Progress Report 2023/24 for Quarter 1 at 30/6/24.

ACRONYMS and INITIALISM	
IMTP	Integrated Medium Term Plan
IQPD	Integrated Quality Planning & Development (Welsh Government Review Meeting)
VCC	Velindre Cancer Service
WBS	Welsh Blood Service

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2. SITUATION/BACKGROUND

2.1 The Integrated Medium Term Plan (IMTP) 2024/25-2026/27 was submitted to the Welsh Government on 28st March 2024. Integral to the successful delivery of our IMTP were a number of actions to support the delivery of the Trust's Strategic Aims, across both cancer services and blood and transplant services.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 The timing of the end of Quarter 1 (April to June 2024), gave only a short time for a detailed assessment of progress against IMTP actions by EMB during early July to meet an earlier Trust Board reporting cycle.

3.2 The table below gives a high-level overview of progress made in the delivery of actions at Q1 for WBS, VCS and Trust-wide.

BRAG Rating	Progress Categories Definitions	Welsh Blood Services IMTP 2024/25 Actions	Velindre Cancer Services IMTP 2024/25 Actions	Trust-wide Initiatives IMTP 2024/25 Actions
BLUE	Action successfully completed with benefits being realized	**2 Q actions**	**1 Q Actions**	**1 Q actions (1 Digital)**
GREEN	Satisfactory progress being made against action in line with agreed timescale	**16 Q actions**	**14 Q actions**	**107 Q actions (24 Digital, 27 Workforce, 6 VBHC 22 Clinical, 14 Estates & 6 Sustainability, 8 Finance)**
YELLOW	Issues with delivery identified and being resolved with remedial actions in place		**13 Q actions**	**11 Q actions (10 Digital, 1 VBHC)**
AMBER	Delays in implementation / action paused due to external issues beyond our control	**2 Q actions**	**1 Q actions**	**1 Q actions (1 Digital)**
RED	Challenges causing problems requiring recovery actions to be identified			
Total IMTP 2024/25 Quarterly (Q) Actions		**20 Q actions**	**29 Q actions**	**120 Full Year Actions**

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3.3 WBS are making satisfactory progress, categorized as '*blue* (16) or gr*een (2) with 2 amber* ', against their 20 actions as at Q1, **see Appendix 1.**

The two WBS amber actions, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relate to:

- National Wales Laboratory Information System (WLIMS) 2.0 hyperlink to (page 12)
- Plasma for Medicines service model for Wales hyperlink to (page 19)

3.4 VCS are also making satisfactory progress, categorized as 'blue (1), or *green (14) or yellow (13) with 1 amber* ', against their 29 actions as at Q1 **see Appendix 2.**

The one amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' is:

- Implementation of the approved Full Business case for the development of the new Velindre cancer centre (nVCC) (page 29)

3.5 There are 120 Trust-wide actions or 'themes' (Digital 36 (1 blue, 24 green, 10 yellow, 1 amber); Workforce & OD 27 (all green); Estates 14 (all green); Clinical & Safety 22 & Sustainability 6 (all green); VBHC 7 (6 green, 1 yellow) and Finance 8 (all green); Good progress is again being made against these actions as at Q1, **see Appendix 3.**

The one Digital amber action, defined as *'Delays in implementation / action paused due to external issues beyond our control*' relates to:

- Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre hyperlink to (page 50)

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	☒

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• A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organization that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	10 - Governance
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	Quality and Safety considerations form an integral part of the Trust PMF to monitor our performance and progress against our strategic objectives
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
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
	Note: the IMTP will be subject to a EQIA assessment as will all relevant service developments proposals detailed within the IMTP
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

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5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	No
WHAT IS THE RISK?	N/A
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	

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APPENDIX 1

Welsh Blood Service - IMTP Quarterly Progress Report 2024/25 for Quarter 1 as at 30/6/2024.

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
SP1: Build a sustainable donor base to meet clinical need and be representative of the diverse communities we serve **(Link to Trust Destination 2033 – Trust Strategic Goals 1 and 5)**	Implement improved donor interaction by 2026/27. 	• Personalised donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision- making). • Increased levels of efficiency/ Productivity.	Introduce updated WBS brand toolkit. Continue to support Digital with development of refreshed booking portal.	Implement refreshed booking portal.	Begin introduction of a co-design forum for donors and advocates.	Begin introduction of a donor experience hub. Begin implementation of a Customer Relationship Management (CRM) System. Continue with introduction of a co-design forum for donors and advocates.	The WBS brand toolkit has been developed and is now in effect. Work ongoing to develop refreshed booking portal with validation about to commence. On track to implement in Q2.	
	Develop and implement the Welsh Bone Marrow Donor Registry (WBMDR) strategy re-appraising the collection model	• Sustained growth and retention of the stem cell donor panel. • Increase in stem cells supply.	Introduce Self-Administration of G-CSF as part of the modernisation of Clinical Services.	Continue to develop model for bone marrow collections in Wales. Review of clinical model	Review and develop of clinical model for apheresis collections. Continue to develop model	Implement identified and developed strategies for maintaining growth of the registry such as collecting 3rd party cellular	Self-Administration model for G-CSF successfully implemented into the WBMDR operating model.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	and its ambition by 2026/27. WBS Futures	• Increased diversity in the donor panel. • Improved resilience in stem cell supplies. • Improved clinical outcomes nationally • / inter nationally. • Increased income levels.	Develop model for bone marrow collections in Wales. Investigate digital replacement solution for WBMDR software.	for apheresis collections. Implement JACIE Accreditation for stem cell collection services. Develop model for stem cell donor medicals. Continue to develop URS and engage with digital suppliers to replace current WBMDR Software	for stem cell donor medicals. Produce and process tender to replace current WBMDR software	products or ATMP starting materials. Follow tender process to replace current WBMDR Software.	The development of a model for bone marrow collections in Wales is currently underway. Work ongoing to scope suitable digital solution. User Requirements Specification (URS) completed and formal tender process to commence.	
SP2: To provide a world class donor experience **(Link to Trust Destination**	Implement new donor strategy by 2025/26. (platelet, blood, bone marrow, plasma) WBS Futures	• Right size/shape donor panel/s. • Increased resilience for supply of products across Wales. • Improved levels of	Re-submit new donor and advocate strategy for approval.	Begin to develop recommendations for systems, processes and people required to deliver the strategy.	Complete recommendations paper for systems, processes and people required to deliver the strategy		The donor and advocate strategy has been approved and is now being actively implemented.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)		efficiency / productivity • Reduced importation and costs. • Increased brand awareness and reach. • Wider population/donor education. • Development of rich data to improved insights and focus efforts in right areas						
SP3: Drive the prudent use of blood across Wales	Implementation of the Pre-Operative Anaemia Pathway programme by 2024/25.	• Improved clinical outcomes for patients post operatively. • Reduced length of stay post-surgery. • Prudent use of (reduced	Evidence of compliance with Health Board action plans issued in July 2023.	Dataflow for treatment data established. Incorporate costing data into Dashboard development.	Health Board Benchmarking to be incorporated into treatment data to evidence compliance with NICE QS138.	Current funding stream ends 31/12/24.	Gap analysis and dashboard data is evidencing health board compliance, along with Preoperative Anaemia Pathway screening across all Health Boards.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 4 and 5)		demand for blood). • Increased equity of care and outcomes. • Reduction in clinical complications associated with receiving blood products. • Compliance with the NICE guidance. • Improved efficiency. • Cost efficiencies.					Ongoing data capture of treatment and access to transfusion data from WLIMS legacy repository and pilot IV iron data. Welsh Government confirmation of recurrent funding for the programme awaited.	
SP4: Quality, safety and value: doing it right, first time **(Link to Trust Destination 2033 – Trust Strategic**	Revised blood collection clinic portfolio by 2025/26. WBS Futures	• Increased • /Sustainable collection model. • Improved access for service users. • Improved collection efficiency. • Reduction in costs. • Improved access to	Complete implementation of tours for North Wales teams.	Begin to develop options for introduction of a new fixed donation venue/s. Begin review of existing blood donation venues.	Continue to develop options for introduction of a new fixed donation venue/s. Continue to explore options for introduction of a new fixed donation	Continue to develop options for introduction of a new fixed donation venue/s. Continue review of existing blood donation venues.	Business Case for implementation of tours drafted and North Wales Tours Plan completed. Employee engagement initiated.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2, 4 and 5)		donors for recruitment to the Welsh Bone Marrow Donor Registry.			venue/s. Continue review of existing blood donation venues.			

IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Introduce clinically led collection team model by 2024/25. WBS Futures	• Improved leadership capability. • Standardization of terms and conditions across collection teams. • Improved quality. Improved safety. • Reduction in staff turnover. • Improved collection efficiency.	Continue to undertake a workforce review, to include roles and responsibilities.	Continue to undertake a workforce review, to include roles and responsibilities Develop new job descriptions.	Begin to implement workforce review in line with Organisational Change Policy (OCP).	Continue to implement workforce review in line with Organisational Change Policy (OCP).	Options Appraisal process has begun to review business needs and workforce requirements.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Develop and implement a platelet strategy by 2025/26. 	• Improved levels of efficiency. • Improved alignment between capacity and demand. • Reduction in avoidable waste. • Reduce wastage.	Development and implementation of the validated Demand and Capacity tool. Implement new platelet pooling packs. Implement apheresis in Platelet Additive Solution (PAS).	Continue development and Implementation of the validated Demand and Capacity tool. Continue with implementation of new platelet pooling packs. Implement apheresis in PAS. Research and development of new components.	Development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet supply including substitutions. Research and development of new components.	Continue development of the collection strategy for apheresis and whole blood platelet collection Optimize the clinical efficacy of platelet supply including substitutions. Research and development of new components.	Demand and Capacity tool in final stages of development. Phase 1 trial for pooling packs completed with trial report in draft. Follow up trial to identify optimum PAS/Plasma ratio is ongoing.	
	To work with the National Wales Laboratory Information System (WLIMS) 2.0	• Modernise patient management software with robust digital support.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation.	Commence deployment.	One month delay to build phase, correction plan in place. No change to overall delivery timescales.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	programme to make sure the needs of the WBS are delivered through the National system by 2025/26. WBS Futures	• Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.					Work ongoing to confirm arrangements for Health Board deployment of 'blood tracking' solutions.	
	Implementation of Welsh Histocompatibility and Immunogenetics Service IT system (WHAIS IT) by 2025/26. WBS Futures	• Improved availability of information. • Increased efficiency • / Productivity. • Improved patient experience. • Reduced turnaround times. • Reduction in avoidable waste	Completion of discovery phase. Commence Implementation. Commence Data Migration.	Commence Environments set-up.	Complete implementation n. Complete Environments set-up.		All work proceeding to plan. On-site supplier visits took place in June 2024.	
	Procure new Blood Establishment Computer	• Regulatory compliance.	New contract procurement commences – Competitive	New Contract Procurement Business	New Contract Procurement .	New Contract Procurement ends.	Prior Information Notice published, and initial supplier	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	System (BECS) contract. 	• Resilient / supported platform. • Operational efficiency.	Dialogue. Recruitment of SMEs. Analyse Semester patch feasibility. Analyse and test Maintenance Patch. Virtualisation of existing infrastructure.	Analysis – ways of working/service mapping. Implement Maintenance patch. Continue analysis of Semester patch. Continue virtualization of existing infrastructure.	Business Analysis – ways of working/service mapping. Analysis of Semester patch if required. Prepare new hardware. Plan and prepare Delta Release.	Continue analysis and testing of Semester patch. Implement Delta Release.	engagement sessions underway. Funding confirmed by Welsh Government for 2024/25, procurement activity. Funding arrangements for implementation and 'BAU' costs yet to be agreed.	
	Assess and implement Advisory Committee on the Safety of Blood, Tissues and Organs (SaBTO) recommendations on blood donor testing to reduce the risk	• Reduction in risk of HepB virus transmission to recipients of blood components in Wales. • Compliance with SaBTO recommendations.	Submit data required for review by SaBTO.	Review updated recommendation from SaBTO and agree an organizational response.	Implement any changes in practice recommended by SaBTO.	Implement any changes in practice recommended by SaBTO.	Data is being submitted to SaBTO as required.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	of transmission of Hepatitis B infection as required 2024/25.							
	Establish a quality assurance modernisation programme to develop and implement strategy which supports more efficient and effective management of regulatory compliance and maximises digital technology by 2025/26	• Maintain compliance with regulatory standards. • Improved quality. • Improved safety. • Improved donor experience.	Complete process reviews and system configuration for new eQMS. System validation for new eQMS to commence. Implement DocuSign Enterprise solution (including staff education / Support).	System validation for new eQMS to be completed. Staff training for new eQMS to be completed. Embed DocuSign Enterprise solution across all WBS. ISO:15189 – gap analysis to be completed and submitted to UKAS.	Development of Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	Development of Medical Devices Regulations (MDR) / In Vitro Diagnostic Devices (IVDDR) Strategy.	Completed process reviews for all modules. Simplification need identified with solutions being designed. Validation Plan is being finalised to begin in August 2024. DocuSign "Enterprise Edition" available without 'Single Sign On'. Use of an alternative platform is being explored.	
	Implementation of Foetal DNA	• Reduction in avoidable administration	Undertake digital developments to support reporting	Implement all Wales service for Cell Free	Embed service.		Completed – service went live in May 2024.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	typing by 2024/25. WBS Futures	of anti-D immunoglobulin to pregnant women. • Improved safety. • Improved patient experience. • Reduction in avoidable waste/costs.	of results. Complete validation and implementation of new test.	Foetal DNA screening.				
	Implement new digital solution for National External Quality Assessment Service (NEQAS) by 2024/25. WBS Futures	• Digital solution will increase free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand customer base. • Flexibility to develop and	Begin validation of new NEQAS system.	Continue validation of new NEQAS system.	Complete validation of new NEQAS system.	Go live with new NEQAS system. Close project.	Implementation approach options appraisal is ongoing. Implementation anticipated to start late 2024 /early 2025.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		change the service. • Capacity to expand service provision. • Improved sustainability as system doesn't rely on paper records. • Complete digital audit trails. • Removal of potential errors caused by manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	Review and Develop strategy for Nucleic Acid	• Robust Service Provision	Develop User Requirement Specification. Identify preferred	Continue procurement of new NAT analyzers.	Continue procurement of new NAT analyzers.	Commence validation and implementation of NAT testing platform.	User Requirements Specification (URS) to be finalised in September 2024.	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Testing (NAT) by 2025/26. WBS Futures	• Enable income generation. • Service Development.	service model. Procurement process.				Procurement timelines agreed in collaboration with SNBTS.	
	Introduction of West Nile Virus (WNV) Testing. WBS Futures	• Ensure minimal impact on the Blood Supply chain due to the projected increase in deferrals with the spread of WNV in Europe • Ability to maintain WBS blood supply chain • Decrease in requirement for importation of blood products to meet demand	eProgesa development work to create test codes and trigger requirement for WNV testing. Develop clinical algorithm. Validate Roche platform for WNV testing. Implement WNV testing.				Completed – service went live in May 2024.	
	Assess and implement the recommendatio	• Learning from the findings of the inquiry and	Attend the launch of the report, review	Commence implementati on of the			IBI report launch attended by VUNHST CEO,	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	ns of the Infected Blood Inquiry (IBI).	optimizing the safety of blood components as recommended. • Maintained compliance.	the recommendations and draft an action plan	action plan and populate the predicted timescales for actions for the IMTP 2024-27.			WBS Director and WBS Medical Director. WBS informing and supporting national discussions (WG, UK Forum etc.) as required.	
SP5: Achieving excellence in research, development and innovation to improve outcomes for our patients and donors **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)**	Work with Welsh Government to develop and introduce a Plasma for Medicines service model for Wales. WBS Futures *(Quality Priority: Introduce leucodepletion filters, Hepatitis A and Parvo B19 testing)*	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation. • Cost • Avoidance/reduction. • Avoids patient rationing.	Complete validation of leucocyte filtration (NQT) blood packs. Continue procurement of Hepatitis A and Parvo b19 testing.	Scope clinical pathway for Hepatitis A and Parvo B19 testing.	Scope Source Plasma collection programme once WG governance arrangements are clear. Develop robust shipping documentation for fractionator.	Commence validation and digital implementation of Hepatitis A and Parvo B19 testing.	The wider Plasma for Medicines programme remains on hold awaiting a policy decision and funding from the Welsh Government. Supporting activity for the procurement of a new NAT testing platform is ongoing to ensure funding delays do not impact the critical path. Validation of leucocyte filtration packs delayed, to commence in	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							August 2024, with no impact to the critical path.	
SP6 Sustainable services that deliver the greatest value to our communities **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2 and 5)**	Develop and implement an energy efficient, sustainable, SMART estate at Talbot Green site that will facilitate a future service delivery model. WBS Futures	• Improved • donor satisfaction. • Improved staff well- being. • Increased service resilience. • Reduction in energy consumption and utilization. • Reduction in carbon emissions. • Compliance with statutory requirements. • Improved efficiency, reduction in waste and carbon emissions.	Development of Outline Business Case.	Outline Business Case completed & internal approval process commences.	Trust Board approval and submission of Outline Business Case to Welsh Government.	Welsh Government review of Outline Business Case.	Welsh Government (WG) approached to consider combined OBC/FBC. Currently engaging with Specialist Estate Services regarding cost proposals prior to seeking formal confirmation from WG.	
SP7 Develop great people and a	Develop a sustainable workforce model which provides	• Enhanced workforce capacity &	Support Collection Teams workforce	Support Collections Teams workforce	Support implementation of Collections	Support implementation of Collections	Paper drafted for extension of temporary	

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IMTP Strategic Priorities Welsh Blood Services for 2024/25								
Strategic Priorities 2023/24	**Objectives**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
great place to work **(Link to Trust Destination 2033 – Trust Strategic Goals 1, 2, 3, 4 and 5)** 	leadership, resilience and succession planning by 2025/26.	capability to meet need. • Enhanced Leadership capacity & capability. • Improved staff satisfaction. • Improved staff well- being. • Improved service quality, safety and donor satisfaction.	review. Commence review of workforce planning across WBS. Plan and deliver training / team development sessions with new Senior Leadership Team (SLT).	review. Continue review of workforce planning across WBS.	Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Team workforce review in line with Organisational Change Policy (OCP). Continue review of workforce planning across WBS.	Recruitment and Retention Premia Decision expected in Q2 from Welsh Partnership Forum. Informal staff engagement plans in place to start at the end of Q2. Wider WBS departmental workforce planning taking place. SLT team development sessions are occurring.	

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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Velindre University NHS Trust

APPENDIX 2

Velindre Cancer Service - IMTP Quarterly Progress Report 2024/25 for Quarter 1 as at 30/6/2024 (TO BE UPDATED)

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital) by December 2024**	• Increased patient access • Increase in uptake of radiotherapy • Reduced patient travel times • Improved clinical outcomes • Improved equity of care regionally • Increased patient satisfaction •	Complete development of service specification and Service Level Agreement (SLA). Develop workforce plan.	• Initiate deployment of new workforce plan. Define model for delivery of outreach activity.	Define and implement necessary digital infrastructure to enable effective and efficient operation of the new Satellite Unit.	Develop and deploy plan for operational handover following successful completion of the construction phase.	Multiple clinical pathway meeting scheduled throughput Aug and Sept to confirm patient pathways and unwell patient. Two additional internal workshop established for Radiation and Finance SLA Completion date under review by ABHB and Construction Team	
Trust Strategic	**Implementation of Integrated**	• Improved patient outcomes	Second new linear accelerator	•Implementation of InSightive	Third new linear accelerator and associated		Third linear accelerator clinincally	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2, 3, 4 and 5	**Radiotherapy Solution Programme by 2026/27**	• Improved quality of care • • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	commissioned and in clinical use. Assess implications of commissioning fourth new linear accelerator to enter service on the current Velindre site and consider alternative options to maintain service provision. Develop contingency plans to ensure maintenance of treatment capacity in the event of catastrophic machine breakdown.	radiotherapy analytics tool. • Develop capital equipment procurement contingency plan to determine options to enable the timely replacement of equipment in the event of failure, etc. before the opening of nVCC site. Develop plan to support transition of brachytherapy service to nVCC site.	infrastructure commissioned and made available for clinical use.		commissioned and in use treating patients at VCC. Capacity and phasing workstream assessing capacity and planning fully underway to deliver phase 2 of the programme – 2 linear accelerators into SRU.	
Trust Strategic Goals 1, 2,	**Implementation of Outreach**	• Increase care close to home. • Improved access.	Engage` with health boards,	Define model for delivery of care		Develop workforce model.	Scoping workshop held in August. Key	

Webber,Liane
11/09/2024 11:52:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
3, 4 and 5	**Programme by 2025-26**	• Improved equity. • Improved patient experience. • Reduction in carbon emissions.	agree intention and principles. Establish programme board.	on outreach contexts.			outputs of meeting include; • Clarity on scope • Identification of key stakeholders • Early engagement with patients • Continued engagement with all local HBs Project Initiation Document shared with HBs – awaiting feedback. Key workstreams identified. Further meeting with HB representatives	

Webber,Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							scheduled for early October.	
Trust Strategic Goals 1, 2 3 and 4	**Implementation of the Transforming Access to Medicines (TrAMs) Model at Velindre Cancer Services**	• Increased service resilience • Increased workforce resilience • Increased levels of efficiency and productivity • Reduced costs • Improved access to medicines in a timely manner	Work with regional stakeholders to support design and delivery of radio pharmacy delivery model. Review governance structure in the context of interim requirements and contingency planning pending delivery of TrAMs model. Secure interim support pending delivery of TrAMs. Identify resource to support clinical and scientific infrastructure for	Develop and assess possible delivery models which will ensure the sustainable delivery of pharmacy services prior to the full implementation of the TrAMs model.	Identify funding stream to support the expansion of pharmacy services in anticipation of future TrAMs dependent requirements.		Timelines for the TrAMS SE Wales Hub OBC and FBC have been revised to take account of the pace of progress in agreeing revenue funding characteristics. Current submission of FBC to Welsh Government date is September 2025. Focus is now on the preparation of the SE Wales Hub OBC, where VCC are working on baseline and ambitious workforce models.	

Webber,Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			national programme.				Clinical readiness project activities are progressing on the VCC centralized clinical verification process and Meds at home direct model. Review of internal JDs. In line with the National review, is almost complete. OCP 2 will not commence until an investment decision has been made.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions.	Regional service coordinator recruited and in post. Project board re-established and revised governance	Develop proposal for OS network structure and implementation.	• Develop work plan to enable delivery of remaining project objectives aligned to Wales Cancer Network	• Undertake review of data requirements. Undertake review of existing	• Acute Oncology Network Manager recruited and in post. • Acute Oncology	

Webber, Lynne 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
		• Improved patient experience. • Reduction in carbon footprint.	structure defined. Undertake benchmarking exercise to facilitate assessment of similar delivery models. Undertake baseline review of current position and activity relative to the Acute Oncology project model. Undertake review of service implementation within VCS. Identify funding stream to support on-going delivery of the service at VCS.		service specification. AOS network board and supporting infrastructure in place. Data sharing agreements and memoranda of understanding (MOUs) in place.	policies and standard operating procedures (SOPs). Develop shared policies and SOPs, where appropriate.	project group re-established (to begin meeting in September 2024).	

Webber,Liane
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Implementation of ePMA for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	Procure system following approval of Full Business Case (FBC) by Welsh Government. Undertake recruitment to externally funded posts required to support implementation.	Commence system implementation following approval of FBC and subsequent award of contract.	Continue implementation of system.		Preferred bidder confirmed. Awaiting WG review of FBC – due for late-July 2024.	
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision- making. • Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety.		• Implement new system and undertake testing. • Undertake data migration to the new system. Develop and deploy training	Full implementation of electronic test requesting.		Supporting national discussions, as required. Revised go-live timescales for VCC, following delay to national pre-implementation activities. Local implementation planning underway.	

Webber, Luke 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved productivity and efficiency levels. • Improved patient satisfaction.		package to facilitate maximize with new system.				
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of the Approved Full Business case for the Development of the New Velindre Cancer (nVCC)**	• Improved quality. • Improved patient safety. • Improved patient dignity and experience. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being. • Reduction in carbon emissions • .Reduced staff sickness. •	Develop transition plans for all services. Develop and deploy plans to maintain capacity during commissioning of replacement linear accelerators and other capital equipment. Undertake digital enablement work - scoping / business analysis of new systems and ways of working, e.g. patient self-check-in / patient flow, hybrid mail	Develop plans to support the transition to the nVCC site and for dual-site running for all clinical and operational services.			Working groups and structure established to enable the development of transition plans for all services. Plans to mitigate capacity loss for Radiotherapy have been developed as part of the IRS programme implementation this is fully engaged with nVCC programme board. Digital scoping has commenced.	

Webber,Liane
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			solution and call centre.					
Trust Strategic Goals 1, 2 and 4	**Implementation of National Programme for Palliative Care and End of Life in Line with National Timeframes**	• Improved quality of care. • Reduction in avoidable admissions. • Improved patient experience.	Identify scope of palliative radiotherapy within VCS and as part of a regional model.	• Identify opportunities for workforce redesign and develop associated workforce plan. Identify possible funding options.				
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implement Relevant Standards of the National Pre-habilitation to Rehabilitation / 3 Ps Deliverables**	• Improved quality. • Improved patient safety. • Reduction in cancelled treatments. • Improved patient health and well-being. • Improved clinical outcomes. • Improved patient experience.	Continue engagement with Prehab to Rehab south- east Wales collaborative and WCN national prehabilitation group. Review funding streams and commissioning models to facilitate prehabilitation	Develop and deploy local implementation and improvement plan.			• An internal prehabilitation project board and working group have been set up. • Phase 1 has completed scoping of prehabilitation services at VCC, understanding	

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			service development				of prehabilitation amongst staff, bench-marking and the development of a VCC prehabilitation webpage. • Participation in national prehabilitation groups ongoing.	
Trust Strategic Goals 1, 2, 3 and 4	**Implement Same Day Emergency Care pathways across Velindre Cancer Services by Q4 2024/25**	• Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels.	Identify and secure consistent funding to support service delivery. Develop business case.				• Working group established to identify financial means to support on-going delivery of the immunotherapy toxicity service.	

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Reduction in avoidable admissions. • Improved patient satisfaction.						
Trust Strategic Goals 1 and 2	**Implement Changes to the Nursing Workforce Which Ensure Compliance with Regulatory Requirements and Supports Delivery of Clinical and Scientific Strategy**	• Improved patient outcomes. • Improved quality of care. • Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	Develop business cases to secure funding to support nursing workforce innovations and developments.	•Implementation of recommendation of Cancer Nurse Specialist (CNS) review. Undertake evaluation of the CNS Navigator role and implement recommendation Introduce Advanced Clinical Practitioner	• Develop Practice Educator role to facilitate person centred care. Define and implement Model for Clinical Supervision (CNO Mandate).	Evaluate requirement for nursing support in radiotherapy.	-Business case development -CNS review underway	
	Ensure the Viability of the Neuro-	• Improved patient outcomes. • Improved quality of care.	Develop business case and secure				-business case development has been initiated	

Webber, Lisa
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Oncology Service	• Improved patient safety. • Improved patient satisfaction. • Reduction in avoidable admissions.	funding to maintain service.					
Trust Strategic Goals 1, 2, 4 and 5	**Undertake Evaluation of SACT Service (to Include SACT Nursing, SACT Bookings and SACT Prepping). Define Recommendations, Develop and Deliver Improvement Plan**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved levels of efficiency and productivity. • Reduced costs. • Improved patient experience.	Service delivery manager recruited and in post.	Baseline assessment complete of SACT service. Service delivery plan developed. Undertake review of booking processes and identify nature and level of Business Intelligence support required to minimize clinical risk.	Alignment of SACT booking processes with wider booking processes. Complete SACT demand profiling exercise		-Work being undertaken as part of the initiation of SACT gold - transition to a BAU group of which this will continue to drive and deliver improvement plans.	
Trust Strategic Goals 1 and 2	**Implement Recommendations from Peer Review of SACT**	• Improved quality. • Improved patient safety. • Improved access. • Improved clinical outcomes.	Receive and prepare response to peer review and determine plan for				-improvement plan developed	

Webber, Janet
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Treatment Helpline	• Reduced waiting times. • Improved patient experience.	implementation (further details to be developed following the receipt of the review).					
Trust Strategic Goals 1, 2 and 5	**Expand capacity and capability of VAP (Virtually Assessed Patient) Clinics**	• Provision of care at home/close to home. • Reduced patient needs to travel. • Increased patient experience / satisfaction.	Development of costed business case to support service expansion. Identify appropriate funding stream to support provision in the longer term.	Deployment of service expansion plan subject to ability to secure funding.	Establish means of service monitoring following deployment of the service expansion plan.	Undertake a review of the service to inform determination of future service delivery model.	-Expansion case has been approved - Work is underway to mobilize this with longer term funding models being developed.	
Trust Strategic Goals 2 and 4	**Implement New Molecular Radiotherapy Treatments at VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention. • Improved staff well-being.	Progress the phased implementation of new Peptide Receptor Radionuclide Therapy (PRRT) service from quarter 1 (dependent upon WHSSC undertaking to commission service and	Actively engage All- Wales Molecular Radiotherapy Advisory Group (AWMOL) on development of all-Wales strategy for Molecular radiotherapy.	Develop plan to increase Molecular Radiotherapy clinical trial participation to expand capacity and capability.		• VCC formally recognised by the Joint Commissioning Committee (JCC) as a preferred provider of PRRT. • Working group established to develop and	

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Enhanced organizational reputation for quality of service.	availability of discretionary capital to facilitate procurement of equipment). Undertake recruitment of of new PRRT service. Additional workforce to support full implementation				implement plan for delivery of PRRT at VCC.	
Trust Strategic Goals 2, 4 and 5	**Review the Radiation Protection Service Resource to Enable Dynamic Response to National, Regional Partner Stakeholder and Internal Ambitions for Delivery of Expanded and**	• Improved quality.		Development of resource requirement plan for design and construction and implementation at nVCC.	Undertake service development options appraisal exercise.	Identify appropriate funding stream to support sustainable. Long-term service delivery.	No planned update for Q1.	

Webber, Lara
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Innovative Diagnostic and Therapeutic Clinical Services with Ionising Radiation Sources							
	Develop and Implement New Pharmacy Strategy for 2024-2030 via Pharmacy Transformation Programme	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop and deploy operational delivery plan for pharmacy which responds to previously undertaken external service reviews.	Complete development of new strategy for the pharmacy service.			-Development of plans has begun inline with outputs of previous reviews and current service demands.	
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Establish project group to direct local implementation of upgraded system. Actively engage with all- Wales procurement of upgrade.	• Complete worksheets and labels upgrade. • Undertake testing of new upgrade.	Complete operational implementation of upgrade.		- Project group established and plans in development for upgrade. -Regional engagement in place	

Webber, Laura
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
				Develop and deploy staff training plan.				
Trust Strategic Goals 1, 3 and 4	**Develop and Implement Model for Clinical Leadership and Supporting Governance Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	Develop new divisional clinical governance structure. Establish revised Site- Specific Team (SST) governance structure. Appoint new SST lead and new deputy Clinical Director.	• Implementation of clinical decision-making framework to support wider service delivery. Embed clinical and scientific strategy.	Site-Specific Team (SST) activity and performance dashboard.		• Prospective new SST governance structure in development. Senior Leadership Team to consider and agree changes early-autumn 2024.	
Trust Strategic Goals 1 and 3	**Design, Commission and Deploy Revised Patient Transport Model**	• Improved patient experience. • Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes.	Develop revised service model to include effective transport of patients undergoing emergency radiotherapy treatments.	Develop business case.	Identify funding and commission revised service.		• Working group to be established at start of quarter 2 to consider service requirements.	

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Velindre University NHS Trust

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 4	**Implement Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes. • Improved patient experience.	Develop and deploy plan to improve capacity and flow in the Outpatients department. Develop implementation plan for replacement video consultation solution. Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.	• Identify services which might be repatriated to local health board contexts. • Introduce interim process for managing electronic referrals. Introduce revised appointment booking Standard Operating Procedures (SOPs). • Introduce revised telephone standards (to include appropriate consideration of the Welsh	• Develop options for amalgamation of booking teams across VCS. Complete full roll-out of new video consultation system.	Implement 'Hospital 2 hospital' system to support standardisation of patient referral processes and to promote efficiencies.	- an initial service improvement led work has commenced which will inform a wider outpatients strategic review Work has commenced in terms of scoping services that can be repatriated in order to otimise treatment capacity and align with patient feeback	

Webber,Liane
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
				language) and system across VCC. • Identify opportunities to improve access to Welsh language training for patient-facing staff. Deploy training plan for clinicians and administrative staff to support introduction of replacement video consultation solution.				
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision- making)					Scoping due to commence in Q3. WG request for separate business case to cover	

Webber, Lara 11/09/2024 10:07:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved levels of efficiency/productivity • Reduced carbon emissions					'digitisation' costs, outside of nVCC FBC.	
Trust Strategic Goals 1, 2, 3 and 4	**Implementation of New Services / Delivery Models**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity. • Reduced waiting times. • Improved staff attraction and retention • Improved staff well-being. • Enhanced organisational reputation for quality of service.	Establish horizon scanning group and undertake review of proposed new service developments to determine priority and timelines for taking forward identified service developments. Implement interim model for delivery of palliative radiotherapy				• Pharmacy horizon scanning group established. • New model for prioritisation developed. Engagement with Senior Leadership Team and Site-Specific Team Leads to be undertaken (September 2024) prior to full implementation . • Proposal for new service	

Webber,Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							development group developed. Proposal to be considered and agreed by Senior Leadership Team and Site Specific Team leads (early quarter 2).	
Trust Strategic Goals 1 and 2	**Implement DHCR Phase 2 by 2024/25**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Review learning from phase 1 to support implementation of further phases. Establish revised governance, reporting and delivery structure for VCS agreed scope and prioritisation of VCS-specific elements for phase 2.	Clarify scope and service delivery requirements.	Develop work plan to support implementation.		Closure of DH&CR Phase 1 scheduled for July 2024. Scoping / prioritization of phase 2 requirements underway. Phase 2 governance yet to be agreed.	

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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	**Objective**	**Expected Benefits**	**Key Specific Quarterly Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goal 1	**Implementation of Consolidated Document Management System Across VCS**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Identify priority areas / services for introduction of new system. Commence deployment of implementation plan.				• Project working group established. • Implementation plan developed. • Project oversight board to be established (September 2024).	
Trust Strategic Goal 1	**Respond to Low / Limited Audit Assurance Findings**	• Improved quality. • Improved patient safety. • Increased levels of efficiency and productivity.	Develop and deploy remedial action plan to address recommendation of CCTV audit Develop and deploy remedial action plan to address recommendation of e-mail audit.				All audits described have established TAF groups, and senior leadership sponsor and a timeline of improvement and recommendation that can take place and embed and improved BAU practice.	

Webber, Liane
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IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			Develop and deploy remedial action plan to address recommendation of medical records storage incident..					
Trust Strategic Goals 1, 2, 3, 4 and 5	**Implementation of Centre for Collaborative Learning and Innovation**	• Creation and sharing of knowledge across Wales/wider to improved cancer care. • Development of network of partners to tackle key issues. • Creation of knowledge economy and innovation across Wales. • Physical space to support innovation and development working across the					Established project team in place to map out plans and timescales to achieve key benefits.	

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Velindre University NHS Trust

IMTP Strategic Priorities Velindre Cancer Services for 2024/25								
Link to Trust Destination 2033	Objective	Expected Benefits	Key Specific Quarterly Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
		region/Wales/wider.						

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

Webber,Liane
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Velindre University NHS Trust

APPENDIX 3

Trust-wide Initiatives - IMTP Progress Report 2024/25 for Quarter 1 as at 30/6/2024.

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Initiatives **Trust Strategic Goals 1, 2, 5** **Digital Strategy: Ensuring our Foundations**	Trust-Wide Telephony including Call Centre Solution	• Improve telephony resilience • New call Centre capability to support improved services for VCS / WBS	Scope	Procure	• Build UAT	• Validate Go-Live		
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organisation**	"Agile" Delivery Squads introduced to Digital target operating model	• Improved delivery of value-adding Digital services • Improved time to value for Digital services • Digital staff attraction and retention • Alignment with industry best-practice	Discovery	• Pilot – Microsoft 365 Pilot – Digital Inclusion	• Pilot – Microsoft 365 • Pilot – Digital Inclusion •	•	**Trust Strategic Goals 1, 2** **Digital Strategy: Digital Organization**	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	Digitally enable Value-Based Healthcare through digital services for the Value Intelligence Centre	• Enable the benefits for the Trust Value Based Healthcare programme	• Data driven sense making • Data Maturity Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity Technical development of SST Dashboards	• Data driven sense making • Data Maturity • Technical developmen t of SST Dashboards	• Data driven sense making • Data Maturity • Technical developme nt of SST Dashboard s		
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	New Patient Reported Outcome Measures (PROMS) system for Value Based Healthcare	• Digital system in place for capturing PROMS from patients • Improved efficiency over current PROMS collection methods		Business Case	• Procure	• Build of PROMS • Go-live		
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Organizatio n**	Robotic Process Automation (RPA)	• Reduced burden of administrative tasks • Efficiency and effectiveness of processes •	• Establishme nt of PoCs / pilots for non-clinical	Commence set up of RPA service.	• Establish RPA service (non-clinical workflows only). • Clinical coding pilot	• Transfer to BAU	PoCs commenced. Procurement of commercial RPA platform ongoing. Microsoft PowerAutomate already being used	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
							to support various use cases.	
Trust Strategic Goals 1, 2 **Digital Strategy: Digital Inclusion**	Digital Inclusion Plan	Digitally connect our donors, patients, and carers and staff to our services 24/7 Place information which is uncomplicated and accessible information into the hands of patients and donors to enable them to make better decisions about the services and support they require. Deliver the technology which supports the provision of more services at home and as locally as possible.	• Digital Inclusion Charter Accreditation Digital Inclusion Plan Q1 Delivery	Digital Inclusion Plan Q1 Delivery	• Digital Inclusion Plan Q3 Delivery	• Digital Inclusion Plan Q4 Delivery	Digital Inclusion plan approved via Trust Board in Q1 2024/25. Process to achieve accreditation underway.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		Provide our staff with the technology to work from a wide range of locations across Wales. • Reduce digital exclusion of people across Wales.						
Trust Strategic Goals 1, 2, 5 **Digital Strategy: Safe and Secure Systems**	New Trust-Wide Network	• Improved network resilience & capacity • New network services available (e.g. location tracking) to support new services for users • Decreased costs for network equipment	Complete design	Commission central network components	• Radiotherapy Satellite Unit on new network	•	Design completed. Technical 'lab' created in WBS to support upskilling of Digital Services team. First deployment scheduled for RSC in Q3 2024/25.	
Trust Strategic Goals 1, 2, 5	IT Service Management (ITSM) Tool - Halo	• Improved efficiency of ITIL processes • Improved visibility of IT	• Build of core ITIL processes UAT	• Validate	• Transition • Go-Live	•	Implementation underway, currently on plan for initial September 2024 launch.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Strategy: Ensuring our Foundations		Assets for Cyber and Information Governance • Compliance with best practice approaches for ITSM						
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Deploy a range of preventative cyber security tools and services, including staff education programme, to reduce likelihood of cyber breach – Cyber Security Strategic Development Plan (CSSDP)	• Improved resilience • Reduced number of Cyber security incidents • Staff are more confident dealing with Cyber threats			•	•	Bi-monthly phishing campaigns now established. Annual update to Cyber Security Strategic Plan agreed via QSP Committee in June 2024.	
Trust Strategic Goals 1, 2 **Digital Strategy:**	Server refresh/virtualization and refresh backup/storage	• Reduction in legacy technology in use • Improved infrastructure resilience	Scope Server refresh/virtualization	• Procurement Server refresh/virtualization Scope Backup/Storage	• Build / UAT / go-live Server refresh/virtualization • Procurement	• Build / UAT / go-live Backup/Storage •	Work ongoing.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Safe and Secure Systems		• Simpler infrastructure changes to support new services			Backup/Storage			
Trust Strategic Goals 1, 2, 4 **Digital Strategy: Digital Organization**	Introduce new Digital Training Platform	• Improved efficiency of training to colleagues • Enablement of the Trust Digital Inclusion Plan	Go-live for digital training platform	Transfer to Business as Usual	•	•	LMS 365 deployed – work ongoing to scale / adopt.	
Trust Strategic Goals 1, 2 **Digital Strategy: Safe and Secure Systems**	Windows 10 to Windows 11 migration and common user/device experience	• Improved Cyber Security • Simplified management of devices	• Win 11 Build Single Sign-On	Win 11 Transition plan	• Win 11 Go-live	•	Migration of users to Win11 commenced.	
Trust Strategic Goals 1, 2 **Digital Strategy:**	Donor/patient management solution (CRM) for Velindre Fundraising and WBS Donor Contact Centre	• Improved digital capabilities to manage fundraising donors/WBS donors	• Funding raising scope WBS Donor scope	• Funding raising Procurement • Fundraising Build	• Funding raising Go-Live •	•	Prior Information Notice drafted. In discussion with Procurement to determine procurement	

Webber, Laura (NHS Wales) 27/09/2024 15:07 GMT+1

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Organization		• Digitally enabled service plans					approach / timescales. Trust-wide procurement preferred.	
Trust Strategic Goals 1, 2 **Digital Strategy: Insight Driven**	Performance Management Framework (Quality Measures) dash board	• Improved efficiency in performance reporting • Automated processing of metrics • Improved data driven decision making	Phase 1 Measures available in PMF dashboard	Phase 2 Measure dashboard definition	• Phase 2 Build • Phase 2 go-live	•		
Trust Strategic Goals 1, 2, 3, 5 **Digital Strategy: Insight Driven**	Transition to VXRails data warehouse platform as the Local Data Repository (LDR)	• Improved performance of Data and Insight jobs • Improved infrastructure resilience	• LDR go-live Transition from existing Data Warehouse (VCC + WBS)	Transition from existing Data Warehouse (VCC + WBS)	•	•	VCC migration completed, planning underway to migrate WBS service.	
Trust Strategic Goals 1, 2, 3	National Data Resource roadmap	• Whole system cancer pathway • Support service improvement re-design • Enable VBHC	• Local Data Repository to National Data Repository connectivity	• Velindre NDR Google Cloud Slice commissioned	• NDR Pilots • Integration of local and national datasets	• NDR Pilots • Integration of local and national datasets		

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Digital Strategy: Insight Driven				NDR Roadmap Agreed				
Trust Strategic Goals 1, 2, 3 **Digital Strategy: Insight Driven**	Trust wide Data and Insight plan	• Creation of a Trust wide service for Data and Insight • Improved business intelligence for decision making • Improved data quality	• Agree Plan for Data and Insight Service • WBS Priority Data and Insight Workplan VCS Priority Data and Insight Workplan	• Transition to Data and Insight Service • WBS Data and Insight Workplan in Place • WBS Data and Insight Workplan in Place	• Transition to Data and Insight Service • WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •	• WBS Data and Insight Workplan delivery • VCS Data and Insight Workplan delivery •		
Trust Strategic Goals 1, 2, 3, 4, 5 **Digital Strategy: Ensuring our Foundations**	New Velindre Cancer Centre (nVCC) digital enablement	• SMART hospital as set out in the nVCC strategic case • Modern, secure digital infrastructure • Improved patient experience of digital • Improved colleague	Recruitment of nVCC Digital team	• Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems	• Patient check implementation into VCS • Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems	• Scrutiny of ACORN Digital systems • Design and Procurement of Trust Digital Systems •	Digital workstream of nVCC established – currently scoping ways of working, priorities etc.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		digital experience • Flexible Digital infrastructure to support service redesign			•			
Trust Strategic Goals 1, 2 3 and 4	**Participate in Radiology Informatics System Procurement (RISP) and Implement System for Use by Velindre Cancer Services**	• Improved diagnostics information. • Better information sharing and enhanced clinical decision-making. • Improved patient outcomes. • Improved quality of care. • Reduced patient waiting times. • Improved patient safety. • Improved productivity and efficiency levels.		• Implement new system and undertake testing. • Undertake data migration to the new system. • Develop and deploy training package to facilitate maximize with new system.	• Full implementation of electronic test requesting. •	•	Supporting national discussions, as required. Revised go-live timescales for VCC, following delay to national pre-implementation activities. Local implementation planning underway.	

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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
		• Improved patient satisfaction.						
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of the Integrated Radiotherapy Solution Programme by 2026/27**	• Improved patient outcomes • Improved quality of care • Reduced patient waiting times • Improved patient safety • Increased patient access to clinical trials • Improved productivity and efficiency levels • Improved patient satisfaction • Improved machine resilience • Reduction in carbon emissions	• Quadris Datacenters commissioned Upgraded Varian solution available to support service design	Integration of IRS into National Architecture	• Integration of IRS into National Architecture	•	Work ongoing to finalise integration requirements for phase 1 of IRS solution. Significant amount of scoping and development required.	
Trust Strategic	**Implementation of electronic prescribing**	• Improved quality.	• Procure system following approval of Full	• Commence system implementation	• • Continue implementat	• • Continue implement	Preferred bidder confirmed.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Goals 1, 2 and 5	**and medicines administration (ePMA) for Use by Velindre Cancer Services**	• Improved patient safety. • Improved information (access to and sharing of). • Improved levels of efficiency and productivity. • Reduction in carbon emissions.	Business Case (FBC) by Welsh Government. • Undertake recruitment to externally funded posts required to support implementation.	following approval of FBC and subsequent award of contract.	ion of system.	ation of system.	Awaiting WG review of FBC – due for late-July 2024.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of clinical service at Radiotherapy Satellite Unit in ABUHB (Nevill Hall Hospital)**	• Increased patient access. • Increase in uptake of radiotherapy. • Reduced patient travel times. • Improved clinical outcomes. • Improved equity of care regionally. • Increased patient satisfaction.	Scope and procure PSBA network connectivity		• Define and implement necessary digital infrastructure to enable effective and efficient operation of the new Satellite Unit. • PSBA network connectivity in place •	• Digital Infrastructure build at RSU •	Work progressing to plan.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 3	**Support Procurement of New Version of ChemoCare and Introduce the System for Use by Velindre Cancer Services**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Establish project group to direct local implementation of upgraded system. • Actively engage with all-Wales procurement of upgrade.	• Complete worksheets and labels upgrade. • Undertake testing of new upgrade. • Develop and deploy staff training plan.	• • Procurement for SACT ePrescribing completed	•	Awaiting update from Procurement re: next steps.	
Trust Strategic Goals 1, 2 and 4	**Upgrade Video Consultation platform to support Pathway Improvement Programme**	• Improved quality. • Improved patient safety. • Reduced waiting times. • Improved access. • Improved clinical outcomes. • Improved patient experience. •	• Develop implementation plan for replacement video consultation solution. • Actively engage in video consultation solution design dialogue facilitated by Tech Cymru.		• • Complete full roll-out of new video consultation system.	•	Contract for current AttendAnywhere platform extended. Scoping work ongoing to determine 'next steps' for VCC.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2 and 5	**Undertake Digitization of Medical Records**	• Improved patient safety • Improved access to information (for sharing / decision-making) • Improved levels of efficiency/productivity • Reduced carbon emissions			• Scoping	• Establish project group. • Identify service improvements / opportunities for change. • • Identify additional resource requirements	Scoping due to commence in Q3 2024/25	
Trust Strategic Goals 1, 2, 3, 4 and 5	**Digital Enablement of Regional Acute Oncology Delivery Model and Network Structure**	• Improved quality. • Improved patient safety. • Improved clinical outcomes. • Reduction in avoidable admissions. • Improved patient experience. • Reduction in carbon footprint.	• support project board re-establishment • support baseline review, benchmarking, and VCS implementation		• Develop digital work plan to enable delivery of remaining project objectives. • • Data sharing agreements and memoranda of understandi	• Undertake review of data requirements. •		

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
					ng (MOUs) in place.			
Trust Strategic Goals 1 and 2	**Electronic Patient Record – Phase 2**	• Improved quality. • Improved patient safety. • Improved clinical outcomes.	• Scope Digital Health Care Record Phase 2 Requirements and investment case • Cancer Informatics Programme – palliative care		• Support Cansic decommissioning •	• • Implement 'Hospital 2 hospital' system to support standardization of patient referral processes and to promote efficiencies.	Closure of DH&CR Phase 1 scheduled for July 2024. Scoping / prioritization of phase 2 requirements underway.	
Trust Strategic Goals 1, 2, 3, 4 and 5	**VCS Service Changes – Other digital activities in support of the VCS plan**	• Improved patient safety. • Improved clinical outcomes.	• Agree PSA Tracker Phase 2	• Transfer RITA chatbot service into business as usual	•	• VCS Call Centre on new telephony platform •		
	WHAIS Digital: Implement a new Laboratory Information Management	• Improved availability of information. • Increased efficiency	Completion of Discovery Phase.	Commence Environments set-up.	Complete implementation.	•	All work proceeding to plan.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	System (LIMS) for Welsh Histocompatibility and Immunogenetics Service (WHAIS) by 2025/26.	/productivity through Improved patient experience. • Reduced turnaround times. • Reduction in avoidable waste.	Commence Implementation. Commence Data Migration.		• Complete Environments set-up.		On-site supplier visits took place in June 2024.	
Trust Strategic Goals 1 and 5	**WBMDR Digital**: Digital enablement of the strategy for sustained growth and retention of the stem cell donor panel (Welsh Bone Marrow Donor Registry) by 2026/27.	• Increased stem cell donor panel. • Increase in stem cells supply. • Improved resilience in stem cell supplies. • Improved clinical outcomes in Wales / globally. • Increased income levels. •	Investigate digital replacement solution for WBMDR software.	Continue to develop URS and engage with digital suppliers to replace current WBMDR software,	• Produce and process tender to replace current WBMDR software.	• Follow tender process to replace current WBMDR software.	Work ongoing to scope suitable solution. A first draft of the URS has been completed. The URS completion will allow us to move to a formal tender process.	
	BECS: Procure new Blood Establishment Computer System (BECS) contract and	• Regulatory compliance. • Resilient / supported platform. • Operational efficiency.	New contract procurement commences – Competitive Dialogue.	New Contract Procurement. Business Analysis – ways of	New Contract Procurement. Business Analysis – ways of	New Contract Procurement ends. Continue analysis and testing of	Prior Information Notice has been published and initial supplier engagement sessions are underway.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	implement digital system.		Recruitment of SMEs. Analyze Semester patch feasibility. Analyze and test Maintenance patch. Virtualization of existing infrastructure.	working/service mapping. Implement Maintenance patch. Continue analysis of Semester patch. Continue virtualizations of existing infrastructure.	working/service mapping. Analysis of Semester patch if required. Prepare new hardware. • Plan and prepare Delta Release.	Semester patch. • Implement Delta Release.	Funding made available by WG for 2024/25, to support procurement activity. Funding arrangements for implementation and 'BAU' costs yet to be agreed.	
	NEQAS: Implement new digital solution for National External Quality Assessment Service (NEQAS).	• Digital solution will free up staff time to deal with marketing and development activities without the employment of additional staff. • Capacity to expand service provision. • Improved sustainability as system doesn't rely on paper records.		Begin Validation of new NEQAS system.	• Continue Validation of new NEQAS system.	• Complete Validation of new NEQAS system.	Options appraisal re: implementation approach ongoing.	

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		• Complete digital audit trails. • Removal of potential errors caused by manual data entry by NEQAS staff. • Digital platform for EQA will reduce turnaround times.						
	WLIMS 2.0: To work with the National Wales Laboratory Information System (WLIMS) 2.0 programme to make sure the needs of the WBS are delivered through the National system.	• Modernize patient management software with robust digital support. • Connectivity to national database. • System improvement. • Increased patient safety. • Access to blood usage data to inform demand planning.	Completion of DHCW collaborative development.	System Integration Testing (SIT).	Completion of SIT. Formal Validation. 1st deployment activity. •	•	Build phase delayed by one month, correction plan in place. No change to overall delivery timescales. Work ongoing to confirm arrangements for Health Board deployment of 'blood tracking' solutions.	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
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			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Trust Strategic Goals 1, 2, 3, 4 and 5	**Plasma for Medicines**: Digitally enable the Plasma for Medicines programme	• Secure the supply chain for Immunoglobulins in Wales. • Reduces need for importation. • Cost avoidance/reduction. • Avoids patient rationing.	Support procurement of Hepatitis A and Parvo b19 testing.	Support the Scope of the clinical pathway for Hepatitis A and Parvo B19 testing.	•	Commence validation and digital implementation of Hepatitis A and Parvo B19 testing. •		
Strategic Goals 1, 2	**Prometheus**: Migrate digital solution from DHCW once service support ceases as part of WLIMS 2.0 programme	• Continuity of the Prometheus messaging platform after LIMS 2.0	Scope service requirements	Procure new service arrangements	Build new hosting platform • Test new hosting platform	Validate new hosting arrangements • Transition and go-live	Supplier engagement commenced. Options appraisal of deployment approaches underway. Target Q3 2024/25 migration of service.	
	Foetal D: Digital enablement of Foetal DNA typing.	• Reduction in avoidable administration of anti-D immunoglobulin to pregnant women. • Improved safety.	Undertake digital developments to support reporting of results.	Support the implementation of all Wales service for Cell Free Foetal DNA screening.	• Embed service.	•	Completed – service live.	

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		• Improved patient experience. • Reduction in avoidable waste/costs. •	Complete validation and implementation of new test.					
Strategic Goals 1, 2	**Live Connectivity:** Introduce live connectivity for the blood collection teams	• Improved connectivity to systems •	Pilot live connectivity system	Scale live connectivity system to all teams	•	•	Pilot in progress with Collections 'West' team. Aim to extend service across all collection teams in Q2.	
Strategic Goals 1, 2	**Donor Interaction and Appointments**: Digitally enable improved donor interaction by 2026/27.	• Personalized donor experience • Wider communication choice for donors. • Increased donor retention. • Improved information (for sharing/decision-making). • Increased levels of efficiency/ • Productivity.	Development of refreshed booking portal.	Implement refreshed booking portal.	•	Begin introduction of a donor experience hub. Begin implementation of a Customer Relationship Management (CRM) System. •		

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Workforce and Organizational Development **Strategic Goal 1** Outstanding for quality, safety and experience	**Theme 1: Wellbeing and Engagement** **Theme 2: Supply and Shape** **Theme 3: Skilled and Developed People** **Theme 4: Leadership and Succession Planning** **Theme 5: Digital Ready People** **Theme 6: Attracting and Retaining the Best Talent**	• Implementing a Health and Wellbeing Framework across the Trust setting out clear and measurable standards to help drive improvement. • Implementing our education strategy to support staff to grow professionally and offer internal and external pathways to gain experience and knowledge • Develop a new Trust Strategic Equality Plan that supports the implementation of our Anti-	**Annual Actions continuous throughout 2024/25** **Planned and Sustained Workforce** **Right people right place right time** 1. Implement the Education Strategy Implementation Plan 24/25 2. Following the agreement of the Clinical and Scientific Skills Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model 3. Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism 4. Attraction and Retention				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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		Racist Action Plan and other aligned anti-discriminatory practices • Implementing an agile approach to working • Targeting an increase in bi-lingual recruitment to grow our Welsh speaking workforce • Improving the ways we celebrate success ensuring our staff feel highly valued for the amazing work they do • Growing the Trust Inspire Leadership and Management Programme	5. Agree a plan for the Widening Access Programme 6. Ongoing recruitment Marketing Campaigns for hard to fill roles 7. Working with Comms Trust wide recruitment campaign in place 8. Evaluate the International nurse Recruitment Programme 9. Develop a Nurse retention plan					

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
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	Strategic Goal 1 Outstanding for quality, safety and experience	•	**Skilled and Developed Workforce Achieving Excellence through our staff** 1. Component caring and capable workforce Deliver the Trust Training Plan 24/25 – clear KPIs to support evaluation 2. Transforming care pathways Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a Multi-Disciplinary workforce Model 3. Developing our academic profile Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre for Learning and Innovation 4. To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology 5. **W**orking with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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	Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	•	**Healthy and Engaged Workforce** Our staff will feel valued and supported and promote a culture of true inclusivity, fairness and equity across the workforce. 1. Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence 2. Implement the Values and Behaviour framework project 3. Triangulate culture work, staff feedback themes and leadership work to deliver an aligned Culture Programme of work that addresses Organisational issues reflects our values and allows staff to speak up freely 4. Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working **5.** Deliver an action plan 24/25 commitment in the Trust Anti- Racist Action plan 6. Monitor Welsh Language Standards, working with Divisions on improvement plans 7. Implement the WL Culture plan 8. Update all WOD related policies and procedures 9. Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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	Strategic Goal 2 An internationally renowned provider of exceptional clinical services that always meet and routinely exceed expectations	•	**People Function Cultural Development – People and Relationships Model** 1. Develop an engagement plan for the function to support the engagement and alignment with service development 2. Implementation of the holistic People and Relationships model 3. Engagement and Commitment from EMB 4. Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback				Satisfactory progress being made against these Annual Actions in line with agreed timescale Quarterly breakdown to be provided next year	

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Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
Clinical Quality and Safety **Strategic Goal 1** Outstanding for quality, safety and experience		•	**Annual Actions continuous throughout 2024/25** **Clinical Quality and safety Priorities:** 1. To further develop administrative and patient communication systems to prevent patient harm and improve patient experience. 2. Mortality reviews will be completed for deaths within 30 days of SACT and 30/90 days of radiotherapy and will align with best practice. 3. To Integrate Clinical Audit within VCS Quality and Safety function 4. Development of robust Site- Specific Quality Metrics 5. To improve incident and risk management. 6. Continue to review and update the WBS Quality Management Framework, including the development of a new electronic Quality Management System 7. To Successfully Introduce West Nile Virus testing within Welsh Blood Service. 8. 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. 9. Review and improvement of donor selection and screening processes					

Webber, Liane
11/09/2024 10:57:44

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			10. Introduction of all Wales foetal D Screening for RhD negative pregnant women. 11. Introduction of electronic result transfer for deceased organ donor HLA typing results to NHSBT-ODT which will reduce risk of manual transcription of results. 12. Achieve JACIE accreditation for the WBMDR 13. Commencing rollout of live connectivity of the BECS at community-based donation clinics 14. Enablement of DATIX, QPULSE connectivity on community- based clinics for incident, risk and concerns recording at point of contact 15. Increase in staff psychological safety (target TBC) scores within VUNHST Staff Survey results.					
	The Quality Impact Assessment (QIA) focuses on Three Main Areas:	•	**Annual Actions continuous throughout 2024/25** • Patient / Donor / Staff Safety – the avoidance of unintended or unexpected harm to people during the provision of health care. • Clinical Effectiveness – the application of the best knowledge, derived from research, clinical experience and patient preferences to achieve optimum processes and outcomes of care for patients. • Patient / Donor / Staff Experience – the way a patient or donor feels about their care based on all interactions, before, during and after delivery of care, or how a member of staff may feel whilst providing the care					

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Strategic Equality Plan and Equality Impact Assessments (EQIA)	•	**Annual Actions continuous throughout 2024/25** • Objective 1: Increase workforce diversity & inclusion, and eliminate Pay Gaps • Objective 2: Engage with the community • Objective 3: Communicate with people in ways that meet their needs • Objective 4: Ensure service delivery reflects individual need					
Value Based Healthcare (VBHC)	**Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre** **Pre-op anaemia programme** This is a national initiative to address the inconsistencies in the diagnosis and management of anaemia for patients undergoing high risk surgery (specifically 10	Reduced post-operative LOS, Reduced demand for blood transfusions for surgery. Eliminating unwarranted variation through implementing a consistent approach to anaemia management across Wales, • Improved patient outcomes	Progress with WBS access to transfusion data Consultation on All Wales Preoperative Anaemia Pathway	All Wales Preoperative Anaemia Pathway guidance issued Promotion of programme aims through conferences, training and senior leadership fora.	Ongoing monitoring of Pre-op anaemia pathway adherence, continued provision of training. Initial preparation for widening scope of programme to allow earlier intervention for patients	Major Surgery dashboard revised to include costing information. Financial benefit of programme to be costed	Pre-operative anaemia pathway launched. POAS test set embedded with impact monitored. Improvement seen in the identification of patient anaemia since project initiation.	

Webber, Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	procedures identified as being most likely to result in a blood transfusion). It has been developed in conjunction with the Wales Blood Health National Oversight Group (BHNOG).							
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre Training, Engagement and Communicatio n: Creating, sharing and delivering developmental content to staff.	• Increased engagement and confidence with the aims and principles of VBHC			Communication strategy created. Case study catalogue underway	Implementatio n of Communicatio n Plan including engagement sessions with Patients and Staff on the digital PROMS system	Engagement sessions held across the Trust with clinical and non-clinical staff.	

Webber, Lisa
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	This includes generating case studies of value in action projects.							
	Value Intelligence Centre Technical Development: Ensuring that linked data sets (e.g. activity, outcomes, and use of resources) are accessible to services to inform decision making. This takes the form of information tools such as dashboards which will be iterated to meet service needs	Accessible data for decision making for clinical services. • Provides the ability to compare treatments.	Development of SST dashboard in conjunction with VCS division	SST Dashboard Launched with demonstration sessions to support staff to engage with this tool.	Ongoing refinement of SST Dashboard and use of tool to understand variation within treatment algorithms.	Embedding usage	Holistic SST Dashboard in place enabling users to look at activity, outputs and use of resources for different patient cohorts.	

Webber, Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	Value Intelligence Centre Data Maturity: This theme focuses on ensuring that the accuracy and completeness of data within patient IT systems is sufficient to enable meaningful analytics. Working with service areas to identify and resolve the most common and critical issues.	• Improved accuracy of key patient pathway data, this improves patient safety, accuracy of income and analysis of activity	Data Quality issues relating to open pathways identified	Clinical requirement for comprehensive metastatic breast patient cohort identified and initial assessment of options undertaken	Data Quality Management Framework agreed	Focused Data Quality Management group in place for SACT	Open pathway issue identified and escalated. With support in place to resolve. Diagnostic work for identifying Metastatic Breast Cancer patients initiated.	
	Digital PROMs Platform: To enable the systematic digital collection of patient reported outcome	Increased time spent on what matters to patients Enhances research and quality initiatives,		Business Case approved by Trust Board	Implementation of digital solution into 3 clinical areas	Ongoing implementation of system within VCS	Options appraisal completed. Business Case written and approved.	

Webber, Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	measures (PROMs) to capture and understand the quality of life and symptom burden that our patients experience.	driving innovation Supports a reduction in unwarranted variation • Improved patient engagement and treatment adherence						
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Patient Outcomes:** We need to agree the questions to be asked. This ensures consistency across pathways and the ability to analyse aggregated data	• Consistent questions in place across Wales that meet the needs of patients and clinicians for each tumour site.	Approach for reaching consensus on a National PROM set agreed. Process initiated for Breast Cancer	Workshop held for Breast PROMS with initial set proposed as an outcome. Review of nationally agreed PROMS for "fit".	Agreement reached for national set for Breast. Process initiated for CUP and Gynae	Support the creation of the national Breast Set (including timelines), Agree national set for CUP	Consensus reached on approach to agreeing national PROMS through close collaboration with WCN and WVIH. This includes a "road map" of priority services based on volume.	

Webber, Lisa
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
	to assess the benefits or the negative side-effects that treatments can have. These parameters are already agreed nationally for some cancer sites, e.g. Lung Cancer. The Value Intelligence Centre is working with our Clinical Teams, the Welsh Cancer Network, and the Welsh Value in Health Centre to agree validated PROMs tools (sets of questions to capture Patient Reported Outcome Measures) for							

Webber, Jane (Corporate)
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
	different types of cancer							
	Value Based Healthcare (VBHC) Initiatives via Value Intelligence Centre **Food Mission:** Velindre's Food Mission sets a long-term ambition to provide our people with access to affordable, healthy food with an objective to source 70% of Velindre's food from Welsh, environmentally friendly or globally responsible providers by 2035.	• It is expected that this will improve the wellbeing of patients, donors, staff, and their families. Further, it will support the delivery of Velindre's wider Value Based Healthcare, Workforce and Sustainability Strategies, the Trust's Wellbeing Objectives, and its ambition to reach Net Zero by 2030. •	Food Mission approved by Trust Board	Preparation for Value Lab and the implementation of a staff veg box scheme. Collaboration with Menter Mon initiated	Value Lab held to create action plan Launch of Veg Box scheme	Implementation of Food Mission action plan, monitoring impact of changes.	Stakeholders identified and planning completed for Food Mission Value Lab	

Webber, Jane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
The Estates Plan	**Theme 1: A safe and high quality estate which provides a great experience** **Theme 2: Healthy buildings and healthier people** **Theme 3: Minimizing our impact to the environment** **Theme 4: Using our estate to deliver the maximum benefit and social value to the community we serve**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	**Annual Actions continuous throughout 2024/25** **Estates Actions** 1. Continuously engage with the users of our estate to understand how it can be designed, adapted or enhanced to better meet their needs 2. Developing an estate that places human values at the heart of design and embrace opportunities for arts and culture with such spaces				1) Regular stakeholder operational meetings are being held to discuss and address operational needs. We are currently in the process of developing the scope of work to enhance the clinical facility requirements. 2) Our Arts in Health coordinator is planning projects to engage patients in creative activities, including a writing program for palliative care patients, bedside activities for those on the ward, and a creative support group at St Fagans. These initiatives will launch in Q2, aiming to enhance	

Webber, Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
							patient well-being through artistic expression.	
			3. Investing additional resources in the maintenance of the existing estate to maintain a Category B				3) We have recently completed condition surveys of the VUNHST estate and are currently reviewing the results to ensure that all areas are risk-assessed. This review process will continue into Q2.	
			4. Implementing our estates, digital, workforce and sustainability strategies				4) We are currently planning implementation meetings for the site improvement plans (SIP) to enhance and align with our sustainability strategies.	
			5. Providing a range of accessible alternative methods of travel focused on walking, bike, public transport and electric vehicles				5) A travel survey was completed in Q1 to identify trends and staff	

Webber, Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
							transportation modes. In Q2, we will assess these results to determine and plan the next steps for interventions.	
			6. Identifying innovative ways to adopt renewable energy sources to service our requirement				6) Further progress has been achieved through ongoing energy optimization service visits by external contractors. We are also holding regular meetings with energy suppliers to ensure the effective purchase of green energy.	
			7. Identifying facilities we can share the use of with other public bodies and wider partners				7) Ongoing community events like the Sustainable Summer Jamboree emphasise sustainability and nature, offering staff, the	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			8. Working with the community and partners to identify how we can open up our buildings, facilities and land to be used as communities assets 9. Working with partner organisations in arts and culture to seek mutually beneficial opportunities for artistic collaboration across our services				community, patients, and their family's opportunities to engage in eco-friendly activities on site. 9) A comprehensive Arts in Health program has received approval and funding. In Q2, the program will offer creative writing courses, music on the wards, and staff choirs throughout the Trust. We are partnering with the Arts Council for Wales to further support these efforts, and the BBC Orchestra has already performed on the wards, with continued	

Webber,Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			10. Delivering a number of transformative capital programmes which have sustainability at their centre of design: 11. Refurbishment of the Welsh Blood Service building in Llantrisant by 2024/2025 12. Refurbishment / development of new outreach facilities by 2024/2025				collaboration at St Fagan's. 10) Ongoing progress being made with nVCC & TGI running through RDD and RIBA2 stages with good progress being made with sustainability being the main focus. 11) TGI Programme benefits meetings taken place, further progress to be made on the combined OBC - FBC to be made in Q2. 12) No progress has been made in this area. Q2 to reestablish update program.	

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
			13. Opening of a Radiotherapy Satellite Centre at Nevill Hall Hospital by 2024 14. Opening of the new Velindre Cancer Centre by 2027				13) Good progress has been made in Q1 on SRU, currently working through partial completion Programme to establish commissioning dates of SRU, Q2 will provide specific dates of commissioning. 14)Date to be changed to 2027	
The Sustainability Plan	**Theme 1: Creating Wider Value** **Theme 2: Sustainable Care Models** **Theme 3: Carbon Net Zero**	**Estates and Sustainability Plan 'Estates Excellence'** The provision of a high quality estate is integral in us achieving our ambitions as it needs to respond effectively to the needs of our	**Sustainability Actions** 15. Implementing our sustainability strategy 16. Applying the principles of the circular economy into our business	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Implementing our sustainability strategy • Providing a comprehensive education and learning programme which provides	• Developing clinical service models which support sustainability • Implementing our sustainability strategy	Good progress being made against all actions	

Webber, Jane 11/09/2024 15:55:44

	Theme 4: Sustainable Infrastructure **Theme 5: Transition to a Renewable Future** **Theme 6: Sustainable Use of Resources** **Theme 7: Connecting with Nature** **Theme 8: Greening our Travel and Transport** **Theme 9: Adapting to Climate Change** **Theme 10: Our people as**	patients, donors and staff, together with the services we provide and the broader needs of the communities we live and operate in.	processes through design, procurement, re-use and lifecycle. 17. Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day').	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Implementation of our carbon reduction plan which will see us achieve Net Zero and transition to renewable energy for our services and facilities.	staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day') • Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community	• Providing a comprehensive education and learning programme which provides staff, patients, donors and partners with learning opportunities to embed the 5 ways of working of the Well-Being of Future Generations Act and supports them to make positive behavioural changes ('a little step every day')		

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			18. Continuous work on major capital projects including the TGI, RSU & nVCC. 19. Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport 20. Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities	to identify ways in which we can deliver wider benefits and value to society through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement	• Improving our offer for staff, donors and patients in travelling to and from our facilities on foot, bike and public transport • Using our procureme nt activities and NHS Wales Shared Services capability to drive a sustainabl e approach and achieve wider ethical and		

Webber, Liane 11/09/2024 10:57:44

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			through employment and apprentices hips, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy	as community assets (e.g. local schools and charity group using them; arts programmes); becoming an anchor institution in place making; and procurement to maximise the reach of the Trust within the Government s Foundationa l economy o	to maximise the reach of the Trust within the Government s Foundationa l economy o	social value in areas including local employme nt and prosperity; carbon reduction; anti-slavery and unethical practices. • Working with partners and the local community to identify ways in which we can deliver wider benefits and value to society through employme		

Webber, Liane 11/09/2024 10:57:44

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
						nt and apprentice ships, the use of our buildings and facilities as community assets (e.g. local schools and charity group using them; arts programm es); becoming an anchor institution in place making; and procureme nt to maximise the reach of the Trust within the Governme		

Webber,Liane
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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	**Objectives**	**Expected Benefits**	**Key Specific Actions for 2024/25**					
			Q1	**Q2**	**Q3**	**Q4**	**Quarterly Progress Update for Q1**	**Progress Rating**
						nts Foundatio nal economy		
The Financial Plan	**Strategic Goal 5** A sustainable organization that plays it part in creating a better future for people across the globe	There is a strategic risk that the Trust becomes financially unsustainable if it does not secure sufficient funding for the provision of services and does not maximise its use of resources. Unwarranted variation could impact the value and effectiveness of the care our patients and donors receive. **These actions are all annual and ongoing through the year to year end**	**Annual Actions continuous throughout 2024/25** **Value & Sustainability** • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In response to national financial pressures the Trust has commenced Finance and Investment Enhanced Monitoring arrangements as enhanced measures. • In line with the Trust's decision to rescind income protection from marginal currency rates and volumes in 2023/24 and work undertaken with NWSSP Medicines Unit to enable supply of two immunotherapy drugs from their Medicines Unit at lower cost than from the incumbent provider, we will continue to explore ways to relieve financial pressures on the system in 2024/25 and beyond. • The Trust will continue to integrate the opportunities identified at national level through the Value and Sustainability Board into the Trust's opportunities pipeline. • Exploring opportunity to expand supply for other drugs working with the NWSSP Medicines Unit. • VBH Pre-operative anaemia pathway work with Health Boards will release bed capacity and plans for further expansion of the pathway to include other patient cohorts will further increase Health Board bed capacity freed-up. • Plasma for Medicine Business case if approved and funded by WG / WHHSC has potential to save c £1.5m in phase 1 on blood derived				Good progress being made against these annual actions – all on track	

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IMTP Strategic Priorities Trust-wide Initiatives for 2024/25								
Strategic Priorities 2024/25	Objectives	Expected Benefits	Key Specific Actions for 2024/25					
			Q1	Q2	Q3	Q4	Quarterly Progress Update for Q1	Progress Rating
			medicines used by Health Board and if phase 2 approved up to £2m saving to Health Boards. • Divisions reviewing non-value adding clinical practice or processes and changing ways of working through Value-Based Healthcare approach.					

KEY:

BLUE	Action successfully completed with benefits being realized
GREEN	Satisfactory progress being made against action in line with agreed timescale
YELLOW	Issues with delivery identified and being resolved with remedial actions in place
AMBER	Delays in implementation / action paused due to external issues beyond our control
RED	Challenges causing problems requiring recovery actions to be identified

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

QUARTER 1 2024/2025 PROFESSIONAL NURSING FORUM REPORT

DATE OF MEETING	12th September 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	Annie Evans, Deputy Director of Nursing, Quality and Patient Experience
PRESENTED BY	Annie Evans, Deputy Director of Nursing, Quality and Patient Experience
APPROVED BY	Nicola Williams, Executive Director of Nursing, AHPs and Health Sciences
EXECUTIVE SUMMARY	The Quarter 1 2024/25 Professional Nurse Forum report provides an overview of the key programmes of work that have taken place during the period 1st April to 31st June 2024. Key highlights include: • ***The All Wales Preceptorship Standards and Clinical Supervision Principles***: Compliance with these Standards and Principles has been mandated by the CNO office. The Trust has undertaken a baseline self-assessment, and has developed an implementation plan. A programme of work has been established at the Trust with a view to achieving compliance with the standards and principles by July 2025.

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	• ***Nursing workforce developments and implementing these across the Trust***, including: Nurse Consultant and advanced practice, Band 4 / Registered Nurse Associate programme, Nurse Retention programme There is a national mandate and impetus to modernise the clinical workforce in Wales, for example by developing the Registered Nurse Associate role, and in developing more advanced practice roles, whilst also ensuring that there is a robust governance framework in place. The Trust is fully engaged with the national nursing workforce programmes and oversight is provided by the Professional Nurse Forum.

RECOMMENDATION / ACTIONS	To **NOTE** the Quarter 1 2024/2025 Professional Nursing update To ***NOTE*** the Restorative Clinical Supervision and Preceptorship self-assessment and delivery plan.

GOVERNANCE ROUTE	
Professional Nurse Forum (PNF): Items for inclusion in the Quarter 1 report was agreed at each Professional Nurse Forum meeting	04.04.24; 02.05.24; 28.05.24; & 20.06.24
Executive Management Board**:** Report was noted**.**	29.08.24

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

APPENDICES
Appendix 1 – Quarter 1 2024/25 Professional Nurse Forum Report
Appendix 2 – Restorative Clinical Supervision and Preceptorship self- assessment and delivery plan

1. BACKGROUND

Webber,James
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The Professional Nursing Forum is chaired by the Executive Director of Nursing and Health Care Scientists and has a core attendance of all the senior nurse leaders across the Trust. The Forum meets on a monthly basis and reports into the Executive Management Board and to the Quality, Safety and Performance Committee on a quarterly basis.

1.1 ASSESSMENT

The Quarter 1 report provides an overview of the key items which the Professional Nurse Forum has been providing oversight and strategic direction for during the period of the 1st April to the 31st June 2024. This includes:

- Working to implement the All-Wales Preceptorship and Restorative Clinical Supervision Standards and Principles at the Trust
- The Nurse Retention programme
- The Band 4 to Registered Nurse Associate programme
- Safe Staffing levels
- Revalidation.

2. 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:*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	**Select all relevant domains below**
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	PNF covers all aspects of Quality and Safety domains from a nursing perspective.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

Webber,Liam
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For more information: *https://www.gov.wales/socio-economic-duty-overview*	**Click or tap here to enter text**
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Prosperous Wales - An innovative society that develops a skilled and well-educated population in an economy which generates wealth and provides employment opportunities
	If more than one Well-being Goal applies please list below:
	The Trust Well-being goals being impacted by the matters outlined in this report should be clearly indicated
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Yes - please outline what, if any, actions were taken as a result
	The Nursing strategy Equality impact Assessment was completed throughout the process of consultation and approval of final document
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
All risks must be evidenced and consistent with those recorded in Datix	

Webber,Liane
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Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

Velindre University NHS Trust's Professional Nurse Forum

Highlight Report

Quarter 1 2024/25

Contents

Section	Topic	Page no.
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2.0	Key highlights from Quarter 1	3
3.0	Priorities for Quarter 2	7

Acronyms

VUNHST	Velindre University NHS Trust
VCC	Velindre Cancer Centre
WBS	Welsh Blood Service
HCSW	Health Care Support Worker
PNF	Professional Nurse Forum
CNS	Clinical Nurse Specialist
NMC	Nursing and Midwifery Council

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1.0 Introduction

Velindre University NHS Trust's Professional Nursing Forum meets monthly and is chaired by the Executive Director of Nursing and Health Care Scientists and has a core attendance of all the senior nurse leaders across the Trust.

It is at this Forum that all strategic professional nursing issues and standards are discussed, the strategic direction is agreed, and priorities are determined. There are regular agenda headings covering - good news stories, feedback from National meetings, workforce, education and development, research, digital, senior nursing priorities, and the sharing of learning.

This report provides a highlight of the activity and key outcomes from the Forum between 1st April and 31st June 2024.

2.0 Key Highlights during the Quarter

2.1 Nursing Successes

Good news stories / successes are shared at each PNF meeting, these have included:

- The First Floor Ward at the Cancer Centre were finalists in the Nursing Times Student Placement of the Year Award.
- The Clinical Support Team at WBS received a Gold award for Improvements to Donor Services.
- The Interim Head of Nursing for the Welsh Blood Service presented at the Haemochromatosis UK Conference and received excellent feedback regarding the service that the Welsh Blood Service provides for patients living with haemochromatosis
- The Cardiff Cancer Research Hub has opened a collaborative study with the haematology team at Cardiff and Vale University Health Board to develop a safe patient pathway.
- The development of an Incident Framework and Learning Framework for the Trust has now been completed

2.2 Nursing Events

2.2.1 Trust 2024 Nursing Conference

The second Trust Annual Nursing Conference was held on the 13th May 2024 (to coincide with International Nurses Day). There were 139 attendees, a mixture of Nurses, Health Care Support Workers and Collections Assistants, in addition to Executive Team members, Independent members.

The Nursing Conference provided an opportunity for nursing staff from the Welsh Blood Service, the Velindre Cancer Centre and the Trust itself to celebrate past successes and to engage with future strategic opportunities. The talks by Ceri Stubbs, Lead Nurse for the Acute Oncology Service at the Cancer Centre, regarding her experience of commencing PhD level study, and Suma John, Ward Manager at Cardiff and Vale University Health

Board, who talked about her experience of working in the NHS as an internationally trained nurse were particularly well received. A session on burnout was also provided by Dr Claire Ashley – this was reported to have resonated with staff who found the advice regarding self-recognition tools and self-management strategies helpful.

During the engagement sessions at the conference, staff had the opportunity to be involved in refining the detail within the Trust's nursing strategy delivery plan. This involved facilitated 'round table' discussions which focused on 4 key themes. which are summarized below:

A. Promoting research within the nursing teams. Suggestions included:
   - Developing a team approach to undertaking research rather than just focusing on individuals
   - For more 'showcasing' of the research undertaken within the Trust so as to inspire more nurses to be involved.
   - Consider providing protected time and backfill for staff to undertake research projects
   - Demonstrate the difference that research can make to patient care and outcomes
   - Promote behaviours that encourage staff to question current practice eg professional curiosity

B. Promoting and Supporting staff well-being. Suggestions included:
   - Consider having Trust 'Burnout' / 'Well-being' Champions and training on recognising burnout
   - Create a psychologically safe culture where its 'safe' to say that youre struggling, including being able to have breaks or time out when feeling stressed at work
   - Work to develop a culture where staff feel listened to
   - Access to healthy food at work

C. Promoting recruitment and retention. Suggestions included:
   - Ensure that staff are listened to and act on feedback
   - Provide greater flexibility with work schedules
   - Develop a positive and supportive culture within teams
   - Replace exit interviews with "too late to retain" interviews
   - Ensure equal career and education opportunities across the Trust

D. Developing sustainable initiatives/projects within work areas
   - Consider encouraging Hereditary Haemochromatosis donors – this would benefit the patients living with haemochromatosis and also the blood supply chain.
   - Consider the opportunities to maximise 'care closer to home'.
   - Develop sustainability champions across the Trust
   - Provide more visual information regarding recycling of waste at work
   - Work with IPC re opportunities to reduce PPE usage

The suggestions from staff will now be incorporated into this year's refreshed nursing strategy delivery plan. Mechanisms of feeding back to staff regarding their suggestions will be implemented.

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Planning for next year's conference (which will be held on 12th May 2025) is underway.

2.2.2 Professional Nurse Forum Time Out Session

A 'time out' session for the PNF took place on 13th June 2024. This was an opportunity for the Trust's senior nurse leaders to get together to have focused discussions on the key nursing issues (both national and internal), and on the progress being made at the Trust with the delivery of the Trust's nursing strategy and with the national nursing workforce programmes. The feedback received from the engagement exercises that took place at the May 2024 nursing conference was also reviewed and discussed.

The 'time out' session provided the opportunity to refine the nursing priorities at the Trust, and to agree the cohesive and timely delivery of these.

Areas for concentration this year centred around the following:

- Developing Champion roles in all areas, including research
- Undertake a review of the PADR framework
- Further develop and promote the virtual Nursing Hub and communication with staff
- Develop an Annual Training prospectus
- Continued focus on psychological safety and positive culture

The outputs from the time- out session will also be incorporated in this year's refreshed nursing strategy delivery plan.

2.3 Implementation of the All-Wales Preceptorship Standards and Restorative Clinical Supervision Principles

The Trust is working on an implementation plan for the All-Wales Precentorship and Restorative Supervision standards. The Chief Nursing Officer's Office has mandated that all NHS organisations commence the phased implementation of these standards by 1st July 2024.

The Trust has undertaken a baseline self-assessment against the Standards and Principles (attached in ***appendix a***) and is on track to ensure that a phased implementation is commenced by 1st July 2024. However, prior to this, a small number of nurses have already been offered restorative clinical supervision (Internationally Trained Nurses, new Registrants, those involved in events or who have been identified as requiring support). There are currently a small number of trained clinical supervisors available (2 internal and 2 external).

A preceptorship programme has been developed at the Cancer Centre, and our Internationally trained nurses and newly qualified nurses are currently progressing through this. There is currently no preceptorship programme available at the Welsh Blood Service, as historically, the Service has not employed newly qualified or Internationally trained staff (as their first NHS employment in the UK). However, as part of the nursing workforce review at the Welsh Blood Service, this will require re-consideration.

A working group to establish and implement restorative clinical supervision at the Trust has been established and is being led by the Trust Retention Lead. The Trust has secured access to 2 fully qualified Supervisors who are external to the organisation, and 8 Trust staff have been identified as having been previously trained in supervision and have experience, but

who require ‘refresher’ training. It is anticipated that by the end of September 2024, the Trust will have a total of 10 Supervisors who can begin to offer supervision.

It has been agreed to initially prioritise the offer of restorative clinical supervision to the following groups of nursing staff:

- Newly qualified
- Internationally trained nurses
- New starters to the Trust
- Anyone who has been identified by their line manager as requiring additional support

It is envisaged that the Trust will be in a position to offer supervision to the above staff groups by the end of September 2024. Upscaling of the programme will then take place during quarters 3 and 4.

The Trust’s Professional Nursing Forum will monitor progress on a bi-monthly basis, and a quarterly update will be provided to the Executive Management Board.

2.4 Nursing workforce developments

2.4.1 Advanced Practice

The Professional Nursing Forum is overseeing the strategic implementation of the National Multi-Professional Advance Practice Framework at the Trust, and progress with this is reviewed by the Forum on a monthly basis.

During Quarter 1, two Nurse Consultant posts have been developed at the Cancer Centre (within SACT and Acute Oncology), and recruitment is underway. These are the first Nurse Consultant posts at the Trust, and the first within Oncology in Wales.

There is a plan for a further expansion of the Nurse Consultant roles within the Trust as part of our workforce modernisation plans, with a Nurse Consultant role within Donor care at the Welsh Blood Service being developed with a view to recruitment in September 2024.

2.4.2 Clinical Nurse Specialist (CNS) Workforce Review

A comprehensive CNS workforce review was undertaken by the Cancer Centre and the results were reviewed by the PNF on 4th April 2024. The findings from the review highlighted that:

- Over 20% of the CNS time was spent in undertaking tasks that a CNS did not need to do – for example in clinic preparation and SACT pre-assessments
- There are no formal cover arrangements in place for the CNSs (including the single-handed CNSs), for example during periods of annual leave / sickness
- Much of the CNS time is involved in prescribing SACT and not in seeing patients
- Not all CNSs are able to meet with newly referred patients at their first clinic appointments due to time constraints
- There were no formally agreed job plans for the CNSs, and no consistent skill mix modelling / structure within the CNS Teams

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The VCC Team has established a programme or work to address the above. The PNF will provide strategic and professional direction to support the work programme, and will continue to have oversight of the progress being made.

2.4.3 National Band 4 / Registered Nurse Associate Programme

The Trust is fully engaged with the national programme regarding the development of Registered Nurse Associates in place of the traditional Band 4 Assistant Practitioner / Health Care Support Worker role. The PNF is maintaining oversight of this workstream and receives updates from the national meetings at each Forum meeting.

2.4.4 Nurse Retention Programme

The Trust's Retention Lead is leading a programme to review and improve retention at the Trust – the initial focus is on improving nurse retention. The PNF has a strategic role in maintaining oversight of this programme, and in ensuring that the Trust delivers on the HEIW 'Retaining and Valuing Nurses within the NHS in Wales – A retention plan'. The PNF receives a report regarding progress being made at each monthly meeting.

There remain concerns regarding retention within certain key areas – for example, within the Welsh Blood Service Collections Team. Retention is a key priority for the PNF, and its leadership and oversight role with this workstream will continue.

The full Trust Nurse retention plan will be received by PNF in September 2024.

2.5 Professional Standards and Regulation

2.5.1 Safe staffing

The Welsh Parliament Health and Social Care Committee's Nurse Staffing Levels (Wales) Act 2016: Post-legislative scrutiny report which was published in April 2024 was reviewed by the PNF in May 2024. The Trust's Nurse Staffing Lead is a member of the PNF and provides an overview of the Trust's compliance with the Staffing Act to the PNF.

The Trust's 3 year nurse staffing report and annual report have been completed and have been endorsed by the PNF. These are now progressing through the Trust's governance framework prior to submission to the Welsh Government in October 2024.

2.6 2023 NHS Staff Survey results – Nursing

The PNF has reviewed the results from the October 2023 staff survey relating to nursing staff (this includes the Health Care Support Workers and Collections Assistants). The results which became available in May 2024 showed areas of concern within the nursing workforce across the Trust, with the most notable issues being – staff not feeling valued, not feeling supported by their line manager, and not feeling able to raise concerns.

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There has been some challenge in fully interpreting the survey results due to the manner in which the data has been presented. Whilst the nursing staff at the Trust (including the Health Care Support Workers and Collections Assistants) are reporting a worse experience of working at the Trust compared with other staff groups, including the medical staff, this is

apparently similar to what has been reported in other Health Boards. This would indicate that as a whole, the nursing profession is reporting a worse experience compared with other staff within the NHS in Wales.

A focussed session to better understand the survey results and to develop a comprehensive plan to address will take place in early September 2024. The action plan to address will include some of the suggestions made by the staff at the May 2024 Nursing conference, and will also link in with the Trust's Healthy and Engaged workstream, the Trust's Values and Behaviours work programme, and the Nurse Retention work programme.

2.7 Nursing beyond Velindre University NHS Trust

The PNF maintains oversight of all key national meetings, national workstreams and national inquiries / reports relating to nursing – this ensures that the Trust is kept abreast of any national developments. Through the monthly forum, summaries are provided from each meeting attended and there is escalation of any issues / actions that the Trust needs to consider / implement. Following the PNF, there is onward dissemination of any key information.

During Quarter 1, the PNF has specifically reviewed the following national reports:

- The Thirlwall Inquiry
- NMC Inquiry
- Martha's Rule

The key learning from these inquiries has been identified and has been shared across the Trust. The learning now needs to be taken forwards, and the PNF will provide oversight regarding this.

2.8 Digitalisation

The PNF maintains oversight of the clinical digital agenda at the Trust via reports and feedback received from the Head of Nursing for Professional Standards and Digital. The PNF has been involved in providing direction with regards to the transfer from the Tendable system to AMAT, and in reviewing compliance with the completion of the Wales Nursing Care Record (WNCR).

The implementation of electronic prescribing and further developments with WNCR are the current large scale projects taking place.

3.0 Priorities for Quarter 2

The following have been identified as key priorities for the PNF during Quarter 2.

- To formally review progress with the Trust's Nursing Strategy and to refine the strategy delivery plan.
- To strengthen the approach within the Trust to the review and monitoring of professional standards – through developing a formal rolling cycle of audits relating to professional standards

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- To continue to support the nurse retention programme as a priority
- To consider opportunities for nursing to lead on strategies to improve the culture within the organisation and the sense of ‘team’

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Baseline Self-Assessment and high-level Implementation Plan for Preceptorship and Restorative Clinical Supervision at Velindre University NHS Trust

June 2024

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1.0 Baseline self-assessment and delivery plan for the implementation of Preceptorship at Velindre University NHS Trust, July 2024

Due to the specialist nature of the Cancer Centre and the Welsh Blood Service, the Trust historically had very few newly qualified or internationally trained staff starting their careers at the Trust. However, in 2024, the Trust welcomed its first newly qualified nurses through streamlining and first Internationally recruited nurses. There has been a concerted effort to work to achieving full compliance with the All-Wales preceptorship standards, and great progress has been made.

A baseline self-assessment against the All-Wales Preceptorship standards has been undertaken and is highlighted below – this has been RAG rated using the scale below. We have rated ourselves as being Amber, as whilst great progress has been made, some elements, for example, formal evaluation of the programme and audit have not been undertaken to date.

RAG rating Scale

RED	**Not meeting Preceptorship standard as outlined by NHS Wales**
AMBER	**Partial meeting of standard as outlined by NHS Wales**
GREEN	**Meeting standard as out lined by NHS Wales with formal evaluation undertaken**

The high-level action plan to ensure that the Trust is fully compliant with the standards by 30th December 2024 is also shown overleaf.

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1.1 VUNHST baseline self-assessment against the All Wales Preceptorship standards.

	All Wales Preceptorship Standards	Baseline Self-assessment
1	***Preceptorship is mandated across NHS Wales and organisations must be preceptee ready.***	• Organisational and Executive Lead in place for Preceptorship within the organisation • 18-month preceptorship programme already in place at Velindre Cancer Centre, including 4 week local induction, 2-4 week supernumerary period in the clinical area, monthly study days between months 6-18, clinical supervision and action learning sets undertaken. • All preceptees are allocated a designated preceptor in their specific clinical area. Velindre Cancer Centre has trained preceptors • Preceptorship policy in place for the Trust – currently being updated • Preceptorship workbook in place but needs refining • All Teams aware of the Trust preceptorship programme including Finance colleagues • No formal preceptorship programme at WBS as historically, Newly Qualified Nurses have not been recruited in the past. However, will be required once the healthcare support workers in post have completed their sponsored nursing qualification.
2	***Preceptorship programmes will be delivered in a healthy, compassionate culture of learning and wellbeing.***	• The local induction offers a wide variety of education and well-being as demonstrated above. The monthly study days are bespoke and the preceptees will help to inform the latter study days in order to ensure that their learning needs are met. • Preceptorship programme evaluation is sought after the 4-week induction, and feedback is positive. Formal evaluation of the entire programme is in progress. • The communication and support to the clinical areas requires strengthening in terms of ensuring that areas are not overwhelmed with Newly Qualified Nurses, internationally trained Nurses and Student Nurses.
3	***Preceptees will be welcomed and integrated into the workplace and will receive effective, timely support enabling growth into accountable, independent, knowledgeable, skilled practitioners. They will be supernumerary for the first month of employment and their programme of preceptorship will last up to 18 months.***	• Details as shown in standard 1. • Audit and formal evaluation required to ensure standard met

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4	***Preceptors will have the necessary skills, knowledge, and allocated time to support preceptees for the duration of the Preceptorship period, to include paid time off for training.***	• Preceptors in place who have completed the Practice Assessor and Supervisor training • Allocated support time is provided, although this can be compromised when there is a large volume of Newly qualified Nurses, International Nurses and Student Nurses • Need to seek feedback from the Preceptees so that support to them can be optimised

Progress is very much under way to achieve full compliance with the All-Wales Preceptorship standards at VUNHST. The remaining actions to achieve this by 31st December 2024 are set out below.

1.2 Action plan to achieve full compliance with the NHS Wales Standards

Action no.	Action required	Link to NHS Wales Preceptorship Standard	Person Responsible	Date	Progress
1	Develop an annual report for 24/25 for the NHS Executive as per national requirements, and internal quarterly reports	1	Head of Nursing Professional Standards and Digital	April 2025 for annual report Q1 report	
2	Develop formal metrics to monitor and assess compliance with preceptorship	1	Head of Nursing Professional Standards and Digital	30th September 2024	
3	Commence planning for preceptees at WBS	1	Education leads for WBS and VCC	30th October 2024	
4	Update current Preceptorship policy, to include NHS Wales standards	1	Head of Nursing Professional Standards and Digital	30th September 2024	
5	Review and update newly qualified induction workbook to align with Preceptor standards	2 & 3	Education leads for WBS and VCC	30th September 2024	
6	Audit Preceptor programme against standards	2	Education leads for WBS and VCC	30th October 2024	
7	Develop a formal evaluation tool / method for the programme to inform future development	2	Trust Retention Lead	30th August 2024	

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8	Undertake a review of areas suitable for preceptees and develop internal standards in terms of staffing numbers and skill mix	3	Head of Nursing Professional Standards and Digital	30th August 2024	
9	Evaluate the experience of the preceptees to ascertain how they can best be supported	4	Education leads for WBS and VCC	30th September 2024	
10	Establish a peer support group for the Preceptors	4	Education leads for WBS and VCC	30th August 2024	
11	Develop a baseline register of Preceptors, to include training and completion dates included	4	Education leads for WBS and VCC	30th July 2024	
12	Create Training needs analysis for Preceptor and Support required	4	Education leads for WBS and VCC	30th July 2024	
13	Agree Numbers of preceptors required to be reviewed annually and approved through Professional Nurse Forum	4	Head of Nursing Professional Standards and Digital	1st April 2025 Annually	

2.0 Baseline self-assessment and delivery plan for the implementation of Restorative Clinical Supervision (RCS) at Velindre University NHS Trust, July 2024

A baseline self-assessment against the All-Wales Clinical Supervision Principles has been undertaken and is highlighted below – this has been RAG rated using the scale below.

RAG rating Scale

RED	**Not meeting Clinical Supervision Principles as outlined by NHS Wales**
AMBER	**Partial meeting of Clinical Supervision Principles as outlined by NHS Wales**
GREEN	**Meeting Clinical Supervision Principles as out lined by NHS Wales**

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The high-level action plan to ensure that the Trust is fully compliant with the standards by 31st March 2025 is also shown overleaf.

2.1 VUNHST baseline self-assessment against the All-Wales Restorative Clinical Supervision Principles

	All Wales Restorative Clinical Supervision Principles	Baseline Self-assessment
1	***Clinical Supervision theory and practice will be included in the Nurse Induction period, taking a person-centred approach, and promoting a healthy culture.***	• Prior to the publication of the All-Wales 'Career spanning approach to preceptorship and clinical supervision in Nursing', VUNHST produced an interim framework in order to guide the commencement of work to meet the expected principles. Progress against this is being made
		• The e-learning theory of Clinical Supervision is included in Induction programme and supervision is encouraged as part of this.
		• Executive Nurse Director to commence 1:1 introductory meeting with all new nursing starters • RCS session to be pre-arranged at the outset for new nurse starters (unless they opt to not receive this) • VUNHST formal framework +/- policy not yet developed • Training Needs Analysis for Supervisors not yet undertaken • Formal support for supervisors not yet in place • No formal reporting re RCS undertaken at present, other than informal updates to the Trust's Professional Nurse Forum
2	***Organisations must provide protected time for staff to access and provide Restorative Clinical Supervision (RCS), in all settings, with its inclusion in structured Preceptorship programmes.***	• Two senior nurses from the Cancer Network (who have been training as Professional Nurse Advocates) have offered their service to three areas within the Trust's Cancer Services • Staff can already access psychological support and clinical supervision at the Trust, and there is protected time • Protected and private space secured for clinical supervision
		• Formal framework for RCS in development and as listed in section 1.
3	***Organisations will organise, enable, and ensure RCS processes are in place, facilitating its delivery, monitoring and evaluation.***	• Executive and organisational lead identified within the organisation • Executive management board and Trust board informed of Clinical Supervision expectation including resource commitment
		• No formal framework in place as yet to formalise the Trust's delivery, monitoring and evaluation of RCS, although, staff can access supervision and psychological support if they require

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4	***Supervisors will have access to supervision, training, and a professional support network. Access to RCS is mandated. The minimum standard is 1.5 hours per nurse four times a year.***	• Agreed for Six Velindre University NHS Trust staff to complete next Professional Nurse Advocate Training • Education Leads been Training through All Wales Network to the cascade training through the organisation • Access to RCS is currently available on an as requested basis and to three clinical areas • Support is also provided by the Psychology Department within the organisation following formal referral.
		• Formal framework for RCS is in development, in addition to other actions as listed in section 1
5	***A restorative model of Clinical Supervision will be delivered flexibly via group, one to one, face to face or online, based on the needs of the supervisee. NB Supervision groups will be no more than 6 individuals.***	• Pilot of group RCS has been undertaken
		• Formal framework for RCS is in development

Progress under way in Velindre University NHS Trust with further work identified to fully comply with the principles set out for Wales.

2.2 Action plan to achieve full compliance with the NHS Wales Principles

Action no.	Action required	Link to NHS Wales Clinical Supervision Principles	Person Responsible	Date	Progress
1	Establish a formal working group to work collectively to achieve full implementation of the RCS principles, including setting up sub groups to work to establish equitable access to RCS and in differing formats (eg individual / group)	2 , 3, 5	Trust Retention Lead	31st July 2024	
2	Review the National RCS framework and consider approval for use within VUNHST	3	Head of Nursing for Professional Standards and Digital	30th August 2024	

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3	Establish a baseline register of Trust staff who are Supervisors, to include a review of their current training and review of their supervision portfolio	4	Trust Retention Lead	31st July 2024	
4	Develop a 'live' register of fully trained supervisors which is accessible to all staff	3 & 4	Trust Retention Lead	31st September 2024	
5	Undertake a training needs analysis for the supervisors	3 & 4	Nurse Education Leads WBS & VCC	31st September 2024	
6	Establish a peer support group for the supervisors	2 & 4	Trust Retention Lead/ Consultant Psychologist	30th August 2024	
7	Undertake quarterly capacity and demand modelling for the number of supervisors required, and consider developing a succession plan	3	Head of Nursing for Professional Standards and Digital	31st December 2024	
8	Develop a communication plan to ensure that all nurses are aware of the offer of RCS and to encourage uptake, and formally 'launch' RCS at the Trust	3 & 5	Trust Retention Lead	15th September 2024	
9	Executive Director of Nursing & Head of Nursing to commence routine introductory meetings with all new nursing starters and to encourage uptake of RCS for all preceptees	1 & 3	Nurse Education Leads WBS & VCC	31st July 2024	
10	To pre-arrange RCS for all preceptees upfront unless they decline to receive this	1	Nurse Education Leads WBS & VCC	31st July 2024	
11	Ensure that updates regarding the Trust's progress on implementing RCS are provided on a bi-monthly basis to the Trust's Professional Nurse Forum	3	Trust Retention Lead	1st August 2024	
12	Develop internal quarterly reports for the Trust's Executive Management Board and Quality, Safety and Performance Committee and an Annual Report for 24/25 for the NHS Executive as per national requirements	3	Head of Nursing Professional Standards and Digital	Q1 2024/25 for internal report / update (EMB Aug 2024) April 2025 for annual report	
13	Develop formal key performance indicators to monitor and assess Trust compliance with Clinical Supervision Principles	3	Trust Retention Lead	30th October 2024	

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14	Develop a formal staff experience evaluation tool / method for the RCS programme to inform future development	2	Trust Retention Lead	30th October 2024	
15	Establish a quarterly review programme to ascertain staff preference with regards to supervision eg individual / group, and use the data to inform RCS planning	5	Trust Retention Lead	30th November 2024	

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Quality, Safety and Performance Committee

NHS – Regulation 28 Annual Report

DATE OF MEETING	12th September 2024
PUBLIC OR PRIVATE REPORT	Public
IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report
REPORT PURPOSE	FOR NOTING
IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	Sharon Wilson, Quality, Safety & Assurance Manager & Chris Kelly, Dep. Head of Quality, Safety & Assurance
PRESENTED BY	Tina Jenkins, Head of Quality, Safety & Assurance
APPROVED BY	Nicola Williams, Executive Director of Nursing, Allied Health Professionals and Health Science

EXECUTIVE SUMMARY	The *NHS Wales - Regulation 28 Annual Report 2023/24* was collated by the NHS Executive and details the 'Reports to Prevent Future Deaths' (otherwise known as Regulation 28) issued in connection with NHS Wales services during the 2023/2024 financial year. 41 Regulation 28 reports were issued in relation to 40 inquests during the year, none of which related to the Trust. However, there is learning for the Trust, mainly relating to ensuring transparency, robust investigations and appropriate and completion of improvement plans. The Trust has taken active steps to improve its management of incidents, concerns, learning and improvement plans, including: - A new learning Framework and Incident Management Framework. - A new Regulatory Quality & Safety Tracker. - Providing investigation training and a revised proportionate investigation report template

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	In addition, the Trust has recently commenced a new integrated Quality Hub structure. This has brought together Trust and Divisional quality teams to ensure Quality & Safety is managed collaboratively.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to ***NOTE*** the NHS Wales – Regulation 28 Annual Report and the work being undertaken to enhance the response, investigation and learning when things go wrong.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	
Integrated Quality and Safety Group: The report was noted and discussion took place regarding how important it is to ensure transparency, robust investigation and ensuring improvement actions are delivered.	31st July 2024
Executive Management Board: The report was noted.	5th August 2024

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
1. NHS Wales - Regulation 28 Annual Report 2023/2024

1. BACKGROUND

Reports to Prevent Future Deaths, commonly referred to as Regulation 28 reports, are issued by His Majesties Coroners, following the conclusion of an inquest process. Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides Coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

2. ASSESSMENT

The NHS Executive has produced the *Regulation 28 Annual Report 2023/2024* which details the 'Reports to Prevent Future Deaths' (otherwise known as Regulation 28) issued in connection with NHS Wales services during the 2023/24 financial year and was issued by the NHS Wales Executive.

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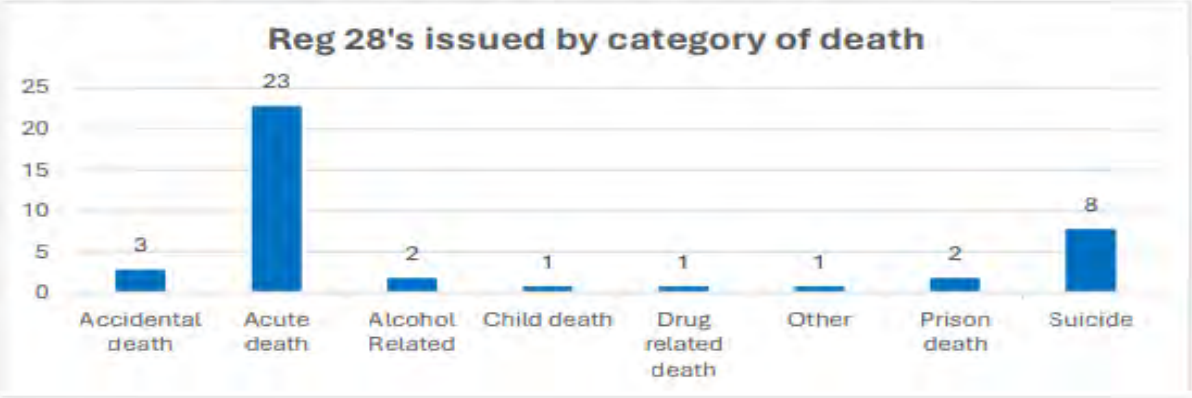
41 Regulation 28 reports were issued in relation to 40 inquests during the year, none related to the Trust. A summary id provided below:

Regulation 28's issued by organisation.

Regulation 28's issued by category of death.



The following themes have been identified where the Coroners 'concern/s' have been identified in 3 or more of the 40 inquests held.

- 9 deaths linked to concerns into Health Board investigation processes / standards.
- 7 deaths related to Emergency Department / Accident & Emergency handover delays.
- 8 deaths were linked to delays in Ambulance arrival at scene.
- 5 deaths were linked to Mental Health/Learning Disability service provision

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3. SUMMARY OF MATTERS FOR CONSIDERATION

The report was reviewed and identified relevant concerns and learning by organisation with assurance of action taken in the Trust.

Relevant Concerns and Learning	Assurance
No evidence of a robust process for managing urgent internal mail processes and any potential delays.	The Trust has identified a number of issues with internal communications at Velindre Cancer Service. These include the use of email to convey urgent clinical information, and the mishandling of clinical referrals. An improvement plan has been developed in order to address administrative issues, and a copy has been requested by the Integrated Quality & Safety Group.
Delay in undertaking an investigation into the patient's death (17 months).	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 Framework reinforces proportionate investigations in the spirit of *investigate once, investigate well*.
Delay in identifying and addressing actions – took over a year to identify and implement.	The Trust 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. 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. Robust investigations are key to identifying the root cause and contributory factors to ensure that the changes that will make the biggest difference are identified. The Trust has developed an improved Proportionate Investigation Template, to assist in the timely conclusion of investigations. The template ensures the investigator fully involves the patient/representative in the investigation process. Trust and Divisional Quality & Safety teams have developed a shared tracker to describe and monitor the workflow of investigations. This tracker is monitored at the weekly Concerns Meeting. Delays to investigations are identified and support is offered to investigators to ensure timely conclusion. Investigation training has been provided to a number of staff across the Trust to ensure quality & consistency of investigations.

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	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. The tracker enables the Trust to manage all recommendations, actions and evidence before, during and following inspections/investigations. There is still evidence that there are some delays in developing timely improvement plans following investigations and some improvement plans on the Tracker are overdue. Overdue actions are reported monthly through governance structures.
Concerns around the strategic management of investigation processes and the implemented learning within the HB.	The Trust has a weekly Concerns meeting to ensure all moderate and above investigations are on track. Completed investigations and improvement plans are shared with the Senior Leadership teams and the improvement plans are monitored via the Quality & Safety Regulatory Tracker. The Quality & Safety Regulatory Tracker governance is reported through Senior Leadership Teams. It is also a regular agenda item on monthly Quality Hub meetings and the Trust Integrated Quality Meeting. An update from the Trust Integrated Quality Meeting is provided at Executive Management Board and any areas of concern by exception are reported to the Trust Quality & Safety Performance Committee.
Disjointed patient safety and governance processes that do not evidence learning and sharing of learning.	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. The Trust has developed Quality Hubs to ensure the integrated working of Quality & Safety teams. Quality Hubs

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	report monthly to the Integrated Quality & Safety Group, with representatives present from across the Trust.
Junior Doctors did not feel empowered to challenge findings with their consultant colleagues.	Training is provided for Junior Doctors in the Trust about raising concerns. The training covers the Speaking Up Safely requirements, and structures and processes available to support junior doctors in speaking up safely.
Lack of adequate and appropriate systems and processes for dealing with complaints.	The Trust has a weekly Concerns meeting to ensure all moderate and above investigations are on track. Any issues are escalated accordingly. Complaints handling and compliance is included in the trust fully integrated Quality & Safety report. The Trust continues to achieve beyond the nationally agreed PTR compliance of 75% consistently. The Trust undertakes a variety of audits of the Once for Wales Datix system The Trust has recently undertaken a Concerns Audit, led by Welsh Risk Pool. Findings will be published shortly. The previous audit (2023) led to the Trust receiving a rating 'Substantial Assurance' for its handling of concerns.

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	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒

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	Equitable ☒ Efficient ☒ Patient Centered ☒
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 Globally Responsible Wales - Consideration of whether an action may make a positive contribution to global well-being.
FINANCIAL IMPLICATIONS / IMPACT	Yes - please Include further detail below, including funding stream
	There will likely be some resource / funding implications as a result of the introduction of Martha's Rule at the Cancer Centre, but this cannot yet be quantified.
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 is for early notification only.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	No legal implications identified at this stage.

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Risks that the Trust could potentially get a regular 28 if we did not evidence learning and closure of improvement plans.*
WHAT IS THE CURRENT RISK SCORE	No specific risk on the register
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	No
All risks must be evidenced and consistent with those recorded in Datix.	

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NHS Wales - Regulation 28 Annual Report 2023/24

1. Introduction
2. All Wales Overview
3. All Wales Themes
4. Regulation 28 Reports by Organisation with Breakdown
5. Assurance Arrangements 2024/25

1. Introduction

This paper details the 'Reports to Prevent Future Deaths' issued in connection with NHS Wales services during the 2023/24 financial year.

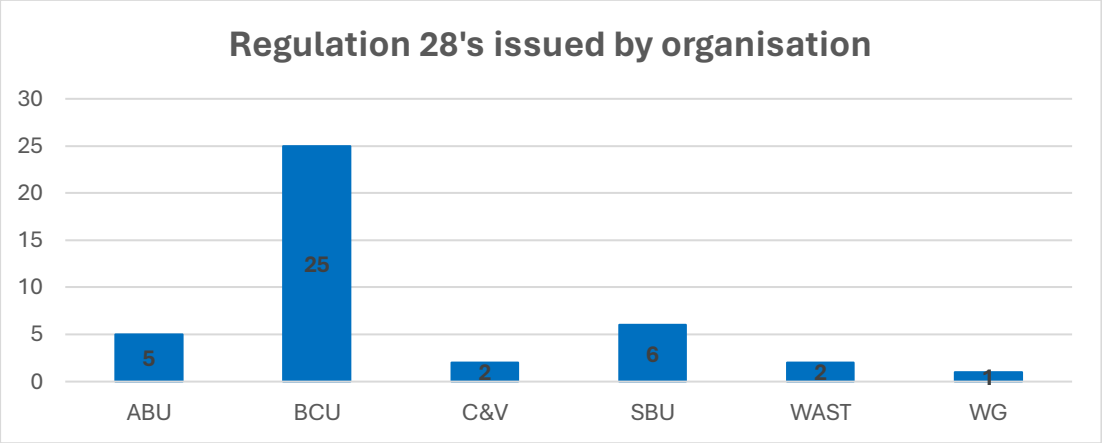
Reports to Prevent Future Deaths, commonly referred to as Regulation 28 reports, are issued by His Majesties Coroners, following the conclusion of an inquest process. Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides Coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

2. All Wales Overview

41 Regulation 28 Reports were issued against NHS Wales services in relation to 40 inquests during the financial year 2023/24.

N.B. One Regulation 28 report, relating to the death of person recently released from custody, was issued to both Swansea Bay UHB and Cardiff and Vale UHB.

Regulation 28's issued by organisation.



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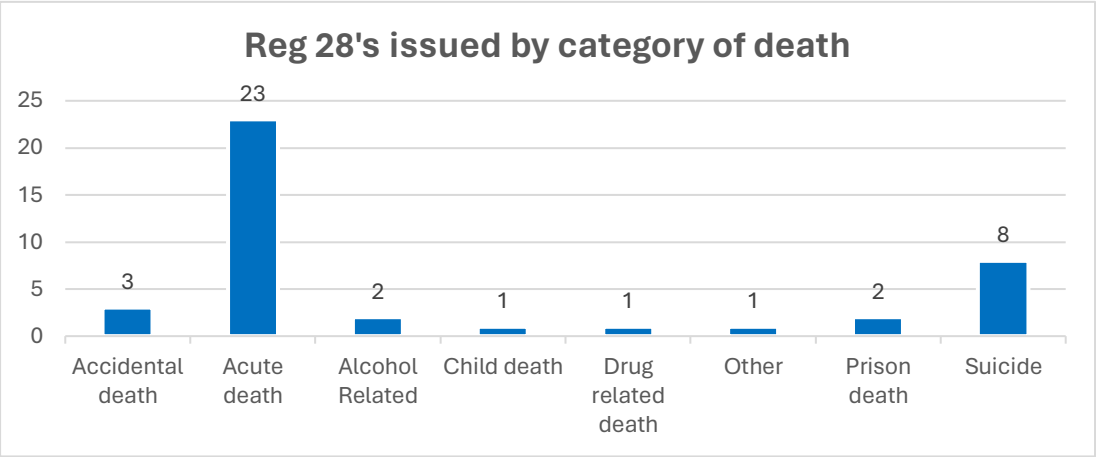
Regulation 28's issued by category of death.



3. All Wales Themes

The following themes have been identified where the Coroners 'concern/s' have been identified in 3 or more of the 40 inquests held.

- **9** deaths linked to concerns into Health Board investigation processes / standards.
  N.B. 7 relate to Betsi Cadwaladr UHB – 1 for Aneurin Bevan UHB and 1 for Swansea Bay UHB
- **7** deaths related to Emergency Department / Accident & Emergency handover delays.
- **8** deaths were linked to delays in Ambulance arrival at scene.
- **5** deaths were linked to Mental Health/Learning Disability service provision delays.
- **3** deaths were linked to provision of Mental Health service provision for prisoners

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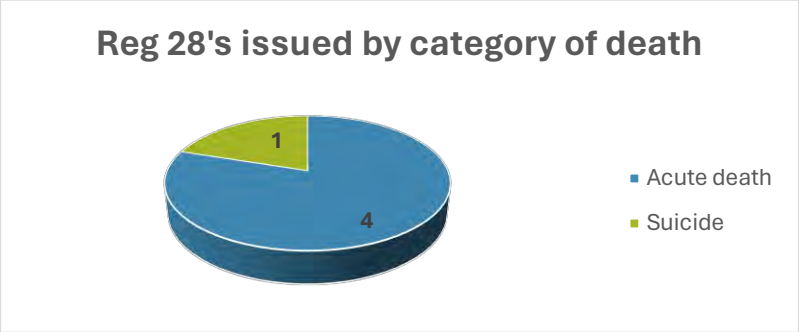
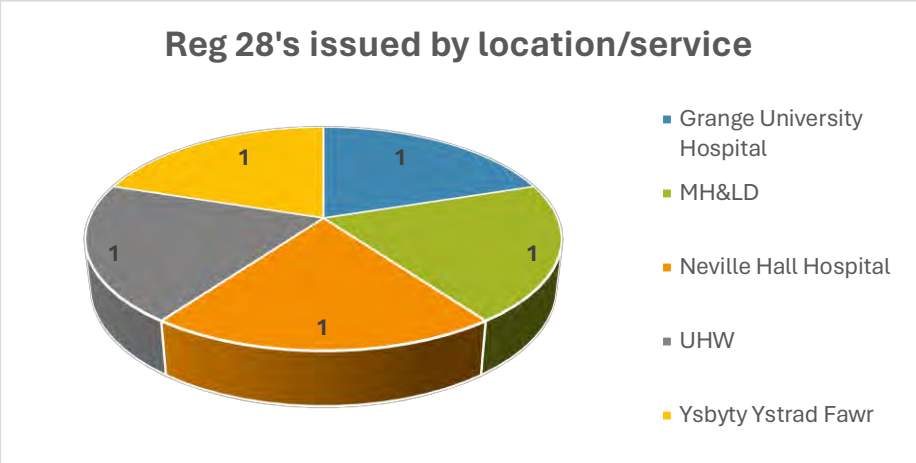
4. Regulation 28 reports by organisation

4.1 Aneurin Bevan University Health Board

Regulation 28's issued by the coroner to Aneurin Bevan UHB by category of death:



Regulation 28's issued to Aneurin Bevan UHB by location/service where the death occurred:



Breakdown

Case	Date report published	HMC Concern/s	Link to report
Acute Death 1	21/04/2023	SALT Team notified the ENT department of the patient's deterioration through an internal postal system and the letter was not collected. There was no evidence of a robust process for managing this process and any potential delays.	https://www.judiciary.uk/prevention-of-future-death-reports/maria-shafighian-prevention-of-future-deaths-report/
Acute Death 2	04/12/2023	No guidelines to establish the level of delegation of nursing duties.	https://www.judiciary.uk/prevention-of-future-death-reports/catriona-martin-prevention-of-future-deaths-report/

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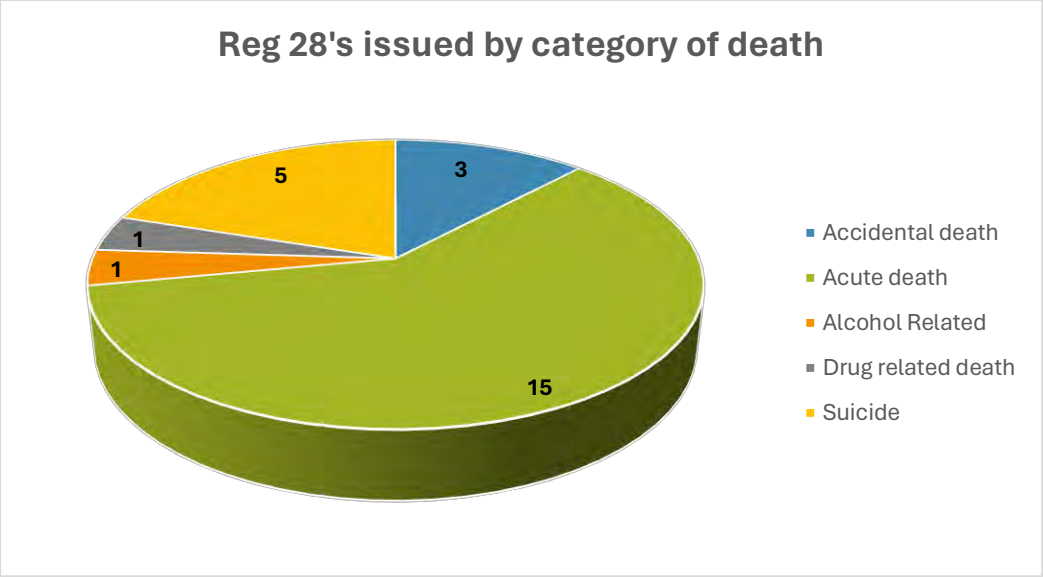
Acute Death 3	20/03/2024	No evidence that investigations were undertaken	https://www.judiciary.uk/wp-content/uploads/2024/03/Neil-Edwards-Prevention-of-future-deaths-report-2024-0153_Published.pdf
Acute Death 4	15/01/2024	Concerns raised around handover times at the Emergency Department	https://www.judiciary.uk/prevention-of-future-death-reports/lynda-blackmore-prevention-of-future-deaths-report/
Suicide	30/06/2023	1. Lack of strategy around family engagement/involvement 2. Lack of 24 hour out of hours support provided by the CRISIS Team	https://www.judiciary.uk/prevention-of-future-death-reports/kaye-mccoy-prevention-of-future-deaths-report/

4.2 Betsi Cadwaladr University Health Board

Regulation 28's issued by the coroner to Betsi Cadwaladr UHB by category of death:



The below shows Regulation 28's issued to Betsi Cadwaladr UHB by location/service where the death occurred:

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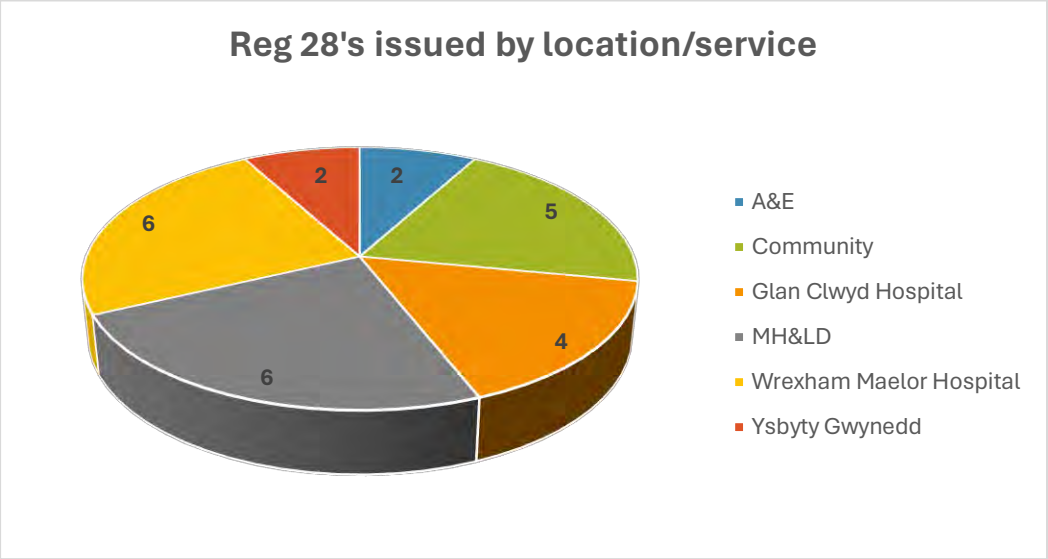

Breakdown

Case	Date report published	HMC Concern/s	Link to report
Acute Death	26/04/23	1. Delay in undertaking an investigation into the patient's death (17 months) 2. Delay in identifying and addressing actions – took over a year to identify and implement. 3. Some of the identified actions were unrealistic and unable to be fully implemented. 4. Concerns around the strategic management of investigation processes and the implemented learning within the HB	https://www.judiciary.uk/prevention-of-future-death-reports/nancy-price-prevention-of-future-deaths-report/
Suicide	31/05/2023	No documented or robust policy in relation to decision making/meeting criteria for patients referred to the HTT	https://www.judiciary.uk/prevention-of-future-death-reports/andrew-shambrook-prevention-of-future-deaths-report/
Suicide	08/06/2023	1. An urgent referral was made to the Psychiatric Liaison Team by his GP - there is no evidence that A&E staff were aware of this referral on his attendance to the department on the 14th of May 2022 2. This issue around paper/electronic notes was not identified in the investigation with no plans to address this issue noted in the action plan.	https://www.judiciary.uk/prevention-of-future-death-reports/eifion-huws-prevention-of-future-deaths-report/

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		3. Investigation report shared with the Coroner did not appear to be finalised and was significantly delayed in sharing and disseminating any pertinent actions	
Acute Death	20/06/2023	Significant delays in ambulance arriving and subsequent handover at hospital site.	https://www.judiciary.uk/prevention-of-future-death-reports/leonard-harmsworth-prevention-of-future-deaths-report/
Acute Death	21/06/2023	1. Significant and unacceptable delay in the ambulance attending the patient's property, leading to missed opportunities to provide end of life care. 2. Significant patient flow issues in the A&E Department 3. No clear evidence of joint working between BCU, WAST and the LA	https://www.judiciary.uk/prevention-of-future-death-reports/jean-frickel-prevention-of-future-deaths-report/
Acute Death	06/07/2023	1. Significant and unacceptable delay in the ambulance attending the patient's property. 2. Ambulance response times do not appear to have improved with no cohesive strategy in relation to hospital pressures	https://www.judiciary.uk/prevention-of-future-death-reports/emlyn-roberts-prevention-of-future-deaths-report/
Acute Death	10/07/2023	1. Significant delay around the attendance of an ambulance and the offload of the patient on arrival to A&E 2. No clear evidence of joint working between BCU, WAST and the LA	https://www.judiciary.uk/prevention-of-future-death-reports/mary-jones-prevention-of-future-deaths-report/
Alcohol	14/07/2023	1. Patient self-referred to third party substance misuse services on multiple occasions. Patient was closed to services due to lack of engagement with correspondence despite this only being written at the time. 2. Due to resource restrictions, telephone communication was not possible. 3. Long waiting times around support sessions & counselling	https://www.judiciary.uk/prevention-of-future-death-reports/emily-corfield-prevention-of-future-deaths-report/

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Accidental	18/07/2023	1. Significant delay around the offload of the patient on arrival to A&E and the allocation of a bed 2. Significant care and documentation issues identified in the A&E department regarding the patient's clinical management. 3. Significant staffing issues were identified in the department with unfilled nursing rotas	https://www.judiciary.uk/prevention-of-future-death-reports/philip-hawkins-prevention-of-future-deaths-report/
Accidental	17/08/2023	Bed rails assessment noted to not to be part of the Welsh Nursing Care Record with no evidence that the patient was assessed for bed rails	https://www.judiciary.uk/prevention-of-future-death-reports/malcolm-unwin-prevention-of-future-deaths-report/
Acute Death	06/09/2023	1. Significant delays in triaging and transferring the patient for surgery. 2. Significant staffing concerns were identified	https://www.judiciary.uk/prevention-of-future-death-reports/james-jones-prevention-of-future-deaths-report/
Acute Death	08/09/2023	1. Inconsistent investigation reports – 3 investigations undertaken all identifying conflicting evidence. 2. Delay in identifying and addressing actions – took 2 years to identify and implement. 3. Disjointed patient safety and governance processes that do not evidence learning – these concerns have previously been raised with the HB. 4. Risk of patient notes being lost on transfer from MH units and acute hospitals – still paper notes	https://www.judiciary.uk/prevention-of-future-death-reports/lynsey-smalley-prevention-of-future-deaths-report/
Suicide	**14/09/2023**	1. The HB investigation was not sufficient in providing details of how the transfer of care did not occur. 2. There was no clear guidance or process on the transfer of care document on how the transfer of care should have occurred. 3. Concerns were raised around the patient notes being paper copies rather than electronic	https://www.judiciary.uk/prevention-of-future-death-reports/richard-griffiths-prevention-of-future-deaths-report/
Acute Death	**09/10/2023**	1. Significant concerns around the pressures on the A&E department and was at the level 4 escalation phase at the time.	https://www.judiciary.uk/prevention-of-future-

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		2. Concerns identified around the level of stress and pressure put on clinicians within the department at the time	death-reports/margaret-kelly-prevention-of-future-deaths-report/
Suicide	**17/10/2023**	1. Staffing pressures within primary Mental Health services resulting in assessment and therapy delays. 2. Whilst on the therapy waiting list, there does not appear to be any alternatives other than self-referral which is a common issue among MH patients. The LPMHSS do not appear to have a standardised process for referring low risk patients for interim support whilst on a therapy waiting list	https://www.judiciary.uk/prevention-of-future-death-reports/twn-bryn-prevention-of-future-deaths-report/
Acute Death	**24/10/2023**	1. No investigation into the lost ERCP referral and it did not appear that the HB were aware until the Inquest was held. Despite the Inquest being held in 2022, it still appears that this issue has not been investigated by the HB. 2. Concerns were raised around the quality and surrounding processes for the HB to undertake investigations with no evidence of effective learning. 3. No evidence of an audit being undertaken to identify any additional lost referrals. 4. Referrals remain paper based with no clear indication of when these will likely be electronic	https://www.judiciary.uk/prevention-of-future-death-reports/jennifer-campbell-prevention-of-future-deaths-report/
Accidental Death	**24/11/2023**	1. Inadequate improvement processes to manage patients with food intolerances. 2. No investigation undertaken by the HB with inadequate governance arrangements surrounding this. 3. Concerns were raised that there were noted to be similar incidents that had occurred but not reported on Datix	https://www.judiciary.uk/prevention-of-future-death-reports/hazel-pearson-prevention-of-future-deaths-report/
Acute Death	**08/12/2023**	Lack of cohesive care and treatment for patients undergoing surgery	https://www.judiciary.uk/prevention-of-future-death-reports/catherine-jones-prevention-of-future-deaths-report/
Acute Death	**18/12/2023**	1. Out of hours emergency endoscopy is unavailable as the provision has collapsed at Wrexham Maelor Hospital	https://www.judiciary.uk/prevention-

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		2. Insufficient doctors and nurses working in the ED as well as significant handover delays. 3. The effectiveness and knowledge around key policy guidance documents 4. Learning from the investigation report was inconsistent and is not shared with the involved clinical teams	of-future-death-reports/vivienne-greener-prevention-of-future-deaths-report/
Acute Death	22/01/2024	1. No Datix raised by the HB when the error was identified due to time constraints on staff. 2. No investigation was undertaken by the HB as to how the patient was lost to follow up. 3. There have been no assurances that any changes in practice had been made following the incident	https://www.judiciary.uk/prevention-of-future-death-reports/thomas-ithell-prevention-of-future-deaths-report/
Suicide	02/02/2024	1. Lack of information sharing between clinical teams around the patient's progress, medication or treatment 2. No written agreement or SOP was in place between the HB and the independent provider around information sharing	https://www.judiciary.uk/prevention-of-future-death-reports/philip-taylor-prevention-of-future-deaths-report/
Drug Related Death	14/02/2024	1. Lack of compliance with the 12-15 monthly medication reviews in the HB with no standard practice for undertaking these 2. Concerns were raised around the patient's medication prescribing	https://www.judiciary.uk/prevention-of-future-death-reports/teresa-bennett-prevention-of-future-deaths-report/
Acute Death	28/02/2024	1. Patient was seen by several orthopaedic doctors of varying grades and Junior Doctors did not feel empowered to challenge findings with their consultant colleagues. 2. HB did not have adequate and appropriate systems and processes for dealing with complaints. 3. No full investigation was undertaken by the HB with a desktop review being undertaken which was questionable. There were therefore no considerations to immediate actions or learning required.	https://www.judiciary.uk/wp-content/uploads/2024/03/Nesta-Jones-Prevention-of-future-deaths-report-2024-0110_Published.pdf
Acute Death	01/03/2024	Concerns were raised around the effectiveness of the bleep system in the HB resulting in a misunderstanding by the Junior Doctor in relation to the administration of the beriplex infusion.	https://www.judiciary.uk/wp-content/uploads/2024/03/Jennifer-

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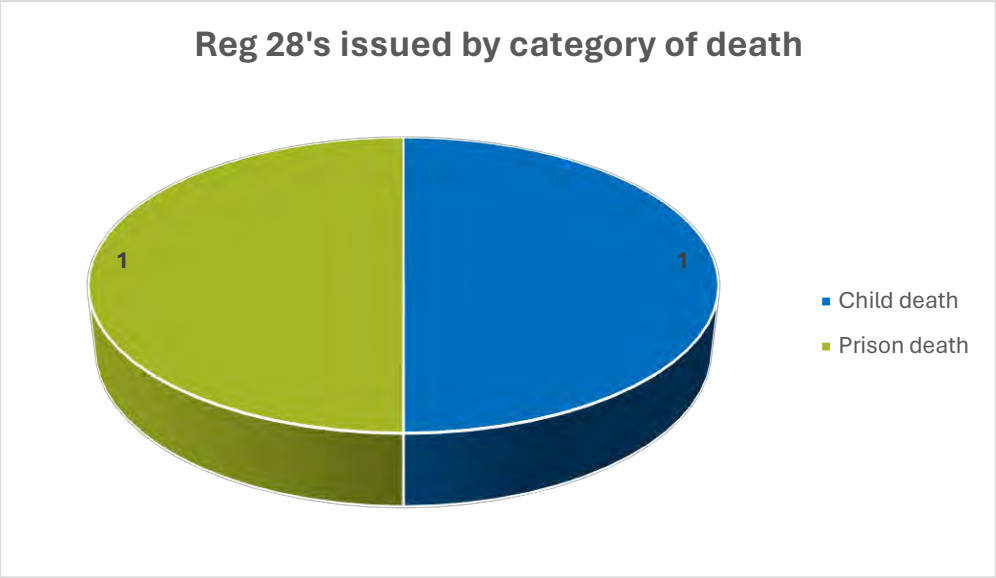

			Trigger-Prevention-of-future-deaths-report-2024-0116_Published.pdf
Acute Death	27/03/2024	Transport request for urgent transfer for vascular surgery should have been booked by the ward with the ACCTS and not WAST. Evident that there was inadequate knowledge amongst clinical staff of the use of ACCTS	https://www.judiciary.uk/wp-content/uploads/2024/04/Maureen-Owens-Prevention-of-future-deaths-report-2024-0177_Published.pdf

4.3 Cardiff and Vale University Health Board

Regulation 28's issued by the coroner to Cardiff and Vale UHB by category of death:

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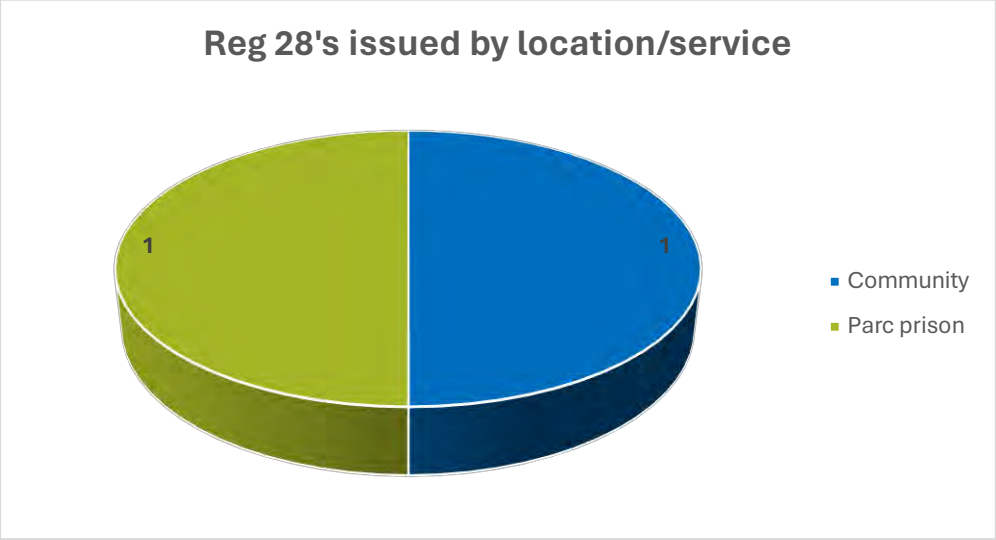
Regulation 28's issued to Cardiff and Vale UHB by location/service where the death occurred:



Breakdown

Case	Date report published	HMC Concern/s	Link to report
Child Death	15/11/2023	Did not appear to be a review of the baby's sleeping arrangements by health visitors before she was 6 weeks old.	https://www.judiciary.uk/wp-content/uploads/2023/11/Ocean-Leigh-Hayes-Prevention-of-future-deaths-report-2023-0455_Published.pdf

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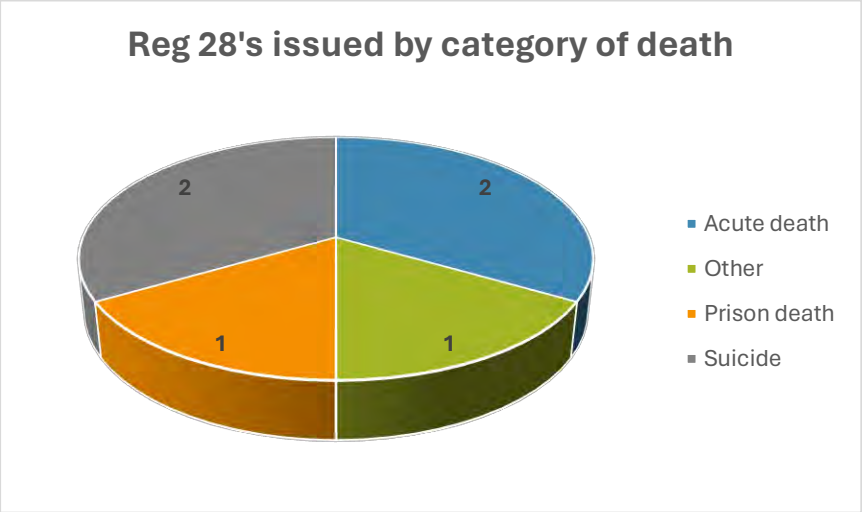
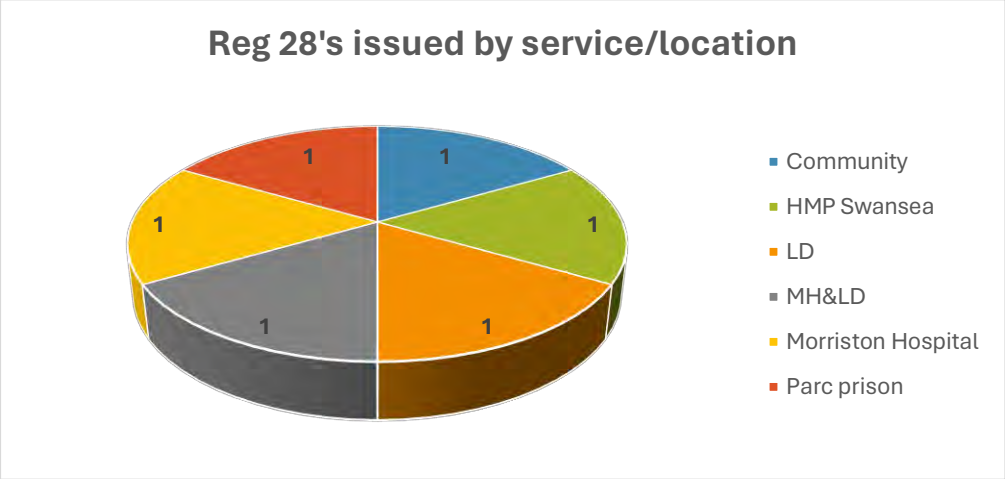
Prison Death (Duplicate with SBU)	21/03/2024	Concerns were raised around the assessments undertaken and subsequent management of the patient whilst in prison.	https://www.judiciary.uk/wp-content/uploads/2024/03/Alan-Davies-Prevention-of-future-deaths-report-2024-0160_Published.pdf

4.4 Swansea Bay University Health Board

Regulation 28's issued by the coroner to Swansea Bay UHB by category of death:



Regulation 28's issued to Swansea Bay UHB by location/service where the death occurred:



Breakdown

Case	Date report published	HMC Concern/s	Link to report
Suicide	18/05/2023	Concerns were identified around access to electronic records between MH teams and substance misuse teams and their overall integration	https://www.judiciary.uk/prevention-of-future-death-reports/samuel-morgan-prevention-of-

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			future-deaths-report/
Suicide (HMP Swansea)	21/06/2023	1. Concerns identified that prior to his detention in prison, an assessment by a forensic psychiatrist noted the patient was suffering with PTSD and was experiencing a psychotic episode linked to a personality disorder. 2. Patients prior suicide attempts were not included on key documents such as the Person Escort Record and the suicide & self-harm form used by Dyfed Powys Police on the patients transfer	https://www.judiciary.uk/prevention-of-future-death-reports/matthew-harris-prevention-of-future-deaths-report/
Acute Death	19/07/2023	1. Concerns relating to documentation were raised with a contradiction between nursing notes and medication charts around laxative prescribing and clinical judgement. 2. Due to the patients LD, some difficulties around communication were identified	https://www.judiciary.uk/prevention-of-future-death-reports/shane-west-prevention-of-future-deaths-report/
Acute Death	04/03/2024	Significant delays in attendance of an ambulance and handover	https://www.judiciary.uk/wp-content/uploads/2024/03/Jean-Thomas-Prevention-of-future-deaths-report-2024-0121_Published.pdf
MH Provision for Prisoners	13/03/2024	1. Concerns were raised around a lack of effective coordination between teams regarding the management of prisoners with MH issues. 2. Concerns were raised that local GP and CMHT assessments were not recorded in an easily accessible format with regard to digital systems. 3. Concerns were raised that there was a lack of guidance across agencies when high risk prisoners are released	https://www.judiciary.uk/wp-content/uploads/2024/03/Jacob-Billington-Prevention-of-future-deaths-report-2024-0136_Published.pdf
Prison Death (Duplicate with C&V)	21/03/2024	Concerns were raised around the assessments undertaken and subsequent management of the patient whilst in prison.	https://www.judiciary.uk/wp-content/uploads/2024/03/Alan-Davies-Prevention-of-future-deaths-report-2024-0160_Published.pdf

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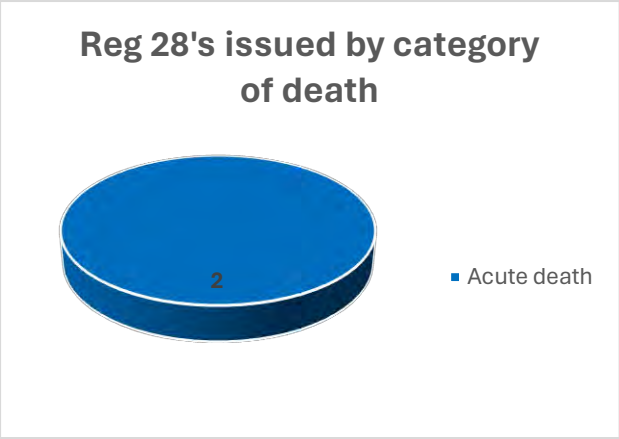
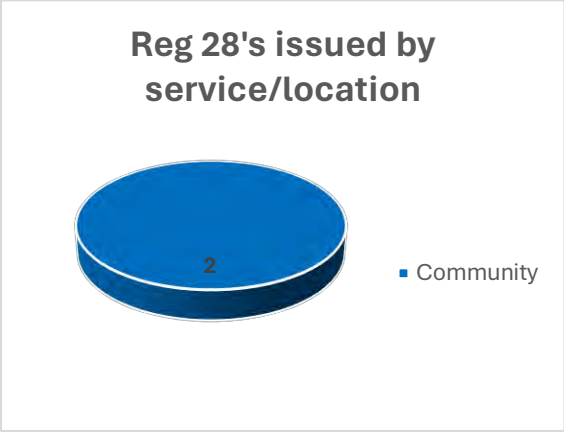
4.5 Welsh Ambulance Services University NHS Trust

Regulation 28's issued by the coroner to Swansea Bay UHB by category of death and location where death occurred:





Breakdown

Case	Date report published	HMC Concern/s	Link to report
Acute Death	12/09/2023	Evidence was provided that a memo/reminder had been issued to staff regarding the 'human error', however there was no evidence as to the effectiveness of such a reminder in the reduction of human error and I am concerned that deaths may occur as a result of failures to provide advice available within MPDS due to handlers not following the correct/most appropriate pathway.	https://www.judiciary.uk/wp-content/uploads/2023/09/Rashdah-Bhatti-Prevention-of-future-deaths-report-2023-0325_Published.pdf
Acute Death	07/02/2024	1. A script used by Operators within WAST as part of the Clinical Safety Plan inform callers not to call back for an estimated time of arrival of the ambulance. They are told to only call back if there is a deterioration in the patient's condition. 2. During periods of a delayed response from an ambulance, WAST best practice is for an Operator to maintain regular contact with callers to assess any change in their condition. During periods of excessive demand, it is considered that this is not always achievable, and therefore Welfare calls are prioritised to callers considered vulnerable. 3. There may be a risk that callers do not understand the instruction to only call back if there is a deterioration, and/or may not recognise a deterioration, and feel they cannot call WAST again. There is a further risk that unless regular welfare calls are	https://www.judiciary.uk/wp-content/uploads/2024/02/Brian-James-Prevention-of-future-deaths-report-2024-0064_Published.pdf

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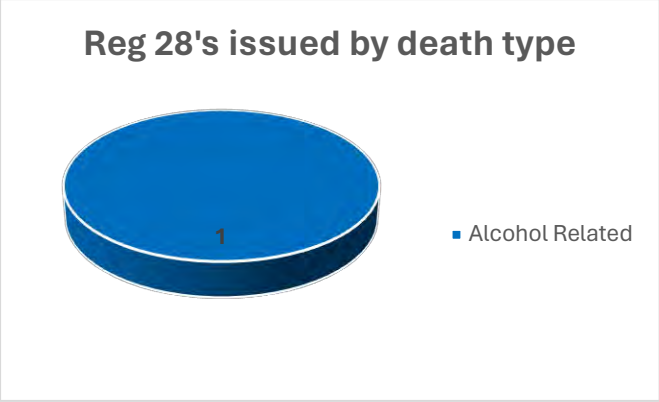
		made during periods of delayed response, there is a missed opportunity to properly re-assess and regrade the response to a call by WAST.	

5.6 Welsh Government

Regulation 28's issued by the coroner to Welsh Government by type of death:



Breakdown

Case	Date report published	HMC Concern/s	Link to report
Alcohol Related	22/02/2024	1. Welsh Ambulance Services University NHS Trust were unable to allocate an available ambulance resource in an Amber 1 category call until over 6 hours from the time of the 999 call; 2. Despite having their full complement of ambulance resources staffed and on shift many of them were held up by delays in handover at hospitals; 3. The number of funded ambulances appeared to be significantly short of what would have been needed in the circumstances.	https://www.judiciary.uk/wp-content/uploads/2024/02/Joseph-Cattle-Prevention-of-future-deaths-report-2024-0107_Published.pdf

5. Assurance Arrangements 2024/25

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2023/24 is the first year that the Regulation 28 reports, issued by His Majesties Coroners Service to NHS Wales Services/Providers, have been collated on an All-Wales basis. This work, undertaken by the Quality and Safety Team within the

Performance and Assurance division of the NHS Wales Executive, now ensures Regulation 28 reports are now;

- Development of data collation processes
- Regulation 28 reports featured in weekly (internal) safety intelligence bulletins.
- Reports discussed and reported to QDB via internal (NHS Wales Executive) Quality and Safety meetings.
- Reports raised and discussed at IQPD.
- Reports inform NHS Wales Escalation Framework/Processes

Whilst this position has given the opportunity to provide an annual overview of the 'concerns' raised, the early life of the process and therefore the ability to provide further assurances in relation to organisational responses to the concerns is limited. During 2024/25 financial year, the following developments are scheduled.

- Broader sharing of weekly intelligence bulletins to NHS Wales Executive functions and Welsh Government
- Routine follow-up enquiries with NHS Wales organisations to assure response quality and timeliness.
- Visibility of reports (including trends) via the 'Beacon' National Quality Dashboard.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

WORKFORCE AND ORGANISATIONAL DEVELOPMENT (WOD) IMPLEMENTATION PLANS

DATE OF MEETING	12th August
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	Susan Thomas, Deputy Director of OD and Workforce
PRESENTED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
APPROVED BY	Sarah Morley, Executive Director of Organisational Development & Workforce
EXECUTIVE SUMMARY	The paper provides an overview of Workforce and Organisational Development Plans in train to support the delivery of the Trust People Strategy.
RECOMMENDATION / ACTIONS	To ***Note*** the WOD Implementation Plans

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GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Audit Committee	10/07/24
Executive Management Board	29/08/24
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS Audit Committee agreed to share With QSP Committee EMB noted the report	

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 A - C	A. People Implementation Plan 24/25 B. Education Strategy Implementation Plan C. Strategic Equality Objectives Plan D. Health and Wellbeing Plan

1. SITUATION

The People Strategy was approved by Trust Board in May 2022 with the key strategic outcomes of achieving a Healthy and Engaged, Planned and Sustained and a Skilled and Developed Workforce. A number of Implementation plans are in train to deliver the outputs required to ultimately achieve the strategic intents in the strategy. This paper provides a collective oversight of the implementation plans in place to support the delivery of the People Strategy. Work is on progress to collate all project plans into one holistic plan for ease of management.

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2. Background/ Matters for Consideration

An overarching People Strategy Implementation plan for 24/25 is in place (Appendix A). This is a live document and is being utilised with service leads to continually ensure the actions meet the desired outputs. The People Strategy Implementation plan provides the actions, outputs and measures in place to deliver the outcomes required for 24/25. It articulates the governance mechanisms through which actions are developed and is triangulated with the Trust Assurance Framework.

To support the overarching People Strategy plan, focusing on a Skilled and Development Workforce, the Education Strategy Implementation Plan (Appendix B) is being delivered. This plan provides more granular details on the delivery of actions to support education, training, leadership and succession as well as new career pathways to support workforce planning. The Strategic Equality Action Plan (Appendix C) has been developed to clarify the operational action taken in year to achieve the four year Strategic Equality Plan and the Health and Wellbeing Plan (Appendix D) highlights the action and activities being taken to deliver a healthy and engaged workforce.

3. Next Steps – Ongoing Reporting and Monitoring

Updates on the overarching People Strategy Implementation plan are produced every two months to the Quality, Safety and Performance Committee via the Supply and Shape paper, providing an outline of WOD risks and the mitigating actions. This paper is triangulated with the performance reports with updates on the TAF - with particular reference to TAF 03 and 04. Updates on the Education Implementation Plan are progressed via the Trust's Education and Training Steering group and the Equality Plan is updated via the Trust's Healthy and Engaged Steering group. Both steering groups provide quarterly highlight reports to the Trust's Executive Management Board.

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4. IMPACT ASSESSMENT

TRUST STRATEGIC GOAL(S)	
Please indicate whether any of the matters outlined in this report impact the Trust's strategic goals: YES - Select Relevant Goals below	
If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☒ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☒ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	03 - Workforce Planning 04 – Organisational Culture
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 ☒
	Click or tap here to enter text
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED:	Not required

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For more information: *https://www.gov.wales/socio-economic-duty-overview*	

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 resources are being assessed to support the implementation of the People plan and will be reported to EMB
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
	EQIA undertaken as part of the strategy development.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.
	Click or tap here to enter text

5. RISKS

ARE THERE RELATED RISK(S) FOR THIS MATTER	Yes - please complete sections below
WHAT IS THE RISK?	*Taf 03 and Taf 04*
WHAT IS THE CURRENT RISK SCORE	

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HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	*As noted above*
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	

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Appendix A

WOD Objectives 24/25

To be read in conjunction with the:

- Education Strategy Implementation plan 24/25 (Appendix B)
- Strategic Equality Objectives 24/25 (Appendix C)

Strategic Driver	Themes of work	Activities (Ref specific Implementation plans for details)	Taf Ref	Governance Mechanism (Reports included – Supply and Shape Paper, Highlight report on H&W and E&T)	Timelines	Measures
Healthy and Engaged Workforce	**Our staff will feel valued and supported** Promote a culture of true inclusivity, fairness and equity across the workforce.	Implement the actions within the Health and Wellbeing Action plan – supporting wellness and managing action plan for sickness absence	TAF 04	Healthy and Engaged Steering group/EMB Run/Quality Safety and Performance (QSP)	March 2025 reviewed quarterly	Sickness Absence Rates
		Implement the Values and Behaviour framework		As above	Dec 2024	Values and Behaviours Framework in place
		Triangulate culture work, staff feedback themes and		Healthy and Engaged Steering Group/EMB Shape/SDC	Oct 2024	Programme in place with clear deliverables

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		leadership work to deliver an aligned culture programme of work that addresses organisational issues reflects our values and allows staff to speak up freely *(A culture of dialogue, openness and psychological safety is prioritised and work arising from Speaking Up Safely, NHS Staff Survey results, Leadership for Patient Safety, Employee Relations review and other initiatives is aligned so that actions and improvements fit the needs of staff)*				linked to staff requirements
		Review performance indicators for a Healthy and Engaged workforce including EQIA measures and hybrid working		Healthy and Engaged Steering group/EMB Run/Quality Safety and Performance (QSP)	September 2024	Measures in place
		Deliver an action plan 24/25 commitment in		Healthy and Engaged Steering group/EMB	March 2025	Action plan output delivered

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		the Trust Anti- Racist Action plan		Run/Quality Safety and Performance (QSP)		
		Monitor Welsh Language Standards, working with Divisions on improvement plans Implement the WL Culture plan		EMB Shape/Strategic Development Committee	March 2025	Improvement plans delivered
		Update all WOD related policies and procedures		EMB Run/QSP	April 2024	Policies Completed
		Deliver an infrastructure to support Industrial Action and wellbeing offer for staff during IA		EMB Run	Ongoing as required	Qualitative Lessons Learnt Reports
Planned and Sustained Workforce	Right people right place right time	Implement the Education Strategy Implementation Plan 24/25	TAF 03	Education and Training Steering Group/EMB Run/QSP	March 2025 reviewed quarterly	Statutory and Mandatory Training KPIs in development
		Following the agreement of the Clinical and Scientific Strategy develop Trust wide priorities and implementation plan for multi-disciplinary workforce model		EMB Run/QSP	Dec 2024	Principles for MDT working agreed across the Trust and signed off by Executive Team

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						Clear priority areas agreed by EMB
		Manage the successful implementation of the WL service provision (SLA) to support service bi-lingualism		EMB Run/QSP	March 2025	SLA in place and delivered
	Attraction and Retention	Agree a plan for the Widening Access Programme		Education and Training Steering Group/EMB Run/QSP	June 2024	No of Apprenticeships agreed
		Ongoing recruitment Marketing Campaigns for hard to fill roles Working with Comms Trust wide recruitment campaign in place		EMB Run/QSP	Ongoing Trust wide Programme Sep 2024	Vacancy Rates
		Evaluate the International nurse Recruitment Programme		EMB Run/QSP	December 2024	Agency Spend reduction monitoring
		Develop a Nurse retention plan		EMB Run/QSP	September 2024	Turnover Rates
Skilled and Developed Workforce	Component caring and capable workforce	Deliver the Trust Training Plan 24/25	TAF 03	Education and Training Steering Group/EMB Run/QSP	March 2025	Statutory and Mandatory Training

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Achieving Excellence through our staff		– clear KPIs to support evaluation				KPIs in development
	Transforming care pathways	Working with the service agree training requirements for care pathways (HSCW, AP and Consultant) through the workforce planning process to shape a multi-disciplinary workforce Model		Education and Training Steering Group/EMB Run/QSP	December 2024	New pathways agreed
	Developing our academic profile	Through the training plan provide education, training, and development opportunities to enable staff to develop their knowledge and skills through life-long learning, through the Velindre Oncology Academy and the Collaborative Centre		Education and Training Steering group/EMB Shape/SDC	March 2025	Evaluation of the Training Plan reporting on KPI within the plan

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		for Learning and Innovation				
	To create a workforce which has the skills, knowledge and curiosity to maximise the opportunities offered by digital services and technology	Working with Digital - Provide training and sources of support to enable the workforce to be confident and competent in the use of new equipment, systems, and technology		EMB Run	March 2025	Qualitative Training feedback working with Digital colleagues
People Function Cultural Development – People and Relationships Model	Employer of Choice	Develop an engagement plan for the function to support the engagement and alignment with service development		EMB Run	December 2024	Qualitative feedback – Customer satisfaction questionnaire
		Implementation of the holistic People and Relationships model Engagement and Commitment from EMB		EMB Run	September 2024	Structure implemented and internal evaluation via WOD Forum

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		Promote the principles of hybrid working and undertake regular pulse surveys to gain feedback			Ongoing	Pulse surveys via WOD governance

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Appendix B Education Strategy Implementation Plan

Education Strategy Implementation Plan - Year 1 2024/25

(TBC)

POD Ref No.	Quadrant of Education Strategy	TAF reference	Objective	Action	Owner/Lead	Interdependencies (POD Ref No.)	Year 1 24/25	Year 2 25/26	Year 3 26/27	Measures How will we know we have met our objectives?	Status
ES1.1	ES1 - Ensure the development of a competent, caring and capable workforce	TAF04	**Develop the infrastructure and systems to enable the effective development of a competent, caring and capable workforce**	Develop processes to capture and report on people development activity	POD		✔	☐	☐		
ES1.2				Colleagues developed in line with appropriate funding frameworks	POD		✔	☐	☐	Bi-annual report provided to PDESG on attrition rates of learners	
ES1.3			**Essential training available to all colleagues to meet statutory and mandatory training requirements**	Support the provision of statutory and mandatory training by working with subject matter experts and systems (ESR) to enable all staff to access training.	POD		✔	✔	✔	85% completion rate for Statutory and Mandatory training maintained	
ES1.4				Deliver the Welsh language training plan	POD		☐	✔	☐	100% of colleagues have completed the Awareness course. Year-on-year increase in the levels of Welsh competency across the Trust reported via ESR	
ES1.5			**Support all colleagues to receive a meaningful PADR with user friendly templates and processes allowing for**	Review current Policy and Procedures engage with stakeholders and external benchmarking	POD		✔	☐	☐	85% compliant PADR Motivated and engaged workforce (measured via Annual Staff Engagement Index) Improvement seen PADR Appraisal results via Staff Survey	Closed

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ES1.6			**a constructive and meaningful conversation, whilst enabling a personal development and career plan.**	Design new processes and paperwork templates following scoping exercise outcomes	POD		✔	☐	☐		
ES1.7				Pilot to ensure process and paperwork meet the objective criteria, update management training and toolkits	POD		☐	✔	☐		
ES1.8				Update all management training, toolkits and launch new process	POD		☐	✔	☐		
ES1.9				Evaluation of new process and paperwork template	POD		☐	✔	✔		
ES1.10			**Provide a fair and equitable approach to development opportunities**	Implement the new People Development Policy and Application Process	POD		✔	☐	☐	Motivated and engaged workforce (measured via Annual Staff Engagement Index) Training, Education and Development opportunities are accessed by colleagues - KPI needed here can be taken from the insight gained from the People Development Application process WRES measurements of access to development	
ES1.11				Pilot to ensure process and paperwork meet the objective criteria, update management toolkits	POD		✔	☐	☐		
ES1.12				Update all management toolkits and launch new process	POD		✔	☐	☐		
ES1.13				Evaluation of new process and paperwork template	POD		☐	✔	☐		
ES1.14			**Provide management and leadership development opportunities required for Destination 2033, as set out in Building Our Future Together and utilising the 'Just in time, Just for me' approach**	Development of a leadership and management development action plan in place	POD		✔	☐	☐	Evaluation of leadership and management interventions and benefit through impact assessments (link with People Relationship team as part of evaluation) Agreed leadership and management development action plan in place	
ES1.15				Deliver and Evaluate the Fundamentals of Management Programme	POD		✔	✔	✔		

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ES1.17				Deliver and Evaluate the Inspire management and leadership development Programme	POD		✔	✔	✔		
ES2.1	**Support development of new training pathways**	**TAF04**	**Enable people from all backgrounds to find a role within the NHS that meets their potential and aspiration.**	Development of a widening access and participation action plan	POD		✔	☐	☐	Agreed widening access and participation action plan in place Relative likelihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues (Data gathered as part of WRES reporting accessed from the People Development Application process and ESR)	
ES2.2				Contacts made with local community groups/schools/colleges sharing information on opportunities and careers within the NHS	POD		✔	☐	☐		
ES2.3				Development of Apprenticeships to grow our own workforce to support succession planning	POD		✔	✔	✔		
ES2.4				Health Care Support Worker and Advanced Practice Frameworks are embedded, making best use of funding by working in partnership with HEIW, Welsh Government and Training Providers.	Clinical Education Leads		✔	✔	✔		
ES2.5				Development of career pathways for all job family groups	POD		☐	✔	☐		
ES2.6				Working with divisions, training and development is planned annually to enable effective workforce planning	POD		✔	✔	✔		

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Evaluation Framework

Evaluation Framework to be presented to Steering Group in June
Evaluation to be undertaken from June to September 2024, to be presented to the Steering Group in September

85% completion rate for Statutory and Mandatory training maintained
100% of colleagues have completed the Awareness course. Year-on-year increase in the levels of Welsh competency across the Trust reported via ESR
85% compliant PADR Motivated and engaged workforce (measured via Annual Staff Engagement Index) Improvement seen in PADR Appraisal results via Staff Survey
Motivated and engaged workforce (measured via Annual Staff Engagement Index) Training, Education and Development opportunities are accessed by colleagues
Evaluation of leadership and management interventions and benefit through impact assessments (link with People Relationship team as part of evaluation) Agreed leadership and management development action plan in place

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Agreed widening access and participation action plan in place Relative likelihood of white staff accessing non-mandatory training and CPD compared to Black, Asian or Minority Ethnic colleagues (Data gathered as part of WRES reporting accessed from the People Development Application process and ESR)
Progress report from Velindre Oncology Academy
HEIW and academic partners regular members of group

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How will we measure our success? How do we know if we have made an impact?

Kirkpatricks's level of learning evaluation	Methods
Level 1: Reaction	
The degree to which participants find the training favourable, engaging and relevant to their jobs	Real time polls and experience evaluation forms
Level 2: Learning	
The degree to which participants acquire the intended knowledge, skills, attitude, confidence and commitment based on their participation in the training	Real time polls and experience evaluation forms and assessments
Level 3: Behaviour	
The degree to which participants apply what they learned during training when they are back on the job	Impact evaluation sent out 3 months post learning activity
Level 4:	

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The degree to which targeted outcomes occur as a result of the training	**Engagement surveys inc. agile pulse survey, staff survey**

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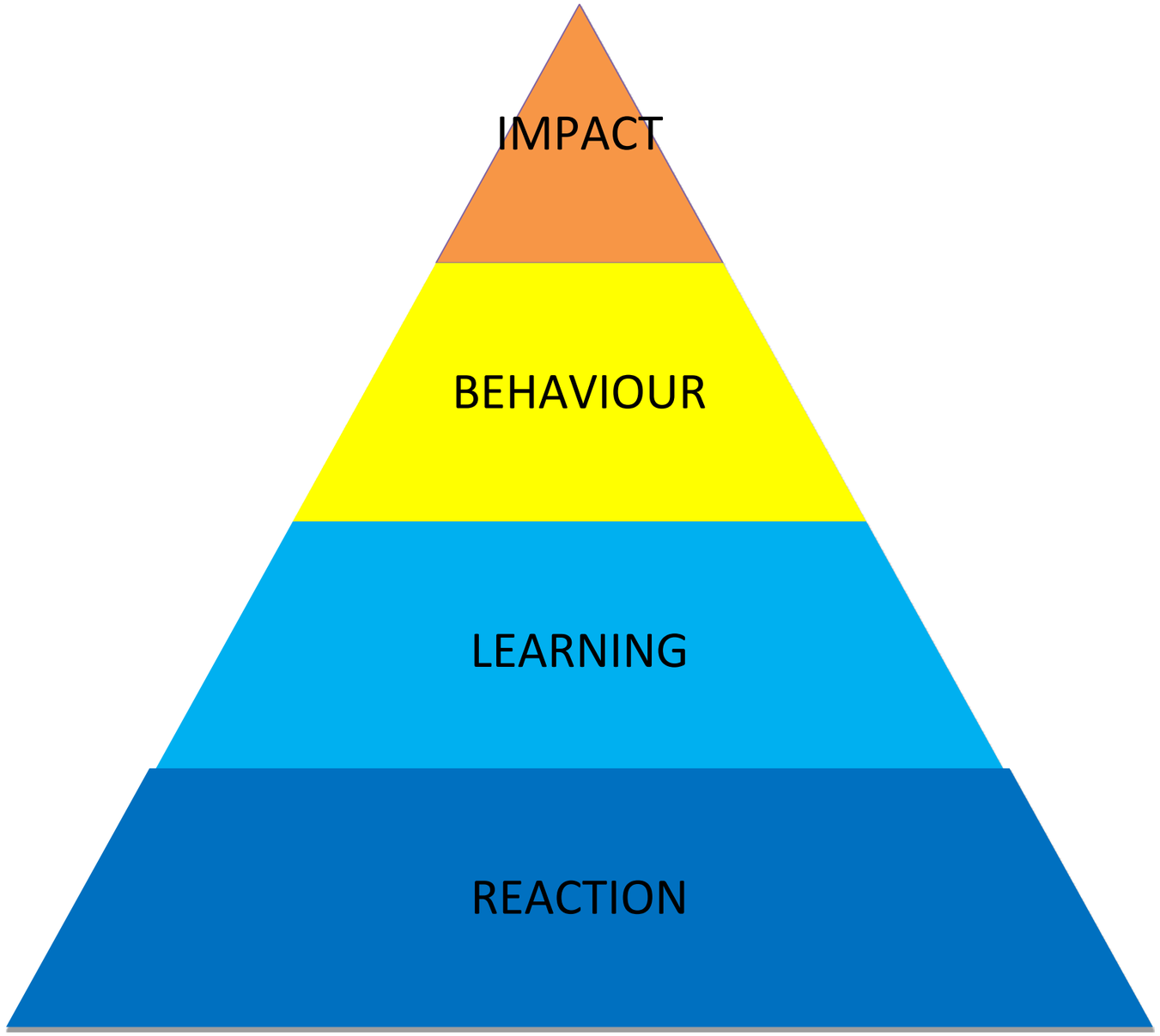

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Appendix C Strategic Equality Action Plan

How will we know we have delivered our actions?	SMART Action	Lead	Date
TRAC data shows equal progression through application, shortlisting and offer for Race, Gender and Disability	A report is produced for 2024-25 showing progression of job applicants through application, shortlisting and offer correlated with Race, Gender and Disability.	CB	31.3.25
The changing workforce profile is quantified and described within the Annual Equality Report.	The Annual Equalities report for 2023-24 describes the changes in the workforce profile over the past three years and the implications this has for the Trust.	CB	31.5.24
People decide to enter employment in the NHS or start training in one of the health professions.	A Widening Access engagement programme is agreed and put into practice and a report produced summarising and enumerating all contacts with schools, colleges and the wider community.	AG	31.3.25
Women in STEM roles report receiving appropriate support to develop within their profession.	A pilot programme is developed with one STEM department to identify what support will help women within their profession.	MF	31.12.24
NHS Staff Survey reflects annual decrease in desire to leave and annual increase in the Employee Engagement Index.	The Values and Behaviour project is concluded. Relevant policies are updated to reflect new values. Training is offered to staff to understand how to use values in their work.	CB	30.9.24
Evidence from staff that reasonable adjustments are utilised throughout their employment journey.	Five case studies are collated from people who offer to share their experiences of needing adjustments in order to thrive at work.	MF	30.9.24
People Development Policy in place making this statement. NHS Staff Survey Development Theme shows improvement year on year.	The People Development Policy is approved, and application process is in place. The change in the 2023 and 2024 Development Theme is reported to the Education Steering Group in March 2025.	VD	31.3.25
Terms of Reference for Race, Gender, LGBTQ+ and Disability Forums are in place. Forums able to meet at least twice a year and submit ideas to the POD team.	Terms of Reference for Race, Gender, LGBTQ+ and Disability Forums are in place. Documented feedback is sent from each Forum to the People and OD team.	MF	31.3.25
Year on year improvement in WRES indicators.	WRES data reported by 30.4.24. Task and Finish Group established to implement changes coming from the Trust Anti-racist action plan in light of WRES data.	MF	31.3.25
Disability Confident Level 3 in place.	Self-assessment completed and actions taken to enable Trust to apply for Disability Confident Level 3.	MF	30.6.24
Pay Gap data is visible in annual equalities workplans.	Gender Pay Gap for 31.3.24 reported in May 2024 and reflected in Annual Equalities report.	CB	31.7.24

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Evidence of connection and liaison regarding equalities communication campaigns.	Communications plan agreed for 2024-25 including themes, dates and target audiences.	MF	31.5.24
Patient Engagement and Donor Engagement functions agree engagement approach. Working relationship with Llais further developed and embedded in service development projects.	Patient Engagement and Donor Engagement leads agree stakeholder engagement strategy that links into the Healthy and Engaged Steering Group.	Divisional Directors	30.6.24
Target of 800 Black and Minority Ethnic Donors on stem cell register is achieved.	Leads can demonstrate that feedback from stakeholders has been used to improve a range of projects.	Divisional Director WBS	31.3.25
Positive feedback from patients and donors regarding use of preferred language. Use of easy read materials for people who need that format.	Review of stakeholder satisfaction with written documentation is completed and recommendations made to relevant Divisional SLT.	Divisional Directors	31.3.25
Positive feedback from patients and donors regarding use of BSL.	To be conducted as part of 4.2 below.	Divisional Directors	31.3.25
No failures in complying with the Welsh Language Standards identified.	Divisional Welsh Language Groups renew their action plans in light of any further feedback from the Commissioner's office in order to deliver the Active Offer.	Divisional Directors	31.3.25
Every project has an EQIA on file with timed actions and closure loop in place.	Every project has an EQIA on file with timed actions and closure loop in place.	Divisional Directors	31.3.25
Evidence of improvements to accessibility in response to feedback. Data set in place which correlates patient experience with protected characteristics. Specific review of accessibility for blood donors with disabilities is completed.	Undertake comprehensive EQIAs for access to cancer treatment and participation in blood donation with a particular focus on Disability. Report findings to Divisional SLT for action.	Divisional Directors	31.3.25
Trust processes capture demographic information including disability and language requirements in particular where this is documented by the Health Board referring a patient.	Identify patient systems and records that would need to be used to measure this improvement.	Divisional Directors	31.3.25
VUNHST present at all Wales discussions and supporting the improvement.	VUNHST can demonstrate our inputs into the project and applies any changes within three months of them being finalised.	MF	31.3.25
Training and resources offered to managers leading to better quality EQIAs being completed for all policies and projects as shown in annual review of EQIAs received.	Six training sessions for managers on EQIAs are delivered between May and December 2024 and the evaluation of impact is reported to the Healthy and Engaged Steering Group.	MF	31.3.25
Improvement in the NHS Staff Survey measures on equality and diversity 2023 compared with 2024.	Learning materials used in Croeso and Inspire are adapted and made available to all staff. Two teams undertake a pilot of the Culture Competence Audit.	MF	31.12.24

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Appendix D Health and Wellbeing Plan

Ymddiriedolaeth GIG Prifysgol Felindre
Velindre University NHS Trust

SMART objective	People Priority	IMTP Objectives	Lead	Deadline	Progress	Detail
A culture of dialogue, openness and psychological safety is prioritised and work arising from Speaking Up Safely, NHS Staff Survey results, Leadership for Patient Safety, Employee Relations review and other initiatives is aligned so that actions and improvements fit the needs of staff.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Deputy Director of People and OD	Mar-25		
Trust level priorities arising from the NHS Staff Survey 2023 are used to shape processes and culture across the Trust using existing work programmes where possible. Divisions and Departments are supported to share results and build improvements into their business as usual.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Head of OD	Sep-24		
Trust Values are embedded in processes for recruitment, appraisal and development. The Communications and Engagement plan for Values is fully implemented.	Healthy and Engaged	VUNHST develops its compassionate, values-led culture where staff are empowered, involved and engaged.	Head of OD	Sep-24		
Monitor the implementation the 2024-25 Action Plan for the Strategic Equality Plan.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	OD Manager - ED&I	Mar-25		
An evaluation methodology for Health and Wellbeing interventions is in place and the first report will be issued in September 2024.	Healthy and Engaged	VUNHST develops its compassionate, values-led culture where staff are empowered, involved and engaged.	Wellbeing Project Coordinator	Sep-24		
Peer support for Wellbeing is enhanced through building on Menopause Buddies and Mental Health First Aider Network. Feedback from staff shows if it is helpful and if changes are required.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Wellbeing Project Coordinator	Dec-24		
The Trust's approach to Health and Wellbeing is reviewed against the NHS Wales Health and Wellbeing Framework (published April 2024). Any gaps are highlighted to the H&E Group and woven into next plans.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Wellbeing Project Coordinator	Jun-24		
Welsh Language Groups in WBS, VCS and Corporate will deliver changes required from the 2023 Commissioner's report: public telephone lines to be answered bilingually and website to be fully bilingual.	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Welsh Language Manager	30-Nov-24		
Welsh Language Skills profile will be measured and monitored quarterly covering compliance with Welsh Language Awareness and improvement in skills levels recorded in ESR	Healthy and Engaged	Promote a culture of true inclusivity, fairness and equity across the workforce.	Welsh Language Manager	30-Jun-24		

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

QUALITY, SAFETY AND PERFORMANCE COMMITTEE

Bi-Annual Value-Based Healthcare Programme Update

DATE OF MEETING	12/09/2024
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	Gwawr Evans Head of Value Based Healthcare
PRESENTED BY	Matthew Bunce, Executive Director of Finance
APPROVED BY	Matthew Bunce, Executive Director of Finance
EXECUTIVE SUMMARY	This report provides an update on the work of the Value Based Healthcare programme, and progress made since March 2024. This is one year since the Value Intelligence Centre was formed in September 2023.
RECOMMENDATION / ACTIONS	The Quality, Safety & Performance Committee is asked to **NOTE** the continued progress of the Value Based Healthcare Programme including: o The imminent procurement and implementation of a digital PROMS

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	solution following successful Business Case o The launch of an NHS Wales Preoperative anaemia Pathway o The approval of the Velindre Food Mission and input from stakeholders to create an action plan.

GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
EMB Run	**29/8/2024**
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS The Executive Management Board noted the progress.	

7 LEVELS OF ASSURANCE	
N/A – Report for Discussion	
ASSURANCE RATING ASSESSED BY BOARD DIRECTOR/SPONSOR	**Select Current Level of Assurance**

APPENDICES	
N/A	

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

1. SITUATION

The vision of the Value Based Healthcare programme is to deliver exceptional services, using linked datasets to identify and deliver continuous improvements that maximise the value, quality, safety, and efficiency of the care our patients and the service our donors receive.

The Trust's Value Based Healthcare programme which is funded by Welsh Government is at varied stages of maturity. This report provides a summary of the work completed since the previous report in March.

2. BACKGROUND

The Value Based Healthcare Programme includes three workstreams as follows:

- Preoperative Anaemia Pathway Project with the Welsh Blood Service
- Value Intelligence Centre
- Food Mission

VBH Programme updates are provided to the QSP Committee on a bi-annual basis and the previous update was provided in March 2024.

A full governance framework is in place for the programme with a route through to the Executive Management Board and up to the Trust Board via QSP and SDC Committees respectively. The Value Based Healthcare Steering group meet monthly to monitor progress and set strategic decisions.

The VBH Programme works closely with the Welsh Value in Health Team and Welsh Cancer Network to ensure that activities align with national standards and strategies.

3. ASSESSMENT

3.1 Value Intelligence Centre

The Centre is formed from a matrix team with resource across Clinical Leadership and Management, Data and Insights, Digital and Finance.

Two of the workstreams are directly linked to a Welsh Government mandatory requirement for the funding. These are to collect Patient Reported Outcome Measures (PROMS) and to share these on a national basis. The programme objectives are defined on the enablers of Value Based Healthcare – to enable

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staff across the organisation to access tools with confidence to apply the principles of VBHC.

The Centre meet on a weekly basis to share and monitor progress and agree next steps.

The workstreams, objectives and status are as follows:

Workstream	Objective for 2024/25	Status
PROMS platform	Assess options, build business case for, secure funding for and procure a digital PROMs platform by September 2024	Complete: The digital PROMS business case is approved. The programme is on track to award the contract by September.
PROMS Questionnaires	Agreement of PROMS tools for site specific teams	Complete: Agreement reached for PROMS tools for prostate and lung. A new national PROM tool for Breast is nearing agreement. Specialties for which there is no current national set will use a validated quality of life tool created specifically for cancer. A road map of tumour sites to select PROMS data sets has been agreed in partnership with WCN.
Technical Development	Launch an SST (Specific Site Teams) Dashboard to show activity, outcomes and resources with filters to enable scrutiny of care given to specific patient groups.	Complete: The SST Dashboard has been in place since March 2024. A sub-group to optimise use of the tool is in place.
Data Driven Sense Making	Publish case studies to promote existing and new Value in Action projects and opportunities.	Partially met: Two case studies created and ready for publication. Three due to be finalised. Pre-operative anaemia case study included within WVIH annual report
Data Maturity Group	Mobilise the Data Quality Management Group with particular focus on resolving data quality issues which have an impact on service delivery	Partially met: A focussed Data Quality Group will be created which will target a particular area of concerns. This is due to be initiated within the SACT service.

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Training, Communication and Engagement	Create a Training, Engagement and Communication Strategy. Develop in house training including a pilot of a Value Lab (bespoke targeted development sessions)	Partially met: The Communication Strategy for Value Based Healthcare at VUNHST has been ratified. Training sessions have been delivered through internal forums and external training courses (via Swansea University). A Value Lab is scheduled for the 27th September.

In addition to the above objectives, the Value Intelligence Centre are supporting the following areas:

1. Currency Code Completeness – to ensure accurate income for activity delivered
2. Denosumab Self-administration project in Outpatients – to reduce the need for patients to attend VCC for this treatment
3. Analytical input to the SACT Improvement Programme
4. Identifying and progressing with key Data Quality issues e.g. an accurate cohort of Metastatic Breast Patients, historical open follow-up not booked pathways – to improve patient safety, enable service planning and accuracy of case load

The priority of the Value Intelligence Centre over the coming year is to implement a Digital PROMS Solution within the Cancer Service. This represents a step change in our ability to understand the outcomes of the care that our services deliver.

3.2 Pre-operative Anaemia

The Welsh Blood Service is leading on a national programme to improve the management of anaemic patients listed for ten of the most high-risk surgical procedures in terms of blood loss.

Patients whose anaemia is undiagnosed and untreated have a longer post-operative length of stay and are more likely to require readmission in addition to a poorer quality of life. Addressing anaemia through iron delivery to the patient avoids the need for blood transfusions, supporting the prudent use of donated blood.

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Research shows that patients whose iron levels are brought within normal range have better outcomes.

Progress since previous update includes:

- NHS Wales Preoperative anaemia Pathway launched on the 31/5/2024
- Facilitated a Conference on Blood Health including Anaemia with Blood Health National Oversight Group held in March
- Updating the Major Surgery Dashboard to include financial information (this is in pre-release format). This dashboard shows the frequency of pre-operative iron tests and the effects of anaemia for a suite of 10 major procedures.
- Presenting “Major surgery outcomes in patients with Anaemia” at VCS Grand Round
- Four posters presented in the NATA (Network for the Advancement of Patient Blood Management) Conference in Bologna
- Presented and won at the ACTACC (Association of Cariothoracic Anaesthesia and Critical Care) Conference in Cardiff
- Linking with 3Ps programme to incorporate anaemia identification into the electronic referral mechanism

Due to the impact that anaemia has on the population, beyond the surgical pathways, particularly within Paediatrics and Obstetrics, a proposal has been submitted to the Welsh Value in Health Centre for funding to widen the scope of the programme to include improving the management of anaemia including within in primary care and cancer pathways. However, due to the absence of confirmation of funding for the programme for 24/25 and onwards no further progress has been made on the above. The lack of confirmed funding also risks staff within the team on secondment moving to permanent roles.

3.3 Velindre Food Mission

The Food Mission has set an ambition for the Trust to provide our people with access to affordable, healthy food, by setting a long-term objective to source the majority of Velindre's food from Welsh, environmentally friendly or globally responsible providers by 2035.

There is a growing awareness within Healthcare of the contribution of food consumed to environmental sustainability and the potential for this to be a net benefit to the local economy, global environment, and to the health and wellbeing of our people (donors, patients and staff).

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By taking a mission-based innovation approach, Velindre will act to help transform the food system in Wales by working within the Trust, across the public sector and, more broadly, through engagement with the wider food system. The mission for Velindre is as follows:

Velindre's Food Mission

Enabling a FutureGen-ready food system in Wales

By 2035 at least 70% of food sourced by Velindre University NHS Trust will be Welsh, environmentally friendly or globally responsible. Our people have access to affordable, healthy food.

The outcomes that we want to achieve through this mission are:

1. Healthier people with access to healthy, affordable food
2. Shorter, more resilient food supply chain which minimises environmental impact and delivers values for money
3. More spaces to enjoy and learn about food across the Trust
4. Reduced food waste and ecological footprint
5. Vibrant local food economy and communities through partnership

Updates following the approval of the Food Mission by Trust Board in March are as follows:

1. Engagement with catering and food production experts within Menter Mon to advise on menu redesign opportunities with the canteen at VCC to increase the proportion of food provided that meets the aims of the mission
2. Scheduling a Value Lab for September to bring stakeholders together to create an action plan to deliver the objectives of the Food Mission
3. Coordinating activities to enable VUNHST employees to benefit from a Wales-based and Welsh-grown, organic veg box subscription

4. SUMMARY OF MATTERS FOR CONSIDERATION

NOTE continued development of the Value Based Healthcare Programme.

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

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If yes - please select all relevant goals: • Outstanding for quality, safety and experience ☒ • An internationally renowned provider of exceptional clinical services that always meet, and routinely exceed expectations ☒ • A beacon for research, development and innovation in our stated areas of priority ☐ • An established 'University' Trust which provides highly valued knowledge for learning for all. ☐ • A sustainable organisation that plays its part in creating a better future for people across the globe ☒	
RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	**Choose an item** VBH Programme is cross cutting and will support mitigation of multiple strategic risks.
QUALITY AND SAFETY IMPLICATIONS / IMPACT	Yes -select the relevant domain/domains from the list below. Please select all that apply
	Safe ☒ Timely ☒ Effective ☒ Equitable ☒ Efficient ☒ Patient Centred ☒
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *The Value Based Healthcare Programme will support across Quality and Safety domains.*
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required

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TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	A Healthier Wales - Physical and mental well-being are maximised and in which choices and behaviours that benefit future health
	If more than one Well-being Goal applies please list below:
	Value Based Healthcare Programme will support the delivery across all of the Trust's Wellbeing Objectives
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Welsh Government Please explain if 'other' source of funding selected: n/a **Type of Funding:** **Revenue** **Scale of Change** Please detail the value of revenue and/or capital impact: Funded through VBH Programme Budget **Type of Change** **Major Programme** Please explain if 'other' source of funding selected: Value Based Healthcare is part of the Building our Futures Together Programme
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
	EQIA completed for Food Misson and Digital PROMS Solution. No immediate actions required.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

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6. RISKS

Not Applicable for this report

ARE THERE RELATED RISK(S) FOR THIS MATTER	Choose an item
WHAT IS THE RISK?	
WHAT IS THE CURRENT RISK SCORE	
HOW DO THE RECOMMENDED ACTIONS IN THIS PAPER IMPACT THIS RISK?	
BY WHEN IS IT EXPECTED THE TARGET RISK LEVEL WILL BE REACHED?	
ARE THERE ANY BARRIERS TO IMPLEMENTATION?	Choose an item
All risks must be evidenced and consistent with those recorded in Datix	

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

TRUST ESTATES ASSURANCE REPORT

DATE OF MEETING	12/09/2024

PUBLIC OR PRIVATE REPORT	Private

IF PRIVATE PLEASE INDICATE REASON	THE MEETING IS HELD IN PRIVATE

REPORT PURPOSE	ASSURANCE

IS THIS REPORT GOING TO THE MEETING BY EXCEPTION?	NO

PREPARED BY	JONATHAN FEAR
PRESENTED BY	JONATHAN FEAR
APPROVED BY	Lauren Fear. Interim Executive Director of Strategic Transformation, Planning and digital

EXECUTIVE SUMMARY	VUNHST Estates Assurance Report outlines the trust's approach to managing its estate, focusing on compliance, fire safety, sustainability, and health and safety. The trust conducts regular inspections to ensure buildings meet standards, enhances fire safety protocols, promotes sustainable practices, and prioritises the well-being of everyone on-site. The report demonstrates the trust's dedication to continuously improving and maintaining a safe, compliant and sustainable estate.

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RECOMMENDATION / ACTIONS	No actions required – this report is presented to the QSP to provide **ASSURANCE** in respect of the ongoing delivery of the Estates Services 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 Management Group	(08/08/2024)
Executive Management Board - RUN	(29/08/2024)
	(DD/MM/YYYY)
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS No comments received.	

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	**Estates** Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes **Health & Safety** Level 2 - Symptomatic issues being addressed **Fire Safety** Level 3 - Actions for symptomatic, contributory and root causes. Impact from actions and emerging outcomes **Sustainability** Level 4 - Increased extent of impact from actions

APPENDICES – N/A

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

1. SITUATION

The Estates Assurance Report provides a comprehensive update on the progress made against the 2024/25 estates objectives. This report also highlights key risks and includes a summary of the training and compliance objectives achieved within the Trust during Quarter 2 of 2024/25.

2. BACKGROUND

The Trust Estates Assurance Report is a key component of the Trust's commitment to maintaining and enhancing the physical environment and infrastructure essential for delivering safe, high-quality healthcare services. The Estates Department plays a critical role in ensuring that all facilities are safe, compliant with regulatory standards and fit for purpose. This report provides an overview of the department's performance in achieving its objectives for the 2024/25 financial year. It includes updates on progress, key risks, and the status of training and compliance objectives, all of which are crucial for sustaining operational excellence across the Trust's estate.

3. ASSESSMENT

Health and Safety Training: Compliance has improved to 85% due to recent efforts by the Head of Health and Safety to enhance this area. This demonstrates significant progress in overall training compliance.

Fire Safety Training (Level 2): Compliance has risen slightly to 63.7% (up from 60.9%). This increase is attributed to bespoke training sessions, though further improvement is still needed.

Estates Compliance: Compliance remains stable, with the rate just below the 95% benchmark at VCC, while meeting or exceeding this benchmark at other sites. Efforts are ongoing to improve training programs, monitor systems, and update protocols to enhance these standards. A recent building condition survey for the Velindre Cancer Centre (VCC) and Welsh Blood Service Headquarters (WBS HQ) has identified a substantial backlog of maintenance work, full details and next steps outlined in report.

Waste Regulations Compliance: New events, communications, and the installation of new bins have been successfully implemented across all sites to comply with the new Waste Regulations.

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The recent building condition survey for the Velindre Cancer Centre (VCC) and Welsh Blood Service Headquarters (WBS HQ) has identified a substantial backlog of maintenance work. The estimated backlog maintenance costs are £11.22 million for VCC and £3.2 million for WBS HQ. There is an urgent need to manage the associated risks effectively to ensure the continued delivery of safe and high-quality healthcare services.

EFPMS and Net Zero Report: Both reports are on track and will be submitted on time.

For detailed information, please refer to the attached report.

4. SUMMARY OF MATTERS FOR CONSIDERATION

No immediate matters for consideration / action.

The report is presented to the Quality, Safety and Performance Committee (QSP) to provide assurance in respect of the delivery of the Trust Estates Assurance Programme.

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	☒

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RELATED STRATEGIC RISK - TRUST ASSURANCE FRAMEWORK (TAF) *For more information: STRATEGIC RISK DESCRIPTIONS*	06 - Quality and Safety
QUALITY AND SAFETY IMPLICATIONS / IMPACT	There are no specific quality and safety implications related to the activity outined in this report.
	Safe ☐ Timely ☐ Effective ☐ Equitable ☐ Efficient ☐ Patient Centred ☐
	The Key Quality & Safety related issues being impacted by the matters outlined in the report and how they are being monitored, reviewed and acted upon should be clearly summarised here and aligned with the Six Domains of Quality as defined within Welsh Government's Quality and Safety Framework: Learning and Improving (2021). *[Please include narrative to explain the selected domain in no more than 3 succinct points].* **Click or tap here to enter text**
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information: https://www.gov.wales/socio-economic-duty-overview*	Not required
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

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FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
	Source of Funding: Divisional Budget Allocation Please explain if 'other' source of funding selected: **Click or tap here to enter text** **Type of Funding:** **Revenue and Capital Funding** **Scale of Change** Please detail the value of revenue and/or capital impact: **Click or tap here to enter text** **Type of Change** **Business as Usual Improvement** Please explain if 'other' source of funding selected: **Click or tap here to enter text**
EQUALITY IMPACT ASSESSMENT *For more information: https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	Not 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

6. RISKS

Currently not applicable in this report.

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ARE THERE RELATED RISK(S) FOR THIS MATTER	No

7. HIGHLIGHT REPORT

ALERT / ESCALATE

Health and Safety

Training

	April	May	June	July
Corporate Division	84.8%	86.3%	87.0%	86.4%
RD&I	89.0%	87.0%	86.6%	87.0%
TCS	84.3%	83.6%	83.6%	84.2%
VCC	75.6%	77.4%	77.1%	77.9%
WBS	92.6%	93.7%	92.7%	90.9
Grand Total	81.6%	82.9%	82.6%	82.5%

There is still a push to increase the divisions training competencies, and as you will be able to see corporate are now maintaining the 85% compliance. A valid effort to TCS this month.

Estates

VUNHST Condition Survey Report

The recent building condition survey for the Velindre Cancer Centre (VCC) and Welsh Blood Service Headquarters (WBS HQ) has identified a substantial backlog of maintenance work. The estimated backlog maintenance costs are £11.22 million for VCC and £3.2 million for WBS HQ. There is an urgent need to manage the associated risks effectively to ensure the continued delivery of safe and high-quality healthcare services.

Immediate Action Plan:

- Prioritise the most critical maintenance tasks based on risk assessments.
- Allocate necessary funds and resources to address high-risk areas urgently.

Short to Medium-Term Measures:

- Implement interim maintenance and repair strategies to manage risks until the completion of the nVCC and WBS TGI project works.
- Regularly review and update the risk assessments as conditions change.

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Long-Term Strategy:

- Expedite the nVCC and WBS TGI project timelines where possible.
- Develop a comprehensive Estates management plan that includes ongoing maintenance to prevent future backlogs.

Assurance and Reporting:

- Draft and submit a detailed SBAR report for assurance and approval from senior management teams by division.
- Provide regular updates on the status of maintenance efforts and risk management to SLT in both divisions.
- Update overarching risks on Datix.

Fire Safety

VCC

Fire Safety training.

L2 training has improved slightly [from 60.9% in April 2024 to 63.7% (up 2.8%) by the end of June 2024]:

NHS|CSTF|Fire Safety - 1 Year|					
Division and Competency	Achieved	Lapsed	Not Achieved	Total Assignments	Compliance
120 Research, Development and Innovation Division					
NHS|CSTF|Fire Safety - 1 Year|	20	9	2	31	64.5%
120 Velindre Cancer Centre					
NHS|CSTF|Fire Safety - 1 Year|	363	131	76	570	63.7%
	383	*140*	*78*	*601*	*63.7%*

Drills and Exercises

Although several unwanted fire signals and other incidents have resulted in emergency evacuations, there have been few scheduled drills / exercises.

WBS

Exercises & Drills

Further drills/exercises to be scheduled as part of the wider business continuity / emergency preparedness [EPRR] workplan.

Corporate

Evacuation Drills

Corporate Services have not run an evacuation drill since the last report. Trust Fire Safety Manager to discuss with Site responsible leads and arrange date.

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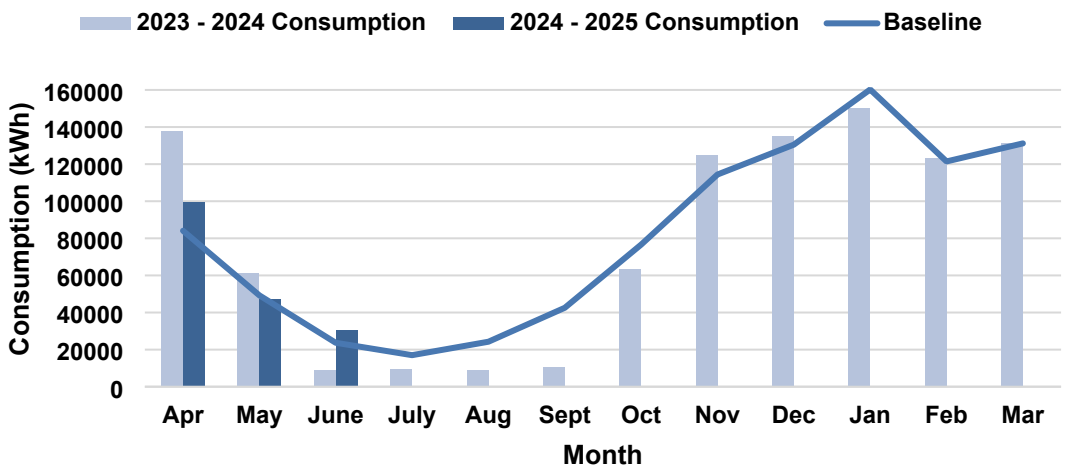
Sustainability

- **Gas Consumption – WBS;**

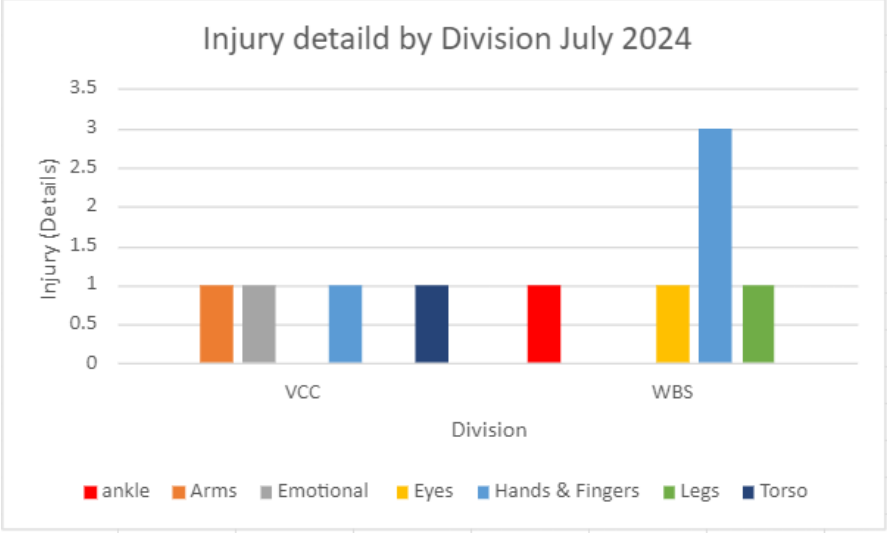


- Significant increase in June gas consumption at WBS. This is due to BMS controls triggering the heating due to outside temperatures.

ADVISE

Health and Safety Incidents in July

There was a total of 10 incidents across the Trust last month. Hands and Fingers has seemed to have raise its head again this month with several first aid cases involving needle stick injuries.



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The number of incidents reported has increase by 2 from the previous month. Overall, we have had 42 incidents as a Trust. We are at the exact same figure overall as this time last year.

Our current trajectory remains at 2.46 which will still push us over the set target of 103 incidents for the year. Our target currently sits at 1.98 per week.

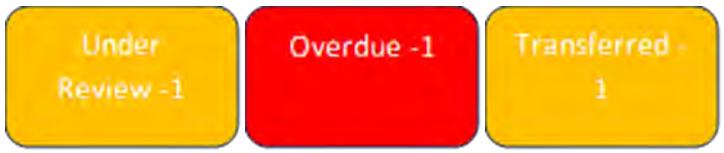
If you look at the incident categories, the only trend we can see is incidents involving needlestick injuries. The team as examining the cases to see if there are any further trends with these.

In relation of how this compares to the same time last year we have decreased from 15 incidents reported in July of 2023

Outstanding Datix Investigations Over 90 days

Corporate - 0
WBS – 2
VCC – 3

Policies Under review



Policy	Version	Policy Lead (s)	Accountable Executive Lead (s)	EQIA rec	Date EQIA Completed	Approving Body	Policy Review Date	Link to policy	Policy Status	Policy Risk Assessment	Comments
QS09 Management of Latex and Latex Allergy Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS09	Policy in Date	Policy in date with no risk assessment required	
QS14 Safer Manual Handling Handling Policy	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS14	Policy in Date	Policy in date with no risk assessment required	
QS15 Management of Violence and Aggression	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS15	Policy in Date	Policy in date with no risk assessment required	
QS18 Health, Safey and Welfare Policy	Version 8	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	23/12/2021	EMB - Endorsement QSP - Approval	Jul-25	QS18	Policy in Date	Policy in date with no risk assessment required	Policy was revised to align with legislation
QS24 Medical Devices and Equipment Management policy	Version 4.1	Medical Devices Officer	Director of Strategic Transformation, Planning & Digital	No	20/10/2020	EMB - Endorsement QSP - Approval	Jan-24	QS24	Policy review date lapsed - Action required	Policy risk assessment being completed	Look to transfer ownership
QS26 Safe Use of Display Screen Equipment	Version 6	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS26	Policy in Date	Policy in date with no risk assessment required	
QS30 Lone Working Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	May-18	EMB - Endorsement QSP - Approval	Mar-23	QS30	Policy review date lapsed - Action required	Policy risk assessment being completed	Needs to be reviewed
QS33 Control of Substances Hazardous to Health (COSHH)	Version 5	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	Nov-23	EMB - Endorsement QSP - Approval	Jan-27	QS33	Policy in Date	Policy in date with no risk assessment required	
QS35 Sharps Policy	Version 4	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	Yes	05/10/2023	EMB - Endorsement QSP - Approval Trust Board - Policy update Noting	Oct-26	QS35	Policy in Date	Policy in date with no risk assessment required	
QS36 Workplace Equipment Policy	Version 7	Head of Health & Safety	Director of Strategic Transformation, Planning & Digital	No	18/05/2020	EMB - Endorsement QSP - Approval	May-23	QS36	Policy review date lapsed - Action required	Policy risk assessment being completed	Add in home working
QS37 Policy for the Management of Occupational Exposure to Blood and High Risk Body Fluids (Needlestick)	Version 4	Head of Infection Prevention and Control	Director of Strategic Transformation, Planning & Digital	No	12/11/2018	EMB - Endorsement QSP - Approval Trust Board - Policy update Noting	Sep-22		Policy review date lapsed - Action required	Policy review date passed with moderate risk	UPDATE 17/04/24 SW - Spoke to Hayley Jefferies and s advised that she worked on this with Helen and this wa amalgamated with the sharps policy QS35. I have sent t Borrow an email advising that QS37 does not exist an should be removed from the list as its showing as outstanding and that is not a true reflection.

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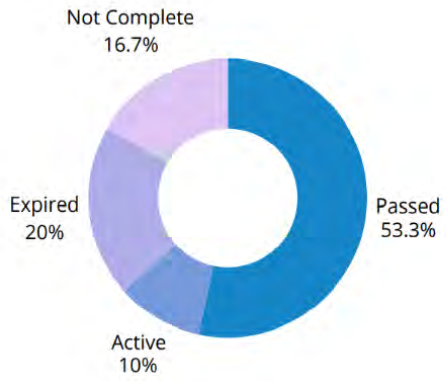
There is no change to the policy status this month as we are currently waiting for the lone working policy to go through the translation process before we make it live on the intranet page.

Patient Manual Handling Training

As previously mentioned PMH training has only been available through Cardiff & Vale since April 2024. Even though discussions are being held to re-instate in house training, we have seen a 5% dip in the training compliance this month as expected. However, this may take a few months to implement, and improve the decreased compliance. All departments are encouraged to book staff onto courses in C&V. Dates of training will be advertised on sharepoint and circulated to heads of departments and training coordinators each month.

IOSH Managing Safely

30 licenses have been issued to WBS and VCC this was escalated in the last meeting and a topic in the annual report. We continue to encourage the outstanding 10% to complete the course before expiry in August.



Health and Safety Risk Register

SLT have decided to close tolerated risks. I have challenged this decision and have now met with the General Services manager to discuss and to have some guidance around the governance of this. Have met with Head of nursing, Quality & Safety manager and Quality & Safety officer as per General service managers suggestion however they are unable to make a decision based on the evidence I have provided in relation to health and safety risks. Further meeting is required to look at this in depth.

Health and Safety Management System

With any successful management system in health and safety the starting point is Leadership and Accountability. As part of the annual report, it was

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suggested that we require to take steps to improve the management system at VUNHST

A proposal is made to increase the awareness of reporting and talking around occupational safety. In line with a well working Health and Safety Management system and following other industry standards. I would like to introduce an Executive audit programme. This will promote safety in the divisions and support the reporting onto Datix. This programme with also improve visibility of the Exco team with the divisions.

Please see the Appendices for the Exco Safety Tour procedure that is suggested.

Health and Safety Policies

Currently we have 11 Health and Safety policies for the Trust. The legal requirement for Health and Safety Policies is 1, which is the Health and Safety Policy. The proposal is submitted via this group to archive all other policies for the VUNHST and to produce procedures that are easily managed by Health and Safety. These will be published on the Health and Safety intranet page where they will be a live tool for all the line manages within the divisions.

Incident Classifications

Each month through the governance process and the PMF it is informed of how many incidents have happened within the Trust. A suggestion is made that the incidents are given classifications in line with the severity of the incident. Therefore, the Exco team can select which incidents they would like to view, (these are likely to be the ones with the highest severity) the Exco team would have this information as part of the Exco safety tour as a talking point to engage with the divisions. A suggestion would be made around the language that we use relating to incidents.

LWC – Lost Work Case
MTC – Medical Treatment Case
FAC – First aid case

When we have an individual that have sustained an injury the line manager would monitor and be responsible for the incident and investigation. However, If the injured party would miss part of their normal job, go home and not return the following day this would be classed as a Lost work case or LWC, this would then become an incident for the safety advisors to watch in the respective areas as potentially could result in a RIDDOR notification.

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MTC – Medical treatment cases are just that. Someone that has sustained an injury and required medical treatment but then returned to work not missing any time.

FAC – First aid case, would indicate minimal injury, a bruise, cold compress, or plaster applied by a first aider.

A standard would be produced to support this proposal once approved by the EMB.

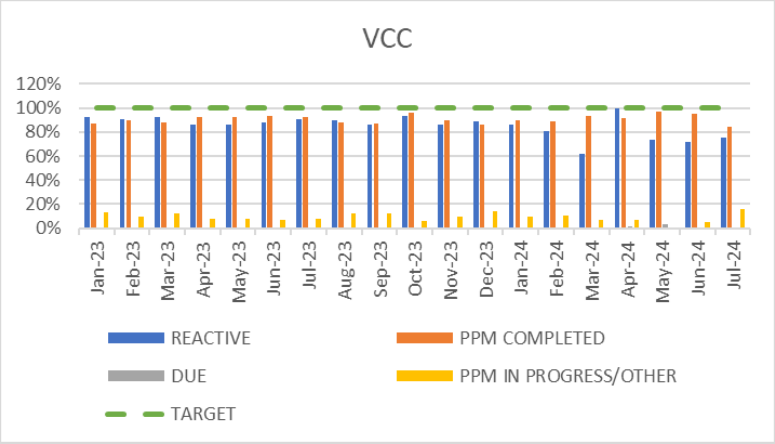
Estates Compliance

VCC

The July PPM benchmark was not met for both PPM and reactive tasks in VCC due to staff absences, including annual leave, sickness, and two vacancies within the department. Additionally, we have migrated our CAFM system to Synbiotix, a new platform that has recently undergone a full asset study and a PPM review, aligned with the industry standard SFG20 and WHTM guidelines. This migration has introduced additional PPM tasks across various disciplines, increasing workload. To ensure task completion, teams are closely monitoring the new system to facilitate a smooth transition.

In addition, we have updated the CAFM management SOP to clearly define department responsibilities, with quarterly audits scheduled to ensure compliance and effectiveness.

See the attached document in the appendices for further details.



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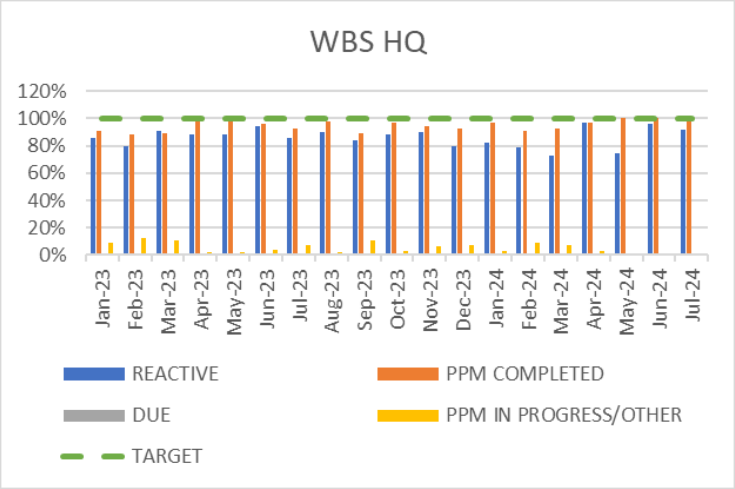
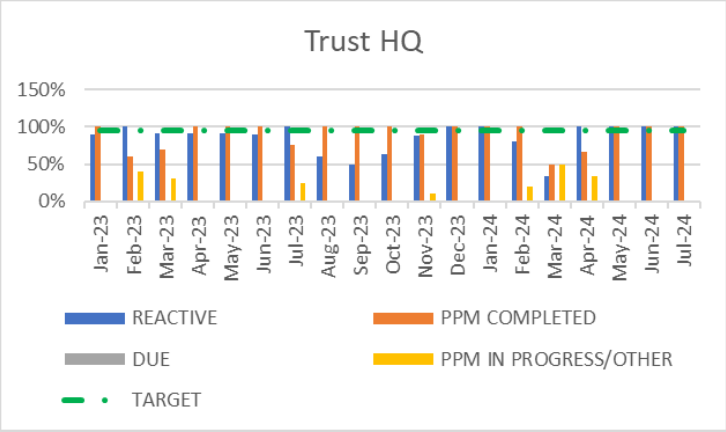
WBS All sites and 19 Park Road & Trust HQ

The PPM benchmark has been achieved across all sites, though the reactive benchmark is slightly below target, primarily due to similar absences at VCC caused by sickness, annual leave, and two vacancies within the Trust. The CAFM system is still operating on the old version, with a project plan in place to migrate these assets to Synbiotix over the next three months. For details, see the project plan in the appendices.





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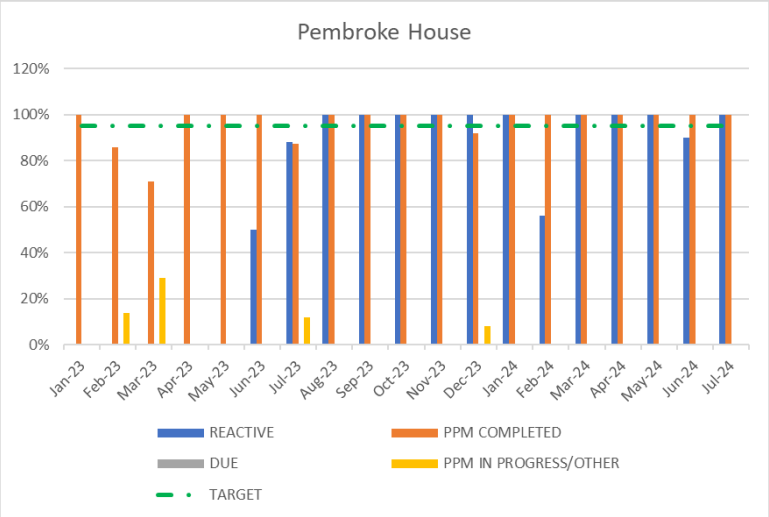

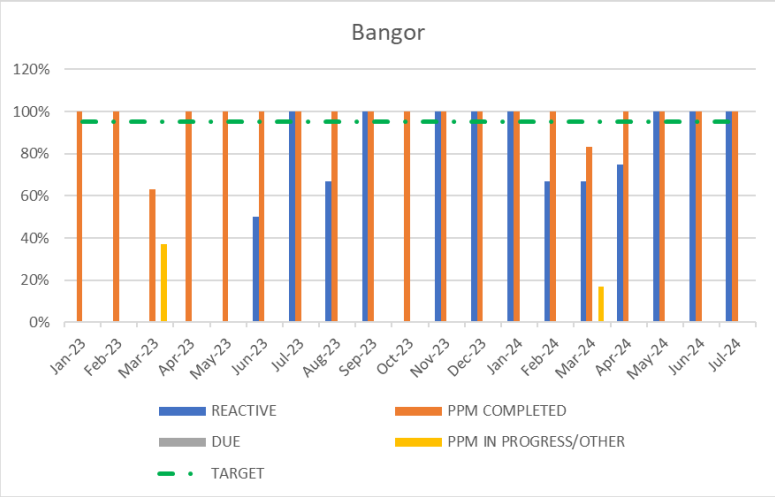

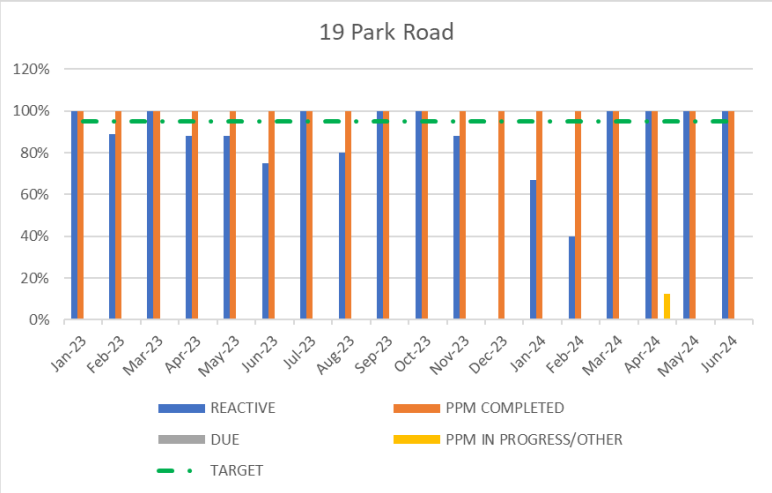

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Water Safety

VCC June Legionella,
JULY, 57 Legionella, samples, Zero positives returned.
JULY, 32 Pseudomonas, zero positives returned.
These results demonstrate good progress of water compliance at VCC.

On going maintenance issue that require further works.
In Zone 1 near Room 38 Isotopes, routine sampling indicates reduced hot water temperatures in this area. The first positive sample was recorded on March 19th (9200 CFU). A resample on April 18th showed positive results both pre-flush (400 CFU) and post-flush (20 CFU) from the corridor outlet. All outlets, including those in cubicles, are now equipped with filters, which are replaced every 12 weeks for assurance. Remedial works are scheduled for out of hours end of August once the RPS is satisfied with safe access to cubicles.

WBS June VCC Legionella
3 samples and 0 Positives.
Ongoing Water management

- Estates labour is strained due to the ongoing workload with AL, sickness and 2 staff vacancies.
- The SACT Mobile Clinic requested assurance on water service management; the Assistant Director of Estates has met with the Deputy Chief Pharmacist to address this.
- Ongoing sampling issues persist at WBS South and North.
- The Aneurin Bevan satellite centre initially provided assurance, but maintaining regular assurance for the Windsor Suite remains challenging, however estates continue to chase reports and will look at points of escalation.
- Maggie's has now provided water safety assurance results, with work needed to ensure regular reporting to the Trust Water Safety Group.
- The WBS Environmental Officer is exploring quotes for a new water fountain at Pembroke House as an alternative to the current drinking water facility.
- Concerns remain regarding the ESR Water Training module, as there has been no update on its acceptance and rollout. Further inquiries are necessary to ensure it is implemented Trust-wide for staff training and awareness.

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VENTILATION COMPLIANCE:

- Ventilation meetings have taken place with good progress being made on actions from the meetings.
- All Critical Verifications for 2024 are complete on time and any remedial works have been actioned.
- Assets have recently been exercised and updated at VCC with a review taken place for PPM's at the Velindre Site, project plan in place to undertake this review at WBS all sites.
- Regular maintenance has taken place on AC split systems with service report recommendations being addressed across all sites.

ELECTRICAL COMPLIANCE:

- Electrical safety group meetings have shown excellent progress, with the Estates team now completing all audit actions previously assessed by NWSSP.
- VUNHST has appointed three Authorized Persons within the Trust, in line with WHTM recommendations.
- Estates successfully completed an annual ACB servicing exercise, which involved extensive planning with key stakeholders at VCC to ensure no impact on clinical or operational activities. This was followed by a HV site shutdown exercise to test the building's resilience in the event of a High Voltage national grid failure.
- Arrangements are being made with contractors for the remaining five-year fixed wire testing at VCC in Zones 5, 7, 8, 10, 14, and 15.
- Both generators at VCC have been refueled for 2024/2025, and the legs on the SR 1 generator bulk storage tank were reinforced before refueling.
- Quotes are being gathered for two new fuel polisher systems for the generator bulk storage tanks at VCC, following a recent recommendation by a servicing Contractor.
- Work has been carried out on the VCC generator fuel tanks due to signs of corrosion on the existing tank structure. Additional maintenance is needed to address painting requirements and prevent further defects.

MEDICAL GAS COMPLIANCE.

- Over the past six months, Medical Gas Safety meetings have made significant progress, particularly in areas such as training for Authorised Persons (APs). Appointments have been scheduled with the AE NWSSP to formally assess competencies, ensuring that the role is performed effectively across the Trust.

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- The Trust has recently received a draft of the Medical Gas Audit report, and comments have been submitted to reflect progress on the reported actions. A meeting with NWSSP AE in August highlighted positive advancements. This report will be presented in the next cycle, including associated actions and timescales for resolution.

Hot Work surfaces risk assessment:
All high-risk issues have been addressed. We are currently scheduling a meeting to discuss the necessary actions for medium and low-risk items.

Estates Finance & Cost Pressures
MO37:

- Aircon defects: £4,492.53 (01/07/2024)
- Artisan flooring clinical trials: £1,100 (02/07/2024)
- Main Gas pipe gas drop test, DESEAR: £26,037 (02/07/2024)
- Service tunnel heating pipe repairs: £2,705.00 (03/07/2024)
- Scaffolding for roof repairs Zone 1 & 2: £4,530 (02/07/2024)
- Roof repairs, edge protection, Zone 15: £TBA (05/07/2024) (Amount not provided)
- Zone 14, heating pipe modifications (La1): £14,562.00 (18/07/2024)
- Prefabricate SR1 Fuel tank additional support legs: £3,480 (11/07/2024)
- LED lighting LAB waiting area (supply only): £1,139.60 (17/07/2024)
- Hydrop Pseudomonas risk assessment: £5,425 (22/07/2024)
- SR1 5000 litre fuel delivery: £3,532.50 (25/07/2024)

MO13:

- GSM unit prepaid sim to replace phone line: £1,219.00

W402:

- Bangor boiler refit: £3,195 (04/07/2024)
- Water service drawing update: £1,900 (12/07/2024)
- North, Supply and install window and outside planter: £3,890 (16/07/2024)

<u>Capital Works</u>

WBS Electrical Infrastructure works
Currently reviewing specification with all pre-construction information, engaged with procurement for tender process, anticipated start date of end of October to meet the end of financial year deadline. Engagement with division to plan and undertake FMEA process, this can be undertaken once a program of works has been distributed by the successful contractor.

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Liquid Nitrogen Vessel WBS

SBAR has been drafted to discuss options at SLT to discuss next steps to update EMB.

Fire Safety

Fire Safety training

Overall L1 training compliance has dropped slightly [0.5%] to 80.3% compared to May 2024 [80.8%]:

NHS|CSTF|Fire Safety - 3 Years|					
Grand Total	1476	185	178	1839	80.3%

Although L2 training compliance has improved [up 5%] to 65.3% compared to May 2024 [63.1%]:

NHS|CSTF|Fire Safety - 1 Year|					
Division and Competency	Achieved	Lapsed	Not Achieved	Total Assignments	Compliance
Grand Total	477	167	87	731	*65.3%*

Drills & Exercises

Although there has been little evidenced progress with drills and exercises, where sites experience incidents requiring emergency evacuation, these events can also be classed as evacuation drills/exercises as staff have had opportunity to "practice" evacuation; procedures have been validated and lessons learnt identified and communicated.

However, this is not considered good practice and should not be relied upon to provide assurance in the medium to long term.

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The chair of the Trust Health, Safety and Fire Management Board has requested assurance from all divisions that they have define plans/schedules to run appropriate drills and exercises by 3rd September 2024.

VCC

Policy, Protocols & Procedures

- Work continuing to ensure that there is sufficient warden coverage across the VCC site with oversight by VCC SLT.
- VCC to undertake departmental gap analysis to identify "regular visitors" to the site.
- Once identified, an abridged version of the Control of Contractor induction to be provided to identified "regular visitors" and records kept.
- Agreed completion date – end of December 2024.
- Assessments, Audits & Inspections
- VUNHST Estates currently requesting quotations for the provision of access hatches to allow access to fire dampers.
- Agreed completion date – end of December 2024.

Miscellaneous Issues

No update on progress with the fire dampers in Pembroke House and the need to liaise with the landlord's incumbent fire alarm contractor to rewire the fire damper relay to ensure that dampers remain open until the fire alarm is reset.

Corporate

Fire Safety training

Although there has been another improvement in fire safety training compliance [from 78.6% in June 2024 to 79.3% (up 0.7%) to the end of June 2024] but remains below the WG benchmark:

NHS|CSTF|Fire Safety - 3 Years|					
Division and Competency	Achieved	Lapsed	Not Achieved	Total Assignments	Compliance
120 Corporate Division					
NHS|CSTF|Fire Safety - 3 Years|	191	21	29	241	79.3%

Sustainability

SUSTAINABILITY IMPLEMENTATION PLAN & TRUST DECARBONISATION ACTION PLAN

- We will begin engagement with Leads across the Trust to start implementing the SIP

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ASSURE	**<u>Health and Safety</u>** • Successful recruitment for the Band 5 Health and Safety Technician post – Awaiting start date. • Radon maintenance checks – This is with responsible staff onsite. • Radon notification – Registration has been completed. The Consent we await invite and the Notification will need to be submitted via Trust appointed staff. • DSEAR Actions are being monitored, we have a monthly meeting to discuss progress and currently at 16% complete. **<u>Estates</u>** **Staffing** • Two staff vacancies have been advertised and successfully recruited with start dates in September for Electrical and Fire Safety. **Estates Progress.** • Good progress has been made in a number of audit actions relating to Electrical recommendations for the recent audit undertaken by shared services. • A recent Audit was undertaken by NWSSP for Medical Gases with good progress being demonstrated, awaiting complete report. • Ventilation Authorised persons have successfully been assessed by NWSSP and appointed for the Trust. • Two Estates staff have successfully completed IOSH managing safely health and safety course. **<u>Fire Safety</u>** Refer to narrative throughout this report. **VCC** Assessments, Audits & Inspections Fire risk assessments up to date. Actions from annual audit agreed with VCC and action plans in place to resolve and presented to Trust Health, Safety and Fire Management Board: • **Fire Training and Evacuation Drills -** *Do persons visiting this site on a regular basis receive appropriate training in fire safety?* • **Maintenance -** *Are all Mechanical Ventilation Systems and Fire Dampers maintained in accordance with BS 9999:2017 Annex W and Clause 32 and/or with the manufacturers recommendations?*

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WBS

Assessments, Audits & Inspections

Fire risk assessments up to date.

Actions from annual audit agreed with WBS and action plans in place to resolve and presented to Trust Health, Safety and Fire Management Board:

- **Fire Training and Evacuation Drills -** *Is specific fire safety training provided* to staff at this site who have predefined roles in a fire emergency?
- **Maintenance -** Are all Mechanical Ventilation Systems and Fire Dampers maintained in accordance with BS 9999:2017 Annex W and Clause 32 and/or with the manufacturers recommendations?

Fire Safety training.

Although compliance for L1 fire safety training has dropped slightly to *87.0%* [down 1.9%] compared to May 2024 [88.9%] but remains above the required benchmark:

NHS|CSTF|Fire Safety - 3 Years|					
Division and Competency	Achieved	Lapsed	Not Achieved	Total Assignments	Compliance
120 Welsh Blood Service					
NHS|CSTF|Fire Safety - 3 Years|	410	40	21	471	87.0%

Compliance for L2 fire safety training remains above the WG benchmark, currently sitting at *88.4%*; [up 2.7%] compared to May 2024 [85.7%]:

NHS|CSTF|Fire Safety - 1 Year|					
Division and Competency	Achieved	Lapsed	Not Achieved	Total Assignments	Compliance
120 Welsh Blood Service					
NHS|CSTF|Fire Safety - 1 Year|	114	12	3	129	88.4%

Corporate

Assessments, Audits & Inspections

Fire risk assessment up to date.

Sustainability

NEW WORKPLACE WASTE SEGREGATION REGULATION & SINGLE-USE PLASTICS

- The Workplace Waste Segregation Regulations are now law
- Trust Environmental & Waste Management Policies have been updated to include reference to the Environmental Protection (Single-use Plastics) Act and has been approved by governance cycle
- Successful roll-out at WBS and continuing roll-out at Trust HQ
- **VCC -** Continuing for the waste segregation regulations – 35 bins received. 2 have been supplied to Trust HQ. DH to have the new bins in place by March 2025 – ahead of schedule
- Workshops are being planned to improve staff awareness of the new waste segregation regulations

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	• New Eco-to-go cups will be launched as well as workshops for the new waste segregation regulations • Introduced biodegradable water cups – positively received • Grass cutting coming to an end – full cut of the site expected in the coming months. No mow may sign from Crown Gardens have been requested for new year • Exploring options for biodegradable aprons and gloves. Gloves are a challenge; new biodegradable aprons company has been sourced – SPRI company considered as a potential partner • **WBS -** Segregation regulations communications and roll-out continuing • Ongoing monitoring of the bins to ensure appropriate segregation. Signage has been placed around the bins to provide information to staff about what type of rubbish goes in what bin • Roll-out of the bins is approximately 95% completed across Welsh Blood Service. North Wales sites have received their bins and communications have been shared • Collections Team's have been provided with sessions to provide further information about the new segregation requirements. Initial concerns that were raised have been addressed. Further site visits have been planned • Additional glass bin has been considered for internal use Laboratory Services have started their own 'Green Group'. MB planning to attend to ensure correct information is provided regarding the new waste segregation regulations • Communal and staff-based plant swap in the courtyard of Welsh Blood Service HQ
INFORM	**<u>Health & Safety Priorities</u>** Trust priorities in relation to fire and safety (quarter 2 - 2024 / 2023) are summarised below: • The development of the Health and Safety intranet page • Introduction and Production of Health and Safety Flashcards (These will be bite sized information supporting the Health and Safety topics for the quarter) • Engaging with divisions • Promoting anti violence collaborative campaign • Continue to cleanse Bank and Agency staff to improve our training figures. **Estates Priorities** • Development of Cafm System for WBS sites with a review of all PPMs and assets • Deliver Capital Works

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- Address – Risk Assess Building condition data recommendations – draft plan.
- DSEAR Fire Safety Actions
- Recruitment of staff
- Ongoing operational actional actions – priorities
- Supporting Health and Safety, Fire Safety, Environmental, and Sustainability efforts to enhance collaboration and drive improvements across all areas.

Fire Safety

Policy, Protocols & Procedures
Trust fire safety policy [PP01] received and approved by the Trust Quality, Safety and Performance Committee subject to minor amendments around training and strategy for emergency drills and exercises.
Work to develop protocols and strategies to support implementation of the policy [PP01].

Assessments, Audits & Inspections
NWSSP have completed development of the new fire risk assessment module which the Trust will adopt moving forward.
The module allows for risks/actions to be shared directly with identified risk owners and also provides a "live" action plan to support monitoring of actions which will, in turn provide more accurate data on progress.

NEXT STEPS: existing FRAs will need to be migrated over to the new module; project plan to be developed to ensure that FRAs are reviewed in timely fashion based on risk.

Miscellaneous Issues
Continued involvement with other areas of compliance [IRR17, EPRR and ISO14001].

Authorised Person (Fire) member of Trust IRR17 working group and T&F group supporting with preparation for HSE registration of sources.

Activity includes contribution to risk assessments and development of appropriate emergency evacuation strategies.

VCC
NIL to INFORM this reporting period.

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	WBS NIL to INFORM this reporting period. **Corporate** NIL to INFORM this reporting period. **Sustainability** **EXTERNAL ISO14001 AUDIT – BM TRADA** • ISO14001 Management Group are working to address key actions identified in the Audit Outcome Report with a workshop scheduled for w/c 17th June • *ISO14001 BM Trada Recertification Audit scheduled for w/c 7th October 2024* • Internal preparatory audits completed for VCC Operational Services and WBS have been scheduled for w/c 28th May – no non-conformities have been raised • Internal preparatory audits to be completed for VCC Estates and Trust HQ in the coming weeks
APPENDIX 1	Standard Operating Procedure (SOP) for Management of the Computer-Aided Facilities Management (CAFM) System at Velindre NHS Trust

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Standard Operating Procedure (SOP) for Management of the Computer-Aided Facilities Management (CAFM) System at Velindre NHS Trust

1. Purpose

This Standard Operating Procedure (SOP) outlines the roles, responsibilities, and processes for managing the Computer-Aided Facilities Management (CAFM) system at Velindre NHS Trust. The goal is to ensure effective planning, monitoring and execution of statutory and mandatory tasks, promoting organisational efficiency, compliance and resource planning.

With the current development of this system this process is currently Work In Progress (WIP).

2. Scope

This SOP applies to the Estates Department at Velindre NHS Trust, specifically focusing on the roles of the Senior Estates Officer Band 7 and two Band 6 Estates Officers in managing and operating the CAFM system.

3. Responsibilities

3.1 Senior Estates Officer (Lead Responsibility)

- **Overall Management**: The Senior Estates Officer holds lead responsibility for the entire CAFM system, Symbiotix. This includes oversight of the system's functionality, data integrity and ensuring that the system aligns with the Trust's strategic objectives.
- **Data Management**: Ensure that Synbiotix holds all estates-related activities, including maintenance, inspections, repairs, and compliance tasks. This comprehensive data capture is critical for accurate measurement, reporting, and analysis of works within the Trust.
- **System Optimisation**: Identify opportunities for improving the system's efficiency, including upgrades, additional features, or integrations with other Trust systems.
- **Reporting**: Generate and analyse reports from Synbiotix to provide senior management with insights into estate management performance, compliance with statutory and mandatory requirements, and resource utilisation.
- **Training and Support**: Ensure all relevant staff are adequately trained in using the Synbiotix system and provide ongoing support where necessary.

3.2 Band 7 Estates Officer (Coordination and Planning)

- **Weekly Coordination Meetings**: The Band 7 Estates Officer will hold weekly meetings with the Band 6 Estates Officers to plan, coordinate, and escalate any issues identified. These meetings will focus on reviewing upcoming tasks, resource allocation, and addressing any challenges or system issues.
- **Issue Escalation**: Ensure that any unresolved issues identified by the Band 6 Estates Officers during their daily monitoring and planning are escalated appropriately. This

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includes escalating significant operational concerns to the Senior Estates Officer or system issues to Symbiotix.

3.3 Band 6 Estates Officers (Daily Responsibility)

- **Resource Management**: Daily management of resources, including allocating and tracking work orders, ensuring tasks are assigned to appropriate personnel, and monitoring the progress of tasks through Synbiotix.
- **Task Planning**: Responsible for the daily monitoring and planning of tasks within Synbiotix. This includes scheduling statutory and mandatory tasks, prioritising them effectively, and ensuring they are planned weeks in advance to allow for optimal resource allocation and compliance.
- **System Monitoring**: Monitor the Synbiotix system to ensure all data is up-to-date, accurate, and that any system issues are promptly addressed and reported to the Band 7 Estates Officer.
- **Compliance Tracking**: Ensure that all statutory and mandatory tasks are tracked within Synbiotix and completed on time. This involves regular checks and updates within the system to maintain compliance.
- **Communication**: Liaise with the Band 7 Estates Officer to report on task progress, potential issues, or resource constraints that may affect task completion.

4. Process

4.1 Task Planning and Scheduling

- **Weekly Planning Meetings**: Band 6 Estates Officers will participate in weekly planning meetings led by the Band 7 Estates Officer to review upcoming tasks in Synbiotix. Tasks will be scheduled based on priority, statutory requirements and resource availability.
- **Advance Scheduling**: Tasks will be scheduled at least 2-4 weeks in advance, allowing sufficient time for adjustments and resource allocation. This advance planning helps in mitigating risks associated with delays or unavailability of resources for escalation to Assistant Director Estates.
- **Team Allocation**: During the planning meetings, the Band 6 Estates Officers will allocate teams for Planned Preventive Maintenance (PPM) and reactive tasks based on workload and resource availability. This ensures that teams are appropriately assigned to handle both scheduled and unforeseen tasks efficiently, preventing bottlenecks and ensuring timely task completion.
- **Compliance Benchmark**: A compliance benchmark of 95% is established as the Trust's monthly target across both PPM and reactive tasks. This benchmark ensures that most tasks are completed on time and within the set standards, promoting operational efficiency and regulatory compliance.

4.2 Task Monitoring and Execution

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- **Daily Monitoring**: Band 6 Estates Officers will monitor the daily execution of tasks via Synbiotix. They will ensure that all tasks are progressing as planned, updating the system with real-time data on task status.
- **Issue Resolution**: Any issues identified during the monitoring process will be escalated to the Band 7 Estates Officer for resolution. System errors or issues that cannot be resolved internally will be further escalated to the CAFM provider, Symbiotix and logged daily, to ensure that necessary developments or system improvements are carried out to rectify any issues identified by the Estates team. This ensures the system remains functional, reliable and effective in supporting the Trust's operational needs.

4.3 Reporting and Review

- **Monthly Reports**: The Senior Estates Officer will compile monthly reports from Synbiotix, highlighting key metrics such as task completion rates, compliance with statutory and mandatory requirements, and resource utilisation. The reports will also track the Trust's performance against the 95% compliance benchmark.
- **Quarterly Audits**: The CAFM system will be audited on a quarterly basis by the Assistant Director of Estates. This audit will evaluate the system's data accuracy, compliance with the 95% benchmark and the overall effectiveness of task scheduling. Audit results will be shared with the Senior Estates Officer to drive continuous improvement.
- **Annual Reporting**: Compile and submit an annual report summarizing key performance indicators (KPIs), compliance with statutory and mandatory tasks, resource utilisation, and system performance. This report will be presented to senior management and the Trust's Board to inform strategic decisions and performance.
- **Continuous Improvement**: The reports and audit findings will be used to identify areas for improvement, with changes implemented by the Senior Estates Officer in collaboration with the Band 7 and Band 6 Estates Officers.

5. Benefits of the Methodology

- **Enhanced Organisation and Structure**: By clearly defining roles and responsibilities, the CAFM system management process becomes streamlined and structured, reducing confusion and overlap of duties.
- **Effective Task Planning**: The ability to plan statutory and mandatory tasks weeks in advance allows for better resource management, ensuring that all necessary tasks are completed on time and within compliance requirements.
- **Improved Compliance**: Regular monitoring and reporting ensure that the Trust remains compliant with statutory and mandatory obligations, reducing the risk of penalties or regulatory issues and critical plant failures.
- **Resource Optimisation**: Efficient allocation of resources based on planned tasks ensures that human and material resources are used effectively, minimising waste and maximising productivity.
- **Proactive Issue Management**: Early identification of potential issues through daily monitoring and advance planning allows for proactive resolution, preventing delays and ensuring smooth operation.

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- **Accountability and Transparency**: Quarterly audits by the Assistant Director of Estates enhance the system's accountability, providing an objective evaluation of the CAFM system's performance and ensuring that compliance targets are consistently met.
- **System Reliability**: Escalating system issues to Symbiotix ensures that any technical problems are promptly addressed and resolved, maintaining the reliability and functionality of the CAFM system.
- **Improved Coordination**: Weekly meetings led by the Band 7 Estates Officer foster better communication and coordination among the Estates team, ensuring that any issues are promptly identified and escalated, leading to more effective task management.

6. Review and Updates

This SOP will be reviewed annually or when significant changes occur in the Synbiotix system or related processes. All updates will be documented and communicated to the Estates team.

Document Control

- **Document Owner**: Head of Estates
- **Review Date**: September 2024
- **Next Review Date**: September

This SOP provides a clear and structured approach to managing the Synbiotix CAFM system at Velindre NHS Trust, ensuring that all estates activities are accurately recorded, and statutory and mandatory tasks are effectively planned and executed. The inclusion of a 95% compliance benchmark for both PPM and reactive tasks emphasises the Trust's commitment to maintaining high standards of operational efficiency and regulatory compliance. Quarterly audits by the Assistant Director of Estates will ensure continuous evaluation and improvement of the system. Escalating system issues to Symbiotix ensures that the CAFM system remains reliable and effective. Weekly coordination meetings led by the Band 7 Estates Officer enhance communication and teamwork, ensuring that any issues are promptly addressed.

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QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	12th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Carl James, Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

ACRONYMS	

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 16th May 2024.

1.2 Key highlights from the meeting are reported in section 2.

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1.3 Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	**Programme Directors Report: Shaping the Next Stages: Verbal Update** It was noted that some elements of the Full Business Case remain to be completed, but that the majority have been approved to allow signature of the MIM agreement. The Trust is working with Welsh Government to get the Full Business Case completed by the summer. The Project Board are working through the issues for the next phase of the project, from June onwards the reporting cycle will be back in place. The Independent Members raised concerns regarding it taking a few months to get back into the rhythm in regarding to the papers being brought to the TCS Programme Scrutiny Sub-Committee. There are so many elements to the TCS Programme, they are all important to the Trust and the wider Health Community. It was queried why the Engagement and Finance agenda items were not included within the May TCS Programme Scrutiny. One of the workstreams includes engagement, which is being reported to Project Board. Due to the new arrangements of the Project Board, it was confirmed the communication and engagement paper won't report to TCS Programme Scrutiny Sub-Committee in the same way going forward. There is no Finance Report for this TCS Programme Scrutiny Sub-Committee as it is 'Month 1' and the report is not usually produced for April. The full workstream reports have been approved at Project Board but the reporting from Project Board to TCS Programme Scrutiny Sub-Committee is yet to be finalised. It is intended that the TCS Programme Scrutiny Sub-Committee will refresh the governance around the reporting to the Sub-Committee. A meeting with the Board is being arranged to discuss arrangements and alignment. It was confirmed the workstreams are consistent with the PWC review.

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	A discussion took place regarding discussions and matters raised at the Public Accounts and Public Administration Committee (PAPAC). Government Officials have been briefed by the Trust
ASSURE	There were no items to assure the Quality, Safety & Performance Committee.
INFORM	There were no items to Inform the Quality, Safety & Performance Committee.
APPENDICES	None.

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QUALITY, SAFETY & PERFORMANCE COMMITTEE

HIGHLIGHT REPORT FROM THE CHAIR OF THE TCS PROGRAMME SCRUTINY SUB-COMMITTEE

DATE OF MEETING	12th September 2024

PUBLIC OR PRIVATE REPORT	Public

IF PRIVATE PLEASE INDICATE REASON	Not Applicable - Public Report

PREPARED BY	Jessica Corrigan, Business Support Officer
PRESENTED BY	Stephen Harries, Independent Member and Chair of the TCS Programme Scrutiny Sub-Committee
EXECUTIVE SPONSOR APPROVED	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital

REPORT PURPOSE	FOR NOTING

1. PURPOSE

1.1 This paper has been prepared to provide the Quality, Safety & Performance Committee with details of the key issues considered by the TCS Programme Scrutiny Sub-Committee held on 20th June 2024.

1.2 Key highlights from the meeting are reported in section 2.

1.3 Quality, Safety & Performance Committee is requested to **NOTE** the contents of the report and actions being taken.

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2. HIGHLIGHT REPORT

ALERT / ESCALATE	There were no items identified for alert/escalation to the Quality, Safety & Performance Committee.
ADVISE	**Programme Directors Report** The TCS Associate Director of Programmes and TCS Programme Director reviewed the TCS Programme's current performance for the reporting period 29th April 2024 – 30th May 2024 and have concluded an Amber status. A TCS Programme relaunch is planned which will clearly set out the scope of the programme and its delivery arrangements. There are a number of vacancies within the nVCC project office and additional roles required for the next phase are not being actively recruited to due to the nVCC Full Business Case not being currently approved. The nVCC Project team and Senior Executives are working with Welsh Government as the investment decision maker to gain Full Business Case approval, aligned with the necessary resources to deliver the nVCC Project. Both internal and external meetings have been arranged to agree and update the Management and Finance Case of the nVCC Full business Case. *Project 3 – Integrated Radiotherapy Solutions (IRS):* Recruitment is ongoing for Project 3 - Integrated Radiotherapy Solutions (IRS), there still remain challenges in appointing to the specialised medical physics roles due to limited availability in the marketplace. *Project 4 - Radiotherapy Satellite Centre:* The project plan within Project 4 – Radiotherapy Satellite Centre is reporting as "red" was noted. Assurance was provided to the TCS Programme Scrutiny Sub-Committee that there is a project plan in place, but the current project plan needs to be reviewed and refreshed. *Project 5 - Outreach:* The Project Initiation Document for the Programme of work has been completed and shared with Health Board colleagues for approval. Velindre Cancer Centre will act as the host for Outreach and encompassed within the Project Initiation Document. There have been no issues that have been escalated to 'high' within this reporting period.

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There have been no issues which have de-escalated from 'high' within this reporting period.

The TCS Programme Scrutiny Sub-Committee **NOTED** the Programme Directors Report.

TCS Programme Scrutiny Sub-Committee Effectiveness Survey Report

The Effectiveness Survey Report was delivered to the TCS Programme Scrutiny Sub-Committee. The report provides the TCS Programme Scrutiny Sub-Committee with the results of the Annual effectiveness survey for the reporting period: 1st April 2023 – 31st March 2024.

The TCS Programme Scrutiny Sub-Committee Effectiveness Survey consisted of twenty questions administered via an online survey platform (Microsoft Forms). 23 people were asked to complete the survey including the Trust Chair, Independent Members, Executive Directors and Non-Executive Directors of the TCS Programme Scrutiny Sub-Committee. 6 responses were received, giving an overall completion rate of **26%**.

The questions across all Committee and Sub-Committee's will be reviewed and further discussions will be held at the board development session on 27th June 2024. All questions across all Committees and Sub-Committees will be reviewed and further developed.

It was suggested for Executive Management Board to review the outcome of the surveys across the board as a whole to identify if there are any trends or patterns.

The TCS Programme Scrutiny Sub-Committee **DISCUSSED** and **ENDORSED** the effectiveness

TCS Programme Scrutiny Sub-Committee Annual Report

Under Standing Order 4.3.2, each 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".* TCS Programme Scrutiny Sub-Committee annual report summarises the key areas of business activity undertaken by the TCS Programme Scrutiny Sub Committee between 1st April 2023 and 31st March 2024.

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	Prior to the annual report going to Trust Board, it will be amended to reflect to say the Trust Chair attended the majority of the meetings but is not a core member. Subject to a few minor amendments the TCS Programme Scrutiny Sub-Committee **DISCUSSED** and **ENDORSED** the Annual Report.
ASSURE	There are no items to assure Quality, Safety and Performance Committee.
INFORM	**TCS Programme Finance Report** The overall forecast outturn for the Programme is an overspend of £6.731m for the financial year 2024-2025 against a budget of £0.663m. No capital funding has been allocated yet for the projects for financial year, resulting in the aforementioned overspend. A funding request for the nVCC Project has been submitted to Welsh Government for c£2.632m and the Enabling Works Project funding request will be as part of the Enabling Works Full Business Case Addendum. The TCS Programme Scrutiny Sub-Committee **NOTED** the Finance Report.
APPENDICES	None.

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QUALITY, SAFETY AND PERFORMANCE COMMITTEE

15 STEP VISIT SCHEDULE 2024/25

DATE OF MEETING	12/09/2024
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	Kay Barrow, Corporate Governance Manager
PRESENTED BY	Non Gwilym, Interim Director of Corporate Governance
APPROVED BY	Non Gwilym, Interim Director of Corporate Governance
EXECUTIVE SUMMARY	The purpose of this report is to provide an update to the Quality, Safety and Performance Committee regarding the programme of 15 Step Visits planned or being scheduled for 2024/25.
RECOMMENDATION / ACTIONS	The Quality, Safety and Performance Committee is asked to **NOTE** the work being undertaken for the programme of 15 Step Visits planned or being scheduled for 2024/25.

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GOVERNANCE ROUTE	
List the Name(s) of Committee / Group who have previously received and considered this report:	**Date**
Executive Management Board	29/08/2024
SUMMARY AND OUTCOME OF PREVIOUS GOVERNANCE DISCUSSIONS	
The Executive Management Board NOTED the work being undertaken for the programme of 15 Step Visits planned or being scheduled for 2024/25.	

7 LEVELS OF ASSURANCE – N/A

APPENDICES	
Appendix 1	Schedule of 15 Step Visits planned or being scheduled for 2024/25.

1. SITUATION

1.1 The UK 15 Step Challenge was inspired by a parent's comment at a patient and family involvement workshop. Patients, donors, families and carers very quickly know whether they feel confident about the service they are visiting and as such, a series of 15 Step Visit Guides have been developed to allow organisations to gain insight into a patient / donor's first impressions and subsequent experience of the services they receive.

1.2 The purpose of the visit is to identify improvements that can be made to enhance the patient/ donor experience and should ideally include both staff and patient / donor representatives. Visits are undertaken via a combination of a 'walkaround observation' of the clinical environment as a whole by a small team, in addition to asking patients / donors a number of informal questions. Communication that the 15 step challenge will be taking place is issued ahead of the visit, and feedback is provided to the clinical team immediately following the walkaround. The 15 Step Visit should be repeated at regular intervals to identify and promote continuous improvement.

1.3 The Executive Management Board agreed to commence undertaking 15 step challenge visits commencing in June 2021. Initially to be conducted by the Executive Director of Nursing, Allied Health Professions & Health Science and one or two Independent Members supported by a Business Support Officer to undertake the administration and general oversight. There was an agreed brief and audit proforma approved by Executive Management Board.

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1.4 It was identified that the visits would be pilots and the documentation would require review and that the visits would in time be extended to be facilitated by all Executive/ Directors and attended by Independent Members and patient representatives.

2. BACKGROUND

2.1 In August 2022, following the initial 'pilot' period, the Executive Management Board agreed that the 15 Step Visits be extended to be facilitated by all Executive Directors and attended by all Independent Members and patient representatives.

2.2 Although visits were initially predominantly undertaken by the Executive Director of Nursing, Allied Health Professions & Health Science, one or two Independent Members and Business Support only, the visits were shadowed by an additional Executive Director, so that further visits would be undertaken on a monthly basis and facilitated independently with their Business Support and other Independent Members as appropriate.

3. ASSESSMENT / SUMMARY OF MATTERS FOR CONSIDERATION

3.1 A mechanism for central capture of all Divisional visits has been arranged by the Corporate Governance Team, allowing effective co-ordination and even distribution of visits to avoid duplication and unnecessary burden on departments and their teams. A schedule of visits was mapped out to include at least one visit per Division per month.

3.2 A 15 Step Visit update report was provided to the Quality, Safety and Performance Committee in March 2024 that provided an update on the visits undertaken since June 2021. A total of 14 visits have been undertaken since June 2021, 6 within Velindre Cancer Service and 8 within the Welsh Blood Service. However, there were no further scheduled visits planned. Following discussion at the Quality Patient Safety Committee of the emerging themes and resolutions, it was requested that a forward programme for future 15-step visits be brought to the Committee to ensure work in this area is continuing at pace.

3.3 The Quality, Safety and Performance Committee is asked to **NOTE** the work being undertaken for the programme of 15 Step Visits planned or being scheduled for 2024/25.

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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 ☒
	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). *There are no specific quality and safety implications related to the activity outlined in this report.*

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EQUALITY IMPACT ASSESSMENT *For more information:* *https://nhswales365.sharepoint.com/sites/VEL_Intranet/SitePages/E.aspx*	Not required - please outline why this is not required
	There is no direct equality impact in respect of this report.
SOCIO ECONOMIC DUTY ASSESSMENT COMPLETED: *For more information:* *https://www.gov.wales/socio-economic-duty-overview*	Not required - please outline why this is not required
	There are no socio-economic impacts linked directly to the activity outlined in this report.
TRUST WELL-BEING GOAL IMPLICATIONS / IMPACT	N/A
	There are no Trust Well-Being goal implications or impact linked directly to the activity outlined in this report.
FINANCIAL IMPLICATIONS / IMPACT	There is no direct impact on resources as a result of the activity outlined in this report.
ADDITIONAL LEGAL IMPLICATIONS / IMPACT	There are no specific legal implications related to the activity outlined in this report.

5. RISKS

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

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APPENDIX 1

DATE OF VISIT	LOCATION	ATTENDEES
May		
16/05/2024	SACT at VCC	Nicola Williams, Executive Director of Nursing, AHP & HS Vicky Morris, Independent Member
June		
13/06/2024	Welsh Blood Service - West Wales Collection Team Swansea Stadium Blood Collection Clinic	Carl James, Executive Director of Strategic Transformation, Planning & Digital Lindsay Foyster, Independent Member Jessica Corrigan, Business Support Officer
July		
18/07/2024	Welsh Blood Service Digital/iHub	Nicola Williams, Executive Director of Nursing, AHP & HS Vicky Morris, Independent Member Sarah Morley, Executive Director of OD & Workforce (shadowing) Liane Webber, Business Support Officer
August		
September		
11/09/2024 - 13:30-16:00	Blood Health Team at WBS	Sarah Morley, Executive Director of OD & Workforce Mel Findlay, Business Support Officer Stephen Harries - Independent Member
20/09/2024 - **Time TBC**	Pharmacy/Aseptic Unit	Nicola Williams, Executive Director of Nursing, AHP & HS Vicky Morris, Independent Member Liane Webber, Business Support Officer
September **Date / Time TBC**	Estates Team at WBS	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital Hilary Jones, Independent Member Jessica Corrigan Business Support Officer
October		
10/10/2024 - 13:00-17:00	Estates Team at VCC	Sarah Morley, Executive Director of OD & Workforce Mel Findlay, Business Support Officer Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital Hilary Jones - Independent Member
10/10/2024 - 10:00-12:00 **11/10/2024** - 10:00-12:00 **21/10/2024** - 15:00-17:00 **Date / Time TBC**	Ambulatory Care	Carl James, Interim Chief Executive Officer Kyle Page, Business Support Manager Independent Member TBC

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11/10/2024 – 12:00-14:00	Early Phase Unit	Jacinta Abraham, Executive Medical Director Sandra Cusack, Business Support Officer Andrew Westwell. Independent Member Sarah Townsend, Head of Research & Development and Trust Sponsor Representative
October **Date / Time TBC**	VCC - Clinical Nurse Specialist - TBC	Lauren Fear, Interim Executive Director of Strategic Transformation, Planning & Digital Lindsay Foyster, Independent Member Jessica Corrigan, Business Support Officer
November		
08/11/2024 – 10::00-12:00	Nuclear Medicine	Carl James, Interim Chief Executive Officer Kyle Page, Business Support Manager Independent Member- Andrew Westwell
22/11/2024 – 09:30-11:30	Radiology Department	Matt Bunce, Executive Director of FinanceAlison Hedges, Business Support Officer Lindsay Foyster, Independent Member
December		
16/12/2024 – 12:00-14:00	Ambulatory Care	Carl James, Interim Chief Executive Officer Kyle Page, Business Support Manager Independent Member TBC
January		
13/01/2025 from 13:00 onwards **20/01/2024 -** PM **22/01/2024** - AM **27/01/2024 -** PM **31/01/2024**	Facilities VCC	**Visit to take place in either November, January or February - Dates TBC** Matt Bunce, Executive Director of Finance Alison Hedges, Business Support Officer Lindsay Foyster, Independent Member
February		
03/02/2025 - PM **07/02/2025** **14/02/2025** **17/02/2025** - PM **25/02/2025** - PM **27/02/2025** Until 12 **28/02/2025**	Facilities VCC	**Visit to take place in either November, January or February - Dates TBC** Matt Bunce, Executive Director of Finance Alison Hedges, Business Support Officer Lindsay Foyster, Independent Member

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LLAIS

Eich llais mewn iechyd a gofal cymdeithasol | Your voice in health and social care

Llais Cardiff & Vale of Glamorgan Region

Visit Report

(Announced)

Clinical Trials Unit, Velindre Cancer Centre, Cardiff.

Friday 16th February 2024

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Accessible formats

This report is also available in Welsh.

If you would like this publication in an alternative format and/or language, please contact us.

You can download it from our website or ask for a copy by contacting our office.

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About Llais

Llais is the independent Citizen Voice Body for health and social care in Wales. We seek to hear and enable members of the public to be actively involved in decisions affecting the design, development and delivery of health and social care services for their families and local communities.

Llais seeks to work with the NHS and social care providers, reflecting what people have told us is important in relation to their health and social care services. Llais routinely shares this information with inspection and regulatory bodies to provide the crucial link between those who use these services, with those who plan and deliver health and social care services in Wales, and importantly those who inspect and regulate them.

Llais maintains a continuous dialogue with the public through a wide range of community networks, direct contact with patients, service users, and families and carers. This is mainly achieved through enquires, our Complaints Advocacy Service, visiting activities, engagement events and through public and patient surveys, with Llais being the “Citizens’ Voice for Health & Social Care” within Cardiff and the Vale of Glamorgan.

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Visit Overview

Two volunteers of Llais visited the Clinical Research Trials Unit (CRTU) at Velindre Cancer Centre, Cardiff on Friday 16th February 2024 at 10:00am.

The purpose of the announced visit was for the visiting team to hear what matters most to the public by engaging and listening to patients, carers, and others regarding their experiences of receiving care within the area being visited. Llais volunteers listen and gather the views and experiences of the patients, carers, and visitors whilst on site.

As part of the visit, the Llais visiting team were able to speak with the following staff:

- Head of Patient Engagement
- Nurse
- Lead Nurse
- Complaints and Patient Experience Manager

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Setting The Scene

Operating Information

The unit is located at the Velindre Cancer Centre (VCC) and has a dedicated entrance situated to the right of the main entrance. There is a push button on the outside. The CRTU is situated straight ahead and is signposted.

The unit operates Monday to Friday, 8:00am – 16:00pm.

The unit does not operate protected mealtimes.

The unit contains 4 beds and 6 chairs.

Patient Cohort

The unit is a mixed gender ward.

The average length of stay for patients on the unit is up to 7 hours depending on their treatment regime.

Patient Facilities

The following facilities are provided for patients during their stay.

- The Dining Room at VCC is open to the public. It provides hot and cold beverages and food.
- There is a hot drinks machine within the unit and tokens are given to patients to receive a free hot drink.
- A member of the catering team attends the unit to offer snakes and sandwiches.
- Patients can be accompanied if required.
- There are dedicated toilet facilities on the unit.

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There are no formal activities for patients within the unit.

Patients will bring their own iPad, kindles etc.

Information on expected waits and appointment times is available via leaflets and the VCC webpages. This provides advice on what things a patient may wish to bring with them which includes devices, reading materials etc.

There is the opportunity for patients to socialise with others, away from their beds whilst on this unit. The beds are spaced apart to meet COVID regulations, but the bays are open spaces which allow privacy and the opportunity for socialisation if the patient wishes to interact with others.

VCC are commencing the reintegration of volunteers with a social and recruitment meeting planned for November 2023. Previously there were no dedicated volunteers in this area.

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Patient Engagement

The Llais visiting team spoke with several patients, all of whom were willing to speak with the team about their experiences.

Patient one said that “the Nurses are brilliant, spot on” and that the unit was “so nice and happy "and it cheered them up. This patient had travelled from West Wales, which they found difficult when having to return for appointments for blood tests etc. on different days from their Chemotherapy days, and felt that it would be better if the unit could combine appointments to cut down on expensive travel. They added “it’s very expensive but what can I do, it’s my life.”

The second patient spoken with was very complimentary about the unit saying that it is “a lovely place, so bright and cheerful.” They commented that the “staff are so lovely; they explain everything so well and answer all my question, even when I ask again.” The patient stated that parking on site has been a problem.

The third patient praised the staff describing them as “very good” and said that they always felt happy, adding that it was “mad when they are giving me painful treatments”. He had been expecting to have blood taken but staff were unaware of this, they did however organise for this to take place.

Patient 4 and their spouse described the service as “excellent”. The patient was diagnosed in July 2023 and was admitted to the cancer centre four weeks later. Following treatments and surgery their consultant suggested a trial which has now resulted in the patient having cancer free blood cells. High praise for the staff saying that “everyone’s been amazing”. There was a delay with administering an injection that staff were unaware of, but this was dealt with by one of the Nurses

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who apologised and carried out the task. The patient commented that the staff “do their best”.

The last patient the team spoke with was also complimentary about the staff saying that the “Nurses are so kind” and that the unit was a “lovely place”. This patient had used the available transport for previous visits and had found this tiring and uncomfortable. They commented that they “felt rough” and as the bus had to carry out a number of stops so it took a long time. They praised the staff at the unit saying that “they've been so good to me”. The patient expressed concerns regarding a lack of support on return home, telling the Llais visiting team “I’m worried about who is keeping an eye on me once finished here and I’m home alone?”.

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Observations

The entrance to the unit was noted to be bright and airy with pleasant garden areas to the front.

The main door to the unit is locked and accessible by a call bell; volunteers noted that this is situated on the wall approximately 4ft from the ground with a handmade A4 sign pointing to the button. As the door and surrounding area has a lot of posters affixed to it, the button sign is not easy to detect.

Decoration of the unit was thought to be reasonable overall, being clean and tidy and although a little worn in places, it felt pleasant, safe and cheerful. Four chairs and a coffee table were present in an area near the entrance door, but volunteers noted these to be of poor quality and not suitable for long waits.

The treatment room had six bays each with a chair. One of the bays had two maintenance personnel working on the ceiling while a patient was receiving treatment in the adjacent bay.

The self-service tea and coffee machines were not working. Staff made refreshments in the unit's kitchen.

Volunteers noted that the water dispenser 'push' button was difficult to use and needed a hard push.

It was observed that the signs for the toilets were being repaired therefore leaving no signage.

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Staff Feedback

The volunteering team were warmly welcomed with all staff greeting them and happy to engage. A Nurse gave the team a tour of the unit.

The team observed that the lead Nurse in the team had a motivational effect on the staff and patients.

There were positive and caring interactions between staff and patients. It was observed that the Nursing team appeared professional and dedicated, carrying out their duties with genuine care and respect for the patients and each other. The volunteers reported that it was an “absolute joy” to witness the relationships between staff, patients and their family members.

Staff explained that the team required another Health Care Assistant and that if two members of staff are absent, the service cannot function and has to close. Demand for the service is present but not the capacity; more staff and equipment are needed.

A member of the Patient Experience Service spoke with our volunteers and commented that the staff were “amazing”. They highlighted the need for a larger space as the services have outgrown the current building. Waiting times are dependent on referrals. They added that emergency patients arrive via the A&E department which is not always ideal but there are hopes for an Acute Oncology Service. A 24-hour helpline is also in existence.

Our volunteering team also spoke with a member of the Patient Engagement Team who stated that the Covid Pandemic had impacted on demand across the Velindre Cancer Centre, with patients' symptoms becoming more severe.

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Staff explained how that the unit is funded by research and cancer charities, Welsh Government grants and local/national funding. This is not secure funding, but staff did not express concern at this time, however, with growing demand and success rates improving, secure funding is required.

Staff also spoke of the validity of volunteers support to the patients at the unit. This was stopped during the pandemic and is in the process of recommencing. The staff feel that volunteers play a key role when supporting patients.

With regards to access to the clinical trials, the staff member commented that more awareness is required nationally as only 20% of patients are currently referred to the service, they added that this is discussion with Health Wales. They also felt that patients may not be fully aware of the free Welsh Ambulance Service Trust transport.

Staff are aware of the travel issues that impact some patients and had listened to their comments. WAST staff were praised as “good” and “helpful” but waiting to be collected, and numerous drop-offs when patients feel poorly is a struggle for them.

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Summary of Visit

Positive Findings

1. Volunteers were satisfied that the overall look of the unit was pleasant in appearance.

2. Patient satisfaction with staff and the service was extremely high.

3. Volunteers praised the welcoming reception from staff.

4. Staff offered hot beverages to patients despite coffee/tea machine being out of order.

Negative Findings

1. Maintenance personnel carrying out a task while a patient was receiving treatment in the next bay.

2. Visiting the unit for tests is costly and time consuming for patients.

3. Waiting room chairs are uncomfortable.

4. Water dispenser is difficult to operate.

5. Tea/coffee machine broken requiring staff to provide beverages from kitchen, taking them away from clinical duties.

6. External sign for the access button is not easily recognisable and low to ground level.

7. Limited parking availability.

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8. WAST transport was said to be unsuitable for patients attending from out of area, following treatment.

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Feedback for Improvement and Good Practice

1. Llais requests that the Velindre Health Trust share the extremely complimentary patient feedback received by volunteers, to unit staff.

2. Llais request that the Trust pass on our volunteer thanks to unit staff for their warm welcome and informative visit.

3. The Trust should endeavour to reduce the number of individual appointments each patient is required to attend, by combining required tests etc. where clinically appropriate.

4. The Trust should ensure that any maintenance work carried out does not negatively impact on patients receiving treatment.

5. The Trust should ensure that the water dispenser provided is fully functional and easily operated by patients undergoing treatment.

6. The Trust should endeavour to repair or replace the hot drinks machine in order to free staff from the task of making drinks for patients.

7. The Trust should ensure the call bell sign on the external door is clearly visible and easily accessible.

8. The Trust should review waiting room seating to ensure it is suitable and comfortable for patients receiving treatment.

9. Llais request that the Trust liaise with WAST to consider improving the current journey lengths for patients attending from out of area.

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10. Llais request that the Trust review parking provision for patients at the Clinical Trials Unit.

11. Llais would be pleased to offer our assistance in sharing any information the Trust would like us to share on the trials and free transport throughout social media channels, newsletter and volunteer networks.

The visiting team would like to thank the patients, family members and carers who gave their time to speak with them during the visit. Thank you also to the staff for their time and assistance on an interesting and informative visit.

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